Assembling a Health [y] Subject

by

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Abstract

This thesis utilises governmentality studies in order to offer an analysis of the governmental hopes and enacted technical practices of Victorian School Based Health Education. The thesis illustrates the ways in which the subject area of Health Education is assembled both officially and within the lived sites of schools and classrooms in the hope of transforming the conduct of youthful subjects. A key concern throughout the thesis is the political and moral work that gets done in the name of Health Education. The study is based on the analysis of a variety of official curriculum documents, teacher interviews, program documentation and classroom observations. The analytical concept of ‘governmental assemblages’ is deployed as a theoretical lens to understand how Health Education operates as an ‘agent’ of government. Throughout the thesis I argue that School Based Health Education is a governmental assemblage in and of itself with complex linkages both within, and to other assemblages. As a conceptual lens, it offers new ways of thinking about the ways in which contemporary approaches to government are assembled and enacted. My analysis reveals that the assemblage is made up of multiple rationalities, techniques and conceptions of the subject that have diverse historical trajectories and internal and external governmental logics. Both individualism and risk emerge as the dominant discourses that circulate throughout and thus permeate curricula and pedagogical assemblages.

The dominance of individualism and risk are not new phenomena in the field of Health Education. However the thesis reveals how individualism and risk are mobilised in actual settlements of curricula and pedagogy. Throughout the thesis I argue that Health Education practices individualise, responsibilise and moralise youthful health related behaviours and status. Health Education, here though is only enacting its governmental hopes in ways that are consistent with contemporary neo-liberal mentalities of rule. However, I argue that the contours of the assemblage are not as smooth and predictable, as one might initially think. Close analysis of curricula and classrooms reveals that whilst expert risk discourses are integral in the assemblage, other hybrid and ‘affective’ risk
discourses emerge within classrooms and their appearance has the potential to corrupt the assemblage. However the dominance of risk and individualism throughout the assemblage effectively means that such ruptures are quickly smoothed over as they are redeployed to do governmental work. The thesis contributes to present understandings of the governmental hopes of School Based Health Education, as well as offering new insights as to how such hopes are translated and enacted within lived settings. Furthermore, the empirical work in the thesis illustrates some of the ways in which various curricula and classroom assemblages are mobilised through multiple expert and non-expert discourses. In concluding I suggest that Health Education’s position within the broader contemporary neo-liberal governmental assemblages limits possibilities for a critical and counter Health Education. Nonetheless I do make some tentative suggestions for a Health Education that might embrace different learnings about health, outside of (or at least alongside) problematic risky health imperatives.
Introduction

Schooling and politics are inseparable. Schools are shaped by the wider economic, political and social context which is reflected in education policy and legislation that delineates what education is and constrains what schooling can be. In turn schools become sites where these wider economic, political and social issues are played out through organizational structures and systems, the curriculum and pedagogy and the subjectivities available to teachers and students; where educators and students are managed, monitored, compared and held accountable; and where normative understandings of schooling are sedimented. And schools are also sites where abiding inequalities are made and remade, even as these become the focus of policy interventions. Schooling then, is shaped and constrained by the prevailing politics of the moment; it is fundamentally political even if the politics of education are often opaque or taken as the normal state of affairs (Youdell, 2011, p. 7).

Questions of politics are at the heart of this thesis. Like Youdell (2011) I have long held an interest in questions of politics in education. I have been particularly interested in the subject area of Health Education, its political alignments, possibilities and implications. If you were to replace schooling in the above quote with Health Education, the quote holds true: Health education and politics are inseparable. The various political entanglements have significant consequences for what Health Education generally can be, and conversely what it cannot be. Within the contemporary moment Health Education is about to get ‘new clothes’ as Australia moves to a National Curriculum. And although we do not know yet what the new Health Education curriculum will look like, we can be certain that like every other curriculum iteration it will be saturated through with political imperatives directed at cultivating healthy citizens. On the surface it is an admirable aspiration, and as a result it can be difficult to critique. Over the years I have had many people ask, in my various critiques of health education, whether I am suggesting that we should let kids be fat and get diabetes, become addicted to heroin, get pregnant and/or die. And my response to that is ‘of course not’. But as Foucault cautions:
...not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous then we always have something to do. So my position leads not to apathy but to hyper – and pessimistic- activism (Foucault, 1984a, p. 343).

In essence what I am suggesting is that we need to be mindful about the work that we do in the name of Health Education. In doing this I follow Harwood and Rasmussen’s (2004) lead in considering an approach to studying schooling, and specifically Health Education, with an ‘ethics of discomfort’. Drawing upon Foucault’s ‘Ethics of Discomfort’, Harwood and Rasmussen suggest that such an approach can unsettle certainty and its limits. Furthermore, they suggest that, ‘in studying schools with an ethics of discomfort one can become vigilant for those shadows that can cast an illusion of new ideas upon the ground of the familiar’ (p. 307). The purpose of such work, and of analysing certainties ‘is not to become more certain, nor to bring about reversal, but to corrupt the pleasantry of certitude’ (p. 308). It is Health Education’s pleasant certitude that this study is interested in corrupting. In doing this I bring an ethics of discomfort to Health Education and its various assumptions about young people’s health, their desires, their capacities, their abilities to eschew structural constraints and take control of their health and be responsible for the health of others.

The beginnings of a healthy discomfort

My discomfort around practices of health education started some time ago, and certainly pre-dates my academic life. As a child, I was force fed milk in the name of good health (and as a consequence I would spend the next half an hour vomiting it back up again, in the name of good health). In grade three I had the privilege of lining up every Monday morning to have a hygiene inspection. During this time our teacher would check that we had a hanky, had clean shoes, that our hair was tidy and that our nails were trimmed and neat. I, being a nail biter, repeatedly failed this test and, as a result, was frequently subjected to the cane. I am certain the teacher never made the connection that the threat of the cane made me chew my nails on the way to school every Monday morning. We
also had half yearly hair checks. Those children with lice were summoned to the office over the PA during the daily home time announcements. I’ll never forget my name being called out. As I walked past my teacher on the way to the office, he said: ‘I thought more of you’. I wasn’t quite sure what to do with that comment, and I know that I cried all the way home.

Health faded into the background in High School and I was probably glad for that given my primary school experiences. From memory we did a little bit of nutrition in Home Economics and we learnt about putting a condom on a banana in Physical Education. It was after all the early 1980s and AIDS had just emerged as a public health crisis and schools of course had been called on to do something. Aside from that though, there were no specific classes called Health Education, and you certainly did not have the option to study it in Year 12.

As a sideline, and a significant one at that, I was being groomed to be a PE teacher. From where I came from, it was that or working at the local factory. I had always imagined going to University, and I didn’t really know what else to do (though I did know I did not want to work at the local factory). No one in my family, immediate or extended had ever gone to University, and nor had any family friends. It was all a mystery. The teachers at my school all encouraged me to study PE. Their encouragement was based on the fact that I was sporty. I represented the school, the region and the State in a range of sports and thus I was considered to be PE teacher material. I was also the top of my PE class. So I completed Year 12. I studied Politics, Legal Studies, English and Physical Education. When I passed and got accepted to Ballarat University College to ‘do’ Physical Education I was elated.

I turned up to College and was told that I had to do Health Education as a second method. I was unsure as to why, and was subsequently told that the subjects I had selected in Year 12 did not permit me to study any of the other methods: Maths, Science or English. And so my fate was sealed and a Health Educator I would be. In our first Health Education lecture we were told that we were special. We were the first cohort ever in Victoria to have the opportunity to study health as a second
method. It was 1989, and Health Education was clearly on the move. And it was on the move in more ways than one. *The Personal Development Framework* (PDF) had just been released, and this became my Health Education bible. I’ll return to discuss the heady days of the PDF shortly. The lecture continued and we were also told that the two subject areas we were studying were like two peas in a pod and thus a match made in heaven. I was not comfortable with that connection then, and am even less so now. In addition we were also told that we had to have a key interest in being healthy. We had to be interested in being personally healthy as it was imperative if we were to become health educators. My levels of discomfort were increasing. The last part of the lecture sealed it for me though. We were all told that as University students, who would of course sleep around, that we should, before we have sex, use a torch to inspect our partners’ genitals to see whether they had a Sexually Transmitted Infection and that we had to be sure that we used condoms. Somebody called out and asked what if you were two women, how does that work? The lecturer replied ‘oh that’s um, well err, well they don’t have sex really like we do so they um probably well they definitely don’t need a condom’. It was the first of many uncomfortable moments in my health education teacher education. And there have been many more since then.

Thankfully though, after a semester of what I remember of as ‘health hell’ we were introduced to a unit called ‘Perspectives of Health’. The unit was designed and taught by Dr Derek Colquhoun. Unbeknownst to us all, Derek was one of the key players in the Australian ‘branch’ of the critical health education movement. The unit introduced us to the concepts of healthism, politics, inequalities in health, the scourge of neo-liberalism, the problematic nature of health education and finally critical theory and pedagogy. I was in ‘health heaven’ because finally we were being educated about health. It was at this time too that Victoria released its new curriculum framework. The subject area of health education was located within the Personal Development Framework. Within the new framework Health Education was about:
...foster [ing] the capacity for young people to adopt a socially critical perspective about health issues... students should also be given the opportunity to evaluate social conditions which might lead to health problems in our community. They may develop strategies to deal with these from a personal perspective, and where practicable, such studies should lead to action projects in the community (Ministry of Education, 1989, p. 79).

They were ‘heady times’ indeed for those of us who were interested in questions of politics and social justice in education. But the primacy afforded ‘socially critical’ in official curriculum versions of health education failed to endure. Subsequent curriculum changes reduced its presence and reconfigured it dramatically. But even though critical health education lost its momentum, I carried on regardless. My teaching and other work were heavily imbued by critical approaches. I went on to complete a Masters that involved the exploration of the use of critical pedagogy in a health education classroom. But towards the end of the Masters I was left feeling both disillusioned and disappointed with critical pedagogy. Nothing much had changed, and I was left wondering, just like Ellsworth (1992), why critical pedagogy didn’t feel so empowering. Critical theory wasn’t working for me, and nor for others it seemed (see Ellsworth, 1992; Gore, 1992; Kenway & Modra, 2002). I had become increasing uncomfortable with critical theory and critical pedagogy. I discuss the shifting sands of critical health education in more detail in Chapter One as I trace the antecedents to my research focus in this thesis.

**Back to the future**

I was sitting in a meeting recently with a group of ‘critical scholars’ discussing the future of health education, amongst other things. Somebody posed the question ‘Why can’t we have a critical health education?’ The question emerges out of a concern about the current state of Health Education. The very fact that it is still being asked in January 2012 says much about the contemporary political terrain of education and the potency, and entrenchment, of neo-liberal agendas. Neo-liberalism has shaped the possibilities for how people understand what health
education is, what it should do, and how it should do it. This despite years of critical scholarship that has reminded us continually that individualistic approaches to health education are ineffective and indeed dangerous. And regardless of its pitfalls, I too feel a nostalgic pull to a return to critical times for health education (and education more broadly) though now necessarily drawing on a different repertoire of theoretical and practical tactics (see Youdell, 2011). The nostalgic pull to a return to a critical health education provided me with the initial momentum for this study. In considering why critical Health Education faded into relative insignificance in official versions of curricula my attention was drawn to Foucault and governmentality. It seemed that most critical scholars had turned to Foucault, and with good reason. On reading Foucault some of the concerns that I had long had about Health Education and politics I felt finally were being addressed. This is because Foucaultian analysis enables an analytical move that goes beyond the simple ‘why’ to address the ‘how’ (Miller & Rose, 2008). So rather than simply focussing on the ‘why’ of Health Education and it’s problematic practices, my gaze slowly shifted to consider ‘the encounters, the plays of force, the obstructions, the ambitions and strategies, the devices, and the multiple surfaces on which they [Health Education] emerge[s]’ (Miller & Rose, 2008, p. 6).

Eventually the enduring ‘ethics of discomfort’ I felt about Health Education, its politics and practices, coupled by my new found interest in Foucault lead me to the field of governmentality studies. Governmentality studies, is a diverse field of studies that collectively brings together scholarship that brings Foucault’s thinking around governmentality into conversation with questions of government in the twentieth, and more recently the twenty first century. According to Dean (2010, p. 18) government involves ‘any attempt to shape with some degree of deliberation aspects of our behaviour according to particular sets of norms and for a variety of ends’. He goes on to suggest that:

Government is any more or less calculated and rational activity, undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledges, that seeks to shape
conduct by working through our desires, aspirations, interests and beliefs, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes (2010, p. 18).

This thesis then, is a study of the politics of Health Education, or said otherwise, government and its effects on Health Education. Utilising Foucaultian, and post-Foucaultian theories of governmentality, the thesis explores the role of Health Education, as an element within the broader governmentality assemblage, and how it goes about enacting its governmental imperatives. Following Dean (1995) I am interested in:

...analyse [ing] those [health education] practices that try to shape, sculpt, mobilize and work through the choices, desires and aspirations, needs, wants and lifestyles of individuals and groups. This is a perspective, then, that seeks to connect questions of government, politics, and administration to the space of bodies, lives, selves and persons (p. 20).

I do this by considering both discursive governmentality and practical governmentality in an attempt to consider the ‘contact points’ of governmentality otherwise referred to as where power connects with technologies of the self (Burchell, 1996). Health education has always had as its raison d’être the desire to change people’s behaviour. Hence it has always been about governing young people. How it imagines and enacts such a project though has altered significantly over time. The thesis attempts to examine how the contemporary project of Health Education is currently configured. In particular it seeks to identify Health Education’s political rationalities, its techniques and its subjects. Central to my analysis is the concept of governmental assemblages. As a concept it permits a take on government that recognises that in its contemporary form it is ‘assembled from a complex and hybrid range of technologies [and] … enacted via a whole range of organisations, a whole variety of authorities and lash ups between diverse and competing bodies of expertise’ (Rose, 2000, p. 323). Health education is but one of the myriad of sites that seeks to govern conduct. But more than this, I argue that health education can be understood to be a governmental assemblage in its own right. Analytically the concept of governmental assemblages opens up some
theoretical space to consider how politics, education, health and policy intersect with pedagogy, classrooms and curriculum. As a concept it permits an interrogation of the diverse linkages that are forged across governmental sites, and how those linkages form and are enacted within curricula and pedagogy. It also enables us to conceptually tease out and pull apart the health education assemblage, to consider the various assemblages that make it up. Teasing apart the various assemblages permits us to consider the heterogeneous elements and discourses that converge or clash within. The title of the thesis then is a play on assemblages and health education’s role within governmental assemblages. As a school subject area health education is assembled together by a multitude of rationalities, techniques and knowledges in an attempt to produce a healthy subject. This work is inextricably linked to politics. To consider how health education is indeed assembled together, and how it attempts to assemble healthy subjects I formulated three central research questions. They are:

1. What elements make up the assemblage of school based health education?
2. What are school based health education’s rationalities, techniques and subjects and how do they come together in settlements of curriculum and pedagogy?
3. What are the implications for the subject of health education itself, and in turn its subjects?

The nature of my questions is both theoretical and practical. And both perspectives, I argue are necessary if we are to know anything about how the hopes of government are translated into practice in classrooms. To date there have been few critical studies that have focussed on School Based Health Education as a separate subject area in and of itself (see for exceptions Beckett, 1990; Burrows & Wright, 2007; Sinkinson, 2011; Vander Schee, 2008a, 2008b, 2009a, 2009b). Furthermore there are to my knowledge no studies that have drawn on empirical data to consider how Health Education curriculum imperatives are translated into health education classroom pedagogy, via the use of empirical data. Rather much of the scholarship that relates to health education emanates from scholars who are
usually located in the field of Physical Education (see Evans, Davies & Wright, 2004; Gard, 2008; Lupton, 1999a; Tinning, 1990; Tinning & Glasby, 2002). This body of scholarship has been generative, though its focus has largely been on health related fitness or the effects of obesity on children and young people. Health Education is much more than that. It includes mental health, drug education, sexuality education, road safety, personal development, nutrition, social and emotional health to name but a few. It thus warrants particular attention. This study then sets out to develop a more thorough understanding of the politics of health education.

**Outline of the thesis**

Chapter One locates my research questions about the governmental project of health education within broader historical and sociological scholarly debates. The chapter serves as what might be understood to be a conventional literature review. The purpose of the chapter is to provide an overview of socio-cultural approaches to thinking about the politics of health education over the past 30 years. In many ways the discussion of the literature in the chapter traces my journey through the assemblage of both critical and Foucauldian scholarship as I have sought to ease my discomfort around questions of power and politics in health education. The chapter is my attempt at identifying the various theoretical ‘conditions of possibility’ that have both enabled, and limited, emergent questions and subsequent analyses related to the politics of health education. In the chapter I review two very influential ways of conceptualizing and interrogating the political project of health education. The first derives from critical theory and critical traditions within education and the sociology of curriculum. And the second derives from Foucault and post Foucauldian studies.

The critical theory literature as I have discussed in the first section to the introduction was formative in shaping my thinking around politics and health education, and also my teaching. In the chapter I focus my discussion on what I refer to as the emergence of critical health education in the 1980s. And although
not necessarily an official term, it serves to capture the effects of the ‘critical turn’ in health education. Within the section I consider some of the broader conditions impacting on health and education at the time, specifically the rise of neo-liberalism and risk. The ramifications of the rise of neo-liberalism and risk within health education created the conditions for the emergence of a critical health education moment. In the chapter I consider the range of critical education and health education scholarship that emerged in response to the shifting neo-liberal political landscape. I suggest that the impact of critical health education reverberated through official curricula assemblages. But, as the chapter reveals, the critical moment did not last, as critiques began to emerge that suggested that the theoretical assumptions and in turn applications were fundamentally flawed.

In discussing some of the critiques and limitations of critical theory I suggest that many turned to Foucault. This shift introduces the second section of the chapter. In this section I begin by charting the turn to Foucault, and suggest some of the reasons as to why scholars interested in questions of power, politics and education looked to him. Here I highlight that Foucault’s ideas challenged many of the assumptions underpinning critical approaches to schooling, and in turn how he offered some important new ways of examining power and knowledge in health education. After a consideration of the uptake of Foucault in Education I consider the early adopters of Foucault in the Health and Physical Education field. This body of scholarship was significant in shaping my early thinking and enabled me to shift my critical thinking and formulate different kinds of questions about the politics of Health Education.

Finally the chapter considers some of the more recent critiques that have emerged that draw on Foucaultian insights. Overall the chapter reveals that over time different theoretical traditions have variously shaped different analyses of the politics of Health Education. I suggest, like others, that Foucault has much to offer those of us who are interested in the political imperatives and practices of Health Education. In addition to this though the review reveals that Health Education has
received scant attention from scholars and thus the chapter establishes a need for a Foucauldian inspired study.

Chapter Two provides an overview of the methodological orientation of the thesis and overviews the various methods that provide the empirical data for the thesis. The chapter builds on the conceptual terrain outlined in Chapter One to elaborate specifically on Foucault’s conceptual work on governmentality. Here I suggest that for scholars who are interested in Health Education and its political effects, Foucauldian and post Foucauldian studies of governmentality are generative. In reviewing the collective body of work that can be termed ‘governmentality studies’ I provide an overview of the theoretical and methodological frame for this thesis. Although the legacy of governmentality is layered throughout the first chapters of the thesis, it is in this chapter that I embark on gathering the conceptual and analytical concepts from governmentality studies, both historical and contemporary, to refine my own analytics.

The chapter is divided into two sections. The first section of the chapter takes as a starting point, Foucault’s scattered comments on governmentality and interweaves them with some of his insights related to health and the population. I then extend on this discussion to review the broader field of governmentality studies and introduce the concept of governmental assemblages. I argue that governmental assemblages is a productive concept by which to understand the complexities of the contemporary governmental project. As a concept it has shaped the conceptual work of several post Foucauldian governmentality scholars. Drawing on these insights I provide an overview of my approach to an analytics of governmental assemblages that in turn informs the kinds of questions that underpin the empirical work of the thesis. In the second section I overview the research methods and processes that enabled me to seek out possible answers to the various research questions posed. In this section I provide an explanation of my approach to interrogating the discursive and practical aspects of the elements of health education via the use of ethnographic methods.
Chapter Three is the first of three empirical data chapters. In this chapter I interrogate the official Health Education curriculum in Victoria, Australia. As a key element in the governmental assemblage, I suggest that conceptualising official curricula as an assemblage in and of itself is necessary if we are to understand the various hopes of health education, and the rationalities, techniques and subjects that are assembled together in the hope of shaping the health[yl] conduct of young people. Throughout the chapter I argue that it is difficult to ‘pin’ down curriculum, as it is often in flux. And if the actual curriculum is not in flux, the broader policy context is, as governments grapple to develop various curricula solutions to complex social and economic problems. Given the myriad of linkages that Health Education curriculum has to broader policy assemblages I necessarily consider the broader policy terrain to examine how shifts in government policy provide the external logistics for Health Education. In a sense, broader governmental agendas and policy assemblages provide the external logics for Health Education. But Health Education has its own internal logistics too and many of these have been accumulated over time. By this I mean that many core rationalities, techniques and notions of subjectivity that make up the subject area have long circulated within the Health Education assemblage. I therefore explore this historicity by reviewing Victorian State based Health Education curriculum documents from the past thirty years. In this chapter I begin my discussion with a review of the first ‘official’ formal attempt at establishing Health Education in Victoria. From there I consider subsequent ‘new’ versions of curriculum through to the present day Victorian Essential Learning Standards. My general discussion explores the various historical trajectories of rationalities, techniques and conceptions of the subject as they appear in the various curricula assemblages.

One of the major analytic lines that evolves throughout the chapter is that neoliberalism has characterised approaches to Health Education for the past thirty years. And thus Health Education has largely always been about governing individuals at a distance via enticing subjects to become healthy, deploying age old rationalities and techniques of knowledges and skills. These knowledges have changed over time, and so too have some of the various skill repertoires. But
nevertheless I argue that the formula has remained strikingly similar across the thirty years. There have been ruptures in the overall assemblage though. Critical Health Education, as it manifested within the Personal Development Framework, is an example of such a rupture. And new themes have been introduced, whilst others have shifted in priority. Regardless of such ruptures and shifts neoliberalism dominates the official curricula assemblage of health education, past and present. This dramatically influences the hopes for, and the rationalities, techniques and conceptions of the subject.

In attempting to understand school based health education as a governmental assemblage, it is essential to look beyond the ‘official curriculum’ to consider other elements that make up the assemblage. In Chapter Three I argue that the official curriculum is a significant element in the overall assemblage as it, amongst other things, enshrines the governmental hopes of health education, as well as providing a schema of techniques that ensure that governmental hopes are supposedly met. However the official curriculum, on its own is merely an inert policy document that remains static until it is put into practice. Many of the governmental analyses to date though, have focused on this particular element of governmentality, or what can be referred to as ‘discursive governmentality’. Chapter Four and Chapter Five of the thesis examine how health education curriculum discourse is mobilised within school contexts. In doing this, my analytical gaze necessarily turns to what Foucault (1994) refers to as the extremities of power or its ultimate destination. In the case of Health Education, the final destination is the school, the classroom and its students. Given that schools and classrooms are located ‘at a distance’ from curriculum writers and government, the chapters examine the journey that official curriculum takes as it makes its way into schools, and in turn into classrooms. Primarily the chapters are concerned with how governmental hopes are translated in schools. And more significantly what happens to official hopes, rationalities, techniques and conceptions of the subject as they are (re) assembled into school programs, and then (re) assembled again in pedagogy. Luke (2010, pp. 1-2) tells us that the translating of official curriculum is by no means a linear process in that it is:
...remade through the lenses and practices of teachers’ substantive world, field and disciplinary knowledge, then brought to life in classrooms in relation to teachers’ pedagogical content knowledge and students’ cultural scripts and background schemata, which include a host of other available messages of media, institutions and community cultures. The enacted curriculum will be influenced by adjacent policies and practices on assessment, evaluation and credentialing (which define ‘what will count’) - and on school funding, governance and leadership; teacher training and professionalism, and so forth.

Given this, it could be possible that the governmental hopes of Health Education may very well be displaced as they are remade at the level of the school, and again in classrooms. This chapter and the next, reveal that overall the governmental hopes of health education stay relatively intact. One of the major reasons for this I argue is that the various governmental translation mechanisms that operate throughout the assemblage in support of curriculum translation at the school level are saturated through with neo-liberalism.

Chapter Four takes as its focus the governmental translation mechanisms of school based Health Education. Within the translation process teachers play a central role as assembling agents, in that they interpret the curriculum to assemble programs that match their school structure and needs and their beliefs about what should be taught and how. Throughout the chapter I draw on teacher interviews to explore how teachers go about their assembly work. In their work they draw on official curriculum, a myriad of resources, textbooks and popular culture to develop their programs. Upon review though, each of the sources that teachers consult are saturated through with neo-liberalism, its rationalities and associated practices. In establishing this I argue that the translation mechanisms of Health Education seemingly all conspire to ensure that the official hopes of Health Education find their way into schools in the appropriate forms.

The chapter also considers teachers as a translation mechanism of governmentality. In many ways teachers are the glue that holds the assemblage together. The decisions they make directly shape their programs and convert official assemblages into school based ones. One of the arguments I develop in the
chapter is that teacher beliefs are central to why the Health Education assemblage stays relatively intact. They are the necessary voluntary accomplices of governmentality in that they passionately subscribe to the official hopes of Health Education. And after considering the various translation mechanisms at play within the Health Education assemblage the chapter turns to describe the various programs that teachers had developed in each of the three schools in the study. The similarities in program focus and content speak to the veracity of the multiple translation mechanisms that support the implementation of official Health Education curriculum hopes.

In Chapter Five, I continue my interest in exploring and analysing the enacted curriculum by following curriculum as it is put into motion within pedagogical moments. Drawing on classroom observations the chapter explores the extremities of governmentality as governmental imperatives are enacted at the micro level. As a focus area of study, such perspectives have rarely been conceptualised in the curriculum studies area (Ball, 1994; Luke, 2010) and within the field of Health Education the scene appears to be even bleaker (Cliff & Wright, 2010; Lupton, 1999a; Vander Schee, 2009a). Given this, it was important that I consider classrooms in an attempt to attend to this deficit. To do this analytical work I argue that understanding pedagogy as an assemblage is a useful conceptual device in order to be able to tease apart the various entanglements of rationalities and techniques that make it up. In essence the chapter is interested in examining the ‘contact point’ of governmentality, where technologies of power and technologies of the self interact (Burchell, 1996). In turning my gaze towards the contact points, I am able to explore the various ways by which young people are enlisted into processes of governmental self-formation (Dean, 1995). Throughout the chapter I argue that risk is central to this work. And although risk permeates broader governmental assemblages, within classrooms I witnessed an amplification of risk.

Throughout the chapter I chart the ways in which risk was deployed in different pedagogical moments in the delivery of two units of work that were offered in one
Secondary School in Melbourne, Victoria. The units were premised on the ‘fact’ that young people were at risk, particularly in Year Nine and Year Ten (when the units were offered). The units then were developed in response to this particular fact, and were directed at helping students manage their risks. Given the hopes attached to both units, I suggest that much of the classroom pedagogy is firstly directed towards ensuring that the students understand the risks that face them and secondly, classroom pedagogy then works to help students develop a host of skills and strategies so that they can manage their risks. The formula is not a new one, and it mirrors the formula that has characterised Health Education, for at least thirty years. Although the formula implies a kind of linearity, the classroom assemblages were anything but. Classroom observations revealed that practical governmentality was indeed messier than discursive governmentality might have us believe. So although curricula, in the form of official documents and school programs were ‘well structured’ organised and planned, classrooms did not necessarily always reflect this. Throughout my discussion of pedagogical assemblages I examine and interrogate the dominance of risk knowledges, and how they shape the possibilities within classrooms. In doing this I argue that expert risk knowledges are central to the Health Education pedagogical assemblage in that they work in tandem with pedagogical techniques to interpellate students into an at risk subject position. This is the usual way in which we understand governmentality to work. However the chapter reveals that there are other risk knowledges at play within the pedagogical assemblages, which appeared to be just as potent in interpolating students into being at risk. I refer to these ‘new’ knowledges as hybrid risk and affective risk knowledges. Although they aren’t necessarily new as they have been in circulation for some time, their use and effects in classrooms has not been previously documented within governmental analyses.

My analysis reveals that expertise is not always central to pedagogy as it is enacted. In fact at times expertise was hidden far from view as students re-told various myths associated with drug use that were factually impossible. Yet the risky stories told by students appeared to strike a ‘governmental’ chord with
teachers, who did not let expertise get in the way of a risky story. Thus I suggest that teachers seize upon student stories and contributions to reinforce risk whether they are versions of expert, hybrid or affective risk. Within pedagogical assemblages multiple rationalities, knowledges and techniques circulate to constitute the at risk subject. And even though classrooms become messy, risk still manages to shine on through, expert or not. It is at this point of contact that the political work of Health Education is bought to life. In the classroom moment, I argue that young people learn that they are responsible for their own health, and the health of others. They learn that they lead risky lives. They learn that they can control their health and others’ health if they take certain precautions and adopt certain practices. They also, through their classroom experiences, learn that being unhealthy is undesirable, that unhealthy people are lazy, ugly and disgusting and solely responsible for their poor health status.

However, the assemblage does not always hold true to its governmental hope of producing and mobilizing notions of the subject that are agentic. In one example I argue that where gender discourses are recruited into the assemblage in attempts to deliver safe sex imperatives, the assemblage fractures. The constellation of discourses that are assembled together in certain pedagogical moments place girls in a seemingly impossible position. Neo-liberal health imperatives demand that individuals be active in their health seeking and protecting behaviours and thus exercise choice. But within the pedagogical moments, sex and drug use were never constructed as something that girls would choose freely (unless they were mad and/or bad?). Rather it was something that was forced upon them by males. Thus I suggest that the presence of traditional gendered discourses that have a hard time reconciling desire, agency and risk create fracture lines, and impossible subject positions within the assemblage. The fracture lines along with the presence of non expert discourses reveals a very different governmental assemblage than the version that is conceived of in official versions of Health Education.
Overall in seeking to consider both the discursive and practical forms of
governmentality my study reveals how School Based Health Education in
Victoria, Australia both imagines and enacts its governmental hopes. The thesis
reveals that neo-liberalism imbues the various assemblages that link to Health
Education, and thus Health Education itself. As a subject area Health Education
has always been involved in political work. And although it has changed shape
and form over time, it still continues to do political work. The thesis advances the
argument that previous ways of understanding the political project of Health
Education have been inadequate¹, and that by drawing on an analytic frame of
governmental assemblages, one is better positioned to understand the
complexities, and constraints, of the Health Education field. Given the capacity
for new insights, I argue that one can then begin to understand why the field may
be characterised by enduring features such as individualism, and certain types of
morality, regardless of any counter imperative that may have been put forward.

The thesis contributes to a burgeoning governmentality literature in education,
and offers new directions for analysis in the field of both education and Health
Education. It builds on the existing analytic work of curriculum and pedagogy
governmentality theorists and extends our understandings of the complex relations
that are produced within classrooms.

¹ See chapter two *Thinking about social control and regulation in health education.*
Chapter One: Questions of politics and health education

Introduction

The purpose of this chapter is to locate my research questions about how health education functions as a site of regulation within broader historical and sociological scholarly debates about education and social control. Specifically, it provides an overview of socio-cultural approaches to thinking about the politics of health education over the past 30 years. In this, it serves as a means to consider ‘the conditions of possibility’ (Rose, 1999) that have both shaped and permitted the kinds of questions that have provided the momentum for my thesis. Moreover, it is part of developing historically based insights into current approaches to health education and ways of understanding the political imperatives of the field. Thus this chapter is largely a review of two very influential ways of conceptualizing and interrogating the political project of Health Education. The first derives from critical theory and critical traditions within education and the sociology of curriculum. The second, characterized as part of the post-structural turn, challenged many of the assumptions underpinning critical approaches to schooling, and offered some important new ways of examining power and knowledge in health education. Amongst the many thinkers, the various works of Michel Foucault have provided significant impetus for rethinking education and how it ‘works’.

This chapter then takes as its starting place the emergence of what is referred to as ‘critical health education’ in the 1980s. And although not necessarily an official term, it does capture the effects of the ‘critical turn’ in health education. My discussion of critical health education considers some of the broader conditions impacting on health and education at the time, specifically the rise of neoliberalism and risk. I then go on to examine some of the reverberations this had across education, with a particular focus on health education. This discussion sets
the scene for the emergence of the various critiques that emerged to produce the critical health moment. After reviewing a range of critical education and health education scholarship, I turn to discuss some of the limitations of the critical health education moment. The second, and final section of the chapter charts the turn to Foucault, and considers the range of scholarship that evolved as a result of the uptake of his ideas. The section focuses primarily on the kinds of analyses that have evolved from the Health and Physical Education field, as a means to consider how questions of politics and social control have been re-imagined and recast as a result of Foucauldian inspired thinking.

**The emergence of a ‘critical’ health education**

As I have previously discussed in the Introduction, health education has a long history in Australian schooling. On the whole approaches to health education had been characterised by the provision of knowledge to individuals as a means to improve health (Lupton, 1995; St Ledger, 2006). The 1980s however saw the emergence of a very different approach to thinking about health education. Critical health education appeared in the broader assemblages of health education, and made its way into policy and academic discourse. In looking back over the history of health education, the emergence of critical health education could be considered to be somewhat of an anomaly. I go on to discuss this in more detail later in the section, and also in Chapter Three where I consider ‘official curriculum’ shifts. As I have discussed in the Introduction, the critical health education ‘moment’ was my ‘professional’ entry point into the field of Health Education. But more than this, it provides a ‘starting point’ for discussions about the critical politics of health education. Given this, this section aims to provide an overview of the critical work that was conducted in the field of health education during the late 1970s through to the early 1990s. My focus here is on examining the nature of critical scholarship that emerged during this time and the broader intellectual and political climate that permitted the emergence of this particular style of critical engagement with health education. In tracing the emergence of critical questions and scholarship, I am wanting to consider the antecedents to my
own research interests and questions. In particular, I make visible the underlying assumptions and subsequent implications (and limitations) of thinking about the politics of health education in these ways.

In order to contextualise and understand the emergence of critical health education it is important to briefly characterise the field during the late 1970s and early 1980s as the majority of literature asserts that the mid to late 1970s was a significant time in the history of health education (see Lupton, 1995; Peterson & Lupton, 1996; O’Connor & Parker, 1995; St Ledger, 2006). During this time, health education became a site of intense policy activity, which in turn, greatly influenced how health education was configured and deployed as a key governmental strategy. The resurgence in activity and emphasis on health education could be understood to be the result of a complex assemblage of shifting neo-liberal political agendas, emerging social movements concerned with the social distribution of health and inequity, shifting approaches to thinking about and managing education and a burgeoning academic field with its gaze firmly set on understanding, and changing, the health of populations. To fully interrogate such an assemblage is beyond the scope of this chapter\(^2\), but I do want to highlight briefly central aspects of the ‘assemblage’ that worked to shape health education in particular ways during this time. These include the rise of neo-liberalism, and the associated rise, and proliferation, of health risk knowledges and their related practices.

In referring to the rise of neo-liberalism, several authors suggest that this political philosophy gained ascendancy in the 1970s (Dean, 1999; Gordon, 1991; Miller & Rose, 2008). This is not to say that prior to this time neo-liberal thought did not exist. As Dean (1999) suggests some of the antecedents to neo-liberalist thought

\(^2\) In the field of health education I do not know of any work that fully interrogates this complex interplay of politics, social factors and the emergence of the New Public Health during the 1970s to 1980s. However Deborah Lupton (1995) and Alan Peterson and Deborah Lupton (1996) do explore the interplay of factors in relation to health education and the emergence of the New Public Health and some of the insights provided are useful to draw from. There is a need for greater exploration of this time and its impact on health education policy and practice.
can be traced to the 1960s and emerging critiques of the welfare state. Neo-liberalism then, as it gained political ascendancy, provided a scaffold for contemporary mentalities of rule, which dramatically altered government and governing. As an approach to government, neo-liberalism is constituted by, and relies on, a multitude of rationalities, technologies, institutions and agencies. This assemblage aims to ensure that government can be enacted from a distance via the translation of ‘political, social, and economic goals into the choices and commitments of individuals, locating them into actual or virtual networks of identification by which they can be governed’ (Rose, 1996, p. 58). The governmental philosophical and practical manoeuvring effectively works to disperse the responsibility of the state to the various institutions, agencies, communities and ultimately individuals that make it up. In doing this neo-liberalism both assumes and requires a different kind of ‘subject’ in that it attempts to work ‘through the regulated and accountable choices of autonomous agents’ (Rose, 1996, p. 61). And in working to achieve ‘vital links between socio-political objectives and the minutiæ of daily existence’ new apparatuses were required, accompanied by new expertise and expert knowledges (Rose, 1996, p. 68). It is within this mix that risk emerged as a significant rationality of government (Lupton, 1999b, 1999c; O’Malley, 2000). Risk reconfigured broader governmental assemblages significantly by providing momentum and technical form to neo-liberal agendas. Risk does this by acting as a conceptual device to render the problems of government thinkable and calculable, and in turn, practical (Lupton, 1999b, 1999c; O’Malley, 1999). In thinking about the implications for health, several authors suggest that the rise of risk discourse produced a heightened emphasis on prevention as well as the emergence, and cultivation of, a new health consciousness (Baum, 1998; Crawford, 1977; Lupton, 1995; Peterson & Lupton, 1996). O’Malley (1996, p. 199) details the impact on health in the following way:

The provision of publicly provided or subsidized medical treatment is downscaled, the scale and range of services provided by the State is narrowed, qualifying conditions for access to such services are made more rigorous and may also be allowed to become less attractive (e.g.
long waiting lists for surgery). Reliance on publicly provided medicine is deterred, for example, by increasing the contributory payments, or by implying that it is immoral for the middle class to rely on public medicine, regardless of salary-indexing of contributions. This is paralleled by promotion of private health insurance and provision of private medical services, as both State and private sector voices stress the moral and rational basis for preferring private sector treatment. The rational and responsible self-interest of the medical consumers is thus relied upon to remove them from dependence on the public health services, per medium of a material and moral manipulation of the service environment. At the same time, all manner of regimes and routines are promoted with respect to the care of the body. Whether commercially provided (weight-loss programmes, fitness centres) or State funded (public endorsement of low fat diets, anti-smoking campaigns), a disciplinary regime of the body has been promoted on the assumption that subjects at risk will opt to participate in a self-imposed programme of health and fitness.

The shifting approaches to neo-liberal government, health and the dominance of risk rationalities resulted in an intensification of individualising responsibility (Gordon, 1991; Rose & Miller, 1992). As Dean (1999) suggests neo-liberal renderings of risk recast ‘State’ responsibility and level it instead at individuals by establishing a necessity, and desire, to manage and mediate personal risk.

The shifting governmental assemblage and the reification of neo-liberalism and risk resulted in a dramatic reconfiguration of both the role, and practices, of health education. This can largely be attributed to the proliferation of risk knowledges and various technologies that emerged out of various centres of expertise. In order to configure the rational, autonomous responsible subject of neo-liberal governance a new raft of knowledges would be required. Such knowledges sought to render individual health behaviours and status as intelligible and ultimately amenable to change. Within this assemblage of knowledges and technologies, lifestyle risks emerged as a significant concept. Lifestyle diseases referred to those diseases that were thought to manifest solely as a result of individual behaviours, such as poor eating habits, lack of exercise, smoking, drug use and so on. The response by proponents of public health was to develop a range of education initiatives charged with the imperative of changing people’s unhealthy lifestyles via the management, reduction or elimination of risk factors. The alignment
between neo-liberal political agendas and the shift towards lifestyle diseases and risk factors worked politically to target individuals and their health choices. It is not difficult to imagine the role afforded to health education here. The assumption that underpinned Health Education was that young people were at risk. By positioning young people as being at risk, Kelly (2001) argues that policy discourse was able to actively individualise and responsibilise risk. This was achieved discursively by displacing responsibility for the management of institutional and environmental health risks to young people. In essence, school based health education became a platform for improving health, and began to target lifestyle risk factors in an attempt to help young people to transform their personal health related behaviours. The assumption here was that young people would respond to targeted education initiatives once they had recognised that they were at risk. Their response would then be to dutifully manage the various risks to improve their health. This assumption endures today, as potent as ever, and can be evidenced through the various iterations of curriculum to the present (see Chapter Three for a detailed discussion).

The emerging emphasis on, and development of, health education initiatives was part of what Peterson and Lupton (1996, p. 1) refer to as a “proliferation of new knowledges and activities focusing on health status, particularly the health status of ‘populations’”. Expert risk knowledges, as I have already suggested were central here, and it is something I will return to discuss in greater detail throughout the chapters in the thesis. But other knowledges evolved too that sat alongside and linked to expert risk knowledges. Health psychologists for example were busy attempting to develop insights as to how and why people behaved in particular ways that were either detrimental to health or health enhancing. As a consequence a vast array of psychological theories appeared. For example the health belief model (Becker, 1974), the theory of reasoned action, social learning theory (Bandura, 1977) and the stages of change model (Prochaska & Diclemente, 1984). The insights gained from the various health behaviour theories were then used to think about and refine educational interventions that were taken up across the media, health promotion, community health and school based health education.
curriculum. The models effectively privileged the role of health information, and
situated it as being integral to one’s capacity to change their health related
behaviours. This is not new in and of itself, as health education since the
beginning has been based on the provision of information (see Colquhoun, Goltz
& Sheehan, 1997; Lupton, 1995; O’Connor & Parker, 1995; St Ledger, 2006).
However what is interesting, is the amalgamation of the types of expertise being
deployed and the subsequent refinement around the types of information that were
required, as well as the timing of information in order to successfully achieve
desired change.

The reinvigoration of health education, and the intensification of individualistic
approaches that characterised the field in the 1970s and early 1980s contributed to
the development of more formalised approaches to school health education. The
kinds of curriculum that emerged from this time were unsurprisingly directed
toward individual behaviour change. Accompanying individualistic approaches in
the quest to produce behaviour change were moral imperatives to be healthy (see
Crawford, 1977; Greco, 1993; Lupton, 1995). Individualism and moral health
imperatives effectively set up a ‘duty to be well’ (Greco, 1993). If individuals
failed their duty, it could be understood to be simply a result of bad behaviour via
making the wrong choice. This perspective very much locates the fault of poor
health on the individual, as well as adding a moral dimension to the equation
(Greco, 1993; Lupton, 1995). The cluster of individualising, responsibilising and
moralising discourses has been referred to in the literature as ‘victim blaming’
(Crawford, 1977). Victim blaming became a central focus of many critical
scholars as they set about interrogating its conditions and the implications for
practice (see Baum, 1998; Colquhoun, Goltz & Sheehan, 1997; Peterson &
Lupton, 1996). The dominance of victim blaming approaches and the emerging
critiques are of significance to this study as they provide an ‘entry point’ into
thinking about questions of politics in health education. I now turn to explore the
nature of this critique, by firstly analysing the emergence of critical health
education scholarship, and secondly by providing an overview of the major tenets
that underpinned critical scholarship in the field of health education at that time, and beyond.

Critical health education

Critical health education literature began to emerge in the early 1980s in response to prevailing approaches to thinking about, and doing, health education. By the mid to late 1980s a large body of critical scholarship had materialised. As I have alluded to in the above section, the intensification of critical scholarship was largely in response to the dominant individualistic notions of health education that were circulating in policy and practice at the time. This literature was generally characterised by a concern with questions of social control and regulation and the role that health education played in such processes (for examples see Beckett, 1990; Colquhoun, 1989; Combes, 1989; Cribb, 1986; Rodwell & Watt, 1986). Given the focus of this chapter, I am interested in exploring this critical literature along two lines of enquiry. First I consider the broader assemblage of knowledges circulating during this period from which critical health education scholars derived their analytical gaze. Second, I provide an overview of the critiques that appeared, their concerns and the possibilities their analyses both afforded and advocated. My purpose here is to begin to locate my own research interests related to social control and regulation within a history of ideas, and how questions and subsequent understandings in this field of scholarship have been shaped by this ‘critical health education’ moment.

The differing styles of critical analyses and commentary that emerged in the health education field in the 1980s were made possible by what might be referred to as the ‘critical turn’ in broader intellectual agendas. This critical turn is located within a broad field of critical scholarship that draws on a range of theorists and theories including the Frankfurt school of critical theory, European Marxist social philosophy, the Italian Marxist Antonio Gramsci, Friere, and Habermas (Crotty, 1998). It is a complex and broad assemblage of literature, and it produced very
different accounts of ‘critical’. However, Crotty (1998, p. 157) offers a useful attempt at an overview by noting that:

...critical forms of research call current ideology into question, and initiate action, in the cause of social justice. In the type of inquiry spawned by the critical spirit, researchers find themselves interrogating commonly held values and assumptions, challenging conventional social structures, and engaging in social action.

He goes on to state that ‘fuelling this enterprise is an abiding concern with issues of power and oppression. Critical inquiry keeps the spotlight on power relationships within society so as to expose the forces of hegemony and injustice’ (Crotty, 1998, p. 157). I am not suggesting that this body of work only came in to being in the 1980s, but what I am suggesting is that the ideas espoused gained some ascendency during the mid to late 1970s and early 1980s. Given the concerns and insights offered by critical theory, it is easy to see why those interested in critiquing neo-liberalism and its tenets, found the insights afforded by critical theory to be very generative. The impact of critical theory was far reaching, but for the purposes of this section I am interested specifically in how it was mobilised in the fields of education and health, and the subsequent critiques that emerged. These emerging critiques powerfully shaped the kinds of analyses conducted by critical health education scholars. In the ensuing section I highlight some of the major concepts that evolved in each field and how they were instrumental in shaping critical health education.

Within the field of health and medicine the critical literature tended to be characterised by concerns related to the politics of health care, the dominance of medicine, and the social distribution of health and illness. In addition scholars were interested in analysing the shifting practices and emphases of health care systems and the potential implications this would have for the perpetuation of hegemonic ideologies and the implications for the already marginalised. Of particular interest here is the work of Robert Crawford (1977, 1980). His work was pivotal in instigating, and informing, critiques of health, and health education.
Crawford developed the term ‘healthism’ which infused his writings, as well as many of the analyses in the field. Crawford (1980, p. 368) defined healthism as:

...the preoccupation with personal health as a primary, often the primary focus for the definition and achievement of personal well being; a goal which is attained primarily through the modification of lifestyles, with or without therapeutic help. The etiology of disease may be seen as complex, but healthism treats individual behaviour, attitudes and emotions as the relevant symptoms needing attention. Healthists will acknowledge, in other words, that health problems may originate outside the individual, e.g. in the American diet, but since these problems are also behavioural, solutions are seen to lie within the realm of the individual choice. Hence, they require above all else the assumption of individual responsibility. For the healthist, solution rests within the individual’s determination to resist culture, advertising, institutional and environmental constraints, disease agents, or simply lazy or poor personal habits.

Healthism as a key analytic concept shaped and underpinned a great deal of the early critical work in health and health education (for examples see Beckett, 1990; Colquhoun, 1989, 1990; Greco, 1993). It is also interesting to note that this concept still holds significant currency in the health and physical education field today, though this body of work draws from different theoretical traditions to analyse its continued significance for contemporary practice (for example Evans, 2003; Evans, Davies & Wright, 2004; Rich, Holyroyd & Evans, 2004; Tinning & Glasby, 2002). I will return to this below when I overview some of the key concerns of critical theorists of health education, and again in the governmentality section. The very fact that as a topic for investigation, we are still concerned with the dominance of healthism in the field speaks volumes. On one hand, as I will show in this thesis, it speaks to the veracity of healthism as it continues to endure and powerfully shape health education. And on another, its survival permits insight into the possibilities and limitations of the emancipatory project of critical theorists of health education at this time.

The effects of the critical turn in health, education and health education were significant. With respect to the field of health, Crawford’s analyses, as well as the burgeoning critical literature at this time, contributed to shifts in public health
policy and practice. For example the emergence of the New Public Health marked a significant move away from individualising approaches to health. As Ashton and Seymour (1988, p. 21) suggest, as an approach, ‘the New Public Health’ brings together environmental change and personal preventative measures with appropriate therapeutic interventions. Many commentators suggest that the New Public Health was a deliberate attempt to move beyond blaming individual lifestyle choices for poor health status, and locating health status within broader environmental and social conditions (Ashton & Seymour, 1988; O’Connor & Parker, 1995). I am not implying here that the critical commentaries circulating in the field were solely responsible for instigating policy change, as the emergence of the new policy directions are far more complex than this3. Rather I am suggesting that they composed part of a broad assemblage of knowledges that came to both instigate, and inform, policy change. The shift to the New Public Health contributed to a marked reconfiguration of official health education curriculum and I will return to explore this later on in the thesis in Chapter Three. What is also of interest here though is whether the advent of the New Public Health actually did manage to shift the gaze from individuals and achieve its intent (see Bunton, 1992; Bunton, Nettleton & Burrows, 1995; Lupton, 1995; Peterson & Lupton, 1996). Such questions and debates about the New Public Health and the possibilities afforded are of interest to this project, and will be revisited later in the section and thesis as they are very much related to the broader possibilities of health education being able to abandon individualistic approaches, or not as the case may be.

Within the field of sociology of education, the turn to critical theory produced an expansive body of literature that has spanned over 20 years (see Pinar, Reynolds, Slattery & Taubman 2002). The early work of Michael Young (1971) and Basil Bernstein (1971) was of particular significance in shifting conceptions of

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3 For a more in depth overview and analysis of the emergence of the New Public Health and its tenets, see Lupton (1995); Peterson and Lupton (1996); Baum (1998); O’Connor and Parker (1995).
education as being thought of as neutral, to understanding schooling more broadly as a mode of social control. They, like other people drawing on various iterations of critical theory were concerned with, in this case, how schooling was implicated in reproducing inequity and contributing to the maintenance of the status quo. Since then, there has been a vast amount of scholarship produced that has sought to develop understandings of how education is constructed and implicated in such social processes (for a review of the debates and themes that arose within this extensive body of critical literature in education see Pinar, Reynolds, Slattery & Taubman 2002).

Scholars working in the field of health education found the insights from the critical fields of sociology of health and education, very generative and mobilised such understandings in their critiques. As a result of such engagements, the majority of the critical health education literature is characterised by several main and interrelated concerns. Generally the critical literature tended to focus on issues related to the politics of curriculum, in particular the dominance of healthism and its limitations. As previously suggested, this type of critical analysis of health education began to emerge in the late 1970s and early 1980s (see for example Tones, 1981). However upon reviewing the literature, it is the mid 1980s, which proved to be a defining time for the field. The period was marked by a proliferation of critical health education scholarship, and shifting educational practices in the field. The following section reviews this scholarship in relation to the types of analyses that emerged, as well as the alternatives these proposed.

Critical health education scholarship

Many of the concerns permeating the literature at this time are reflected in the 1986 publication of an edited collection entitled The politics of health education: Raising the issues (Rodmell & Watt, 1986). The book was published in the United Kingdom, and drew contributions from both the community and school sectors. It was the first book of its type and emphasis, and its publication denotes a marked rise in a concern about health education imperatives and practices. It was one of
the first (and possibly only) books to take up questions related to the politics of health education as a central focus. In their introduction the editors Rodmell and Watt (1986) state that the book came into being as a response to their, along with others, concerns with prevailing individualistic and behaviouristic models of health education. In particular they suggest that "the extent to which health education is able to challenge inequities in the area of inequalities in health and illness is the basic subject matter of this book" (1986, p. 2). The contributors to the book analyse themes such as the medical dominance over health education practices, stereotyping and stigmatising certain social groups based on lifestyle, issues related to the nature of healthy choices, and the emergence of the field of health promotion and its impact on health education (Rodmell & Watt, 1986). The themes are consistent with the concerns of critical theory more broadly and reflect the types of analyses offered in both the health and education critical literatures. Though it must be noted that the majority of literature does draw its insights from the sociology of health literature, rather than that of education.4 Within the collection, Jenny Naidoo’s (1986) chapter on the Limits to individualism is of particular interest, as her critique of individualism is echoed in many subsequent critical health education writings. She criticises health education for being too focussed on individualistic behaviour change, that is, it is dominated by the ideology of individualism, and thus is marred by three fundamental flaws: it ignores health as a social product; it wrongly assumes the existence of free choice; and it is ineffective in preventing ill health (p. 35). These themes mirror the central questions taken up in ensuing Australian literature.

Building on the critical work in health, education and health education internationally and nationally, the critical health education movement gained momentum in Australia in the late 1980s. As previously noted, the emergence of

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4 This trend is significant and reflects generally the dominance of health and health promotion in the field of health education. Apart from the critical health education moment that happened in Australia, most of the activity in school based health education now comes from outside of education, and from more broader health/wellbeing research/health sciences. This reflects the policy shift to the New Public Health, and how health education gained policy momentum under the new guise of health promotion.
this type of critique has much to do with the kinds of knowledges and practices that were circulating at the time. For example, health education was undergoing a metamorphosis at the policy level as a result of neo-liberal policy agendas, and developing public health knowledges. In addition, the 1980s were characterised by an invigoration of curriculum activity, where different iterations of health education curriculum were not only invented, but were endorsed by various education and health government bodies. Related to changes at the school level, was the emergence of health education teacher education, and pre service teacher education courses. The emergence of critical health education in Australia can be located within this flux of activity, as well as the growing critical body of literature in health and education. Within Australia there was a small, but prolific, group of academics engaging with the new sociology literature and its implications for health education. This work very much set the scene for the then current and many of the subsequent critiques emerging from the field. The Australian literature picked up on broader critical themes and tended to be largely characterised by concerns about healthism as a problematic dominant ideology in health education. The early work of Derek Colquhoun, for example, centred its analysis on health related physical education and the dominance, and impact, of healthism (1989, 1990, 1992). The shifting nature of physical education to health-based physical education was of concern, for Colquhoun as it was for other scholars in the field (see Tinning, 1990). In particular critical analyses centred on the ways in which healthism as a dominant ideology was manifesting in school based physical education practices.

The critical health education movement seemed to peak in Australia during 1990, when a special edition in the Higher Education journal, Unicorn was published. The special edition was devoted entirely to health education. As David Kirk (1990, p. 67), in his editorial suggests, the compilation of articles:

...indicate that 1990 marks the beginning of a crucially important decade for the fate of health education in Australian schools. Public, political and professional sentiments seem to be converging on the conclusion that schools can and should be awarded a serious role in educating future generations in and about health.
Further, Kirk adds that the special issue provides a collection of papers which “collectively, seek to problematise the notions of ‘health’ and of ‘health education’, to raise questions about what constitutes each of these ideas, and to undermine the popular view that there are necessarily shared and undisputed answers to these questions” (Kirk 1990, p. 67). This special issue of *Unicorn* was illustrative of the central concerns critical health educators had at the time around practices of health, physical education and education. The issue comprised of articles that specifically focused on health education (for example Beckett 1990; Kirk & Gray, 1990) and those which explored associated fields of drug education (Walker, 1990), physical education (Tinning, 1990) and environmental education (Colquhoun & Robottom, 1990) as well as nursing curriculum (Bruni, 1990).

Of particular interest in this issue, is Lori Beckett’s (1990) article ‘A critical edge to health education’. It is significant because it was one of the first Australian journal articles to emerge that concentrated on school based health education as a sole focus for interrogation. Prior to this much of the critical discussion in the field was tied to the project of physical education (see Colquhoun 1989; Tinning 1990). Beckett’s article aimed to ‘put health education in touch with critical theories of curriculum’ in an attempt to explore how health education works as a site of reproduction of the current social, cultural and economic forms or maintains and reproduces the social order and its health problems. Drawing from ‘reproduction’ theories she took issue with how health education at the time was dominated by behaviourist notions of health and behaviour change, and how this emphasis was responsible for upholding the ‘relationship between schooling and the economic structure and the transmission of cultural norms’ (p. 94). The arguments and analyses offered by Beckett here, encapsulate the central tenets of the critical health education project more broadly, both in Australia and internationally. It is also important to note that the critical project was not only about offering a critique, it was also about a re-visioning of school based health education, with the aim of overcoming the inherent problems of individualistic approaches. For example Colquhoun (1992) in his book *Health education: Politics and practice* called for ‘Australian health educators to shake off the
shackles of healthism ... and to promote a new, more overtly politicised version of health education/promotion’ (p. 23). He goes on to suggest that this style of health education would be underpinned by a socio cultural critique which would permit and ‘encourage a questioning of traditional practices and a re theorising of many of the key terms such as self esteem, decision making, lifestyle, behaviour/context, reflexivity and so on’ (p. 23). This would be with the intention of tackling ‘some of the central issues such as equity, social justice, social change, participation and empowerment’ (p. 23).

Beckett (1990) too, follows a similar line of argument suggesting that health education needs to ensure that it ‘acknowledges children’s health as an intensely social and political issue” (p. 93). In terms of what critical health education might be she proposes that it could:

...begin with a critical sense of our own health needs set against a backdrop of the complex interconnections between the economic, political and ideological structures of the dominant society. We also begin with a strong sense of our own self-determination, believing that substantial changes can be made, which means a preparedness to struggle over the issue of health as well as the forces and obstacles that operate against this and the realisation of good health. This also means critically and reflectively constructing and reconstructing the patterns of our daily lives by addressing health as the condition of our own existence so that it is nothing less than human welfare and survival. But it is also a concern for our common welfare, characterised by a genuine caring and responsibility for our mutual health, welfare and survival (1990, p. 96).

In discussing classroom practices Beckett (1990, p. 97) suggested that the aim of health education classrooms should ‘be to generate a critical consciousness of the teachers’ and students’ experiences of human existence and the prevailing social order so that people can act as ‘human agents’ who are able to effect improvements and change in constructing their own social realities’.

The new style of health education that Beckett and Colquhoun were calling for reflected the kinds of directions being advocated in the international literature. For example Naidoo (1986), after conducting a discussion on the limits to
individualism, suggested that health education ‘should be effective, client centred without being victim blaming, and should focus on the real causes of health and illness’ (p. 35). Cribb (1986) too was calling for health education to be largely about political education. And Tones (1981) believed that the way forward for health education was to focus on empowering individuals as well as to generate political and social awareness (p.127). Overall the reforms advocated by critical health education scholars reflect two different but related approaches to health education practices. The first is empowerment education and the second combines the notion of collective action and consciousness raising.

These shifts mirror changes not only in the critical education and health literature, but also in the reconfiguration of public health approaches at the time. By this I mean that emerging models of health education were shaped by the shifting landscape of how health was being conceptualised. This involved a shift away from purely physical and medical definitions that had been dominant, to a social model of health that encompassed the spiritual, emotional, mental and environmental aspects of health. The New Public Health mobilised this definition of health, and as part of its policy platform, the Ottawa Charter, called for individual empowerment and collective action (World Health Organisation, 1986). As a result, both empowerment education and collective action were taken up in health education, and changes at the curriculum level at this time. For example, in 1989, with the emergence of a new curriculum document in Victoria, health education found itself located with what was now called the Personal Development Framework. Within this curriculum document the tenets of the critical health project are obvious. The document suggests that:

Health education must foster the capacity for young people to adopt a socially critical perspective about health issues... students should also be given the opportunity to evaluate social conditions which might lead to health problems in our community. They may develop strategies to deal with these from a personal perspective, and where practicable, such studies should lead to action projects in the community (Ministry of Education, 1989, p. 79).
I will return to explore the various approaches enshrined in the Personal Development Framework, and subsequent curriculum documents in Chapter Three. For the purposes of this chapter though my point here is that critical health education was proving to be generative in producing new approaches to thinking about and doing health education.

The above discussions suggest that the critical project had a significant impact on the types of research undertaken, analyses conducted and the types of curriculum and pedagogy developed. With particular reference to health education, critical research agendas largely interrogated healthism, and the consequences that this had on the broader project of social justice. As a result of this work health education was asked to transform itself, supposedly moving from traditional behaviouristic individual models, to incorporate self-empowerment and radical consciousness raising activities in an attempt to achieve the utopian dream of liberation and health for all. However despite its impact and wide appeal for those with a keen interest in social justice, it became clear that there were a number of problems and dangers associated with the critical health education project. Critical pedagogy and critical theory in education more broadly became the subject of considerable critique. Critiques came from within the field itself, with scholars taking issue with theoretical assumptions, and solutions posed. In addition critiques also emerged from those who had begun to engage with post structuralist theories and thinking (for example Luke & Gore, 1992). Many questions began to be asked of the critical education project. For example, and borrowing from Colquhoun (1992), had the new critical health education been successful at shaking off the shackles of healthism? Upon reflection the answer is quite obvious, it had not (and still has not). In fact the emancipatory ideals enshrined in critical approaches such as empowerment education and collective action did not counter neo-liberal principles. Rather, as Dean (1995) suggests they were remapped onto the neo-liberal imperative. Thus the emphasis was still very much on the individual and neo-liberal configurations of the modern subject. Given that individualistic approaches to health education continue to permeate the field, I am interested in exploring this further throughout the thesis. I am particularly
interested in considering other theoretical lenses that might offer a different approach to engaging with questions of politics in health education.

**Being critical of the critical question**

The scholarship around the politics of health education and the reforms proposed reflected the belief that health education had potential to effect social change. The reforms made their way into curriculum and classrooms, with the Victorian curriculum document, the Personal Development Framework (Ministry of Education, 1989) being an exemplar of such an approach. However as I have mentioned above, this emancipatory promise, appeared to be just that, a promise.

Why hadn’t we seen the promise realised in health education? Why hadn’t individualism gone away? And why was it so difficult, if not impossible, to enact the pedagogical imperatives espoused by critical health education scholars and enshrined in curriculum documents? And the obvious question, why are we still grappling with healthism? In order to answer such questions one needed to go outside of the immediate critical health education field (see for example Luke & Gore, 1992). While critical health education was reaching its zenith in Australia, and having profound implications in the field (and on me), another body of literature was emerging that had begun to take issue with, and interrogate critical theory and its application in educational settings. Similar critiques were emerging in the sociology of health field as well (see for example Peterson & Bunton, 1997). The emergence of this new body of literature reflects a broader intellectual shift to post structuralism.

Within this shift to post structuralism, the work of Michel Foucault was taken up by scholars who were interested in questions of politics, social control and regulation in health, education and health education. Significantly Foucault was providing new possibilities and new lines of enquiry for those who were interested in exploring lingering questions related to the critical project of health education. I will now turn to consider Foucault’s impact on emerging scholarship in the associated fields of education and health education in particular. My discussion here will focus on providing an overview of the kinds of questions, and analyses
that have developed as a result of scholars working with Foucauldian inspired analyses.  

**Entrée Monsieur Foucault**

In thinking about the significance of Foucault’s work, it is interesting to consider both its emergence and its uptake. Foucault’s work had been in circulation since the 1960s and in the fields of health and education there are certainly early references to his ideas in the late 1970s (see Baker & Heyning, 2004a, Crawford, 1977). However it was during the 1990s that his work appeared to have well and truly made its mark across the human sciences (Dean, 1999) and in the fields of education (Baker & Heyning, 2004a, 2004b) and health (Harrison, 1995; Peterson & Bunton, 1997). In the field of education and health several ‘Foucault’ inspired collections emerged (see Ball, 1990; Peterson & Bunton, 1997; Popkewitz & Brennan, 1998) accompanied by a proliferation of articles and conference papers drawing from his works. The turn to Foucault, and what Baker and Heyning (2004a, p. 7) refer to as a ‘proliferation and swarming’ around his ideas, had a significant effect on scholarship, and dramatically changed the kinds of analyses that were being conducted around questions of politics in the fields of health, education and in turn, health education. For the purposes of this chapter I am going to concentrate on two major bodies of literature. First, I want to consider how scholars in the field of education took up Foucault’s work. And second I want to consider how scholars in the field of Health and Physical Education have engaged with his work over time.

**Educating Foucault**

While never really writing extensively about schools or health education per se, Foucault’s work has much to offer analyses of health education. It is not possible to review the vast field of Foucauldian studies in education (for comprehensive

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5 I explore Foucauldian thought in more detail in the following chapter where I develop my Foucauldian inspired analytics of governmentality.
reviews see Baker & Heyning, 2004a; Popkewitz & Brennan, 1998; Tamboukou & Ball, 2003). Generally though, the broad scope of scholarship is well captured by Baker and Heyning (2004a) in their review of Foucault literature over the past 25 years. From their review they identify three major ways in which educational scholars have taken up Foucault’s work during this time. They are:

1. Historicisation and philosophizing projects with relativization emphases.

2. Denaturalization projects without overt historical emphases and with diversity emphases.

3. Critical reconstruction projects with solution emphases (p. 29).

The scholarship encompasses an extensive range of analytic sites such as the construction of teachers, the child, different curriculum areas, the emergence of schooling, and pedagogy. And they are trends that continue into the contemporary context (see for example Peters, Besley, Olssen, Maurer & Weber, 2009). From this field of many, I want to focus on two scholars in particular, Thomas Popkewitz and Jennifer Gore. Their work provides interesting insights that can be mapped backwards to refigure analyses offered up by critical scholars. In addition their focussed work on both curriculum (Popkewitz, 1997, 1998) and pedagogy (Gore, 1995a, 1997, 1998, 2002) has provided the foundations for my rethinking questions of politics in health education.

Curriculum has long been a site of intellectual critique for those interested in social control (see Pinar et al, 2002). The work of Foucault has proved to be generative for those curriculum scholars interested in such questions. Thomas Popkewitz’s (1997) writings, borrowing from Foucault, on *The production of reason and power: Curriculum history and intellectual traditions* provide some useful insights into the production and functioning of curriculum, suggesting that “curriculum is a practice of social regulation and the effect of power” (1997, p. 131). He goes on to elaborate by explaining that:

I view curriculum as a particular, historically formed knowledge that inscribes rules and standards by which we ‘reason’ about the world
and our ‘self’ in the world as a productive member of that world. The rules for telling the truth in curriculum, however, are not only about the construction of objects for our scrutiny and observation... Curriculum is a disciplinary technology that directs how the individual is to act, feel, talk, and ‘see’ the world and ‘self’. As such curriculum is a form of social regulation (1997, p. 132).

His theorizing on curriculum takes the sociology of curriculum as its central problematic, with his focus on developing understandings around how current problems of schooling have become constituted in particular forms (1997, p. 131). In drawing on Foucault’s notion of governmentality Popkewitz offers a conceptual map that locates curriculum and schooling within a history of ideas. He is particularly interested in linking curriculum knowledge with issues of power and regulation, and argues that curriculum is a modern invention that seeks to regulate and discipline the individual. By historicizing curriculum he suggests that changing curricula reflect changing forms of governing. In analysing the shifting nature of curriculum, he suggests that many institutions, such as health and welfare are implicated in the governmental project. He makes links across ‘pedagogical knowledge, state practices, social science and population reasoning in order to consider the production of regulatory patterns’ (1997, p. 142) to reveal different technologies of governing at different times. For example curriculum theories, psychological theories of development, pedagogical knowledges and classification systems have all contributed to understanding the learner, as well as shaping the role of schools and how they were to regulate citizens, in terms of how students come to know themselves and be in the world. Those rationalities and technologies though are all produced in a particular epoch and as curricula are reinvented, so too are approaches to thinking about and doing education. In summarising he suggests that ‘curriculum inscribes rules and standards by which reason and individuality are constructed. The rules and standards produce social technologies whose consequences are regulatory’ (1997, p. 145). He goes on to suggest the current possibilities of schooling and curriculum are constrained, due to their emergence being historically embedded. Such insights encourage one to re-conceptualize health education as a social technology that is linked to other institutions and reflects changing rationalities of governance. Popkewitz’s work
here also encourages questions about how curriculum might be constrained given the ways in which it is assembled and the associated imperatives of the field. It is a very different kind of view of curricula to previous critical perspectives and the insights afforded here by Popkewitz provide a Foucauldian inspired lens through which to think about curricula differently.

For those interested in questions of pedagogy, power relations and classroom practice Jennifer Gore’s work has proved to be fruitful. One of the major reasons for this is that there are currently very few scholars who have set about such an empirical task. As a result her work has been central in shaping subsequent analyses of classrooms (for example see Wright, 2000). Although Gore’s interest in power relations and pedagogy can be traced back to the early 1990s (for example see Luke & Gore, 1992) it is her work conducted in the late 1990s that is of interest to the present discussion. This body of work is characterized by a continued concern with power relations in pedagogy from a Foucauldian perspective. Her chapter, Disciplining bodies: On the continuity of power relations in pedagogy (1998) provides an overview of her empirical work that has formed the basis of much of her scholarship on pedagogy.

Her research explored pedagogical practices across four quite diverse sites. These included a high school physical education classroom, a first year teacher education cohort, a feminist reading group and a women’s discussion group. She states that her observations were centred on exploring the question ‘Are the mechanisms of schooling like the mechanisms of prisons in terms of the micro practices of power Foucault identified?’ (1998, p. 234). Her interest in such a question is foreshadowed by her discussion of Foucault’s (1977) theories of power relations, as they are developed in Discipline and punish: The birth of the prison. Her analytic frame is derived from Foucault’s exploration of prisons as disciplining institutions, in which she explores whether schools could be equated to prisons in terms of circulating micro practices of power.

The discussion of findings is organised under eight coding categories that constitute techniques of power. These include surveillance, normalisation,
exclusion, classification, distribution, individualisation, totalisation and regulation. Gore found that each of the aforementioned techniques of power operated in all sites, in varying forms, and at times simultaneously. Thus she concludes by stating that ‘pedagogy as a modern enterprise has some continuous features across quite different locations’ (1998, p. 245). This has particular importance when thinking back to the alternative pedagogies advocated by critical health education scholars. Gore’s findings suggest that alternative pedagogies such as collective action and self-empowerment, are in fact, unable to escape power relations. As she suggests ‘many educational theorists would expect quite different practices of power in the four disparate sites in which my study took place. For instance some feminist, critical, and other radical pedagogues have argued that their classrooms should or can do away with power’ (1998, p. 245). This is in and of itself interesting as it speaks back to the hopes attached to the critical project by various critical scholars. But in terms of pedagogy, Gore’s work offers valuable insights into the operation of power in educational contexts and specifically through pedagogical relations. In suggesting that pedagogical power relations are complex, and highlighting how those relations play out through pedagogy her work provides a valuable backdrop to the kinds of work carried out in this thesis. The scholarship of both Popkewitz and Gore was central to my early conceptual work and the decision making that has shaped this thesis. Their work has continued and I return to consider it again in Chapter Three, Assembling the official health education curriculum and Chapter Five Risky pedagogical assemblages. I want to now turn to discuss how Foucault was taken up in the specific field of Health Education.

**Foucault gets healthy**

Tracking the impact of Foucault on the field of health education is not a straightforward task. Unfortunately at this point in time, there is no ‘Foucault and Health Education’ collection to turn to, unlike the collections that emerged out of previous critical moments. And with the exception of a very few scholars there aren’t many dedicated attempts to engage with the field of health education in its
own right (see Beckett, 1999; Gastaldo, 1997; Vander Schee, 2008a, 2008b, 2009a). This might be partly attributed to the fact that health education has for much of its existence sat at the centre of various disciplinary intersections. Much of the earlier critical work for example was conducted by scholars who had largely been concerned with the field of Physical Education, and had found themselves drawn to consider issues of health. The other group of scholars who were contributing to health education scholarship were those located within the field of sociology of health and health promotion. This trend has continued to the present day, though many scholars have turned to Foucault to conduct their analyses, and with good reason. And of course there are some new kids on the block. Given this, the following discussion considers some of the Foucauldian emergences in associated fields that have links to health education, specifically the field of Physical Education. In addition to this I consider the scholarship that has centred specifically on health education. The scholarship as it emerges over time engages differently with Foucault’s work, and again it is a trend that is mirrored across many of the various disciplines that turned to Foucault. In trying to tease out the major works and themes, it is without a doubt messy business. There are analytical arrivals and departures over time as ideas in the field evolve and/or analytical interests change. This too is exacerbated by the continued release of Foucault’s work over time. What follows is my attempt to glean some of the major trends and insights that characterise the various fields to consider the impact of Foucault, as well as glean some insights to put to work in the thesis.

Just as Foucault was making his work felt in the field of Education, it appears that he too was making an impression in the field of Physical Education (see for example Kirk, 1994a, 1994b; Kirk & Colquhoun, 1989; Kirk, Macdonald, Tinning, 1997; Kirk & Tinning, 1990; Macdonald, 1992; Wright, 1996). Scholars here were either nodding to Foucault, or embracing his ideas in their various analyses of physical education. It appears that at least some of the usual suspects that I have reviewed in the preceding section had moved on from critical theory to adopt Foucault as one of their key theorists. But it really was not until the late 1990s and probably more significantly, the 2000s to mid 2000s that Foucault
became the darling of scholars interested in critical questions in the broad field of HPE.

As I will discuss later on, from the mid 2000s on there has been quite a surge of scholarship that relates to health, and health education. This has largely come about in response to the effects of the moral and public panics related to the ‘obesity epidemic’. I would argue here that the ‘obesity epidemic’ has galvanised scholars in a way that bears similarities to the surge of critical scholarship that emanated from the ‘critical turn’. The surge of scholarship here has largely been in response to the rise of problematic body pedagogies that have emerged to intervene in the crisis. Such pedagogies have included lunch box surveillance, weighing, body fat testing, banning of foods and the demonizing of particular kinds of bodies (see Burrows & Wright, 2007; Leahy, 2009; Leahy & Harrison, 2004; Rich, 2011a). I would suggest though that the crisis has reignited critical scholarship in the field and thus has provided ‘food for thought’ for scholars interested in questions of health, education, the body and questions of politics.

In turning to review some of the literature that has emerged over time, for heuristic purposes I have tried to cluster similar works together. The following discussion is divided into two sections. The first section considers the work of the early adopters and the analyses that emerged from their uptake of Foucault at the time. The work here is significant as it effectively laid the foundations for this study. The second section explores the later uptake of Foucauldian perspectives in the field from the mid 2000s though to the present day. This body of scholarship has emerged alongside the analytical work of this thesis. In addition to this, work from this thesis has found its way into that mix. The review here simply aims to map the nature of the field in recent times.

**The early adopters**

As I have suggested Foucault was certainly in the sights of scholars working in the Education, Physical Education, and Health fields in the 1990s. Towards the late 1990s and early 2000s though we witnessed an increase in the uptake of his
work. Significantly here, the work that was being generated had greater linkages to the field of health education. In the newly defined field of HPE, Foucault’s work proved to be generative (for example see Beckett, 1999; Kirk 2004; Lupton, 1999a; Tinning & Glasby 2002). The work at this time was significant as it was around this time that I was ‘doing’ the early conceptual work that laid the foundations for this thesis. This literature too, changed the focus of my study. I had previously been interested in questions based around gender and sex education in schools, but upon reading through the literature found that there was a rather large gap in relation to the broader field of health education. So I changed tack, and although the focus of my study shifted away from gender and sex to the broad subject area of health education, they are never very far away as the empirical work of the thesis will attest.

Beckett (1999) in her article entitled *Spaces for freedom in health studies* explores Personal Development Health and Physical Education (PDHPE) curriculum development in NSW, Australia. Her turn to Foucault is of interest as it marks a departure from her earlier ‘critical theory’ work. Her paper, amongst other things, offers an analysis of the technologies of self and technologies of domination that are evident in the curriculum. She suggests that ‘the common way of thinking about PDHPE, in terms of its concern with the whole person and health improvement, has assumed the status of truth’ (1999, p. 16). Truth in this context is inspired by Foucault’s discussion of regimes of truth and how they function powerfully as governmental apparatuses. After her analysis she proffers a way forward for PDHPE. In her conclusion she states that the aim of PDHPE becomes one of ‘support them [students] to make informed decisions about their health and lifestyle, but [also to] identify the ways of increasing their social responsibility and school community actions around the social issues of health and welfare’ (1999, p. 21). This recommendation for practice, is offered up as an alternative to reigning techniques of dominance and self, and resonates strongly with past critical moments (see Beckett, 1990).
Beckett’s work here offers a ‘critical reading’ using Foucauldian inspired concepts to offer up new approaches to health education that advocate that students take responsibility for themselves as well as for society more broadly. Woven through this work is the spectre of critical pedagogy, though in this iteration it finds itself assembled together with tenets from the New Public Health. The forward suggestions made by Beckett here are reflected in various official versions of health education curriculum over time, which I will take up again in detail in Chapter Three.

In their article Pedagogical work and the cult of the body: Considering the role of HPE in the context of the New Public Health, Tinning and Glasby (2002) revisit a theme that has served as an old favourite, Healthism, the cult of the body and health and physical education. As a site of analyses it is interesting to note that clearly Healthism lingers, regardless of the aspirations and practices of the critical theorists and pedagogues who were dedicated to its eradication. The difference here though is that the authors suggest that development of new forms of Healthism have coincided with the rise and dominance of the New Public Health. Rather than drawing from critical theory, the authors have turned to risk society theorists and governmentality theorists to argue that still, at the end of the day, ‘HPE is still doing the ideological work of healthism’ (2002, p. 111). In their analyses, amongst other things the authors pose questions related to why certain books are not included in the curriculum and in turn classroom discussions, for example Louise Hay’s You can heal yourself. Here they seem to be pointing to the fact that such texts are subjugated knowledges. By this they mean they are text books that sit outside of dominant health knowledge systems. The authors here are suggesting that the use of such texts provides an opportunity to render the old villain of Healthism redundant, if only perhaps for a moment. On reviewing such texts though, I would suggest that they are the epitome of healthism, and are need to be viewed liked everything else ‘as dangerous’. Regardless though such texts have indeed found their way into classrooms, and I refer to this in Chapter Four when discussing school programs. Tinning and Glasby’s (2002) article does offer some interesting analytical lines for pursuit however. Taking issue with the New
Public Health and its individualising effects on school based HPE they also provided an opportunity, and to my mind an invitation, to revisit healthism and the how and why behind its enduring nature and powerful impact on health education.

Both Beckett’s (1999) and Tinning and Glasby’s (2002) early move to Foucault appeared to be attempting to straddle the great divide between critical theory and Foucault. This approach is not unusual and it certainly characterised many of the earlier education engagements with Foucault as his work was often used to supplement critical traditions and projects (see Baker & Heyning, 2004; Hunter, 1996). McLeod (1995, p. 44) too noted this practice suggesting that it is somewhat fraught. She suggests that:

…the deployment of post structuralism as a critique and as a set of principles on which to base educational reforms is said to promise freedom from constraint and the emergence of a more authentic self…In some ways this is not a new set of truths about identity or expectations of schooling, as it is a reworking of a familiar set of progressivist dreams in fancy new rhetoric.

The reworking to which McLeod refers to can be evidenced in the kinds of recommendations made for future practice by Beckett (1999) and Tinning and Glasby (2002). And the fancy new rhetoric in this case is the language of Foucault.

In some ways though the recruiting of Foucault for conducting the ‘critical project’ does offer some insights on how to recast and reconsider the kinds of problems that were being investigated differently. But the project becomes precarious when offering suggestions that suggest that freedom and emancipation are possible. As McLeod (1995, p.45) suggests recruiting post structuralism in this way involves a certain forgetfulness or blindness to the regulatory mechanisms at play within the critical project.

Deborah Lupton’s (1999a) work on the other hand, avoids straddling the divide to which I referred to above. In her article Developing the whole me: Citizenship,
neoliberalism and the contemporary health and physical education curriculum she interrogates circulating discourses in HPE and considers how the site works as a governmental space in neoliberal times. Drawing from the Victorian HPE curriculum document, as well as HPE teacher interview transcripts, she suggests that HPE is a powerful site for the enactment of the contemporary project of governance. Of particular interest to her analysis, just like Tinning and Glasby (2002) is the New Public Health, and how its tenets very much shape how curriculum writers and teachers, think about, and work in, the health education space. She suggests that health and physical education, like the New Public Health, places a significant emphasis on ‘personal responsibility for health states and represents the ‘rational’ subject as valuing good health over other outcomes’ (1999, p. 292).

In a sense she revisits the dominance of individualism in the field, and links the emphasis on responsibility to neoliberal forms of rule. She goes on to interrogate the outcomes expected from studying Health and Physical Education (HPE), suggesting that the field has become all encompassing by its broad focus on the promotion of individual and community health, as well as seeking to cultivate capacities to manage relationships, emotions, communicate as well as explore identity, and constantly reflect on themselves and others. Implicitly drawing from Nikolas Rose’s work, she suggests that the emphasis on developing such capacities reflects a ‘broader discourse in contemporary western societies that privileges the ‘open’ expression of emotion in certain contexts and the importance of ‘knowing’, working upon’ and ‘managing’ one’s emotional self’ (1999, p. 293).

In terms of the teacher interviews, her analysis revealed that teachers do mobilize understandings of students that are similar to those enshrined in curriculum documents, the New Public Health and broader neoliberal conceptualizations of the modern subject. Her analysis also revealed that teachers could be resistant to the imperatives of health espoused in the new curriculum, and the subsequent implementation of such imperatives. For example she found that teachers
struggled around discerning, and reconciling, the apparent differences in the subject area of health and physical education, difficult students, and organizational constraints such as timetabling. She suggests that:

...even in a context in which there is the general acceptance of the tenets underlying a particular governmental apparatus ... [the curriculum document] ... resistance to implementing these tenets, whether deliberate or unintended, emerges for a number of sites. Projects of governance and their strategies are inevitably partial, susceptible to falling short of their target because of the very diversity of the competing interests, discourses and institutions in giving meaning to implementing them (1999, p. 299).

Her point here is a thought provoking one as it speaks to some of the messiness and unpredictability that governmentality theorists speak of when they discuss the possibilities of enacting the various hopes of government (see for example Rose, 1989, 1996). Her curriculum work and interviews with teachers reveal some of the ways in which Health Education seeks to shape conduct, and how such a project can misfire. The insights are valuable, and they provided at the time a very different lens by which to think about the governmental project of health education.

Denise Gastaldo’s (1997) work entitled Is health education good for you? Rethinking health education through the concept of biopower, too interrogates the imperatives of health education. Although her analysis is located in the public health realm her work reveals some striking parallels to school based health education practices. In her article she argues that:

...health education represents a singular contribution to the exercise of biopower. Its involvement with prevention and health promotion, as well as its educational nature, enhance the set of power techniques that come into play in the management of individual and social bodies (Gastaldo, 1997, pp. 113-114).

Put simply biopower is understood to be ‘power over life’ or in other words it is power that is ‘employed to control individual bodies and population’ (Gastaldo, 1997, p. 114). But it is a very different type of power that is deployed to control. This power seeks to breathe life into the subject, to enlist it actively into caring for
itself (Foucault, 1984b). I will return to discuss biopower in more detail later on in this section as it informs some of the more recent work in the field. I also expand on it in the next chapter as an analytical device that can be put to work to understand governmentality. Drawing on a historical analysis of a series of official health education directed policy documents produced in Brazil she charts changes to approaches and strategies of health education. In her conclusion she argues that:

Practices and policies suggest that health education has not been challenged in its constituent elements (e.g. confession, self discipline, etc.) but has been reformed or transformed in its general strategies of approach – from traditional approaches to participatory practices. As bio-politics, health education policies have been disseminating discourses of participation and empowerment. This means that the health system is turning from repressive approaches to constructive approaches to manage the population (Gastaldo, 1997, p. 130).

Her analysis here, like others engaging in critiques of empowerment and participation (see Cruikshank, 1999; Ellsworth, 1992) offers a number of useful insights. New ‘critical’ versions of health education, and the resultant new raft of participatory and empowering strategies do not eschew power. They are merely a different form of power, aimed at different results and deployed in different ways. I draw on Gastaldo’s work again in Chapters Three and Four of this thesis to discuss the move to critical health education in Victoria, as well as the legacy of this movement evident in the ways in which teachers talk about the role of health education.

All in all the early Foucauldian inspired work in the fields of governmentality studies, education and HPE ‘kick started’ my thinking and provided the early conceptual frame for the thesis. At the time, each of the various forays added another perspective and allowed me to make some analytical inroads into thinking differently about questions of politics as they related to health education. Governmentality, in particular was proving to be very generative for rethinking questions of politics in education, as well as providing insights as to the how and why the critical project had failed, or been impossible from the start. I thus
determined that it would be of use for a project like mine. What was missing though at the time, was a serious engagement with the field of health education, as opposed to the amalgamated Health and Physical Education subject area. Further, it was clear that a great deal of scholarship had focuses on the level of policy or curriculum. Given this, I was inspired to fill the void with a study that sought to consider the governmental project of health education (as opposed to HPE)⁶ with a particular emphasis on curriculum and pedagogy.

The fat lands⁷

Since arriving at my initial decisions, and after completing my fieldwork, there has been, as I have alluded to earlier, a surge in scholarship that has critically engaged with health and schooling. In drawing on Rich (2010a) and Vander Schee and Gard (2011) I would suggest that the surge of scholarship has evolved out of a response to a proliferation of policies and initiatives oriented toward the surveillance of young people’s bodies in schools. And although moral and public panics around health are not new, the obesity epidemic has provided the impetus for many scholars to enter the debate. I would suggest that one of the reasons for this surge in interest by scholars is that the obesity epidemic has, and is, impacting on the subject area of HPE. And like moments gone by when Physical Education folks entered the critical debates about health education, largely on the back of concerns levelled at the rise and dominance of Healthism in Physical Education, the obesity epidemic has provided a similar impetus (see the early work of Evans, 2003; Evans, Evans, Evans & Evans, 2003).

From the mid 2000s there have been a number of books and Special Edition journals published exploring the body, health, obesity and control. And work from this study has found its way into some of those publications, either directly as

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⁶ For a detailed analysis of HPE and it’s role in governing healthy citizens see Mc Cuag (2008)

⁷ The Fat Lands is a title borrowed from Burrows and Wright (2007). They were using the term as a subheading to review the rise, and impact, of the obesity epidemic. I use it here to highlight that the obesity epidemic has provided the impetus for a ‘bulge’ in critical scholarship.
published chapters or as cited work in other articles and chapters. The body of work that has evolved in response to the obesity epidemic is marked by allegiances to a number of theorists, however Foucault is well in the mix as one of the major theorists scholars have drawn from. I want to turn now to review the major publications and special issues, though keeping in mind that this body of scholarship is put to work throughout my discussions in Chapter Three, Four and Five of the thesis. The purpose of my review then is to consider the ways in which Foucault has been utilised, in terms of the major analytical themes that are brought out to play.

In 2004 an edited collection was published entitled *Body knowledge and control* (Evans, Davies & Wright, 2004) a range of scholars from the UK, US, New Zealand and Australia contributed chapters that sought to consider the theoretical resources that may be valuable in shedding light on the how and why of the intensification of health imperatives and the impact on schools. Further to this, chapters also considered the implications for the body, health and identities in various curriculum and pedagogical contexts. The collection is theoretically diverse with authors calling on Bernstein, Beck, Durkheim, Giddens and Foucault to name a few. But as Wright (2004, p. 29) suggests:

> ...what the contributors share is a desire to interrogate, to ask question about the ways in which institutional and cultural processes work to produce particular forms of identity or selves, particularly as these relate to the social construction of the body, well-being and health.

Foucault’s work though is referred to in many of the chapters. And if he is not directly cited, many authors have cited works that have explicitly drawn from his various analyses. What is interesting is that authors draw from a range of his works and ideas across time to conduct their varying analyses. For example Kirk (2004) draws on *Discipline and punish* (Foucault, 1977) to consider historical approaches to disciplining bodies in physical education. In moving to consider contemporary approaches to Physical Education he necessarily moves to consider Foucault’s later work (Foucault, 1980) to interrogate new looser forms of power. The shifting approaches documented by Kirk parallel with Gastaldo’s (1997)
mapping of changing forms and strategies in health education. Overall though Foucault is put to work in varying ways throughout the chapters to consider questions related to how the body is regulated via health discourses and risk discourses within educational policies and practices.

Further to this the concerns are clear, what are the implications of practices that are aimed at the body in these ways? The authors in this collection are united in that there is certainly cause for concern in the ways in which practices are individualised, internalised and moralised. The concerns and questions highlighted throughout the collection are clearly of interest to me, and this study (see Leahy & Harrison, 2004). And although some of the authors are still trying to find reasons for the enduring presence of Healthism, the prevailing analyses on offer vary significantly from those on offer during previous attempts via critical theory.

In 2009 another edited collection Biopedagogies and the obesity epidemic: Governing bodies (Wright & Harwood, 2009) was published. In this edition Wright (2009, p. 1) states that:

> The contributors to this book came together because of a joint concern as educators with the ways in which ‘truths’ of the obesity epidemic, as they are recontextualised in government policy, health promotion initiatives, web resources and school practices have implications for how children and young people come to know themselves.

And as the title might suggest, the Foucauldian analytic that is put to work throughout the book is biopower. The editors develop biopower in relation to its usefulness in thinking about pedagogies, and arrive at the term ‘biopedagogies’ (Harwood, 2009; Wright, 2009). They use the term biopedagogies:

> ...to describe the normalising and regulating practices in schools and disseminated more widely through the web and other forms of media, which have been generated by escalating concerns over claims of a global ‘obesity epidemic’ (Wright, 1990, p.1).

Wright goes on to add:
Through each of the chapters, this book makes the argument that biopedagogies not only place individuals under constant surveillance, but also press them towards increasingly monitoring themselves, often through increasing their knowledge around ‘obesity’ related risks, and ‘instructing’ them on how to eat healthily, and stay active (1990, p.1).

The editors cast a wide net in contemplating the various sites for the enactment of biopedagogies including families (Burrows, 2009; Fullagar, 2009), the medical profession (Jutel, 2009; Murray, 2009), health promotion (Beausoleil, 2009) and schools (Leahy, 2009; Rich & Evans, 2009). The various analyses detail the ways in which biopedagogies work to shape the conduct of the population. What is interesting in this collection too is the move by some to consider the limitations of a governmental analytics (Walkerdine, 2009). For example my work, as well as Fullagar’s (2009) highlights the role of affect and emotion as being powerful contributors to projects of governance; whether they are woven through official projects mediated by schools, or as part of one’s project of the self. My chapter in the book was an early version of Chapter Five in this thesis, and so I will extend on this discussion later there.

Since then many more articles have been published, as well as a number of Special Editions of Journals. In 2010 a special edition of the journal ‘Sport, Education and Society’, Body pedagogies, education and health was published. The papers in the collection:

...specifically deal with body pedagogies oriented towards defining and shaping particular bodies and which are intimately connected with contemporary developments in culture relating to health (specifically obesity discourse) and their translation into education policy and practice (Rich, 2010a, p. 147).

These articles explore how various body pedagogies are put to work in a range of pedagogic settings including kindergartens, schools and new media, as well as consider the effects of the pedagogies as they are internalised or resisted. Again works in the collection trouble the impact of the obesity epidemic and how it is shaping the contours of policy as well as people’s lives, professionally and/or
personally. Throughout the collection authors draw from multifarious theoretical resources to inform their discussions of body pedagogies and again Foucault is never far from the frame. Interestingly, healthism again has been identified as a significant player and in need of consideration (see for example Lee & Macdonald, 2010).

Another special edition emerged last year in the journal ‘Policy Futures in Education’. The title of the edition was Politics, pedagogy and practice in school health policy and the purpose of the edition was to provide an overview of scholarship that ‘describe[s] existing and emerging health issues and detail[s] how policy responses are produced, enacted and received by students, teachers and policy makers’ (Vander Schee & Gard, 2011, p. 308). Again the works are largely targeted toward developing insights into the various forces influencing policy responses and how such responses are playing out in people’s lives.

Amongst the critical scholarship on obesity, Carolyn Vander Schee’s various works stand out as being more clearly concerned with the field of Health Education (see for example Vander Schee, 2008a, 2008b, 2009a, 2009b). Her work is explicitly Foucauldian and draws on governmentality studies to shed light on the various ways in which policy is construed in response to governmental imperatives and prevailing rationalities. Additionally though her work explores how health discourses are taken up in a variety of settings, by a variety of people (for example in families, schools and by teachers). Her work aligns with mine in many ways and I use many of her analytical insights to shed light on some of the data discussed throughout the chapters of this thesis.

The kinds of analyses that emerge from a Foucauldian inspired lens differ dramatically from the earlier critical scholarship that took issue with the politics of health education. The various Foucauldian inspired analyses have provided significant insights into the different reasons as to why health imperatives have come to dominate the contours of late modernity. And further empirical studies have considered how such imperatives have come to permeate our embodied lives. The reality is though, as it was when I began this study, very few scholars
have comprehensively engaged with the governmental project of health education as a subject area. We know a great deal about the effects of the obesity epidemic and as a result health and the body as it is interpellated by obesity discourse. However the flip side here is that such an intense focus means that we know very little about other aspects of school based health education. For this reason I want to build on some of the various analytical inroads overviewed above, to interrogate health education as a contemporary site of governance.

Using governmentality as a theoretical frame permits different types of questions and encourages the location of health education within a history of practices that have sought to render the population governable. These are very different ways of talking about, and understanding the politics of health education compared to those offered by critical traditions. Within a governmentality frame, power is conceived of very differently to ideas of power that circulate in critical theory. Power, according to Foucault (1984a, p. 93) in this frame, is:

...everywhere; not because it embraces everything, but because it comes from everywhere ... Power is not something that is acquired, seized, or shared, something that one holds on to, or allows to slip away; power is exercised from innumerable points, in the interplay of nonegalitarian and mobile relations.

So power not only emanates from juridical and sovereign sites, it also circulates in the everyday. Within this then re-conceptualisation, questions related to the politics of health education and social control, are recast to be questions about governmental rationalities and techniques that are assembled together across multiple sites.

Conclusion

The purpose of this chapter was to consider the ways in which researchers have engaged with questions of politics, social control and regulation in health education over the past 30 years. The chapter reviewed two ways of conceptualizing the political project of health education. In the first section I offered a review of the critical health education literature and explored the fields
informing such analyses, in a sense its historical contingencies. Although this work was significant in shaping new forms of health education, it had the effect of reinstating and reproducing regimes of truth that simply repackaged forms of responsibility and action. Further to this, the critical moment never did live up to its promise to eradicate the presence of individualist approaches to health education. In the second part of the chapter, I explored what Foucault and his writings around governmentality offered those interested in understanding questions of politics in health education. The various analyses that have evolved from Foucauldian inspired insights provided a very different approach to contemplating the how and why of health education through a consideration of the effects of the obesity epidemic. Having established the basis for exploring new sets of questions about the politics of health education, in the next chapter I extend on my discussions to explore how I put Foucault to work in this thesis to consider how health education ‘acts’ as a site of governance.
Chapter Two: Methodology and methods

Introduction

In the previous chapter I charted some of the major conceptual terrain and literature that has made up, and continues to make up, the broad field of inquiry within which this thesis is located. In the chapter I highlighted that, over time, many scholars who had been interested in questioning and interrogating the political project of education conceptually wound their way to Foucault. And like those who came before me, so too did I. In reflecting back to the initial beginnings of the project, it was actually difficult to think ‘otherwise’ at the time, as the Foucauldian wave that was washing over education caught many in its wake. Importantly though, it seemed the perfect wave to catch. Although there were burgeoning critiques of his work at the time (for example see Sawicki, 1991), Foucault’s conceptual work on governmentality, and in particular those elaborating on it, was proving to be incredibly generative. Dean (2010, p. 2) has termed this collective body of work ‘governmentality studies’. It is this body of work that emerged out of Foucault’s scattered comments on governmentality (Miller & Rose, 2008, p. 10) that provides the theoretical and methodological frame for this thesis. Although the legacy of governmentality is layered throughout the first chapters, the purpose of this chapter is to specifically gather some of the various conceptual and analytical concepts from governmental studies, both historical and contemporary, to enable the development of an analytics of government.

The first section of the chapter takes as a starting point, Foucault’s scattered comments on governmentality (Miller & Rose, 2008, p. 10) and interweaves them with some of his insights related to health and the population. I extend on this discussion to review the broader field of governmentality studies and introduce the notion of governmental assemblages. The section goes on to explore the notion of governmental assemblages as a conceptual apparatus that has been developed by several post Foucauldian governmentality scholars. Drawing on
these insights here, I propose an analytics of governmental assemblages that informs the kinds of questions that underpin the empirical work of the thesis. The second section of the chapter provides an overview of the research methods and processes that enabled me to seek out possible answers to the various research questions posed.

Section one: Governmentality

In this section I provide an overview of the field of governmentality studies as a backdrop to the development of the analytics that shape my research questions and in turn inform the empirical work of the thesis. Dean (1999b, p. 2) suggests that governmentality is a field of study that is ‘of necessity a collective process, conducted in many places and from many perspectives’. Drawing on Deleuze and Guattari’s (1987) concept of the rhizome, Dean suggests that governmentality studies is rhizomatic in character, in that it can start at local centres, form networks and appear to connect in unlikely places. To find a starting point within this rhizome then, I turn to a beginning that many scholars turn to, Foucault’s 1978/79 lecture series and specifically a lecture entitled ‘governmentality’. From here I map some of the contours of the field, the various connections and key analytical elements that have been developed by Foucault, and also others. The section essentially weaves its way through what might be referred to as the rhizome of governmentality and finishes with an overview of an analytics of ‘governmental assemblages’. Given the rhizomatic nature of the field, and thus the various and tangled threads, this section could never provide a definitive overview of governmentality studies. Rather what is offered here is an overview of my attempt to traverse the rhizome to develop an analytics that I can put to work in an examination of school based health education. In the spirit of Miller and Rose (2008, p. 8) I have ‘picked and chose[n], added ideas and concepts from elsewhere’ throughout the rhizome. This was a necessary process. And as I spent more and more time immersed within the rhizome concepts appeared to morph, new connections were formed, paths forged and new rhizomes created. In many
ways my engagement with Foucault’s and others’ work resonates with St Pierre’s retelling of her experience. She states:

...that each of us must constitute him again and again for our projects and our lives as we reconstitute ourselves. And as we work hard to think differently than we have before, we go back to Foucault differently and find him again and again in another thinking space (2004, p. 326).

Regardless of the circularity of thinking, and the picking and choosing of concepts there is no doubt that my work ‘evinces a wandering fidelity’ to governmentality studies (Dean 2010, p. 2). I now turn to review Foucault’s writings on governmentality, before considering insights from the broader field of governmentality studies to map out the analytics that shapes and informs the remainder of the thesis.

**Foucault on governmentality**

This subsection and the next is ‘dedicated to tracing the multiple and tangled lines that constitute the history of governmentality’ (Dean 2010, p. 40). As previously stated Foucault’s lecture series given at the College de France in 1977/78 and 1978/79 provides governmentality scholars, and myself, with a possible beginning (Senellart, 2007, 2008). The series was entitled ‘Security, territory and population’ and ‘The birth of biopolitics’ respectively and had at its centre questions related to what Foucault refers to as the ‘art of government’, though his thinking on government was not just confined to the series. What did Foucault mean by government? Foucault defined government as ‘the conduct of conduct’ stating that government relates to the ‘way in which the conduct of individuals or groups might be directed: the government of children, of souls, of communities, of families, of the sick ... to govern in this sense, is to structure the possible field of action’ (Foucault, 1982, p. 220-221). His various analyses, or what Gordon (1991, p.3) refers to as ‘different and discontinuous forays’ sought to explore questions related to how conduct, and attempts to shape conduct, were imagined and enacted within different historical epochs, states and sites (Gordon, 1991). An instructive example of this style of analyses can be found in one of his lectures in
the series, entitled ‘Governmentality’. In this lecture Foucault explicitly began
‘making an inventory of this question of government’ (Foucault, 1991, p. 87). His
starting place in the lecture was sixteenth century Europe because, in his words,
‘government as a general problem seems to me to explode’ during this time. He
highlights a number of problems that emerge:

One has, for example, the question of the government of oneself, that
ritualization of the problem of personal conduct which is characteristic
of the sixteenth century Stoic revival. There is the problem too of
government of souls and lives, the entire theme of Catholic and
Protestant pastoral doctrine. There is the government of children and
the great problematic of pedagogy which emerges and develops during
the sixteenth century. And, perhaps only as the last of these questions
to be taken up, there is the government of the state and Prince. How to
govern oneself, how to be governed, how to govern others, by whom
the people will accept being governed, how to become the best
possible governor – all these problems in their multiplicity and
intensity (Foucault, 1991, p. 87).

In seeking to explain the explosion in questions related to government, Foucault
suggests that they emerged at what he refers to as the crossroads of two processes.
He states:

There is a double movement, then, of state centralization on the one
hand and the dispersion and religious dissidence on the other; it is, I
believe, at the intersection of these two tendencies that the problem
comes to pose itself with this peculiar intensity, of how to be ruled,
how strictly, by whom, to what end, by what methods, etc. There is a
problematic of government in general (Foucault, 1991, p. 87).

The analytical lines taken here by Foucault direct us towards a consideration of
how changing social and political contexts present varying problematics for
government, and in turn solutions. Of significance in this lecture, as well as in
Foucault’s other work, is the charting of the shift away from sovereign power
towards emerging forms of power necessary for governing the modern state (see
for example Foucault, 1982, 1984c, 2003). Central to the development of
the modern state, amongst other things, were the introduction of economy and the
development of population as a governable domain. Below, Foucault discusses the
shift:
In contrast to sovereignty, government has as its purpose not the act of government itself, but the welfare of the population; the improvement of its condition, the increase of its wealth, longevity, health, etc.; and the means that the government uses to attain these ends are themselves all in some way immanent to the population; it is the population itself on which government will act either directly through large-scale campaigns, or indirectly through techniques that will make possible, without full awareness of the people, the stimulation of birth rates, the directing of the flow of population into certain regions or activities, etc. The population now represents more the end of government than the power of the sovereign (Foucault, 1991, p. 100).

The shifts documented by Foucault here amongst other things point to how population health finds itself brought into the sights of government. The shift also heralds a new form of politics and political power which Foucault termed ‘biopolitics’ and ‘biopower’ respectively (Foucault, 1984). In thinking about gathering conceptual tools to put to work in this thesis, this juncture in Foucault’s essay on ‘governmentality’ is significant as it opens up new lines of interrogation about the relationship of health to politics and power. The essay highlights the various entanglements of amongst other things, health, biopower and modern government and marks the very beginnings of my rethinking and reformulating of questions related to the political project of health education. In order to move forward with my analytics though, it is necessary to move elsewhere within the rhizome, to consider Foucault’s interconnected writings in biopower and health. This move necessitates a step back in time, to Foucault’s various earlier lectures on health and biopower.

Foucault’s thoughts on biopower and health are scattered throughout his body of writings (see for example Foucault, 1984a, 1994, 2003). Of particular interest to this thesis is his essay entitled ‘The politics of health in the eighteenth century’ (Foucault, 1984a). In this essay, Foucault documents the ways in which health becomes inextricably linked to the project of modern government. He suggests that:

...the emergence of the health and physical well-being of the population in general as [is] one of the essential objectives of political power. Here it is not a matter of offering support to a particularly
fragile, troubled or troublesome margin of the population, but how to raise the level of health of the social body as a whole. Different power apparatuses are called upon to take charge of “bodies”, not simply so as to exact blood service from them or levy dues, but to help and, if necessary, constrain them to ensure their own good health. The imperative of health: at once the duty of each and the objective of all (Foucault, 1984, p. 277).

The shift he says is tied to:

…the great eighteenth-century demographic upswing in Western Europe, the necessity for coordinating and integrating it into the apparatus of production, and the urgency of controlling it with finer and more adequate power mechanisms cause “population”, with its numerical variables of space and chronology, longevity and health, to emerge not only as a problem, but as an object of surveillance, analysis, intervention, modification, etc. The project of a technology of population begins to be sketched: demographic estimates, the calculation of the pyramid of ages, different life expectations and levels of morality, studies of the reciprocal relations of growth and wealth and growth of population, various measures of incitement to marriage and procreation, the development of forms of education and professional training (Foucault, 1984, p. 278).

Within the above excerpts, one can begin to trace the antecedents to modern health education. Following Foucault, given the linkages being formed between population health and government, it becomes necessary to make health the duty and objective of all. The question then becomes where and how then to do this? In relation to the where, Foucault highlights that in order to bring the stated governmental hopes into being there is a need for the development of a myriad of apparatuses and technologies. Education is cited as one such technology that is required. Given this, it is difficult not to think that the stage is being set for health education to make its grand entrance. In thinking about the emergence of health education then, and the associated expectations, Foucault’s insights here shed some light on the hopes for school based health education. My point here is that in developing an analytics of present entanglements, understanding past entanglements has proven to be generative. The very reasons for health education are interlocked with imperatives for health, and indeed the enactment of modern government. This insight is an important one and will feature in the following
chapter where I consider the official curriculum context and the associated hopes for contemporary school based health education.

I want to turn now to consider the questions ‘How to make the imperative of health the duty of all?’ What kind of power is required ‘to help and if necessary constrain them [individuals within the population] to ensure their own good health’? And Foucault answers his own questions by stating that ‘different power apparatuses are called upon’, one that is different to sovereign power, one that breaths life into the subject as opposed to suppressing it. Foucault (2003) termed this power, biopower.

Foucault’s discussions of biopower occur throughout his 1975-76 lectures Society must be defended and in the final chapter of the History of sexuality volume one. He also revives it in his lecture series The birth of biopolitics, suggesting that it is a political technology of modern governmentality. So whilst on the one hand sovereign power is considered to be ‘repressive’, on the other hand biopower is necessarily ‘productive’ and ‘it is over life, throughout its unfolding, that power establishes its dominion’ (Foucault, 1984, p. 138). Foucault (2003, p. 81) suggests that biopower has two poles that operate concurrently. They include biopolitics, or in other words the regulation of the population, and anatomo-politics which refers to the disciplining of individual bodies. The health of the population, and within this, individuals, is swept up within the shifting mentalities of government. Biopower works through social and individual bodies via an ‘...abundance of technologies and discourses that circulate, modify, multiply’ (Harwood, 2009, p. 18) produced by ‘the explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations’ (Foucault, 1984, p. 140).

Biopower has been a useful analytic for scholars interested in thinking about health (see for example Gastaldo, 1997; Lupton, 1995; Nadesan, 2008; Turner, 1997; Wright & Harwood, 2009). Following Harwood (2009) I too want to suggest that there is value in utilising biopower as an analytic in that it ‘sheds light on the problem of the subject because it shows up the control of individuals and populations through bios practices associated with the body in the modern
state’ (p. 20). It is an important conceptual device that I put to work throughout the chapters in the thesis.

Before concluding this section, I want to return to Foucault’s lecture on Governmentality, to consider what he meant by the term. According to Foucault governmentality means three things. They are:

1. The ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political economy, and its essential technical means apparatuses of security.

2. The tendency which, over a long period and throughout the West, has steadily led towards the pre-eminence over all other forms (sovereignty, discipline, etc.) of this type of power which may be termed government, resulting, on one hand, in the formation of a whole series of specific governmental apparatuses, and, on the other hand, in the development of a whole complex of savoirs.

3. The process, or rather the result of the process, through which the state of justice of the Middle Ages, transformed into the administrative state during the fifteenth and sixteenth centuries, gradually becoming ‘governmentalized’ (Foucault, 1991, p. 102-103).

Foucault’s above outline of governmentality, and my tracings of his interconnected and tangled writings on biopolitics, biopower and health provide a starting place from which to launch the thesis. But they are only one part of the rhizome of governmentality. I want to turn now to consider the field of studies that has emerged out of Foucault’s writings, as a means to further develop the analytic frame that informs this thesis.

The field of ‘governmentality studies’

As previously mentioned Foucault’s writings on governmentality provide a possible beginning for questions related to politics and health education. There are of course many possible beginnings for scholars interested in such questions, and it did not take me long to find other analytical starting lines, middles and ends
within the rhizome of governmentality studies. Of significance here is the work of
governmentality scholars Colin Gordon (1991), Graham Burchell (see for
2007), Mitchell Dean (see for example 1995, 1999, 2007, 2010), Peter Miller (see
for example with Rose 1990, 2008), Jonathon Inda (2005) and Patrick O’Malley
(2004). Collectively their work brought Foucault’s thinking around
governmentality into conversation with questions of government in the twentieth,
and more recently the twenty first century. This work is integral to my analytics.

Further to this, analytic discipline clusters branched off and formed, and have
continued to form, as scholars from various disciplines took up different lines of
analysis being made available to them both within and outside Foucault’s work on
governmentality. In particular scholarship around the clusters of psychology
(Rose, 1998, 1999), health (Harrison, 1995; Lupton, 1995; Peterson, 1997;
Peterson & Bunton 1997; Peterson & Lupton, 1996; Nadesan, 2008), youth
studies (Kelly, 2001; Tait, 2000), education (Baker & Heyning, 2004; Gore, 1998;
Hunter, 1996; McLeod, 1995; Peters et al 2009; Popkewitz, 1998; Popkewitz &
Brennan, 1998; Zipin & Brennan, 2009), physical education (Evans, Davies &
Wright, 2004; Kirk, 2004; Wright, 2000), health education (Beckett, 1999;
Gastaldo, 1997; Lupton, 1999; Tinning & Glasby, 2002; Vander Schee, 2008,
2009) and more recently obesity (Rich, 2010a; Rich, Monaghan & Aphromor,
2010; Vander Schee & Gard, 2011; Wright & Harwood, 2009) have all shaped my
analytics of governmentality. The various clusters listed above are part of what
might be referred to as a broader governmental assemblage. I would suggest that
school based health education is part of this broader governmental assemblage,
with intersections and connections with multiple clusters, or assemblages. The
notion of governmental assemblage is significant here as it captures a certain way
of thinking about a governmental field, and its relationships and inter/connections
to other fields. Given the suggested analytic significance I want to now turn to
consider some of the contemporary writings on governmentality, and in turn
governmental assemblages to establish the analytical framework for the thesis.
Assembling an analytics

The analytics for this thesis is inspired by many, and for the duration of my research I have found myself inside the rhizome of governmentality pursuing various paths, settling on a trajectory for a moment and then wandering off again. What follows is a version of analytics that I have settled on for the time being, though as I continue to write my way through the thesis, I know that a changing analytics is not too far away. This is something I and others have nodded to more recently in our continuing engagement in thinking about, and rethinking the usefulness of governmentality as a theoretical and methodological lens (see Leahy, 2009; Rich, 2010b, 2011; Walkerdine, 2009). A more in depth discussion of the possibilities and limitations of governmentality as a lens for analysis forms part of the conclusion of the thesis, as I consider the ‘where to from here’. Another factor impacting on my capacity to settle on an analytics emerges from what Dean (2010, p. 13) refers to as ‘the mash up’ of concepts and ideas that result as scholars work in the field. The mash up results from ‘the production of new concepts in the course of that study, or in the course of using other scholars study. The production of concepts multiplies possibilities of analysis; concepts come back combined with those of others, in different empirical domains. It is little wonder it has been difficult to settle on a particular trajectory for my analytics. But settle I have. In particular I draw from the work of Nikolas Rose and Mitchell Dean, though others make their way into the frame. Both scholars have spent a significant amount of time considering the fragments of Foucault’s governmentality in analysing how ‘this present has been assembled’ (Miller & Rose, 2008, p. 8) and their influence can be traced throughout the discipline clusters in the rhizome of governmentality studies. I utilise their writings on governmentality, to not only refine workable definitions, but also to conceive of how the ‘conduct of conduct’ is actually conducted within the contemporary moment. Much of their work too features throughout the remaining chapters of the thesis as I make sense of the relationship that school based health education has to an arts of government, as well as how it goes about doing governmental work.
In searching through the rhizome to settle on definitions and workable terms, various ‘mash ups’ and interpretations circulate. Rather than review the many attempts at reworking and adapting Foucault’s earlier thoughts on what governmentality is, I am going to draw on Dean’s (2010) attempt at a coherent and concise overview of some of the key terms. Dean expands on Foucault’s thinking around governmentality and the ‘conduct of conduct’ and suggests that the term ‘governmentality’ seeks to discern the particular mentalities, arts and regimes of government and administration that have emerged since ‘early modern’ Europe. Government then involves ‘any attempt to shape with some degree of deliberation aspects of our behaviour according to particular sets of norms and for a variety of ends’ (p. 18). He goes on to suggest that:

Government is any more or less calculated and rational activity, undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledges, that seeks to shape conduct by working through our desires, aspirations, interests and beliefs, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes (2010, p. 18).

In contemplating approaches to the analysis of government, Dean (2010) suggests that:

Government concerns not only practices of government but also practices of the self. To analyse government is to analyse those practices that try to shape, sculpt, mobilize and work through the choices, desires and aspirations, needs, wants and lifestyles of individuals and groups. This is a perspective, then, that seeks to connect questions of government, politics, and administration to the space of bodies, lives, selves and persons (p. 20).

Dean’s definitions and approach to analytics gathered together with Foucault’s work on the emergence of health and wellbeing as a site of governance, provides significant momentum for the forging of one of the main arguments I posit in this thesis. The argument that I am making is that school based health education can be understood to be an apparatus of government, in that it seeks to shape individuals’ behaviour in ways that are consistent with contemporary imperatives.
of government. This argument gets taken up and explored in more detail in the following chapter where I analyse the contemporary policy/curriculum landscape in which health education is presently located and enacted. But in coming to understand how it is that school based health education has been assembled together, and in turn how it functions as a cog in the governmentality machine, further analytical devices are required. Foucault (1990, p. 102) in his initial lecture on governmentality referred to it as being ‘the ensemble formed by the institutions, procedures, analyses and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power’. The ensemble mentioned here by Foucault, has been a concept that I, along with others, have found generative. However rather than persisting with ensemble, I have followed Rose’s lead and utilised the term ‘assemblages’ as a key analytical device for attempting to understand how government is conceived of and enacted within the contemporary moment. The assemblage is a concept that is borrowed from Deleuze and Guattari (1987) and is integral to my study, as the title of my thesis might attest. I want to suggest that analytically it is useful to understand school based health education as a governmental assemblage. This line of analysis emerges out of the work of Rose and Dean as they offer their take on contemporary governance and the multifarious ways it is enacted. The insights afforded by their renderings of how government operates within the contemporary context suggest that the practices of government:

...cannot be understood as expressions of a particular principle, as reducible to a particular set of relations, or as referring to a single set of problems or functions. They do not form those types of totalities in which parts are expressions of the whole. Rather they should be approached as composed of heterogeneous elements having diverse historical trajectories, as polymorphous in their internal and external relations, and as bearing upon a multiple and wide range of problems and issues (Dean, 1999, p. 29).

Similarly Rose (2000) suggests that at the general level, the project of contemporary governance is one that materializes as confusing as it is ‘assembled from a complex and hybrid range of technologies [and] ... enacted via a whole
range of organisations, a whole variety of authorities and lash ups between diverse and competing bodies of expertise’ (2000, p. 323). The end result being that:

...current control practices manifest, at most, a hesitant, incomplete, fragmentary, contradictory and contested metamorphosis, the abandonment of some old themes, the maintenance of others, the introduction of some new elements, a shift in the role and functioning of others because of their changed places and connections with the ‘assemblage’ of control (2000, p. 322).

In following both Dean and Rose’s lead here in forging an analytics, I find myself in new and exciting relatively uncharted territory. The various discipline clusters of education and health have not extended their analysis to consider the multiple elements that make up the assemblage of school based health education. And, as I have discussed in the previous chapter, there has been precious little scholarship that acknowledged the ‘messiness’ or ‘confusion’ inherent within the assemblage of governmentality, and what this might mean for empirical work. In drawing from these insights, several new questions emerge in relation to school based health education and its governmental entanglements, both internally and externally.

In pursuing the analytical lines forged here I want to suggest that it is generative to understand school based health education as an assemblage in and of itself with complex linkages and connections to other assemblages. In thinking about it in this way, interesting questions are opened up in relation to how school based health education is assembled, and how it functions in its designated role within the broader governmental assemblage. For example: What are the elements that make up the field of health education? How do the linkages support each other? How might they contradict each other? How has Health Education morphed over time? What are the enduring features of health education? What features are no longer present? What role is given to health education in broader governmental assemblages and how does this impact on how health education is assembled?

Before settling on an analytics and my research questions though, I want to consider a second, but inter-related tier of analysis. This tier draws again from
Rose and Dean’s work as they make suggestions for what empirical adventures might ensue for those who are interested in interrogating approaches to thinking about, and doing, government. And although I have touched on some of these in Chapter One I want to extend on that discussion here. Dean (2010, p. 13) suggests that ‘the study of governmentality indicates an empirical terrain of the rationalities, technologies, programmes and identities of regimes of government’, whilst Rose (1999, p. 19) elaborates on this by suggesting that governmentality requires:

…studies of a particular ‘stratum’ of knowing and acting. Of the emergence of particular ‘regimes of truth’ concerning the conduct of conduct, ways of speaking truth, persons authorised to speak truths, ways of enacting truths and the costs of so doing. Of the invention and assemblage of particular apparatuses and devices for exercising power and intervening upon particular problems. They are concerned, that is to say, with the conditions of possibility and intelligibility for certain ways of seeking to act upon the conduct of others, or oneself, to achieve certain ends. And their role is diagnostic rather than descriptive: they seek an open and critical relation to strategies for governing, attentive to their presuppositions, their assumptions, their exclusions, their naiveties, and their knaveries, their regimes of vision and their spots of blindness.

Both Rose and Dean provide ample direction for the formulation of a number of analytical lines, and I follow these lines, as I work towards developing research questions and conducting my analysis throughout the remaining chapters. In settling on which lines, it seems that Rose and Dean’s (plus a myriad of others) analyses have clustered around three major themes for investigation. They are as Inda (2005) summarises the themes of reasons, technics and subjects. The analytical themes contribute to the shaping of my research questions, and in turn feature throughout the chapters of the thesis. And although I utilise Inda’s framework below as I examine the various approaches, I replace the terms technics, with techniques. The reason for this is that the expression techniques tends to be the preferred term used by many in the field.

The first analytical theme, reasons, relates to the political reasons and rationalities of government. As Inda (2005, pp. 7-8) suggests:
...this domain specifically directs us to consider the forms of political reasoning ensconced in governmental discourse, the language, vocabulary of political rule, the constitution of manageable fields and objects, and the variable forms of truth, knowledge, and expertise that authorize governmental practice. Political rationalities, in short, name the field wherein lie the multiplicity of endeavours to rationalize the nature, mechanisms, aims and parameters of governmental authority.

For Rose (1999, p. 30) analysing the political reasons and rationalities of government involves ‘analysing what counts as truth, who has the power to define truth, the role of different authorities of truth, and the epistemological, institutional and technical conditions for the production and circulation of truths’. Analytical attention is given here to the ‘intellectual machinery that render[s] reality thinkable in such a manner as to make it calculable and governable’ (Inda, 2005, p. 7). And according to Inda (2005) this includes giving consideration to the kinds of rationalities that are sustained by, and depend on, expertise and a wide range of knowledges and their relationship to conceiving of, and implementing government. In addition a focus on reasoning and rationalities also calls into question how ‘problems of government’ are imagined, what kinds of knowledges are bought to bear on such problems and how governmental discourse at the time shapes responses.

The second analytical theme, techniques, relates to how government is put into motion. The focus here is very much on the practical form of government and the guises it takes. Analysis here is concerned with the practical mechanisms by which authorities seek to shape conduct. Or in Inda’s (2005, p. 9) words it is concerned with ‘the various complex of techniques, instruments, measures, and programs that endeavours to translate thought into practice and thus actualize political reason’. According to Inda (2005) techniques reveal themselves in two ways, the programmatic and technical instruments. In referring to the programmatic, Inda (2005) is talking about how programs are deliberately formed to shape conduct with the analytical emphasis placed on considering how ‘such governmental schemes conceptualise, manage and endeavour to resolve particular problems in light of specific goals’ (Inda, 2005, p. 10). School based health education then might be understood as a program in and of itself, and it may well
be understood, depending on how it is enacted in schools, to rely on multiple programs that reach into an overall school program. For example school based health education is directed towards shaping young people’s health in light of government goals for better health outcomes. In addition to this as a subject area it has its own goals for what it hopes to achieve and these are detailed in versions of official curriculum. In drawing attention to the programmatic form of governmentality, school based health education is necessarily brought into the frame for consideration. But the programmatic needs to be considered in light of the other analytical domain that falls under the umbrella of techniques, and that is technical instruments.

Inda draws from Rose (1996, 1999) and Dean’s (1999) work to offer various examples of technical devices that are integral in shaping the conduct of conduct. Of particular significance here for my analysis is the identification of devices that include the standardized tactics for the training and implementation of habits, techniques of notation, numeration and calculation, pedagogic, therapeutic, and punitive techniques of reformation and cure and architectural forms in which interventions take place (Inda, 2005, p. 9). Within the field of health education, technical devices might be understood to be the various teaching and learning strategies that try to enlist young people into valuing and participating in health[y] practices. They might also include the various life skills that health education attempts to instil in its subjects. Given the role of technical devices in the ‘doing’ of governmentality, they become a key point of interest when analysing the ‘how’ of school based health education.

The final ‘analytical’ theme in Inda’s (2005) trilogy of themes is that of subjects. The analytical focus here is on how governmentality imagines, but also seeks to cultivate, its subjects. Inda turns to Dean (1999, p. 32) to summarize some of the key questions that might be asked in relation to this analytical theme. Dean writes:

What forms of person, self and identity are presupposed by different practices of government and what sorts of transformation do these practices seek? What statuses, capacities, attributes and orientations are assumed of those who exercise authority (from politicians and
bureaucrats to professionals and therapists) and those who are to be governed (workers, consumers, pupils and social welfare recipients)? What forms of conduct are expected of them? What duties and rights do they have? How are these capacities and attributes to be fostered? How are certain aspects of conduct problematized? How are they then to be reformed? How are certain individuals and populations made to identify with certain groups, to become virtuous and active citizens, and so on? (Dean, 1999, p. 32)

The questions posed above by Dean are generative for thinking about the subject of school based health education. There is a double play here, in that the subject of health education has a particular subject in mind. This thesis is interested in exploring how the subject is imagined within the mentalities of government, and what kind of subject school based health education wishes to cultivate.

**Assembling my research questions**

In making my way through the rhizome of governmentality studies, I have gathered various conceptual tools from Foucault, and others to form an analytics for this thesis. Central to the analytics is an understanding that school based health education is a governmental assemblage, in and of itself, with entanglements to other assemblages. It is an assemblage that has evolved over time and is made up of multiple elements (including curriculum, programs and classrooms) and within those multiple reasons, techniques and imaginings of subjects. This thesis then is interested in exploring a number of research questions that will enable me to consider school based health education’s role within contemporary governmental assemblages, as well as identify some of its elements, rationalities, techniques and conceptions of its subjects. The research questions that emerge at this juncture are:

1. What elements make up the assemblage of school based health education?
2. What are school based health education’s rationalities, techniques and subjects and how do they come together in settlements of curriculum and pedagogy?
3. What are the implications for the subject of health education itself, and in turn its subjects?
Section two: Assembling methods

To understand formations, cohesions and transmutations of governmental assemblages, we do need to look at the loci of state action through which discourses promoting mentalities such as human capital circulate; but we must also look across multiple institutional and lived sites where mentalities are more tacitly taken up and put to work by actors in specific contexts (Zipin and Brennan, 2009, p. 343).

The above quote was not published at the time I was considering the empirical work of the thesis. However it very much reflects my thinking when I was deciding on an approach to fieldwork. The suggestion that in order to understand the how of governmentality we need to consider lived sites where governmentality is put to work here is a significant one. The very nature of my analytics, research questions and my subsequent thinking around methods reflects a desire to, amongst other things, consider and engage with the ‘lived sites’ of school based health education. At the time when I was attempting to settle on my research questions and the ensuing methods, there were few studies that considered governmentality in motion in the lived sites of educational places and spaces. Moreover there were few, if any, studies that analysed school based health education from a governmentality perspective, let alone considered how such attempts to govern were being played out in schools. I would suggest that this is still largely the case, although there have been several studies recently that have explored how teachers enact health imperatives in schools (for example see Cliff & Wright, 2010; Rich, 2010; Vander Schee, 2009). And whilst looking for a method to impersonate and adapt to my research needs (Honan, 2001) I soon discovered that there was no established path to follow. The situation is exacerbated by the dominance of genealogical research in the rhizome of governmentality studies, or versions thereof, that seek to analyse documents, be they historical or contemporary policy documents, curriculum documents or other supporting texts. Shifting ones gaze to ‘the lived sites of governmentality’ requires a somewhat different approach.
This section of the chapter then provides an overview of both the why and how of the empirical work of the thesis. It is divided into three subsections. In the first subsection I briefly consider what elements make up the assemblage of school based health education. This is a necessary analytical manoeuvre that permits a preliminary mapping of the assemblage. The purpose here is to identify the various elements and, in turn, potential sites for investigation. The second subsection provides both an overview and justification of the ‘elements’ that I have elected to focus on in this thesis. This subsection effectively comprises what is usually referred to as ‘research methods’, and consequently I set about describing the why, how, when and what of the fieldwork. In the third subsection I describe the approach I take to analysing data. This section weaves together an adapted version of Foucauldian discourse analysis conducted along the analytical lines developed in section one.

The elements of school based health education

As I have previously suggested, a central tenet of my research is the understanding that school based health education is a governmental assemblage. Following Dean (1999) and Rose (2000) I want to suggest that this assemblage is made up of multiple elements, which are, in turn, made up of various assemblages of reasons, techniques and/or subjects. The ‘make up’ of the assemblage is something that I address in more depth in the following chapters given that it is one of my key research questions. However for the purposes of this chapter I need to ‘slice through’ the assemblage of school based health education to identify the key elements that will provide the focus for this study. In deciding on where to make the incisions, I turn to the broader field of curriculum studies and utilise the categories of official curriculum and enacted curriculum (see Jackson, 1996; Luke 2010; Yates & Grumet, 2011). These categories are used to establish analytical lines between official versions of curriculum, for example State based syllabus documents, and how those syllabus documents are enacted at the school level. Following this, I want to suggest that the official curriculum and versions of the enacted curriculum, both programs and classroom teaching, are key elements in
the governmental assemblage of health education. In trying to answer my research questions and grasp the reasons, techniques and subjects that make up the elements of the assemblage of school based health education I suggest that each element must be considered in analytical isolation. There are a multitude of reasons as to why I make that suggestion. As previously stated, much of the governmentality scholarship to date has tended to focus on interrogating the political rationalities of policy and curriculum. And although there is a significant literature in this area of educational scholarship, there is little in the way of analysis of the official curriculum documents of school based health education. Thus the official curriculum is a necessary beginning for this study. Given the dominance of policy work and genealogies, or what McKee (2009, p. 473) refers to as ‘discursive governmentality’, there have been very few attempts at exploring how governmental educational hopes are played out, or not, in everyday lived sites.

The present study is interested in both the rationales of government as they manifest in key governmental documents, as well as the more specific ‘concrete art of governing’ (McKee, 2009, p. 473). To capture this, it becomes necessary to take ‘Foucault to the field’ to consider the enacted curriculum. In particular I focus on school based program versions of health education and classroom teaching. But taking ‘Foucault to the field’ requires what Tamboukou and Ball (2003) refer to as an intellectual border crossing. And as precarious as it may be, I consider it a necessary crossing to make, if I am to make any sense of the how the political hopes for health education are realised in practice.

**Researching the elements**

The intellectual border crossing I refer to above relates to the tensions that arise when working with Foucault in the field, namely with ethnography or ethnographic methods. The tensions emerge as ethnography and Foucault are not necessarily considered to be theoretically aligned (see Rabinow, 1985). Regardless though numerous others have made the crossing before me and have carved out a network of pathways by which to make possible crossings (see for
example Brady, 2011; Burrows, 2010; Gore, 1995a, 1995b, 1997, 1998; Harwood, 2000; Honan, 2001; Li, 2007; Tamboukou & Ball, 2003; Vander Schee, 2009; Wright, 2000). What tempts me though to consider fieldwork, as opposed to just sticking with policy and curriculum analysis, is the lure of the promises and possibilities that ethnographic methods hold. Like Britzman (2000), I live in hope that ethnography can offer education a more complicated version of how life is lived. My hopes are attached to being able to better understand the contemporary arts of government, and how school based health education operates as a governmental apparatus. In light of this, Brady (2011, p. 267) suggests ‘ethnographic methods bring to governmentality studies an ability to conduct ‘bottom up’ analyses that focus on responses to new political rationalities and technologies’. She goes on to argue that ‘governmentality studies informed by ethnographic analysis which seeks to understand what happens when plans to govern meet the processes and subjects they seek to transform’ are insightful. Similarly, Tamboukou and Ball (2003, p. 4) discuss the value of working with ethnographic methods and suggest that it can ‘make it possible for previously unthought connections to occur in both research and theory’. Like Zipin and Brennan (2009) I want to suggest that a consideration of the lived sites of governmentality is a necessary ‘border crossing’ that scholars in the field of governmentality studies need to make if they are interested in revealing the minutiae, and the complexities, of government in action. The following reflection from Rose, O’Malley and Valverde (2006, p. 101) serves as added comfort as I make the crossing:

The analytical tools developed in studies of governmentality are flexible and open-ended. They are compatible with many other methods. They are not hard wired to any political perspective. What is worth retaining above all from this approach is its creativity. We should not seek to extract a method from the multiple studies of governing, but rather to identify a certain ethos of investigation.

What follows is a discussion of how I think about, and in turn utilise ethnographic methods in my research. The discussion draws from poststructuralist writing on
ethnography as a means to ease the tensions, or at least nod towards them, as one makes the border crossing.

**Using ethnographic methods**

Ethnography is a well established and recognised approach to doing educational research that draws from a range of theoretical, analytical and conceptual approaches, for example interactionist, critical, feminist and post structuralist approaches (Gordon, Holland & Laheulma, 2001). The range of methods too vary and include the usual suspects of observation, interviews and collection of documentary data to try to capture the minutiae of lived experiences (see Hammersley & Atkinson, 2007). And it is these usual suspects that I utilise to research the elements of school based health education. On reflection my study is not, and nor did it attempt to be, a fully-fledged ethnography. Rather I would suggest that at the time of making decisions about how I was going to go about research I drew from writings on and around ethnography. My approach to research and data collection features some of the characteristics of ethnography, and may even at times mirror what might be considered to be an ethnography (Hammersley & Atkinson, 2007). If I had my time again, I probably would not hesitate in claiming my approach to research as ethnography, and approach it as such. Here I am resisting retrospectively rebranding and reconfiguring my study as an ethnography. Rather I am suggesting that my methods are assembled together in the spirit of ethnography though perhaps not necessarily in its image. In the following section I provide an overview of the various methods I utilised to collect data. As I have previously highlighted I decided to research a number of key elements within the governmental assemblage of school based health education. These include the state based official health education curriculum documentation and school based translations of these documents. The section provides a description of the what, why and how of data collection. In true ethnographic form, I utilised multiple methods to collect key texts from the assemblage. My discussion begins with ‘official curriculum documents’, and then
moves to consider enacted versions of curriculum as a means to follow govern ‘mentalities’ as they are put into motion in the lived site of the school.

**Official curriculum documents**

Official curriculum documents are without doubt one of the key elements in the governmental assemblage of school based health education. As key governmental artefacts, curriculum documents reveal what Popkewitz (2007) refers to as ‘the hope of schooling’, and following this, the hopes of health education. Such hopes are intensely political as schools, and the curriculum documents that frame much of what is to happen in schools, are ostensibly about changing people (Popkewitz, 2007). Curriculum documents then effectively provide the schema by which such changes are thought about and supposedly enacted in classrooms. Thus they contain explicit and implicit governmental reasonings, techniques and subjects of school based health education. They are what Foucault (1990) would consider to be ‘practical texts, which are themselves objects of a ‘practice’ in that they were designed to be read, learned, reflected upon, and tested out, and they were all intended to constitute the eventual framework of everyday conduct’ (p.12).

During the time that I have been engaged with this study, I have witnessed a number of curriculum changes in the form of revisions, as well as a curriculum revolution in Victoria. We are also about to witness another shift, as health education goes national in the coming year (or perhaps the next) as part of the ongoing roll out of the ‘Australian Curriculum’. The shifting ground of curriculum settlements is discussed in detail in the following chapter. For the purposes of my study the discussion levels its focus and analysis on the current Victorian health education official curriculum documents. At present, the traditional subject area of health education forms part of the broader curriculum assemblage of the Victorian Essential Learning Standards (VELS), and is in this present curriculum iteration referred to as ‘Health knowledge and promotion’. Given health education’s entanglements within the broader assemblage of VELS it is necessary to consider official curriculum documentation that pertains to VELS more broadly as well as the formal ‘Health knowledge and promotion’
curriculum area. Such entanglements then require a broader consideration of a range of governmental documentation that provided the backdrop to the shift to VELS for example various Blueprints and discussion and consultation papers. All of the documentation I refer to is available online through the Victorian Curriculum Assessment Authority and/or the Department of Education and Early Childhood Development.

As part of my analyses it was also necessary to consider previous state based Victorian health education curriculum documents, as well as curriculum movements. In doing this, I am influenced by Foucauldian and post-Foucauldian writings on genealogy, though my explicit purpose is not to conduct a full blown genealogy (see for example McLeod, 1995; Meredith & Tyler, 1993). My purpose here is to understand and borrow from what Burchell (1996) refers to as the ‘invented-ness’ of our world. Following this notion one can begin to ask questions of the ‘invented-ness’ of health education. I draw on Foucauldian insights here to render what Meredith and Tyler (1993) refer to as making the present strange. This analytical manoeuvre permits different vistas to come into view. The taken for granted-ness of the health education landscape becomes somewhat hazy and unfamiliar as one begins to follow this line of analysis. As one seeks to make connections to the broader assemblage of curriculum, past and present, a different reading of various shifts and settlements that make up the present health education curriculum are made possible. In summary, in analysing current state based health education curriculum, I consider other elements in the broader curriculum assemblage. This involves reviewing state based curriculum and supporting documentation, and historical state based health education curriculum and supporting documentation. The analysis seeks to reveal the myriad of reasons, techniques and subjects that assemble together to produce official versions of health education in Victoria in the present, and to understand this in the context of the past.
Enacted curriculum - school translations

As previously stated official versions of curriculum are an important element within the governmental assemblage of health education. However in an attempt to ‘get at’ the everyday practices of government it is necessary to consider other elements of the assemblage. Foucault himself suggests that this is an important analytical move directing us to consider a:

...way that is more empirical, more directly related to our present situation, and one that implies more relations between theory and practice. It consists in taking the forms of resistance against different forms of power as a starting point. To use another metaphor, it consists in using this resistance as a chemical catalyst so as to bring to light the power relations, locate their position, find out their point of application and methods used. Rather than analyzing power from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies (Foucault, 2003, p. 128–9).

It is the point of application that I was interested in. In the case of school based health education, versions of the enacted curriculum were of interest to my study. And again although not written at the time of my decision making Zipin and Brennan (2009, p. 344) capture my thinking around my desires to research applied government via the enacted curriculum. They state:

Educational policy workers thus weave discourses and techniques circulating from multiple sites: other government agencies, industry bodies, international policy documents and more. Not least are institutional settings where people in everyday life put such resources to work. In this vein we emphasise that mixes and new emergences of reason and tactic arise not only in venues of government per se, but in schools, workplaces and other locations where learners take up and assemble both discursive and practical-technical resources.

Given the aforementioned, it becomes necessary to consider how curriculum is applied or ‘enacted’ in schools. Teachers are central to this work, as educational policy workers, or what Rose (1999) would term ‘translators’. I consider ‘translation’ to occur in at least two different but entangled elements of the health education assemblage. First I was interested to consider how the official curriculum is ‘translated’ into school programs. In order to explore this element I
needed to consider the role of teachers as translators or ‘curriculum assemblers’, and in turn the programs that they produced in their schools. The second element of the enacted curriculum I was interested in considering for the study were health education classrooms. Here I was interested to consider the reasons, techniques and subjects of governmentality as they were put into motion in lived sites, or in other words, health education pedagogical spaces. The kind of research I was proposing required ethics approval from both the Department of Education, Employment and Training (approval number SOS01729) and LaTrobe University (approval number FHEC00/221).8

Given my interests I focused my research on three different Victorian public secondary school health education programs. The schools were purposefully selected, via the use of key informants in the field, in an attempt to identify ‘data rich’ sites. By ‘data rich’ I mean schools that had what might be considered a ‘health education’ champion teacher and a well established and comprehensive health education program that spanned across the compulsory years of schooling (years seven to ten). In reality my sampling strategy reflects my reluctance to ‘try’ any school as in many cases health education is a marginal subject that is delivered in ad hoc ways. It also reflects a belief at the time that only schools that had comprehensive programs would be ‘data rich’. In hindsight I know that most schools could provide interesting and rich data, perhaps different, perhaps not. But regardless my thinking at the time directed me to three particular schools. Each school had a health champion at the helm who oversaw the development and implementation of a comprehensive health education program. After identifying the schools I sent a letter to each Principal asking if I could conduct research in their school. Upon receiving approval I then approached each of the coordinators to arrange an initial time to discuss the project. Where schools had more than one staff member I organised a time to meet with the staff to present my research

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8 I was enrolled at LaTrobe University at the time I completed my research and so gained ethics approval from them. I moved my PhD to Deakin University post fieldwork.
proposal and outline what the research would be looking at and what would be involved. All but one staff member agreed to participate.

I returned to each school for approximately one week in May, 2001. During that week I mostly sat in the health staff offices, though I occasionally got out and about in the school. One of the first things I did after I arrived at the schools was to organise an initial interview with health education staff. I was curious to explore how govern ‘mentalities’ had been taken up by teachers in relation to health education. In addition I was also interested to explore how teachers talked about assembling programs, in particular what resources and mentalities did they mobilise in working to develop their programs and classes. The interviews were semi-structured and largely directed at exploring some of the following themes:

- Their professional background, what they studied at University, why they became a teacher and whether they had taught much health education
- What they perceived the value of health education to be
- How they thought about and went about programming for health education.

Interviews were taped and transcribed. In addition to this I spent time with staff reviewing their program documents, resource lists and resources. This involved spending time searching through filing cabinet drawers, bookcases or resource kits. This was sometimes assisted and other times I was left alone. Regardless, all of the teachers were more than happy for me to ‘take what I wanted’. I photocopied a lot of resource material, program documentation and took copious amounts of field notes. Throughout my time at each school, teachers continued to talk to me about health education. Conversations might have been prompted by something I was reading when they walked back into their office, or by an incident that had happened in the class they were teaching before they walked back into the office. At times teachers would approach me to tell me something they thought they had forgotten to talk about in the initial interview and they wanted to be sure that I ‘got it down’.
These kinds of incidental interactions that took place after the first interview provided perhaps some of the ‘richest data’. A good example of this is when Ms Batt\textsuperscript{9}, from \textit{Ash Secondary College}, mentioned to me one morning that she remembered something she thought I would be interested in, and that she must catch up with me at lunchtime. And so we had lunch. She then told me about how she forgot to mention that at the school they try to program to student need. At lunch she proceeded to tell me about an incident where she had heard “via the grapevine’ that two year nine girls had been giving blow jobs in exchange for alcohol on weekends. As a result of hearing this, she called a year nine special assembly to talk to the students about how awful prostitution was and that it was never acceptable as it was degrading and dirty. Students got to build on their understandings developed from the assembly in health education that week. Had I not been at the School for the week, I would never have heard that particular version of how the teachers at the school developed programs according to student need. This story features again in Chapter Five of the thesis where I discuss pedagogy, affect and the production of the other in health education. For now I am highlighting that time spent at the research site allowed for different types of data to be gathered. In addition to this, I too would start conversations based on what I had read, seen, heard or had been thinking. If I could not take notes at the time I would jot them down as soon as I could. Given I was at each school for a week, I was fortunate enough to have time to consider and reconsider ‘the data’ along my analytical lines and follow up on certain aspects of it if I needed to. What follows is a brief description of the three schools, the health education staff and an overview of the health education timetabling and allocations.

\textbf{The schools}

\textit{Ash Secondary College} was a coeducational school located in country Victoria. The school had approximately 700 students. The health education teaching team comprised of two teachers. Ms Batt was a Home Economics and Health Education

\textsuperscript{9} Teachers names and their schools have been replaced by pseudonyms
teacher in the school, and the coordinator of the Health Education curriculum area. She had been teaching for twenty years. Ms Scott was a Health and Physical Education teacher in the school. She had been teaching for 10 years. Both Ms Batt and Ms Scott were responsible for the delivery of the health education in the school. Health education was officially timetabled with physical education, though classes were divided into practical and theoretical modes. Physical education was the practical, and health education was the theoretical. An interesting feature of this timetabling arrangement was that it allowed ‘health teachers to teach health’ and ‘physical education’ teachers to teach physical education. What this meant though in reality was that the male teachers taught physical education and the female teachers taught health education. This arrangement was ‘most agreeable’ to all staff involved. Health education was a core subject for students in year seven, nine and ten. It was taught for two terms in a semester equalling 20 weeks. A breakdown of classes follows:

- **Year seven:** 1 x 50 minute period per week
- **Year nine:** 2 x 50 minute periods per week (combined as a double 1 x 100 minutes)
- **Year ten:** 2 x 50 minute periods per week (combined as a double 1 x 100 minutes).

*Wattle Secondary College* was a coeducational college located in country Victoria. The school had approximately 250 students. Ms Perry conducted the health education teaching. Ms Perry had been teaching for 30 years and had recently completed a Graduate Diploma in Health Promotion/Education. Like *Ash Secondary College*, health and physical education were timetabled as a subject with the theory block being dedicated to health education. Again the timetabling served to enable Ms Perry to coordinate and teach all of the health education in the school. Physical education was left to the male physical education teachers. This arrangement suited Ms Perry as she said that she was the only one who had any training in health education. Health education was a core subject for students in years seven and nine for two terms, a total of 20 consecutive weeks at each of
the stated year levels. In year ten, students attended a ‘one day health fair’ that was conducted at the end of term four. A breakdown of the classes follows:

- Year seven: 2 x 45 minute periods per week (as single lessons)
- Year nine: 2 x 45 minute periods per week (as a double 1 x 90 minutes)

*Paperbark Secondary College* was a single sex girls’ college located in metropolitan Melbourne. The school had approximately 1000 students. The health education team comprised of five teachers, although only four agreed to be involved in the study. Ms Hill was the coordinator of the HPE Key Learning Area. She had been teaching for 20 years. The other teachers Ms Woods (teaching for 20 years), Ms Hill (teaching for five years) and Ms Carr (teaching for seven years) all taught into the HPE area. All had physical education training and had developed an interest in health during their time teaching. Here students had the same teacher for health education as they did for physical education. Health education was a core subject for students in year seven, eight, nine and ten for two consecutive terms, a total of 20 weeks for each year level. The school utilised a two week timetable cycle. This meant that across a two week cycle students had the following classes:

- Year seven: 5 x 40 minutes of HPE (3 of which were health education)
- Year eight: 5 x 40 minutes of HPE (2 of which were health education)
- Year nine: 4 x 40 minutes of HPE (2 of which were health education)
- Year ten: 4 x 40 minutes of HPE (2 of which were health education).

The three schools above, as I have previously mentioned, provided what I considered to be at the time ‘rich data’ collection opportunities. This data features in Chapter Four of the thesis, *Lost in translation*, where I discuss teachers’ work...
as assemblers of school programs and some of the various translation mechanisms that are at play as govern ‘mentalities’ make their way into everyday settings.

The second element of the enacted curriculum that was considered in this thesis is the health education classroom. The impetus here largely evolved out of my recognition that there was very little (if any) research that considered what Foucault (1980, p. 96) would refer to as:

...power at its extremities, in its ultimate destinations, with those points where it becomes capillary, that is, in its more regional and local forms and institutions ...the point where power surmounts the rules of right which organize and delimit it and extends itself beyond them, invests itself in institutions, becomes embodied in techniques, and equips itself with instruments and eventually even violent means of material intervention.

In thinking about school based health education, and taking Foucault’s words seriously here, it is difficult to ignore health education classrooms. Classrooms are in essence the extremity of governmentalities as they pertain to school based health education. They become the site whereby deliberate attempts are made to realise the hopes of health education official curriculum and seek to infiltrate, persuade and seduce individuals into becoming healthy/healthier subjects. In essence they are the contact points’ of governmentality, or said otherwise where power connects with technologies of the self (Burchell, 1996). I now want to turn to overview how I went about gathering classroom observation data.

Even though I had already included three schools in my study, I decided to focus the collection of classroom observation data at one of the schools, Paperbark Secondary College. The decision to select one school was largely based around thinking about practicalities such as ethics, access, time and travel. In addition, I wanted to ensure I spent enough time in the school and with the respective classes to ensure I ‘knew’ my data and that I got to reach ‘data saturation’. Echoes of various ethnographic approaches to research crept into, and continue to seep into, the ways in which I think about research and education. The echoes were perhaps
a little louder as I commenced my data collection, and thus in turn influenced the way I thought about structuring my research.

In addition to this, Paperbark Secondary College had the most comprehensive health education program that was offered across the whole year. This provided me with an opportunity to observe the same class being taught by the same teacher twice (once per semester) as well as being taught by other teachers twice (once per semester). Also a further consideration early on in the research was that it was an all girls’ school. When I first commenced the study I had slightly different interests. I was initially going to interrogate how health education sought to regulate gendered and sexual subjectivities (via sex education) and so it made sense to me to consider how such things played out in a single sex girls’ school. My research interests changed very early on however, and I became interested in thinking about health education more broadly. Regardless, Paperbark Secondary College provided me with ample opportunity to observe health education in action. In total I observed approximately 80 hours of health education classes across year seven to year ten. The majority of those hours were spent observing year nine and year ten classes. I made the decision to concentrate on years nine and ten after spending approximately a month in the school. Again, my decision here was partly based on practicalities, I found myself in data overload. Further to this though, the year nine and ten classes were proving to be the most interesting or ‘data rich’. The focus of health education for this particular year grouping appeared to be levelled around the concept of ‘young people at risk’ and explored the topics of drugs, food, sex and alternative therapies. Although the alternative therapies addition may seem peculiar in the mix here, I explain its presence in more detail in Chapter Four. It also speaks back to Tinning and Glasby (2002) when they wondered as to why texts by Chopra and Hay aren’t part of classroom discussions. In this school they were. I observed approximately $35 \times 100$ minute health education classes taught by Ms Hill, Ms Woods and Ms Murray.

On entering the classroom for the first time, students were curious about who I was, and why I had all of a sudden appeared. In saying that though, there were
some who looked like they did not really care. Each teacher introduced me, told the students where I was from and what I was doing, and that I would be in their class observing for the foreseeable future. Each of the teachers then added in their own way a statement that implied I was an expert in health education. I will return to discuss this positioning, and other classroom interactions along these lines in the next section.

I would often sit down the back of the class (I would often be first to class and was able to claim that space) or to the side with students filling in the seats around me. And I would start to make field notes via pen and paper. I would write down the class word for word as best I could. I would make notes about what was written on the board, what was being said, who was saying it and what students were doing. Often during the class, or after a class, the teacher would make comments to me either telling me about what they were doing, what they were going to do next, or point something out that they thought might be significant for my study. After each school day I would type up my field notes and make various notes about moments of interest or moments that perplexed me. The data generated via observations is discussed in detail in Chapter Five of the thesis entitled *Risky pedagogical assemblages*.

**Ethnographic thoughts/afterthoughts on dealing with data**

I have referred to this section as thoughts/afterthoughts as admittedly much of my thinking around ethnography and my use of it in this thesis has taken place post the data collection phase. One of the major reasons for this is that the majority of the literature that I draw from has emerged post completing my fieldwork. Nonetheless recent literature has been significant in shaping my thinking about my research process as well as how to think about ‘data’ and approach analysing it. The work of several post structuralist ethnographers has been insightful (for example see Britzman, 2000; Kehily, 2002; Youdell, 2006, 2011) as well as governmentality scholars who have conducted ethnographies (see for example Brady, 2011; Ferguson & Gupta, 2002; McKee, 2009). In locating my use of ethnographic methods within poststructuralism, traditional approaches to
ethnography and the concern to reproduce transparent accounts of ‘the real’ are necessarily reconfigured. For poststructuralists concerns for an ‘objective real’ are pushed to the side, considered redundant or deemed impossible. As Youdell (2011, p. 75) states:

Ethnography underpinned by the sorts of post–structural theory I have explored earlier has moved away from a concern with authenticity and reciprocity to foreground the circulation of discourses and their constitutive force, including the ways they constitute particular sorts of subjects, in research encounters, representations and analyses.

In compiling my observation notes together with interview transcripts, curriculum support materials and documentation, my approach to working with data reflects that of Youdell’s. I am particularly interested to consider the data that I have generated via the use of various ethnographic methods as being the product of discourse. Given this, the classes that I observed, the teachers that I interviewed and the various documents I collected are all understood to be the product of discourse. Or as Britzman (2000, p. 32) suggests ‘...in post structural versions of ethnography, subjects may well be the tellers of experience, but every telling is constrained, partial and determined by the discourses that prefigure, even as they promise representation’. Such insights are useful and bring to the fore a focus on discourse.

**Discourse analysis**

Foucault (1972, p. 49) describes discourse as ‘practices that systematically form the objects of which they speak. Discourses are not about objects; they constitute them and in the practice of doing so they conceal their own invention’. Adding to this Arribas-Ayllon and Walkerdine (2008, p. 105) suggest that:

Discourses are not things but form relationships between things; they are not objects as such but rules and procedures that make objects thinkable and governable; they are not autonomous entities that cohere among relations of force; and finally, discourses do not ‘determine’ things when there is always the possibility of resistance and interdeterminacy.
Further they state that:

…discourse describes rules, divisions and systems of a particular body of knowledge. In this sense discourse approximates the concept of ‘discipline’ in at least two ways: it specifies the kind of institutional partitioning of knowledge such as medicine, science, psychiatry, biology, economics etc. But it also refers to the practices through which certain objects, concepts and strategies are formed (Arribas-Ayllon and Walkerdine, 2008, p. 99).

It is through discourse that power and knowledge are woven together (Foucault, 1984). Youdell (2011, p.25) discusses the joining together of power and knowledge in discourse. She notes that:

As conduits of productive power, discourses are not descriptive but creative – they have the potential to produce and regulate the world in their own terms as if they were true. Particular discourses may well be taken as reflecting ‘truth’, the way things are, but for Foucault these are not reflections but the very moment and means of the production of these truths.

Youdell (2011, p. 26) suggests that a focus on discourse opens up many possibilities when considering the enterprise of education. For example discourse:

…offers a lens for understanding how education comes to be understood as a particular sort of activity with particular ends, for understanding the way that particular knowledges are propagated and circulate in education policy as well in the daily activities of educational institutions and for conceiving of how these discourses are unsettled as subjugated discourses are constantly deployed in practice.

In thinking specifically about HPE Wright (2004) suggests discourse is useful as an:

…analytic technique drawing from Foucault [and] has been used to conceptualise and deconstruct the relations both within and between physical and health education, the body, identity and health, as socially constructed domains (p. 20).

In thinking about my research questions, and the types of data I collect, discourse is a central analytic as it enables me to gaze across data sources, to identify different discourses as they manifest in policy and practice, and to begin to
contemplate the effects of discourse. I want to turn now to consider a schema for using discourse as an analytic, via a consideration of an approach to Foucauldian discourse analysis outlined by Arribas-Ayllon and Walkerdine (2008) in an article entitled *Foucaultian discourse analysis*.

**Doing discourse analysis**

There are a myriad of approaches to discourse analysis (Hall, 2001; Wright, 2004), but given the theoretical investments of my study I am interested in Foucauldian approaches to discourse and discourse analysis. Arribas-Allyon and Walkerdine (2008, p. 91) suggest that at this stage it ‘is customary to offer the disclaimer that there are no set rules or procedures for conducting Foucaultian inspired analysis of discourse’, however I would argue that there are certain characteristics that differentiate it from other approaches (Hall, 2001). As I have alluded to above my approach to Foucauldian inspired discourse analysis adheres very closely to the approach set out by Arribas-Ayllon and Walkerdine (2008). In their article they offer a ‘light sketch of what a Foucaultian approach might look like’ (p. 98).

Arribas-Ayllon and Walkerdine (2008, p. 100) suggest that ‘the analyst must recognize discourse as a ‘corpus of statements’ whose organization is relatively regular and systematic’. In a similar light, Kehily (2002) in her discussion of discourse analysis, refers to the notion of discursive clusters as a mechanism by which to consider discourse. Regardless of the concept though, decisions then need to be made regarding the kinds of texts that are appropriate. Clearly this decision was made some time ago for me. Arribas-Ayllon and Walkerdine (2008) suggest that Foucauldian discourse analysis can be applied to any type of text, though they put forward a list of five that they deem to be particularly suitable: spatiality and social practice, political discourse, expert discourse, social interaction and autobiographical accounts (p. 100). The texts selected relate to the research questions posed, and my discourse analysis is guided by my inter-related research questions and my stated analytic themes of reasons, techniques and subjects of governmentalities in school based health education. Specifically I read
the various ethnographic texts for discursive clusters of statements that make up rationalities, techniques and subjects of health education and within this I consider clusters of continuity and discontinuity.

Conclusion

This chapter has developed both the theoretical and methodological components of the thesis. The first section of this chapter considered Foucault’s development of the term governmentality in light of broader debates about governing, but also too in relationship to the changing contours of governing the population and their health. Given the proliferation of scholarship that builds on Foucault’s initial writings, the section also reviewed the impact Foucault had on the broader field of governmentality studies. I concluded the section by exploring the notion of governmental assemblages as a conceptual apparatus. Central to this discussion was the idea that contemporary attempts to govern are made of multiple elements. Drawing on this, I proposed an analytics of governmental assemblages that informed the development of my research questions and thus, in turn, my research methods. The second section of the chapter provides an overview of the research methods and processes that enabled me to seek out possible answers to the various research questions posed. In this section I provided an overview of the various ethnographic methods I put to work. Before putting ethnography to work, I considered some of the tensions that arise between poststructuralist theory and ethnographic work. I discussed the use of discourse and provided an overview of a Foucauldian inspired approach to discourse analysis. The following three chapters discuss my findings from my ethnographic work and discuss the various discursive clusters that constitute the governmental rationalities, techniques and subjects of school based health education.
Chapter Three: Assembling the official health education curriculum

Introduction

In the previous chapter I suggested that understanding contemporary school based health education as a governmental assemblage is a very useful way to interrogate and make sense of the complex ways in which health education enacts its governmental imperatives. One of the key elements of the health education assemblage is the ‘official’ curriculum and the various rationalities, technologies and conceptions of subjects that have been assembled together to make up state based versions of health education. As key governmental artefacts, curriculum documents reveal what Popkewitz (2007) refers to as ‘the hope of schooling’. Such hopes are intensely political as schools, and the curriculum documents that frame much of what is to happen in schools, are ostensibly about changing people (Popkewitz, 2007). Curriculum documents effectively provide the schema by which such changes are thought about and supposedly enacted within classrooms. The purpose of this chapter is to interrogate the rationalities, techniques and conceptions of subjectivity that are assembled together in the contemporary Victorian health education official curriculum documentation.

Throughout the chapter I consider how curriculum connects to broader governmental assemblages, in this case broader past and present health and education assemblages, and discuss the implications for the hopes and possibilities of contemporary health education. The first section of the chapter provides an overview of thinking about curriculum as an assemblage. The second section reviews the recent history of health education in Victoria to consider the various historical trajectories of rationalities and techniques as they have been assembled together over time in versions of Victorian health education official curriculum. The section then goes on to consider the current official curriculum. Central to the discussion is a consideration of the current hopes for health
education curriculum and the associated rationalities, technologies and subjectivities privileged by the documents.

**Section one: Assembling curriculum**

Making sense of curriculum, specifically ‘official curriculum’, is difficult business (see Yates & Collins, 2008; Yates, Collins & Wright, 2011). Part of the reason for its complexity is that curriculum as a field is rarely static, with the exception that at various moments in time, curriculum settlements are reached and are captured in official documentation (Luke, 2010). But even settlements do not seem to stay settled for long. Over the duration of this thesis, the official health education curriculum in Victoria has been disassembled and reassembled several times. Since 2000, there has been a curriculum revolution, a major revision and a few minor revisions and revised editions of official curriculum. The current official curriculum in Victoria was released in December 2004 in stages and is referred to as the Victorian Essential Learning Standards (VELS) (VCAA, 2004a). But recently State based curriculum ‘settlements’ have been unsettled, to say the least, by the Federal Government’s move to establish a National Curriculum. Phase one of the development of Australia’s curriculum for the learning areas of English, Mathematics, Science and History is well underway (Australian Curriculum and Reporting Authority, 2011).

Health Education, along with Physical Education has been relegated to phase three of curriculum development. And, although according to the Australian Curriculum and Reporting Authority (ACARA, 2011) we will not see the final version until the end of 2013, there is a great deal of writing already on the wall. For example already we know that the subject area of Health Education finds itself entangled yet again in the Key Learning Area (KLA) of Health and Physical Education (HPE). And the advisory team has been selected and the key ‘Shape’ paper is to be released for consultation shortly. Further to this, much of the macro architecture is in place, including the cross curricula priorities and the general capabilities. How that publication shapes future developments in health education
in Victoria is yet to be seen, however it appears that the Australian Curriculum is going to be morphed into what the Victorian Curriculum and Assessment Authority (VCAA) refers to as AUSVELS (VCAA, 2011). AUSVELS effectively will be what Dean (2010) refers to as a ‘mash up’ of the current Victorian Essential Learning Standards and the Australian Curriculum. But regardless of how Victoria takes up the version of health education that is produced at the national level the governmental hopes of health education are already in circulation within broader ‘official’ governmental documentation. The direction of national curriculum developments is being shaped by the Melbourne declaration on educational goals for young Australians (Ministerial Council for Education, Early Childhood Development and Youth Affairs, 2008). And health is very much amongst the many of the hopes that the government has for its young people. For the purposes of the present discussion I want to highlight the explicit links made to curriculum in the document. In the discussion of steps for promoting a world-class curriculum the Ministerial Council for Education, Early Childhood Development and Youth Affairs (MCEECDYA) (2008, p. 13) states that the curriculum ‘will also enable students to build social and emotional intelligence, and nurture student wellbeing through health and physical education in particular.’ The value here is connected to broader hopes that students will develop ‘a solid foundation in knowledge, understanding, skills and values on which further learning and adult life can be built’ (MCEECDYA, 2008, p. 13).

In some ways these are familiar linkages, though some new elements have crept into the mix and that have for example reconfigured social and emotional health into social and emotional intelligences. Wellbeing too, has arrived as a stated explicit key focus for the HPE curriculum. The arrival of intelligences and wellbeing into the ‘official’ assemblage is an interesting one and provides a glimpse of possible future settlements (though we are yet to see what impact this will have as the new either comes to sit alongside, morph or replace the old in pending new assemblages).
The glimpses of future curriculum hopes provided by the *Melbourne declaration*, and taken up by ACARA, are already in motion as they work forward to shape new curriculum. But they have also been worked backwards into existing State based settlements. For example the VCAA (2008) moved to explicitly state on their website that the VELS align with and incorporate various educational frameworks, including the *Melbourne declaration of educational goals for young Australians* published in 2008. Furthermore, minor amendments were made to the curriculum in 2008. Specifically domain introductions and learning focus statements were altered so as to highlight and reflect the relationship they had to the recently published National Statements of Learning (VCAA, 2007a). What becomes clear from the above is that broader assemblages that contain school based health education assemblages are in perpetual motion. This makes the tracking of complex linkages that are forged in and across curriculum documents difficult indeed. But regardless of the shifting assemblage, 2008 revised state based settlements of VELS and HPE curriculum continue to guide teaching and learning in Victoria until at least 2014. In the next section I consider the 2006 settlement of curriculum, as both a key element of school based health education, and educational assemblages more widely. Before doing that though I provide a brief history of official health education in Victoria as a means to map some of the historical discourses that have shaped health education over time, and the various continuities and discontinuities. The brief history provides a means to trace the antecedents to the present version of official curriculum. In particular I am interested to map the historical trajectories of rationalities and techniques over time as they have been assembled together as well as consider any new additions, or deletions.

As I have suggested in Chapter Two, and again above, the health education official curriculum is a key element in the assemblage of school based health education. It is also an assemblage in and of itself that too, has complex linkages and connections both within, and with, other assemblages. This is not a new suggestion and I have argued the case before (see Leahy, 2009; Leahy & Harrison, 2004). In thinking about curriculum as curriculum assemblages
questions can be asked about the various linkages that are made both within the health education official curriculum, as well as external to it. As I have begun to highlight above contemporary versions of official health education curriculum are influenced by various connections and linkages to other governmental assemblages. Broadly these include educational policy and curriculum assemblages, and health promotion assemblages, which have linkages and connections to wider governmental assemblages. There are of course important linkages to other assemblages as health education incorporates various associated topics such as sexuality education, drug education, nutrition, mental health and safety. These topic areas have their own historical trajectories, internal, external logistics, linkages, rationalities and techniques. This makes for a curriculum that is overall assembled by, and reliant on, a range of diverse governmental knowledges and techniques. In reviewing the assemblage of health education curriculum, its broad structure and various content I am interested in considering what Rose and Miller (1992) refer to as the ‘intellectual schemata’ for thinking about, and doing, health education. The schemata draws from a range of political rationalities and techniques to establish in essence the why, when and how of health education. In reviewing the ‘schemata’ I am interested to consider what Rose (1996, p. 42) suggests as the:

...epistemological character, in that they [curricula] embody particular conceptions of the objects to be governed – nation, population, economy, society, community – and the subjects to be governed – citizens, subjects, individuals. And they deploy a certain style of reasoning; language here is understood itself as a set of “intellectual techniques” for rendering reality thinkable and practicable, and constituting domains that are amenable – or not amenable – to reformatory intervention.

In following this line of thought the official curriculum, as a key governmental document, effectively works to render health education, young people and their health thinkable, whilst providing direction on how best to guide, shape or rectify health [y] conduct.
Section two: Health education curriculum assemblages in Victoria

Health has long been on the schooling agenda in Victoria. In 1906 the Head of the Victorian Education Department, Mr Frank Tate, wrote an article on the importance of hygiene for schools in the Education Gazette (St Ledger, 2006). School based health education gained further momentum from an International Conference on the Health of School Children held in London in 1907 (St Ledger, 2006). According to St Ledger (2006) the conference was a culmination of a range of ‘Commissions of Inquiry’ held throughout Europe during the latter part of the 19th century. Improving children’s health via schools had become a priority during this time with the focus of health education largely directed towards temperance education, moral education, hygiene, sex and nutrition (see Brodribb, 1891; Lupton, 1995; St Ledger, 2006). Schools were considered to be a site of easy access to children, and health was considered to be amenable to manipulation via education. The move to target children’s health via school based intervention here is one example of what Foucault (1984c) was alluding to when discussing how the health and physical wellbeing of the population, in this case children, became a concern of, and targeted by, political power (see Foucault, 1984c). In essence school based Health Education provided a point of ‘contact’ where power and technologies of the self could interact (Burchell, 1996) with the hope of transforming the health[yl] conduct of children and young people.

As a subject area Lupton (1995) suggests that there was little change in health education up until the 1960s and early 1970s as the focus on personal hygiene and morality endured. It was during this time that school based health education found itself back in the spotlight. This can be attributed largely to the burgeoning body of scholarship that established causal links between personal lifestyle behaviours and health status (see Lupton, 1995; O’Connor & Parker, 1995; St Ledger, 2006). I have reviewed the broad ‘conditions of possibility’ that set the scene for the re-emergence of health education in Chapter One of the thesis. The discussion here centres on exploring shifting governmentality, and the impact that neo-liberalism and risk had in shaping the approaches to population health. The following health
education curriculum history, then builds on, and draws from, the insights provided in Chapter One. The review reveals some of the ‘real effects’ that shifting governmentalities had at the time, at least at the official policy level.

**Health and human relations education**

As previously stated, the foundations for a renewed focus on school based health education started in the 1960s and 1970s (see Lupton, 1995; St Ledger, 2006). During this time, there was a great deal of policy movement taking place across various government and non-government sectors (see Chapter One). Within education circles, several reports emerged that considered the role of health education in schools and in 1982 health education made it onto the official stage via the release of curriculum guidelines for Health and Human Relations Education. The release of the guidelines, and their content, reveal a very deliberate attempt at shaping the conduct of students via school based education. The hopes of Health and Human Relations are revealed below in the introduction to the document:

Health and Human Relations Education begins with the premise that the total health of a person, including his [sic] relationships with others, can be enhanced by a person knowing how to care for himself. Health education promotes the skills necessary for this. It is a process involving information about how health can be achieved and maintained, and a development in the kinds of skills needed to make decisions which affect health. Since humans live together, the way they relate to each other affects their health. Health and Human Relationships Education, therefore promotes health and recognises the interrelationships between the physical, social and mental aspects of individuals and the society in which they exist. This can be achieved effectively by providing educational opportunities for students to develop skills and competence in areas such as problem solving, decision making and communication, so that they become more autonomous and develop respect, tolerance and consideration for the needs, feelings and interests of others, as well as their own (Education Department of Victoria, 1982, p. 2).

The hopes for this document are indeed high. Not only was Health and Human Relations Education directed towards improving the health of the population, it was also expected to enact the Education Department’s *Equal Opportunity and
the Elimination of Sexism policy by targeting human relations for intervention (McLeod, 1995, 1999). In bringing together health and relationships, the official curriculum is not only targeting the individual body, it also takes aim at shaping the conduct of the social body. According to Peterson and Lupton (1996) enabling self discipline is core to the work of governmentality, but the project must also establish practices whereby individuals must ‘constantly interrogate their lives and relationships in the quest for self improvement, the achievement of authenticity, the maximisation of life changes and the exercise of choice from among alternatives’ (p.64). It is in this way that individuals are enlisted into what Dean (1995) refers to as the process of ‘governmental self formation’. According to Dean (1995, p. 563) governmental self-formation can be defined as:

The ways in which various authorities and agencies [in this case Health Education] seek to shape the conduct, aspirations, needs, desires and capacities of specified political and social categories, to enlist them in particular strategies and to seek definite goals.

The dual focus of health education on health and relationships is a feature of the health education curriculum assemblage over time, up until the advent of the VELS. I will return to discuss this when I consider the VELS in more detail later in this chapter. Given this dual focus this curriculum was focussed on the total health of the person. The broad focus signalled a shift away from previous narrower definitions and foci that privileged the individual and the physical.

As a curriculum document, the Health and Human Relations curriculum is an exemplar of how hopes of government are imagined, and how the problem of health, and indeed human relations, can be resolved at that particular point in time. The curriculum is explicitly directed towards producing a more autonomous individual who is responsible in their relations both to others and themselves, who develops decision making skills, problem solving skills and communication skills that will assist them to make decisions that affect theirs and others’ health. And so in the first official health education curriculum assemblages of the 1980s tenets of neo-liberalism powerfully inflect the assemblage. This is not a surprise as it was around this time that neo-liberalism as a rationality of government was gaining
momentum in Anglophone countries (Lupton, 1995; Youdell, 2011) and several authors had been signalling its presence and influence for some time in the health fields (see Crawford, 1977, 1980). As a dominant rationality of government it marked the curriculum in particular ways. Central characteristics of neo-liberal imaginings that appear in the curriculum are evident in the assumptions and expectations made of subjectivity and responsibility. Specifically the curriculum assumes that individuals are rational, responsible and autonomous citizens. Thus the subsequent techniques that are called on to ensure health all rely on those fundamental assumptions (for example decision making skills). In addition to this, the curriculum makes the assumption that students must all be in pursuit of health (Lupton, 1995).

The Health and Human Relations curriculum was specifically designed to cultivate individual’s practices via the inculcation of health[y] desires and aspirations (Dean, 2010). In addition to this the curriculum targeted the social body (Rose, 1999). What is more though, both in this curriculum iteration and in subsequent curriculum developments, is that health education explicitly was attempting to remake subjectivity. In this particular instance, the curriculum was not only directed at producing healthy subjects, it was also intent on remaking gendered subjectivity (McLeod, 1995). The kinds of practices that were charged with bringing about desirable subjectivities were problem solving skills, decision-making skills and communication skills. These skills have proven to be a mainstay of health education over time, and derive their impetus from the health psychology literature that dominated ways of thinking about health (see Lupton, 1995). Knowledge + skills = behaviour change proved to be a powerful combination that has had policy writers and curriculum writers convinced that such a combination could bring about the right conduct. The formula combines a range of techniques of neo-liberal government. By this I mean as a formula it provides a mechanism by which ‘we’ can think about people’s health behaviour, and in turn intervene into their lives via the adding of health knowledge and skills so as they improve their behaviours.
There is much to be said about the Health and Human Relations education curriculum\textsuperscript{10}, however for the purposes of this chapter, I simply want to highlight how even the early hopes of formal and official health education were shaped via neo-liberal rationalities. Further, the early focus on health knowledge and skills in health education has proven to be significant for subsequent versions of official health education. Many of the hopes of health education, and the various rationalities, techniques and conceptions of the subject at this time have endured over time.

**Decision making in health education: A guide to curriculum planning for schools**

The focus on health knowledge and skills continued in the next iteration of health education curriculum *Decision making in health education: A guide to curriculum planning for schools* (Education Department of Victoria, 1985). The purpose as outlined in the foreword of the document, was to ‘show school communities how an effective health education curriculum can be provided within the Education Department of Victoria’s Guidelines for Health Education 1984’ (Education Department of Victoria, 1985, p. 4). The guide explicitly connects the provision of health education to the realisation of government policy, both broadly, and also in relation to schooling agendas. The Government at the time placed an emphasis on developing healthy communities, and the need to prevent or minimise health problems. Health education was considered to be a key platform in achieving the government’s aims. This imperative coupled with the desire of Government for schools to play a more significant role in society, provided at least in policy increasing momentum for health education. It was thought that health education could contribute to both agendas by:

- Promoting attitudes and behaviour which contribute to personal and community wellbeing;

\textsuperscript{10} For a comprehensive discussion of the hopes attached to the Health and Human Relations curriculum and its development, implementation and associated controversies see McLeod (1995).
• Developing in students the ability to make decisions about personal and community health matters and encouraging students to take responsibility for such decisions;

• Providing accurate information about health and health-related matters; and

• Developing an understanding of factors which influence the quality of life enjoyed by an individual or a community (Education Department of Victoria, 1985, p. 9).

The guide highlights the changing focus of health education. In providing an overview of the teaching and learning program platform, it states that:

The focus of health education is now shifting from fact-giving to decision making, that is, helping individuals to increase their health knowledge, to understand their feelings in relation to that knowledge, to make and carry out personal decisions and then evaluate the results. It is hoped through comprehensive class programs in health education, students will be better equipped to take on more responsibilities for their health during and after their school years (Education Department of Victoria, 1985, p. 7).

Similar to the previous curriculum, the hopes and tenets of neo-liberalism shape curriculum possibilities. The rationalities and techniques that are assembled together in this document are all directed towards ensuring that individuals can increase responsibility for their health. Again health knowledge + a kit bag of skills, in this case, decision making skills, is considered to be core to enabling young people to take on more responsibility. And although decision-making was a feature of the previous curriculum, it seems to have ascended to a higher plane in this iteration.

The use of decision making though as a technique is not without its problems and contradictions. Both Gard (2008) and Vander Schee (2009b) have discussed some of the problematics around a focus on cultivating decision-making skills. Building on their analyses I suggest that healthy decision making and free choice is always discursively foreclosed within the health education assemblage. The idea of free choice according to Rose (1996) is a central technical condition of neo-liberal governmentality. But according to Rose neo-liberalism relies on ‘artificially
arranged or contrived forms of the free choice’ (p. 23). In following Rose, this means that there can only be certain decisions thinkable and thus permissible in this mix. This plays out in a myriad of ways. For example the assumption that runs through Health Education is that somebody who has knowledge and decision-making skills will not use illicit drugs, or eat unhealthy foods, or live a sedentary life. Borrowing from Gard’s (2008) analysis of the Ontario HPE curriculum, I would suggest, like he has, that the mantra of free choice, as it manifests in the rhetoric around decision-making in health education is really a call for obedience. And as Rose (1996) has suggested, it is not about free choice at all. Rather, the expectation is that choices will (and should) align with the various governmental imperatives. This approach to decision making also problematically assumes that the range of options for an individual to select from is unlimited, and that there are a host of healthy choices on offer. Overwhelmingly we know that this is indeed not the case. Research on the determinants of health, over time, has revealed that health, and within this, healthy choices, are limited by a multitude of factors including: income and social status, education, physical environment, social support networks and access to health services (WHO, 2012). And whilst the curriculum would have us hold on to the mantra that it is helping to encourage young people to make choices for themselves, the reality is that the only choices that young people are expected to make are the healthy choices. The dominance of individualism within the assemblage effectively means that the broader social, cultural, political and environmental factors are disavowed. Individuals must be able to be accountable for themselves and in turn be responsible for their health. A focus on the broader determinants of health here would effectively work to diminish individual responsibility. Within neo-liberal mentalities of rule, this is not tenable. The manoeuvre to look to the social determinants would effectively shift responsibility back to the state. The irreconcilable tension between individualism and personal responsibility on one hand, and a focus on the broader social determinants of health on the other is a mark of every curriculum iteration. It is probably most pronounced in the next curriculum iteration, the Personal
Development Framework. Before discussing that particular curriculum document though I want to consider the effects of individualism to this point in time.

The dominance of individualistic approaches and the constraint around choice in health education connects to, and mobilises, a moral imperative to be healthy (see Crawford, 1977; Gastaldo, 1997; Greco, 1993; Lupton, 1995). As I have discussed in Chapter One, the focus of health education to this point in time produced an imperative to be well, and individuals who failed to fulfil their ‘duty to be well’ could effectively be deemed to be immoral and irresponsible (Greco, 1993; Lupton, 1995). This notion, as suggested previously, is often referred to as ‘victim blaming’ (see Crawford, 1977). And in both this curriculum iteration and the previous version (Health and Human Relations) the curricula assemblages were permeated by neo-liberalism. It is these particular approaches to health education that critical health education scholars took issue with (see Baum, 1998; Colquhoun, Goltz & Sheehan, 1997; Peterson & Lupton, 1996). The emergence of critical scholarship was indicative of shifts taking place within broader assemblages. The backlash against individualism, was both produced and accompanied by shifts within broader related health and education assemblages and governmentalities (see Chapter One). The ‘critical turn’ impacted significantly on the shape of the next version of health education to come along, the Personal Development Framework (Office of Schools Administration, 1989).

**Personal Development Framework**

The Personal Development Framework (PDF) was one of nine curriculum frameworks released in the late 1980s as part of a Ministerial curriculum move to provide support for schools to review and rewrite their programs (Office of Schools Administration, 1989). The Personal Development Framework provided an umbrella under which six subject areas were listed. How curriculum writers arrived at the idea of developing and naming the overarching umbrella Personal Development is beyond the scope of the thesis, however similar moves took place in other states. For example in 1991 Health and Physical Education in New South Wales changed form and was renamed Personal Development Health and Physical
Education. The naming might be related to curriculum writers searching for an overarching concept that could connect to seemingly disparate subject areas. For example the subject areas that were bought under the PDF in Victoria included: health education, physical education, textiles and clothing, home economics, outdoor education and traffic safety education. But the shift to Personal Development can also be evidenced in broader cultural shifts taking place around this time. For example Rose (1998) discusses the emergence of self-help and self-realisation as key technologies of the self in the late 1980s. Regardless of its emergence, Personal Development shaped Health Education in some new ways, which I will turn to discuss next. However, Personal Development wasn’t the only rationality making up the assemblage as right along side it was critical theory and it is at this time that ‘critical’ approaches to health education crept into official health education curriculum discourse. Consider the goals of health education as they are documented in the PDF:

Health education is a lifelong process. It values critical thinking about personal and community wellbeing and active interaction between school, home and community. The goals of health education are to:

- Promote attitudes and behaviours which contribute to personal and community wellbeing;
- Develop in students the ability to make decisions about personal and community health matters and to encourage students to take responsibility for such decisions;
- Provide accurate information about health and health related matters; and
- Develop a critical approach towards personal safety and social factors which influence the quality of life enjoyed by an individual or a community.

(Ministry of Education, 1989, p. 45)

The inclusion of critical perspectives and approaches indicates a significant curriculum shift. And although the goals outlined above draw on and reproduce some of the curriculum mainstays of health education to this point in time (for example: knowledge, attitudes, decision-making and responsibility), the inclusion of both critical thinking and critical approaches marks a significant departure from
previous curriculum versions. In fact it is an example of where a set of subjugated knowledges make their way to prominence within the assemblage. The appearance of ‘critical’ in official curriculum can be linked to the critical turn that I mentioned previously and discussed in depth in Chapter One of the thesis. But critical approaches here also sat alongside enduring neo-liberal approaches to promoting and improving health. As I have discussed above, the two are uneasy and unlikely bedfellows as the hopes of critical health education are antithetical to those of individual approaches to health education. The unlikely combination probably has much to do with the various successes (or lack thereof) of enacting the critical health education agenda (and thus perhaps the disappointments that critical health educators experienced).

The emergence of critical approaches to health education was accompanied by, and reliant on, new rationalities and techniques. A key approach that was seen to offer the solution to overly individualistic health education was a combination of empowerment, conscience raising and social action (see Chapter One). Critical approaches to health education did not stay long in the stated aims of official curriculum discourse, however their legacy lingerers in the broader school based health education assemblage in various curriculum strands or domains. Teachers too, continue to talk about how health education can empower young people (see Chapter Four). I would also suggest that some of the concerns and hopes of critical education still rouse educators although many as I have highlighted in Chapter One have turned to different theoretical frames (see for example, Youdell, 2011)

In addition to the focus on critical approaches and perspectives to health, the PDF marked another significant shift in how health was being conceptualised at the time. The prioritising of Personal Development as an overarching framework under which Health Education was positioned marks the recognition by governments that schooling, and indeed health education, is explicitly about shaping not only the healthy conduct of individuals, but also about shaping the interior via techniques that permit one to develop the self in particular ways. The
curriculum areas in the PDF that specifically focused on developing the self were: being myself, caring about myself, association with others, sexuality and physical growth and development.\textsuperscript{11} Health education in this context then becomes a place for explicitly engineering the human soul in that it incites individuals ‘to live as if making a project of themselves’ via working on their emotional and social worlds (Rose, 1998, p. 157). The intention of health education is to render our relations to ourselves and to others amenable to intervention via pedagogic techniques that ‘promise to allow us to transform our selves in the direction of happiness and fulfilment [and health]’ (Rose, 1998, p. 157). The emphasis on Personal Development in this document provided momentum for some different practices in Health Education. Some commentators, for example Ledger (2006) believe that the emphasis on personal development and critical thinking approaches in this particular curriculum meant that it was devoid of any explicit call for health behaviour change. I would suggest otherwise, as the PDF was all about changing subjects by inciting people to change their relations to themselves and others, as well as maintaining a focus on responsibility, knowledge and skills. The PDF provided the curriculum framework in Victoria for six years, until the next revision produced the Curriculum Standards Framework in 1995 (Victorian Board of Studies, 1995a).

\textbf{The Curriculum Standards Framework}

The Curriculum Standards Framework was developed as a result of significant curriculum flux at both State and Federal levels. Federally, the Australian Education Council had made significant moves to develop a national curriculum. As part of this manoeuvre they came up with eight ‘Key Learning Areas’, which amongst others included Health and Physical Education (HPE). The process of

\textsuperscript{11} The other areas: food and nutrition, consumer health, community health and safe practices were more directed towards instilling particular kinds of knowledges and practices related to individual and community health\textsuperscript{y}y conduct.
reaching this settlement along with the development of the National Statement and Profiles in HPE has been well researched and documented by Glover (2001). Her analysis provides an in-depth exploration of the dominant and contesting discourses that shaped the development of the Statement and Profiles, as well as revealing the fraught curriculum writing process itself. But Victoria did not take on board the published National Curriculum documents; rather it produced its own version of HPE in what was termed the Curriculum Standards Framework (Victorian Board of Studies, 1995b). An interesting new feature of this curriculum was the introduction of standards as a means to provide guidance about the stage related level of expected attainment for every student across the state. The focus of HPE in the CSF can be evidenced in the following excerpt from the curriculum:

Studies in the Health and Physical Education area promote understanding of physical activity, movement, food and nutrition, health, safety, human development and human relations. Within this context the area examines personal action: beliefs, attitudes and values held by families, cultural groups and the wider community; public policies affecting health and physical activity; and the settings and contexts of activities in the area (Victorian Board of Studies, 1995b, p. 9).

Given the general aims of the learning area, it is no surprise that the major content areas in this curriculum are: human movement; physical activity and the community; human development; human relations; safety; health of individuals and populations; and people and food. The seven strands are not necessarily new and looking back over previous curricula they have all had a place, albeit in slightly different guises. What is new however in this assemblage, is the prominence afforded to the New Public Health. And although there are traces of the New Public Health in the PDF, its tenets gained momentum in this particular curriculum iteration. As a result we witness a significant shift in the terms that are being called on to establish the hopes of HPE, as well as differences in thinking about how those hopes might be enacted.

The emphasis on promotion, families, community, public policy and settings all mirror the tenets of the New Public Health, and more specifically The Ottawa
Chapter Three: Assembling the official health education curriculum

Charter (World Health Organisation, 1986). They are also attempts at reconciling the tension between individual approaches to health education and a socio-cultural approach to health education. The curriculum document now had both. A number of authors have explored the impact of the New Public Health on HPE and have suggested that it in essence has territorialized the field in ways that recruit HPE to govern the bodies and souls of its subjects via responsibilisation and the reproduction of individualistic practices albeit via a different schema than say for example, the PDF (for more detailed analyses of the move to the New Public Health see Lupton, 1999a; Tinning & Glasby, 2002).

Curriculum Standards Frameworks II

In 2000 the CSF was revised, and Curriculum Standards Frameworks II was released. The brief for the KLA of HPE was extended somewhat in this iteration:

The Key Learning Area of Health and Physical Education draws from the dynamic and multi-dimensional nature of health and the significance of physical activities in the lives of individuals and groups in our society. It promotes an understanding of the importance of personal and community actions in promoting health and lifelong participation in physical activity, and of the crucial role that supportive physical and social environments play in the development of the health of individuals and communities. This key learning area helps young people learn about the factors, including nutrition, that promote and protect the physical, social and emotional health of individuals, families and communities, and the range of services and products available in the community. They learn to identify the harms associated with particular situations and behaviours, and how to take action to minimise these harms. They consider personal and community rights and responsibilities, and the cultural and social diversity of Australia in relation to health and safety, so that they are informed about making decisions about their own and others’ lives (Victorian Board of Studies, 2000, p. 5).

The assemblage of various content areas and expectations of what it is that students were to learn in the KLA is mind boggling to say the least. In a sense this statement is a catch all, as it tries to put the tenets and understandings of the New Public Health into play whilst responding to, and including emphases on new health panics (see the newly prioritised focus on harm minimisation).
The curriculum sets about addressing all of the dimensions of health, at the individual, family and community level, it addresses cultural and social diversity, access to services and responsibility and decision making as well as learning about the social determinants of health (via an emphasis on physical and social environments). To do this work the CSF II contained three strands (the previous CSF had seven). The new strands were: Health of Individuals and Populations; Self and Relationships; and Movement and Physical Activity. Health education in the new CSFII was afforded two strands, whilst physical education was reduced to one strand only. The two strands, and indeed this curriculum context, is of significance in this thesis as much of my fieldwork directly relates to versions of the enacted curriculum from this particular curriculum moment. Some of the curriculum units of work I discuss in the following chapter were developed in line with expectations outlined in the CSFII.

The two strands capture the varying content emphases of the health education field over time. The strand Health of Individuals and Populations captures the focus on promoting individual and community health, whereas the Self and Relationships strand captures the essence of the push for Personal Development and the focus on enhancing Human Relations. The strands that did not make it appear to have been reclassified, recast and woven through the three new strands as curriculum focus statements, and outcomes and indicators. For example, aspects of food, identity, safety, growth and development are peppered throughout both strands. Effectively the CSFII assembled together many of the previous rationalities and techniques of curricula past and arranged them under a schema that was shaped powerfully by the New Public Health.

The CSFII had a shelf life of approximately six years until it was replaced by a new curriculum, the Victorian Essential Learning Standards (VCAA, 2004a). I want to turn now to consider the move to VELS and how health education has been assembled together in the new curriculum structure.
**VELS: An essential education**

As I have mentioned previously, and as I have reviewed above, Victorian (health education) curriculum has undergone several revisions, and experienced its own revolution over the thirty years. And as the previous section attests, curriculum flux is not new, given that over that time we have witnessed five different State-based curriculum changes that have involved health education, as well as the development of National Statements and Profiles. The varying curriculum shifts significantly influence what versions of health education are possible. In addition to previous versions of health education, we also need to consider shifts in broader curriculum assemblages. As educational policy and language changes, curriculum architecture changes, and as a result, so too does health education. I will explore this in more detail later on in this section, but for now my focus here is on the broader shifting curriculum context that set the scene for the emergence of Victorian Essential Learning Framework in 2004 (VELS).

The impetus for, and shape of, VELS arose out of the 2003 publication of the *Blueprint for government schools: Future directions for education in the Victorian government school system* (Department of Education and Training, 2003). The impetus for the Blueprint was linked to the governmental concerns and pressures about how to best prepare young people for the 21st century so as to ensure social and economic success in an increasingly globally competitive environment (Yates & Grunet, 2011; Yates & Young, 2010). The pressing need was for education to develop an approach that would best be able to cultivate a ‘new’ type of citizen for these ‘new times’. This ‘new citizen’ would be able to negotiate rapid social and economic change, respond to changing workforce demands with new personal and professional skills, flexibility, digital literacies and more (see Yates & Young, 2010). The kinds of concerns driving educational change can be evidenced throughout the various circulating curriculum background documentation and reports produced during this time. For example the executive summary of *Curriculum Victoria: Foundations for the future report* states that:
Governments in many developed and developing countries are attempting dramatic changes in their systems and approaches to education. They are doing so because successful education systems are increasingly seen as key elements in social and economic success in the 21st century, a century in which knowledge based industries and the ability of societies to be innovative and productive are expected to be essential ingredients of progress (VCAA, 2004a, p. 1).

Given the concerns highlighted above, the Blueprint provided the framework by which the kinds of hopes and concerns above could be addressed. Amongst the many directives for change that emerged, 'student learning' was listed as Flagship one (out of a possible seven Flagships). Falling into line underneath Flagship one were several strategies that were designed to address student learning. Of significance for this chapter was the directive to the Victorian Curriculum Assessment Authority to ‘identify a broad framework of “essential learning” for all students within Victorian schools’ (Department of Education and Training, 2003, p. 5). Victoria was not acting in isolation in moving to recast curriculum as ‘essential learnings’. The move was being echoed across a number of States and Territories, and internationally, as various curriculum authorities sought to identify the types of ‘essential learnings’ that were considered central to enabling young people to function effectively in our changing society (Yates & Collins, 2008; Yates and Young, 2010).

In Victoria’s response to the prevailing global uncertainty, and the various associated problems, the Victorian government’s new VELS curriculum framework was informed by neo-liberalism. For example, the forward to the VELS enshrines the neo-liberal hopes for government and for subsequent curriculum shifts. It states:

All young Victorians need a high quality education that equips them with a broad range of knowledge, skills and personal qualities to confidently meet the challenges of life in a complex, information-rich and constantly changing world. In releasing the Blueprint for Government Schools in November 2003, The Minister for Education and Training, Lynne Kosky MP, asked the Victorian Curriculum and Assessment Authority (VCAA) to develop a new framework of essential learning for all Victorian schools that would both reinforce standards and promote flexibility at the school level. The Victorian
Essential Learning Standards, the VCAA’s response to this request, provides the framework for schools to deliver teaching and learning programs that support students to develop capacities to confidently manage themselves and their relationships with others, make sense of the world in which they live and effectively participate in that world (VCAA, 2007a, p. i).

The move towards an ‘essential learnings’ curriculum framework heralded a radical shift away from a focus on traditional academic content via the dominance of KLAs in curriculum thinking and planning towards a model that emphasises ‘valuable’ procedural knowledges that are expected to serve young people across all facets of their future lives (Yates & Collins, 2010, p. 97). It must be recognised that the idea of ‘essential learnings’ was not a new one, and that it has antecedents in Dawkins’ uptake of the Thatcher UK government’s attempt to align and value generic competencies as a means to improve vocational outcomes (Ball, 1993; Yates & Collins, 2010). Given the shifting emphasis and ‘new’ requirements a new curriculum architecture was required, and subsequently emerged.

Within the new VELS, learning was organised into three interrelated essential learning strands, as opposed to the previous eight KLAs that had been characteristic of the official Victorian curriculum since 1995 (see Victorian Board of Studies, 1995a). The essential learning strands, and a description of what students are expected to learn and do under each strand, are detailed below in Table 1.
Table 1: VELS essential learning strands

<table>
<thead>
<tr>
<th>Physical, personal and social learning</th>
<th>Discipline based learning</th>
<th>Interdisciplinary learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students learn about themselves and their place in society. They learn how to stay healthy and active. Students develop skills in building social relationships and working with others. They take responsibility for their learning, and learn about their rights and responsibilities as global citizens.</td>
<td>Students learn the knowledge, skills and behaviours in the arts, English, humanities, mathematics, science and other languages.</td>
<td>Students explore different ways of thinking, solving problems and communicating. They learn to use a range of technologies to plan, analyse, evaluate and present their work. Students learn about creativity, design principles and processes.</td>
</tr>
</tbody>
</table>

Each strand is organised into a number of domains. They are listed in the following table.

Table 2: The domains within the VELS essential learning strands

<table>
<thead>
<tr>
<th>Physical, personal and social learning</th>
<th>Discipline based learning</th>
<th>Interdisciplinary learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health and Physical Education</td>
<td>The Arts</td>
<td>Communication</td>
</tr>
<tr>
<td>Interpersonal Development</td>
<td>English</td>
<td>Design, Creativity and Technology</td>
</tr>
<tr>
<td>Personal Learning</td>
<td>The Humanities – Economics</td>
<td>Information and Communications Technology</td>
</tr>
<tr>
<td>Civics and Citizenship</td>
<td>The Humanities – Geography</td>
<td>Thinking Processes</td>
</tr>
<tr>
<td></td>
<td>The Humanities – History</td>
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</tr>
<tr>
<td></td>
<td>Languages other than English</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maths</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Science</td>
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</tbody>
</table>

(VCAA, 2007a)
The new curriculum configuration provided a new way to think about, and organise, teaching, based on the three essential learning strands, although the new structure never completely erased or replaced the old KLA super structure. Rather, KLAs were reconfigured into Domains and sorted under select strands. The vast majority of KLAs were considered to be essential Discipline based learning, and others were relocated into the strands of Interdisciplinary learning (for example Information and Communications Technology) and Physical, personal and social learning (for example Health and Physical Education). Additional domains were added into the mix to ensure that the curriculum would cultivate important new capabilities for new times (for example thinking processes, communication and personal learning).

An essential health education

The new architecture and subsequent restructure of the curriculum had a significant impact on official curriculum versions of health education. Although Health Education again found itself assembled together with Physical Education in the form of ‘Health and Physical Education’, it had been reclassified as a domain in the newly developed ‘Physical, social and personal learning’ strand. The location of Health Education in the realm of the personal is not new, as I have discussed above. But the move was considered to be a radical ‘removal’ for HPE given that HPE had been afforded KLA status in Victoria since 1995. The previous positioning of HPE as one of eight KLAs could be read, at least in theory as HPE being considered to be of equal importance to the other KLAs. The recent rebranding of HPE and its relocation outside of the strand Discipline based learning produced a number of effects. Firstly, within the broader field of HPE teachers, academics and associated professional associations many were concerned the shift would mean a (further) lowering of subject status. This perception emerged out of the belief that all of the important subjects found themselves listed under the Discipline based learning strand. With respect to health education, there were also comments being made at both the academic and school levels related to health education’s repositioning in the reconfiguration in
the curricula assemblage. Although some were ambivalent (it was yet another curriculum change that would have little impact on day to day work) many were concerned that the shift would mark the end of health education. At the same time some others were expressing hope that the new curriculum innovation might just provide new conditions of possibility that would provide the impetus to facilitate (greater) cross curricula integration and thus contribute to improving teaching in the area of health education.

As it went the new structure and newly developed domains did not lead to the demise of health education per se. And as an interesting aside, in what might be called a curriculum twist, HPE has been classified as a KLA at the National level (see ACARA, 2011; MCEETYA, 2008). But, a second, and I would suggest a more significant effect related to Health Education’s shift into the strand of Physical, personal and social learning, was the emergence of some new elements within official versions of health education. Health education was again explicitly linked to a strand that is solely directed towards physical, personal and social learning. And although this may appear to be both a logical and common-sense move given the long standing official hopes of health education (see Lupton, 1995; St Ledger, 1992, 2006) the shift discursively constrains the possibilities, at least for official versions of health education.

The new version of health education that emerged as a result of its relocation and redevelopment within the curriculum assemblage resulted in a significant narrowing of the subject area, compared to previous versions of health education. For example strands (in the new guise of dimensions) had been reduced with the removal of one of the key mainstays of health education, self and Relationships. Below I describe in more detail the new version of health education that emerged in the curriculum shift to VELS.

New assemblages for new times (the Emperor’s new clothes?)

As the preceding discussion highlighted, the broader shift in curriculum thinking in Victoria, lead to a reconfiguration of health education. Health education (as HPE) was disconnected from other previous KLAs (now domains) and
repositioned in the essential learning strand of *Physical, personal and social learning*. The positioning in this strand is significant in that it sets the tone for what it is that learning in health education is about, and in turn what it is expected to do. The stage is set in the introductory notes to the *Physical, personal and social learning* strand:

A curriculum designed to equip students for the challenging world of the twenty-first century needs to ensure that students develop as people who take increasing responsibility for their own physical wellbeing, learning, relationships with others and their role in the local, national and global community (VCAA, 2008, p. 3).

The excerpt above provides the context and the direction of the various domains that are located within the strand: Health and Physical Education, Interpersonal Development, Personal Learning and Civics and Citizenship. And although not explicitly connected in the above excerpt, the Health and Physical Education dimension is charged with ensuring that students can take increasing responsibility for their health. The document goes on to elaborate on the function of each of the learning domains. In the overview of the HPE domain the hopes for the curriculum area are revealed:

A healthy, physically active lifestyle is conducive to more effective participation in all that society has to offer and greater levels of success within and beyond school. This requires students to develop the knowledge, skills and behaviours that enable them to:

- Maintain good health and live a healthy lifestyle
- Understand the role of physical activity in ensuring good health
- Engage in physical activity (VCAA, 2008, p. 3).

In the above excerpts, the push is for HPE to ensure that students are able to take increasing responsibility for their health, via assisting them to develop knowledge, skills and behaviours in order to prepare them for the challenges of the 21st century. The only thing that is new here is the acknowledgement that we are in the 21st century. The focus on increasing responsibility has dominated health education assemblages over the past thirty years. What is interesting though is that given that the 21st century is characterised by flux and uncertainty, it seems a little
simplistic to at this point suggest that young people are in any real position to take increasing responsibility for their health. Global economies are faltering, conflict is on the rise, employment and labour patterns are changing, the environment is in distress, health knowledge changes rapidly and within all of that, neo-liberalism would hold young people 100% accountable for their own health status, as well as others.

The new essential health education, based on a need to prepare students for new times looks remarkably like an old health education, just re-gifted with some new rhetoric added in to the mix. There are changes in rhetoric to be sure, but fundamentally this curriculum version of health education seems to ignore the fact that control is not necessarily in the reach of many, or if it is, it might not be stable. Neo-liberal renditions of health education effectively minimise or silence the social forces at play, in turn placing sole responsibility for health at the feet of the individual. It is this kind of health education that has been squarely in the sights of ‘critical’ and Foucauldian and other poststructuralist scholars since the 1980s. So regardless of what we know about the broader social determinants and how they shape lifestyle and choice, curriculum writers who might be drawn to socio-cultural models of health education, find themselves reduced to reproducing problematic curricula that espouse neo-liberal tenets. Possibilities then for health education in the new VELS are foreclosed (again) by the continued dominance of neo-liberalism within broader governmental assemblages. This is by no means a new suggestion, and curricula and programs from the US (Vander Schee, 2008b), Canada (Gard, 2008), New Zealand (Burrows, 2010; Sinkinson, 2011) and the UK (Evans, 2003; Rich, 2010b) also find neo-liberalism firmly entrenched, and dominating the governmental assemblage still. And it appears with every new version of health education curriculum, despite what critics have been telling us, individual approaches to ensuring students can take responsibility for their health endure. I will return to discuss what this means for practices of health education throughout the remaining chapters. But for now I want to drill down further into the document to consider some of the privileged techniques of governmentality.
As I have suggested above, effectively health education's (and physical education's) purpose, as it is documented in the various introductions and overviews to the strand and domain, is to ensure that students become more responsible for their physical wellbeing via the development of knowledge, skills and behaviours that in turn will enable them to maintain good health and live a healthy lifestyle. Within this particular assemblage, curriculum writers at this level in the curriculum are no longer even bothering to pay lip service to the broader structural determinants of health. Such forces have been effectively eradicated from the assemblage. Drilling down further into the HPE domain, the introductory section elaborates on the broad scope and purposes of the curriculum area. Throughout the HPE introduction, reference is made to both Health Education and Physical Education. For the purposes of analysis I have italicized the Health Education specific purposes. Within the VELS, the domain of HPE has the following scope and purposes:

*The domain of Health and Physical Education provides students with knowledge, skills and behaviours to enable them to achieve a degree of autonomy in developing and maintaining their physical, mental, social and emotional health. This domain focuses on the importance of a healthy lifestyle and physical activity in the lives of individuals and groups in our society.*

This domain is unique in having the potential to impact on the physical, social, emotional and mental health of students. It promotes the potential for lifelong participation in physical activity through the development of motor skills and movement competence, health-related physical fitness and sport education.

Engaging in physical activity, games, sport and outdoor recreation contributes to a sense of community and social connectedness. These are vital components of improved wellbeing.

Students’ involvement in physical activity can take many forms, ranging from individual, non-competitive activity through to competitive team games. Emphasis is placed on combining motor skills and tactical knowledge to improve individual and team performance. Students progress from the development of basic motor skills to the performance of complex movement patterns that form part of team games. They learn how developing physical capacity in areas
such as strength, flexibility and endurance is related to both fitness and physical performance.

Students progress from learning simple rules and procedures to enable them to participate in movement and physical activity safely, to using equipment safely and confidently. Students undertake a variety of roles when participating in sports such as umpire, coach, player and administrator and assume responsibility for the organisation of aspects of a sporting competition.

This domain explores the developmental changes that occur throughout the human lifespan. It begins by identifying the health needs necessary to promote and maintain growth and development, followed by discussion of significant transitions across the lifespan including puberty, to gaining an understanding of human sexuality and factors that influence its expression. The exploration of human development also includes a focus on the establishment of personal identity, factors that shape identity and the validity of stereotypes.

Students develop an understanding of the right to be safe and explore the concepts of challenge, risk and safety. They identify the harms associated with particular situations and behaviours and how to take action to minimise these harms (VCAA, 2008, p. 5).

The above arrangement of scope and purposes reveals a range of hopes, rationalities, and techniques. Firstly, what becomes clear, if it wasn’t already from previous curricula moments gone by, is that there is a substantial difference between the scope and hopes of Health Education and Physical Education. As subject areas, although they sit within a HPE curriculum assemblage together, there are effectively few points of contact. Where there are moments of connection, the connections between Health and Physical Education are forged around the concept of health related physical fitness as well as the emotional and social aspects of sport and physical activity via community and social connectedness. The continued assembling together of Health Education and Physical Education needs to be called into question given the various divides in the assemblage. One has to question whose interests are being served by the continued joining of the two. What are the implications for Health Education? And what are the implications for Physical Education? I discuss some of the implications in the following chapters where the subject divides play out at the
level of programming, timetabling and staffing (see Chapter Four). This in turn shapes classroom practices and experiences (see Chapter Five).

Secondly, health education’s scope in this iteration has been reconfigured and I would argue, narrowed. It appears that some things did not make the cut in the new assemblage. This can be most clearly evidenced by drilling down further into the curriculum structure where the HPE ‘domain’ is further broken down into two dimensions. Health education, at this level, is reflected in the dimension ‘Health knowledge and promotion’. The VELS overviews the dimension in the following way:

The Health knowledge and promotion dimension examines physical, social, emotional and mental health and personal development across various stages of the lifespan. It focuses on safety and the identification of strategies to minimise harms associated with particular situations or behaviours. Students examine the promotion of health of individuals and the community through the use of specific strategies and the provision of health resources, services and products. They examine the factors that influence food selection and the role of nutrition on health growth and development (VCAA, 2008, p. 7).

The move to two dimensions is an interesting one in this version of curriculum. Previously health education linked explicitly to two strands, Health of individuals and populations and Self and relationships. Whereas in the VELS health education finds itself effectively represented in the dimension Health knowledge and promotion. On review it appears as if Health knowledge and promotion has superseded Health of individuals and populations. And the focus on Self and Relationships have been removed and placed into another domain. If the tenets of the New Public Health weren’t explicit before, they are now in the naming of the dimension. In addition, the dimension’s name brings to the fore a heightened emphasis on health knowledge with a link to Health Promotion. It is very much a worrying hark back to yesteryear when traditional approaches to health education focused on the provision of health knowledge in attempt to promote individual health. In addition to this, health status is reduced to the role of knowledge, which defies much of what we know about health status and the complexities involved when seeking to improve health status. I want to turn now to consider some of the
tactics of health education, or governmental techniques. Given that health education is expected to ensure that young people can take responsibility for their health, what are the techniques, or the practical mechanisms that are expected to enact this hope?

**Tactical assemblages of health education**

In the previous section where I discussed the hopes of health education, I necessarily touched on some of the tactics of health education, as it is difficult to isolate one from the other (see Hay, 2009). I want to now explicitly consider the various tactics of health education, as they are assembled together in the official curriculum. To do this I consider Level 5\(^{12}\) of the HPE dimension as one illustrative example. The structure of the curriculum provides teachers with *learning focus statements* and *standards*. The learning focus according to the VCAA (2008, p. 6) provides an:

> ... outline [of] the learning that students need to focus on if they are to progress in the domain and achieve the standards at the levels where they apply. They suggest appropriate learning experiences from which teachers can draw to develop relevant teaching and learning activities.

Standards then according to the VCAA (2007b) ‘should form the basis of curriculum planning and assessment at both the whole school and classroom level’. The learning focus statements are provided for the overall HPE area with standards being dimension specific. In the following extract from the curriculum document I have only included the health education specific learning focus statements.

As students work towards the achievement of Level 5 standards in *Health and Physical Education*:

Students explore views about fitness and suggest what fitness might mean to various groups in society. They develop their understanding of the physical, mental, social and emotional benefits of participation in

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\(^{12}\) Level 5 usually is delivered to students who are in Year Seven and Eight at Secondary School (approximate age range from 12-15 years of age). I explore Level 6 in the next chapter.
physical activity, and examine factors which influence such participation. They consider the relationship between physical activity, fitness and health, and explore ways to measure their own fitness and physical activity levels. They explore the relationship between their physical activity and nutrition in order to understand how they can maintain physical health. They investigate and address positive and negative motivational factors that influence the value they place on participating in physical activity. They are introduced to the components of performance-related fitness, and learn how to analyse and evaluate sports and activities from this perspective.

Students continue their study of the changes associated with adolescence by identifying what changes have already occurred and what changes (physical, social and emotional) they can expect to experience. They describe the influence of the family on shaping personal identity and values. They explain how community attitudes and laws influence the sense of right and wrong.

In developing strategies to minimise harm and to protect their own and others’ health, students consider health resources, products and services, and the influences of the law, public health programs, their conscience, community, attitudes, and religious beliefs. They begin to clarify a cohesive set of personal values and how they could be used to improve their health.

Students describe the health interests and needs of young people as a group, including those related to sexual health (for example, safe sex, contraception, abstinence and prevention and cure of sexually transmitted infections) and drug issues (for example, tobacco, alcohol, cannabis use). They explore actions at personal, family and societal levels that help to meet these needs, and identify the influences of individuals and groups. They explore ways of dealing with change, especially the social and emotional aspects of transition from primary to secondary school. They learn how to access reliable information about health issues affecting them and to identify barriers and enablers to accessing health services.

Students reflect on the range of influences on personal food intake: peers, advertising, mass media, mood, convenience, habit, cultural beliefs and values, and access to food products and services. They explore topical issues related to eating, and identify personal and community factors that influence their own food selection. Students consider the nutritional requirements for growth and activity at different stages of life, and learn to set nutritional goals using food selection models. They learn how to analyse nutritional information provided in advertising and product labels, and to make decisions
about how this information can be used by, or influence, individuals in their food choices (VCAA, 2007b).

The standards listed for the Level 5 dimension of Health, knowledge and promotion are:

At Level 5, students describe the physical, emotional and social changes that occur as a result of the adolescent stage of the lifespan and the factors that influence their own development. They describe the effect of family and community expectations on the development of personal identity and values. They identify outcomes of risk-taking behaviours and evaluate harm minimization strategies. They identify the health concerns of young people and the strategies that are designed to improve their health. They describe the health resources, products and services available for young people and consider how they could be used to improve health. They analyse a range of influences on personal and family food selection, and identify major nutritional needs for growth and activity (VCAA, 2007b).

The above curriculum overview of health education as it currently sits within the VELS reveals a great deal about the hopes, rationalities and techniques that are assembled together in official curriculum documentation. The overview and description of learning focus statements and standards reveals ‘rather unwieldy’ curricula assemblages (Luke, 2010, p. 2). The focus statements detailed above in Level Five (and indeed across all of the levels) are illustrative of the very unwieldiness to which Luke refers. The learning focus statements for example combine statements that provide focus and direction to the traditional curriculum areas of Health Education and Physical Education, whilst also incorporating a vast range of topic areas, requisite skill and knowledge requirements along developmentally prescribed appropriate lines. The same can be said for the other levels in the curriculum. This particular assemblage of skills, knowledges, subject areas and topics results in a curriculum area that might be considered to be, in Luke’s (2010, p. 2) words ‘bloated or conceptually incoherent’, and even bordering on nonsensical at times. For example the initial links that are forged between health and the essential learning area of Physical, personal and social learning centre around the significance of helping students increase their responsibility for physical wellbeing. The focus on the physical is a rather
surprising one, as it departs from previous emphases on holistic health, and in essence from the broader health promotion literature (Lupton, 1999a; Peterson & Lupton, 1996; O’Connor & Parker, 1995). But the curriculum does not remain consistent in its focus, as further along in the detail of the dimension of *Health knowledge and promotion* the emphasis shifts to include *physical, social, emotional and mental health and personal development*. The movement from physical wellbeing at one level to an all-encompassing multi dimensional approach to health at the dimension level reveals slippage in the assemblage. How this happens, is anyone’s guess. For example it could have been an oversight by curriculum writers, the broader approach to wellbeing might have been edited out due to word length requirements of statements, it might be that a physical education oriented person wrote the statement that refers to physical wellbeing, or the health education person who wrote the dimensional statement would not let go of the idea that health is much more than just the physical. I don’t know the answer in this instance, and can only wonder about the writing process and how things played out at that level. But from what we know about official curriculum writing processes, invited writers bring many varied investments and interests to the table, and various opinions and perspectives find themselves being privileged, whilst others are silenced (see for example Evans & Penney, 1995; Glover 2001; Penney & Glover, 2006).

In addition to this, assembling curriculum requires writers to bring together subject areas with diverse, and at times incompatible, historical trajectories, that then need to be adapted to the current curriculum architecture and thus aligned with dominant political rationalities shaping curriculum development at the given time. They also need to consider various submissions from lobby groups, who have particular interests that they want represented in the curriculum (see Evans & Penney, 1995; Glover, 2001). And although the health education curriculum both in this iteration, and in previous iterations might appear unwieldy and made up of heterogeneous and diverse elements, there are some lines of consistency that run through the various curriculum assemblages that are of interest to this study. I want to turn now to consider these lines to illustrate the various rationalities and
techniques that are assembled together in the contemporary health education curriculum.

Health education essentials

Throughout the different versions of curriculum I have reviewed above there are a number of themes that recur regardless of the broader curriculum architecture at play. Throughout health education curriculum, at least for the previous thirty years, personal responsibility, personal choice, decision making, personal development and fulfilment, responsibility for others, rationality and autonomy are discourses that circulate and cluster together within curriculum assemblages. They have been mainstays of health education curriculum assemblages, although we may have witnessed some shifts within the assemblage as different themes and approaches are prioritised over time. The themes can be all linked to attempts to shape the health[y] conduct of young people, both for the present and in the future. The health education curriculum assemblage, as I have discussed, is made up of linkages to rationalities within broader education and health promotion assemblages, as well as its own internal logics and links via the incorporation of themes from times gone by. When discussing the various linkages, my intention is far from trying to set up the idea that there is any deliberate linearity to this. The notion of government assemblages as discussed by both Dean (1999) and Rose (2000) in the previous chapter suggests otherwise. Assemblages are formed as various linkages join up. In turn linkages can be formed as a singular rationality or technique connects into an assemblage, or from a range of fragmented elements of rationalities, techniques and conceptions of the subject. The various singularities and fragments assemble together to make new versions of, in this case, curriculum. In doing this they form what Kehily (2002) refers to as discursive clusters.

Within the official version(s) of health education curriculum that I have reviewed above neo-liberalism is central to the various discursive clusters and thus permeates health education’s hopes and techniques. Within broader assemblages,
and within the health education curriculum assemblage neo-liberalism as a political rationality powerfully shapes how each curriculum document has set about responding to the problem of young people’s health; how to best understand health and how to best work to improve health. Given that neo-liberalism powerfully shapes educational policy and curriculum as well as imperatives and approaches inherent within the New Public Health it is little wonder that health education finds itself entangled in, and shaped by neo-liberalist rationalities, techniques and conceptions of the subject.

The implications for health and health education have been well documented (see for example Lupton 1999a; Peterson & Lupton, 1996; Burrows and Wright, 2007; Vander Schee, 2008a, 2008b, 2009a). A health education curriculum that emphasises individual responsibility for health, whilst assuming that people are autonomous rational actors is a product of contemporary mentalities of government. Such mentalities work to assume and produce an active reflexive subject who aspires to health, and who possesses the means by which to achieve health. The various technical devices that are prioritised within the health education curriculum provide the ‘means’. A young person who has a kit bag full of health knowledge, decision making skills, communication skills and harm minimisation strategies is expected to be able to select the appropriate skill and/or strategy to ensure that both they, and the broader community in which they live, are healthy.

**Conclusion**

Throughout this chapter I have analysed ‘official’ versions of health education curriculum in Victoria, Australia. In understanding how school based health education does governmental work, it is significant to consider curriculum given that it fundamentally encapsulates the hopes of health education. In essence, health education and the official curriculum provide government with an opportunity to govern at a distance via the linking up, and extension, of the obligations of political authorities with the health, happiness and wellbeing of the
population (Rose, 1996). As I discussed in the Introduction to the thesis, and in this chapter, health education has long been in the sights of policy writers and schools have long been considered key settings for attempts to govern health. In addition to stating specific hopes, curriculum assemblages set out ways for bringing the stated hopes to fruition via the privileging of various knowledges, techniques and strategies. Over the past thirty years, curriculum hopes and techniques have remained remarkably similar, although they have been repackaged, reformulated and reconfigured as shifts have taken place in broader curriculum and health assemblages. The hopes of health education as they are revealed in official curriculum are very much linked to neo-liberal hopes of producing a healthy, responsible and autonomous subject whose every action is directed towards enhancing health, both their own, and others.

However, as I have suggested in Chapter Two, the official curriculum is only one element of the governmental assemblage of health education. The following two chapters consider what happens to the curriculum when teachers enact its hopes and translate the curriculum into school programs, and then into classrooms.
Chapter Four: Assembling school based health education curriculum

Introduction

In attempting to understand school based health education as a governmental assemblage, it is essential to look beyond the ‘official curriculum’ to consider other elements that make up the assemblage. As I discussed in Chapter Three, the official curriculum is a significant element in the overall assemblage as it, amongst other things, enshrines the governmental hopes of health education, as well as providing a schema of techniques that ensure that governmental hopes are supposedly met. And though the official curriculum is a powerful element in the assemblage, on its own it is merely inert policy discourse that remains static on the pages of a document until it is put into practice. The purpose of this chapter then, and the next, is to examine how health education curriculum discourse, is mobilised within school contexts. In doing this, my analytical gaze necessarily turns to what Foucault (1994) refers to as the extremities of power. As Foucault (1994, p.213) states:

The analysis in question should not concern itself with the regulated and legitimate forms of power in their central locations, with the general mechanisms through which they operate, and the continual effects of these. On the contrary, it should be concerned with power at its extremities, in its ultimate destinations, with those points where it becomes capillary, that is, in its more regional and local forms and institutions. Its paramount concern, in fact, should be with the point where power extends itself beyond them, invests itself in institutions, becomes embodied in techniques, and equips itself with instruments and eventually even violent means of material intervention (1994, p. 213).

In the above excerpt Foucault draws our attention to the place where power is enacted, its ultimate destination. The final destination, and thus the ultimate extremity of the official curriculum is the classroom and its students. The focus of
this chapter then is on the ‘extremities’ of curriculum, and how it is enacted within school contexts (Jackson, 1996; Luke, 2010).

Given that schools and classrooms are located ‘at a distance’ from curriculum writers and government, I am interested in the journey that curriculum takes as it makes its way into schools, and in turn into classrooms. How are governmental hopes translated in schools? What kinds of programs emerge? And how is curriculum enacted? Luke (2010, pp. 1-2) suggests the translating of official curriculum is by no means a linear process as it is:

...remade through the lenses and practices of teachers’ substantive world, field and disciplinary knowledge, then brought to life in classrooms in relation to teachers’ pedagogical content knowledge and students’ cultural scripts and background schemata, which include a host of other available messages of media, institutions and community cultures. The enacted curriculum will be influenced by adjacent policies and practices on assessment, evaluation and credentialing (which define ‘what will count’) - and on school funding, governance and leadership; teacher training and professionalism, and so forth.

Luke here highlights the multifarious components that make up the ‘enacted’ curriculum assemblage. To understand how curriculum is enacted, and thus how power makes its way to the extremities, this chapter and the next, seek to explore and analyse the remaking of the official curriculum vis-a-vis the ‘enacted curriculum’.

Firstly, the chapter offers an analysis of the process of writing school based curriculum, and in particular the central role that teachers play as ‘assembling agents’ as they interpret the ‘official curriculum’ to develop their health education programs and classes. This exploration draws from a range of data sources including interviews with health education teachers from each of the three schools in the study, curriculum support web documents, health education textbooks, and school curriculum documents. The current chapter also explores the end product of this process, to consider how written programs align with the official hopes of curriculum. My analysis and discussion draws from the curriculum documents that were developed by each of the three schools. In Chapter Five, I continue with
my interest in exploring and analysing the enacted curriculum and in this chapter, I follow curriculum as it is put into motion within pedagogical moments. Drawing on classroom observations the chapter explores the extremities of governmentality, its techniques at play and the enactment of governmental imperatives at the micro level. What is interesting to note is that such analyses are rare or largely inadequately conceptualised in the curriculum studies area (Ball, 1994; Luke, 2010). Within the field of health education the scene appears to be even bleaker (Cliff & Wright, 2010; Lupton, 1999a; Vander Schee, 2009a). It is in this way that the thesis attends to that deficit. I offer both an analysis and an exploration of the ‘enacted curriculum’ in an attempt to better comprehend ‘how’ school based health education attempts to meet its official imperatives.

Lost in translation?

In the introductory section to the official curriculum documents, the VCAA (2007b, p. 5) state that:

The [curriculum] Standards have not been designed as an organisational template on which to develop timetables or school structures. They are designed to be used for whole school curriculum planning. School teams will decide how to meet the essential learning standards. For some this may be through explicit teaching focused on a particular standard and for others it will be by creating units of work which address a number of standards at the same time.

This policy approach to curriculum development places teachers ostensibly at the centre of school based curriculum development: in essence they are curriculum makers (Clandinin & Connelly, 1996). This manoeuvre at the policy level is interesting in and of itself as a governmental tactic, and I will return to discuss it in the next section. But for now I want to focus on the role allocated to teachers here, and the subsequent processes involved in curriculum making at the school level. Both the role of curriculum maker and curriculum making processes have been variously named, and studied, in the literature over time. For example, Basil Bernstein wrote extensively on the social construction of pedagogic discourse, and refers to the work of teachers interpreting and transforming official texts as
recontextualising work (Bernstein 1990). Ball (1994) refers to the work of teachers in adapting policy as secondary adjustment work. Honan (2001) on the other hand refers to teachers as bricoleurs. As bricoleurs they, in the construction of their bricolage, assemble together possible readings and renderings of syllabus documents. Within the broader field of governmentality studies though, Rose (1999) terms the movement of governmental hopes into practical programs as translation. Drawing from this literature, I want to consider the significance of teachers as assembling agents given that they are responsible for translating official curriculum into school programs and classrooms. In assembling curriculum teachers interpret, adjust, recontextualise, remake and re-assemble curriculum documents. It is this translation process, its agents and its supporting mechanisms that I am interested in exploring in the ensuing sections as they are key elements in the functioning of the broader governmental assemblage.

Translating curriculum assemblages

In considering government writ large, Rose (1999, p. 48) posits the question:

How is it possible for all the calculations, strategies and programmes formulated within such centres to link themselves to activities in places and activities far distant in space and time, to events in thousands of operating theatres, case conferences, classrooms, prison cells, work places and homes?

It is useful to contemplate this in relation to education and curriculum more broadly. It begs the question how do official curriculum imperatives, created in centres, work their way into classrooms? In seeking to answer this I draw on Rose’s (1999, p. 49) response to his own question posed above. He states that:

In the dynamics of translation, alignments are forged between the objectives of authorities wishing to govern and the personal projects of those organizations, groups and individuals who are the subjects of government. It is through translation processes of various sorts that linkages are assembled between political agencies, public bodies, economic, legal, medical, social and technical authorities and the aspirations, judgements and ambitions of formally autonomous entities, be these firms, factories, pressure groups, families or individuals.
Translation of curriculum then, relies on a multitude of mechanisms to ensure that each domain is linked: the curriculum to the school/teaching team and then to the classroom. What are these mechanisms and linkages then that aid the translation? I would suggest that the call by official curriculum authorities for schools to develop their own programs, and the linking in of teachers as central agents of translation is one of the mechanisms through which governmental hopes are realised. But this move, given the reliance on teachers, might be considered to be risky. Rose (1999) for example considers translation mechanisms to be precarious given the reliance on various lash ups and linkages. Ball (1994) tells us too, in relation to educational policy, that ‘solutions to the problems posed by policy texts will be localised and should be expected to display ad hocery and messiness’ (p. 7). Following this, one might be forgiven for thinking that locating curriculum development responsibilities at the level of the school might mean that governmental hopes get lost in translation. This has certainly been the case in some instances of curriculum work. For example Honan’s (2001) study on English teachers curriculum work attests to the multiple and varied plausible readings of official syllabus documentation that are made. Her research shows that teachers resist, comply and recreate curriculum documents in ways that could well disrupt, destabilise and derail official curriculum hopes. However, in contrast to this, in my research, the formal documented curriculum offerings in the three schools in my study were remarkably similar. Given this, and returning to consider Rose’s (1999) earlier claims about the precariousness of translation, it is interesting to consider the following question: How it is that three schools, hundreds of kilometres apart with very different staff, have similar health education programs given that they have the freedom to determine their own offerings? I remember being surprised and disappointed by this similarity at the time of data collection as I was sure I had ‘sampled’ for diversity, and had, perhaps naively, expected it. I had sampled a metropolitan, rural and regional school. I had included a single sex school and coeducational schools. I had included teachers who were differently aged and who came to health education via different teacher training programs, teaching methods and qualifications. But
despite this, on the whole teachers in my study assembled very similar programs. The similarity across programs reveals something about the translation mechanisms at play here, and thus something about the inner workings of the assemblage. To return to Rose (1999) and the questions he posed above about how the hopes of government, that are forged at centres, make their way to the extremities, the translation mechanisms of government are integral to the functioning of government. Given this, I want to consider the ‘translation mechanisms’ of curriculum, what they are and how they operate to ensure that health education curriculum hopes are mobilised in classrooms. Within governmental translation mechanisms teachers are central. But they are not really set free to develop the curriculum of their choice. Rather, their work is ‘supported’ by a whole host of official curriculum ‘translation’ devices. A review of the various support documentation reveals a multitude of officially sanctioned websites and official curriculum advice documentation that is designed to help teachers translate and enact the official curriculum. I want to now consider some of the support documentation, or translation mechanisms more closely, to consider how they shape the work of teachers to ensure that the hopes of curriculum are translated at the school level and make their way into classrooms.

Given the many elements operating here, for heuristic purposes, I firstly consider the ‘call’ for schools and teachers to produce their own curriculum programs. As I have previously mentioned this is an important mechanism of translation. I draw here on contemporary curriculum documentation and official curriculum support materials to discuss how these produce particular readings and thus enable particular versions of curriculum. Second I draw from teacher interviews from across the three schools in the study to consider more closely the role of teachers as curriculum assemblers and the various processes that teachers utilise to translate official curriculum to assemble school curriculum programs.

**Regulating curriculum assemblages**

As previously discussed, teachers are central to the translation of curriculum hopes at the school level as they are called on to develop curriculum by
curriculum authorities. This is not a new mechanism for curriculum development, and the devolving of responsibility to schools for management and curriculum development has been a feature of educational policy for some time. As an approach to governing education and schools, devolution gained momentum in the 1980s with the rise of neo-liberal agendas (Ball, 1994; Gordon & Whitty, 1997; Whitty, Power & Halpin, 1998). The impact of this shift in (govern) mentalities was, and continues, to be seismic. It certainly changed the face and functioning of education across sectors and countries (see Ball, 1993, 1994; Gordon & Whitty, 1997; Sachs, 2001). With specific reference to curriculum development, the shift to devolve responsibility to schools was part of the neo-liberal agenda. And at face value, the move suggests that teachers and schools are free to create their own curricula offerings. But the move to devolve responsibility for curriculum development to schools is actually bound to moves for greater regulation (see for example Ball 1994; Whitty, Power & Halpin 1998). This tightening of regulation takes place through the various translation mechanisms and devices that are put into place to ensure that the official curriculum is enacted in accordance with its aims. The mechanisms that I am referring to here include the official curriculum design, coupled with the vast array of curriculum support documentation that teachers are provided with by the relevant curriculum authorities. Thus some of these mechanisms are interwoven through curriculum schema, and others are found in the various advice literatures that are developed and put in place to support translation. I will turn to consider some of the various mechanisms in the next section when I discuss how teachers in my study translated official curriculum. For now though I am interested to consider the internal translation mechanisms that are woven through official curriculum documentation.

The introduction section of the overview to the VELS, the VCAA (2007a) invites ‘schools teams’ to decide on how to best ensure that students can meet the essential learning standards. The standards are provided for teachers in the official documentation. In addition to the provision of standards, the curriculum also
provides a range of learning focus statements. The learning focus statements provide an:

… outline [of] the learning that students need to focus in if they are to progress in the domain and achieve the standards at the levels where they apply. They suggest appropriate learning experiences from which teachers can draw to develop relevant teaching and learning activities (VCAA, 2007a, p. 6).

In providing standards and learning focus statements, the VCAA are effectively trying to ensure that teachers program in certain sanctioned ways. For example, a teacher, or a team of teachers, who decide to develop or review a health education program for Year 9 and 10 students would (in an ideal official curriculum world) look to the official curriculum for direction. They would find the following learning focus statements and Standards for Level 6 students:

**Level 6 Health knowledge and promotion**

**Learning focus**

Students extend their learning about the major tasks in establishing personal identity. They describe social and cultural factors, such as family, the media, community expectations influencing the development of personal identity, including the development of identity as it relates to gender. They discuss ways to express independence and the rights and responsibilities associated with the development of increasing independence. They rehearse strategies for being assertive when protecting their own and others’ health.

Students discuss relationships and how the different aspects of relationships vary between people and over time. They consider how the different roles and responsibilities in sexual relationships can affect their health and wellbeing. They explore a range of issues related to sexuality and sexual health such as safe sex practices, sexual negotiation, same sex attraction and the impact of alcohol on sexual and personal safety.

Students explore assumptions, community attitudes and stereotypes about young people and sexuality. They learn strategies for supporting themselves and other young people experiencing difficulties in relationships or with their sexuality, and learn about the community services available to assist. Students investigate and evaluate the policies and practices in their school in relation to sexual and racial
harassment, homophobia and/or discrimination, and consider their rights and responsibilities in these areas.

Students examine mental health issues relevant to young people and consider the importance of family and friends in supporting their mental health and emotional health needs. They consider the stigma of mental illness as well as the challenges for those with a mental illness and for those caring for them.

Students examine perceptions of challenge, risk and safety in a variety of settings such as in the home, school, the workplace and the community. They contrast risks that promote personal and social growth with those that endanger health. They discuss ways to balance risk and safety, and refine and evaluate harm-minimisation strategies. They examine strategies to promote safety such as those associated with occupational health and safety.

Students examine the concept of adventure in outdoor activities as well as perceived and actual risk. They learn basic first aid skills such as cardiopulmonary resuscitation (CPR), asthma management and sports injury management.

Students explore assertiveness and resilience strategies that could be used in a range of situations. Using techniques such as role-play or simulation games, students are provided with opportunities to practise and reflect on the usefulness of these strategies.

Students learn to use simple health data to identify the major causes of illness, injury and death in Australia. They investigate personal behaviours and community actions that may contribute to the health of specific groups. Students investigate the work of government departments and non-government bodies in promoting and protecting the health of young people, including laws, policies and provision of health services. They identify the services provided through Medicare.

Students examine the relationship between nutrition and stages of growth and development, and the eating practices associated with different stages in life. They learn to analyse the links between diet and current community health issues, and consider special dietary needs, and ways of improving their own diet. They research patterns of food consumption in Australia and investigate factors that influence food choice, such as changes in family life.

**Standards**

At Level 6, students identify and describe a range of social and cultural factors that influence the development of personal identity and values.
They identify and explain the rights and responsibilities associated with developing greater independence, including those related to sexual matters and sexual relationships. They describe mental health issues relevant to young people. They compare and evaluate perceptions of challenge, risk and safety. They demonstrate understanding of appropriate assertiveness and resilience strategies. They analyse the positive and negative health outcomes of a range of personal behaviours and community actions. They identify the health services and products provided by government and non-government bodies and analyse how these can be used to support the health needs of young people. They identify and describe strategies that address current trends in the nutritional status of Australians. They analyse and evaluate the factors that affect food consumption in Australia.

(VELS, 2007b)

The combination of learning focus and standards is an example of how policy does indeed limit the discursive space and possibilities for curriculum development. As Ball (1994, p. 21) suggests the official curriculum architecture and supporting information establishes the location and timing of the context, in this case health education’s subject matter and the rules by which health education is to be taught.

The curriculum focus and standards function as translation mechanisms in that they operate to ensure teachers construct ‘authorised’ versions of curriculum. The standards and statements effectively regulate the curriculum writing space by placing boundaries around what can be thought, spoken, felt and taught to young people in the area (see Popkewitz, 1998). So even though on one hand schools and teachers are free to make curriculum decisions, on the other they are only free to decide on how it is that students will work towards the set ‘Standards’. The specified ‘Learning Focus’ statements are directly related to standards, which are specific and finely tuned to ensure the governmental hopes of health education are translated. For example they prescribe what it is that students should be examining, thinking, learning, acquiring, developing, understanding and analysing.
In the little room there is left for any curriculum manoeuvring, teachers are supplied with a range of ‘official’ support guidelines and examples to guide their curriculum development. For example the VCAA website has links to various translation documents including; assessment maps, concepts and skills charts, cross curricula perspectives, design awareness in schools, English as a Second Language (ESL) companion to VELS, graphic organisers, progression point examples, sample units, student with disabilities guidelines and teaching and learning advice (VCAA, 2007c). In addition to this, the DEECD provide links to the following; assessment advice, domain pages and continuums, eLearning and ICT, multi-domain assessment tasks, Principles of Teaching and Learning, Student reports and Themed programs (DEECD, 2010).

In summary then, the expectation is that teachers assemble together programs that enable students to meet the specified standards at a particular level. To do this, teachers are directed to the learning focus statements. Both the standards and the learning focus statements are significant translation mechanisms that are located internally within the official curriculum document. In addition to this, they can draw from some, or all, of the official support documentation provided.

The official governmental translation mechanisms of health education effectively work to forge alignments and linkages across the official curriculum context to ensure particular versions of curriculum are translated at the level of the school. In essence then the invitation to write curriculum is a tactic of government. The tactic creates the illusion of freedom of curriculum choice. According to Rose (1999, p. 4) this illusion of freedom is a necessary and intrinsic element of governmentality because ‘to govern is to presuppose the freedom of the governed. To govern humans [teachers] is not to crush their capacity to act, but to acknowledge it and utilize it for one’s own objectives’. Teachers can act, and are invited to do so, by curriculum authorities. But from a curriculum writing perspective, the freedom to act is constrained by the embedded translation mechanisms of learning focus statements and standards contained within official curriculum documents.
The official health education curriculum then not only contains governmental hopes for Health Education it also functions as its own translation mechanism by setting out various learning focus statements and standards, which in turn seek to dictate how government is enacted at a distance. The internal translation mechanisms are vital in the governmental assemblage of education because they work to try to ensure that the various rationalities of government flow into schools and classrooms in ways that are intended. In addition to intrinsic mechanisms within the official curriculum, there is a range of other translation mechanisms that circulate within the governmental assemblage. I will explore these in some detail in the next section as I consider the ways in which teachers work to assemble curriculum in their respective schools.

Assembling curriculum

To this point in time, I have considered the role of official curriculum documents and support materials as governmental translation mechanisms of curriculum. And it is without question that they are indeed significant elements within the governmental project of school based health education. However, teachers use official curriculum in varying ways to develop their programs and lesson plans. This section is interested in examining how teachers actually go about assembling curriculum at the school level. How do they, for example, use the official curriculum and its support materials? What other sources do they draw from? What shapes their decisions as they work to assemble programs in their schools?

The teachers in this study were all involved in assembling curriculum programs and lesson plans for health education. This is not surprising though given at some stage teachers need to work with official curriculum documents, or develop unit plans and/or lesson plans. I was particularly interested to explore two aspects of their work. First I wanted to consider the nature of their involvement in curriculum development, and how they went about assembling curriculum. In addition to this, I was also interested in how they understood their role as an assembling agent and how this impacted on the ways in which they assembled
programs and lessons. Specifically I was interested to examine the discourses that teachers mobilised when discussing their role as a health educator as well as the perceived role that health education played in young people’s lives. I now turn to consider how teachers work to assemble curriculum at the school level.

**Out with the old, in with the new?**

The ways in which teachers went about their curriculum assemblage work varied across school context and time. At the time I collected the data, Victoria had only just revised and released the new ‘improved’ CSFII in 2000. In many ways it was a perfect time to explore how new curriculum impacts on existing school programs, and specifically how teachers work with the arrival of the new curriculum, and what happens to the old. Every teacher I spoke to expressed some relief that the CSFII had arrived. They believed that the HPE CSF had been ‘monstrous’, ‘unwieldy’, ‘frustrating’ and ‘ridiculous’ to work with. Ms Hill (school), a KLA manager, described the CSF as ‘a good example of the bureaucracy gone mad’ and the ‘Ben Hur’ of curriculums. Given this, it is little wonder then that the new improved curriculum provided relief as the new CSFII had deliberately ‘cut back’ the number of strands to three. As I have stated in the previous chapter, the CSFII attempted to simplify the curriculum by narrowing and refining the strands and this, in Ms Hill’s mind ‘made much more sense’.

At the same time though, the relief that teachers felt was also accompanied by a sense of frustration. Overwhelmingly the teachers believed it was yet another curriculum that had to be considered, and that had implications for their curriculum planning and programming, and thus workload. For some of the teachers who had been teaching for twenty years, namely Ms Batt, from Ash Secondary College and Ms Woods and Ms Hill from Paperbark Secondary College, this was their fifth curriculum change, and they expressed that there had been too many changes, with very few discernable differences in the overall end product. By this they were referring to the fact that overall the curriculum changes made very little difference to what they did in the classrooms. It appeared to them, that at the curriculum level health education was simply being repackaged and
delivered in a different guise. Given this, most of the teachers thought that at
times curriculum shifts were simply a waste of time and frustrating, as they
supposedly had to according to Ms Batt ‘keep going back to the drawing board’.

Given this, I was interested to follow this up to explore with the KLA managers
what they actually did with new versions of curriculum. Though their responses
varied, there were some similar approaches. The three KLA managers in this
study managed the arrival of the new, mostly by reconfiguring their old program
to suit the structural requirements of the new curriculum. Rather than going back
to the drawing board and starting afresh, teachers in the three schools in this study
said that they ‘tweaked’ their existing programs a little bit, played around with
what they had and added things where they thought they needed adding. Ms Batt
commented though that they would work in line with the new CSF II and make the
relevant changes on paper, the reality was not much had really changed that would
make much difference to what they would teach. Effectively she was alluding to
the fact that changing curriculum structures to this point impacted little on what
went on in the classroom. She did say however that assessment would need to be
altered. This was because the standards were different, and that assessment tasks
would need to be developed so students could work toward those.

Ms Perry from Wattle Secondary College on the other hand, working on her own,
said that she had not had time to really consider the new curriculum and what it
meant for her overall school program. She did think that she would take the
opportunity to review and redevelop the health education program, but she would
pipeline in changes starting at Year 7 and then write through the course each year
from there. Ms Hill looked upon the introduction of a new curriculum as an
opportunity to make some ‘big’ changes that she and her team had been talking
about for awhile. In response to the new CSF II she organised a few all day
meetings where a core staff sat down to rewrite their school curriculum, so as ‘to
bring it into line’ with the new structure. They had, prior to the introduction of the
CSF II done a lot of work to develop their courses in line with the CSF and they
‘weren’t about to start again from scratch’. As part of this process though, Ms Hill
and her writing team came up with a new way to organise their units, and offer them. Ms Hill indicated that once they had determined their structure they could pick and choose from what they already had and place those things (i.e. teaching ideas/resources) in their appropriate place in the structure. Ms Hill said that once that stage was completed, the team read through the new curriculum documentation to identify what was missing. They then added those ‘things’ in if they thought they were useful, or necessary. One of the key changes though that took place for Ms Hill and her team was the complete restructure of how HPE was organised in the school. Early on in the meeting, they made the explicit decision to integrate health education and physical education, and make it core for years 7 through to years 10.

The approaches to developing curriculum discussed above reveal some significant insights into how curriculum is assembled in schools. On one hand official curriculum assemblages can, and do, create new possibilities for the development of new approaches to programming for teaching and learning. How teachers respond to the arrival of new curriculum though varied. The practice that did not vary though, was the practice of combining the new with the old. This practice is of interest in understanding how school health education functions as a governmental apparatus. The practice of combining the old and the new speaks to the features that characterise contemporary approaches to government (Rose, 2000). Rose (2000, p. 322) states that:

...current control practices manifest, at most, a hesitant, incomplete, fragmentary, contradictory and contested metamorphosis, the abandonment of some old themes, the maintenance of others, the introduction of some new elements, a shift in the role and functioning of others because of their changed places and connections with the ‘assemblage’ of control.

In considering the approaches that the teachers adopted to respond to a new curriculum, it is clear that its arrival did not mean that previous established versions of programs were forgotten. Rather its introduction meant that some themes and practices were abandoned, as teachers sifted through what they had already, what would fit and what wouldn’t fit in the new structure. By their very
nature new versions of curriculum arrive and are inserted into an already established curriculum field and sedimented health imperatives and teaching and learning practices. In drawing on the notion of governmental assemblages here and the work of Ball (1994) and Foucault (1980) new curriculum assemblages enter into existing school curriculum assemblages and work to reshape the old. The different effects of new curriculum can be evidenced in the contrasting comments made by Ms Woods and Ms Batt. Ms Woods stated: ‘I am very excited about the new program that we developed, its brilliant and we got to do something really wonderful by getting more health into the program in fun and interesting ways’. On the other hand Ms Batt’s comment that the new curriculum would barely come into contact with their current approaches to programming for teaching and learning suggests that new curriculum at times does not necessarily always get taken up, at least in the initial instance.

Textbooks and resources

As I have already discussed teachers follow numerous paths when assembling curriculum. Regardless of the path that teachers followed, their discussions revealed that as they worked to develop new curriculum, or when they developed their previous programs, they all utilised a number of key resources to assist them. When asked what kinds of resources they drew from, the teachers all mentioned the role that textbooks played in shaping their program. Ms Murray, for example, said that in developing the school curriculum program:

Ms Murray: We use textbooks a lot. To help us develop our units and also for students to work out of. You’ll see in the program that every topic we have a chapter for and suggested activities from the text. So it’s all there really. And it matches to the curriculum so that’s good.

Ms Perry too commented that textbooks were ‘very useful, and I get a lot of ideas from them, and photocopy bits of them for classes’. The use of textbooks for curriculum development was common across the three schools for curriculum development and their use featured in most of the classrooms. This practice is not
uncommon, in fact Wright and Dean (2007) suggest that textbooks are one of the main sources of knowledge utilised in schools regarding health. Teachers in their programming utilised textbooks for topic ideas, the filling of content, activity and assessment ideas. Throughout curriculum documentation, textbook references were dotted everywhere. Almost every topic listed had an accompanying textbook reference for teachers to refer to, and refer their students to. The textbooks that teachers mostly referred to were specific texts that had been written to the Victorian curriculum specifications. Textbooks in this case functioned as a surrogate curriculum (Venezky, 1996). Given the significance of their use, by teachers (and students) I would argue that textbooks act as a significant mechanism in the translation dynamics of governmentality, perhaps even more so than some of the formal authoritative documents provided by the VCAA and DEECD. Teachers rarely, and some never, mentioned consulting official support documentation, rather their approach would involve reading the curriculum, and then going straight to the relevant textbooks. The use of textbooks then is significant in the enactment of governmental hopes.

Analyses of health and physical education textbooks have shown that the regulatory discourses of governmentality are alive and well within HPE textbooks (Wright & Dean, 2007). This is interesting, though not surprising. It is interesting because the State does not seek to produce textbooks, or control their production. Rather businesses, in the form of publishers, and authors (often teachers) enter into the publishing field on their own accord. And in producing textbooks that align with curriculum imperatives, they become part of, and integral to, the governmental assemblage. Rose (1999, p. 49) here might say (if he ever contemplated HPE textbooks) that their development and use is a example of the ‘forging of alignments between political aims and the strategies of experts, and upon establishing relays between the calculations of authorities and the aspirations of free citizens’. Here the free citizens are the authors of the textbooks, as well as the teachers who use the textbook and the students to whom the lessons inherent in the text are directed. Textbooks, and their private commercial production by
various publishing companies become a key mechanism in the translation of governmental imperatives in the HPE field.

In addition to textbooks, teachers would also draw on specific resources that had been either sent to the schools, or that the schools had purchased. In each of the KLA managers’ offices a range of resources sat on the bookshelves. According to Ms Batt, ‘that is where they stayed collecting dust’. But most teachers used topic specific resources to assist with developing ideas for specific health issues. The reason being that resources, unlike textbooks, tend to be targeted towards a particular health issue. Below is an excerpt from a conversation I had with Ms Hill about the nature of curriculum development and the role of specific resources in the process:

Deana: Can you give me an example?

Ms Hill: Um maybe road safety. I mean there is a whole range of community concerns and they are things like promoting healthy schools, sun stuff, sun smart, water safety that’s been quite well supported, unless you are analysing pauses, ums etc. they can be left out of the transcript Mind Matters so the mental health, a program came out about that, um so if you wanted to, you could just pick up all of those one off initiatives and that could be your program because enough materials come out to support those things. But when you look at things like okay we are looking at relationships and we are looking at behaviours and how to build relationships and friendships so if, so then if you want to look at bullying, there’s a whole kit on bullying. But it is really about pulling all of those resources together to make one really useful, practical resource and really the emphasis of CSFII in health is a lot about analysing, interpreting, researching, it’s a lot about skills, I mean it’s a lot about content but it is also about developing those skills so that your students are ready for VCE. And that is the other part of the picture that you need to consider. So if I just wanted to use all of these kits that are produced to write our course I could do that, but often they
don’t, they are really, they are just activity based. Which can be good, I am not criticising it totally but don’t know, it is a difficult one. But I think a lot of things that are community concerns end up in health and they are some really good examples.

Ms Hill touched on a number of issues during this conversation. Firstly, she talked about the many resources that have been developed as a result of various ‘community concerns’. Here, she says that each of the resources could form the basis of a whole program. Ms Hill and others identified some shortcomings of relying on resources, and so used them to ‘pull bits out of’ to develop particular aspects of the program. It is in this way that various specific health resources developed by government and non-government organisations function as governmental translation mechanisms. The resources, often compartmentalised and separated off from the whole subject area, were used to assist teachers to assemble specific health issue based lessons. Key organisations and authorities produce school-based resources and send them out to government schools to assist teachers with curriculum planning. A quick review of organisations that have produced resources relating directly to health education curriculum outcomes includes:

- Australian Drug Foundation
- Diabetes Institute of Australia
- Family Planning Victoria
- Commonwealth of Australia, Department of Education and Early Childhood Development
- Beyond Blue [mental health education]
- Department of Education and Workplace Relations
- Obesity Prevention Australia
- VicRoads
- Life Education Australia
- Department of Health and Ageing
In addition to resources there are also organisations that offer their programs to schools; the idea being schools pay various organisations to come in and run workshops, seminars, assemblies, classes and so on with a specific health interest in mind. Much of the resource development is conducted by organisations that are closely linked to government health authorities with explicit links to the governmental hopes of health education. Interestingly some of the organisations are private enterprises, where individuals or businesses seek to get involved in the activities of schools. Here it would appear that there is some distance from government, but the nature of the alignments that were forged in the school programs that I reviewed suggest otherwise. Teachers were undoubtedly very adept at selecting appropriate activities that slotted in with the official curriculum context. But just like the textbooks, the various resources provided to schools, all reinforced the duty to be well via the insistence that students develop key knowledges and skills so as to ensure that they could take responsibility for their own health and others.

In thinking about the various governmental translation mechanisms of health education, it is clear the role government organisations, individual private businesses and non-government organisations play in translating governmental hopes into practices at a distance. As key translation mechanisms, resources have received some critical attention from scholars (see Burrows & Wright 2007; Vander Schee, 2008a; Wright & Dean, 2007). The various analyses have suggested that school resources are significant in governmental work, in that more often than not the resources available (re) produce imperatives that closely align to prevailing governmental hopes. The vast majority of textbooks and resources that teachers in this study utilised as they assembled programs consisted of health knowledge supplemented by a range of activities that students can do to help them be healthy. Within the mix, resources and texts provide scaffolds for problem solving, decision-making, communication, goal setting and planning for action. The combination of knowledge and skills is reminiscent of the formula mobilised in health education curriculum documents over the past thirty years. Effectively
the governmental techniques evident within resources and texts are targeted towards individuals developing the appropriate knowledge and skills so that they can be more responsible for their health.

Given the role of the varied organisations and publications I would suggest there needs to be more critical attention given to the ways in which such resources are utilised by teachers and their programming and teaching. Furthermore, consideration needs to be given to how the various resources align with, or create fracture lines both within themselves, but also too as they are assembled together with other resources, and the curriculum. Assembling programs together from diverse resources, programs, and curriculum support materials, can create a relatively smooth assemblage in that governmental hopes line up together neatly. Or in some cases the assemblage may not align well at all and be riddled with contradictions and fracture lines. For example Leahy and Harrison (2008) explored the impact on the calls for health education to intervene in the obesity epidemic, whilst also trying to meet calls for young people to accept their and others body shapes and sizes. The two do not sit easily together and make it very difficult for teachers to realise both sets of hopes, whether they are desirable or not (see Cliff & Wright, 2010; Leahy & Harrison, 2008). I suggest that the analytical gaze needs to be cast across a much wider list of resources given their role in the governmental project of health education.

Finally, one teacher in the study found that she had very little to do in terms of assembling curriculum programs. She states:

Ms Robbs: I was lucky because when I arrived they had their program pretty much in place. The curriculum had changed just this last year but there was a full filing cabinet, organised by topics I guess. And it was the same. And there were ideas for activities and things, so it was a matter of choosing from that selection, and maybe adding some of my own stuff, and ideas and things. I like to use stuff from shows, like what the kids are watching, um, yeah or what is popular on TV or at the movies to use with them.
While not necessarily drawing from the various resources and texts on offer, she
does draw from popular culture to do similar work. For Ms Robbs, assemblage
work was largely about taking the program that had already been written and
adding to it. The ‘stuff’ she added included videos, TV, music, and different
books as a means to engage with the students around particular issues. It was a
good example of how an old lesson plan was ‘jazzed’ up with a focus on
contemporary issues via popular culture. When I asked how this worked with
existing lesson plans, she stated that it was easy to substitute things. So instead of
a worksheet that talked about relationship problems, she would find a snippet of
Neighbours to use as a prompt instead. Ms Robbs said she thought the students
responded very well and even started suggesting ideas for shows that they would
like to watch in their class. The use of popular culture was common across the
three Schools, though it was very rarely documented. Teachers appeared to make
personal decisions about what popular culture they would use and thus it is
difficult to offer much analysis here. However from what I could glean it appeared
that the use of popular culture more often than not worked to reinstate the
dominant discourses of health education. This is not surprising as recent research
suggests that much of the popular culture resources available to children and
young people works to reproduce understandings of health that align with neo-
liberal mentalities, and in addition provide resources that can enable people to
engage in healthy projects of the self (Rich, 2011b). In the following chapter I
discuss various pedagogical moments where popular culture was used to deliver
health education classes. What is interesting here are the various choices that
teachers made around what popular culture to use (and thus what not to use) and
how they used it. My observations certainly reflect those of Rich (2011b) and
others who have considered the individualising discourses that are inherent within
various programs and resources that may support teaching in health education.

Within the governmental assemblage of health education, there are numerous
translation mechanisms in place to ‘support’ teachers as they assemble curricula at
the school level. Significantly, the official curriculum contains its very own
internal mechanisms in the form of standards and learning focus statements. These
are put in place to ensure that when the hopes of government are translated into practice that these hopes stay relatively intact. In addition to the ‘official’ translation mechanisms, there were a multitude of other translation mechanisms that teachers referred to as they developed their programs. All of the resources and text books utilised by teachers in this study, mobilised dominant discourses that reinforced the neo-liberal hopes of health education as well as provided the mechanisms for rendering such hopes practical in the form of worksheets, activities, personal health reflections, scenarios and problem solving activities to name a few.

Translating teachers (beliefs)

To this point, I have considered the role of various curriculum support mechanisms, and how teachers engage with those mechanisms (or not) to develop their programs. Within the governmental assemblage of school based health education, teachers are located at the very centre of curricula and pedagogical work. Working as pivotal hinges (Ellsworth, 2005) they are a central translation mechanism of governmentality. Without teachers, curricula imperatives remain static. Effectively teachers provide the force that enables governmental imperatives to flow into school programs and classrooms. And as Kehily (2002) suggests teacher biographies, beliefs and perceptions significantly impact on the work they do in schools. The beliefs that teachers hold, and in turn the decisions they make impact significantly on the resultant curricula and pedagogical assemblages. Following Kehily (2002) then I am interested in exploring teacher beliefs about young people’s health, and the perceived role of health education in young people’s lives. The following discussion largely draws from conversations with the three Key Learning Area managers in each of the schools, though I did talk with several other teachers about their views on health education and I have included their perspectives as well.

A risky subject

All of the teachers interviewed in my study believed that health education was essential for young people. They wholeheartedly believed in ‘the good’ of the
subject area and what it had to offer young people. The hopes that teachers held for the subject were very high. In fact, the commonly held belief was that if young people missed out on the opportunity to do health education, according to Ms Woods ‘then they would certainly be worse off for it’. The subject area was deemed by teachers to be amongst other things to be vital, integral, essential and absolutely necessary. Teachers believed that health education offered important opportunities to explore areas that no other curriculum area would or could cover, at least not in the same way that health did. This sentiment is captured in the following discussion Ms Batt and I had about the value of health education:

**Deana**  
So, um, I am wondering about what you think the importance of health education is, for young people?

**Ms Batt**  
It is absolutely crucial, this stuff. They don’t get this kind of information anywhere else, and if they do, well its not definite that it is accurate. So we give them that.

**Deana**  
…you mean information?

**MS Batt**  
Yes, yes, um yes knowledge. We give them that so that they can make healthy decisions. And then we do more than that, we give them skills too. And they are so so so important.

**Deana**  
Um skills, what kinds of skills do you mean? And why are they so important?

**Ms Batt**  
Life skills of course. Information is not very helpful just on its own, so we make sure they have life skills.

**Deana**  
I guess I am interested to hear what you mean when you say life skills.
Ms Batt  Oh I see, well essential life skills, like decision making skills, problem solving, assertiveness skills.

Deana  And why do you think they are important in the mix then? Here?

Ms Batt  Because they enable the students to look after themselves, like to be able to take control of their decisions, or something. So if they are offered drugs, or if they are being pressured to have sex, or to get in a car with someone who is drunk they can make decisions and be assertive, so that they don’t get hurt, or harmed. It is kind of like a good way to help them manage or avoid the risks out there to them.

In the discussion above it is clear that Ms Batt believes in the value of health education, as it offers the opportunity to give students knowledge and skills, that they would otherwise miss out on. The combination of knowledge and life skills is a familiar one. It is a mantra that captures the official platform of health education. In essence the focus on knowledge and skills are at the very heart of what health education promises. And so it is little wonder that all of the teachers could recite the mantra, and believe in it. In terms of justifying health education as a curriculum offering, and thus the vital need that students had for health knowledge and life skills, all teachers resorted to the idea that young people were ‘at risk’. Ms Batt, for example toward the end of the excerpt above, turns to risk to justify the inclusion of health education and the necessity of life skills and knowledge. Ms Hill too placed emphasis on the role of risk in young people’s lives. She states:

Ms Hill  You think about everything that they have to face and you know, the risk out there to them. So we do things like nutrition and physical fitness and we also look at issues to do with drugs. So we are teaching them ways of looking after themselves, how to eat good food, be physically fit and minimise risks related to drugs. We give them
knowledge, and then some skills and they can make informed choices. It is the last chance we have to get at them, to show them things they can do for themselves, so they can be healthier.

Thus the idea that young people were at risk, and that health education could help young people manage or eliminate risk was common throughout teachers’ discussions of young people, their health issues and the value of health education in young people’s lives.

The overwhelming belief held by teachers that young people are at risk is significant for a number of reasons. Firstly the dominance of risk discourses reveals a shift in the assemblage of health education. Risk appears to have come to dominate the ways in which teachers talk about and think about young people and in turn health education. The emergence, and dominance of risk, is not surprising given that governmentality theorists including O’Malley (2004), Rose (1993) and Turner (1997) have been discussing the role that risk plays within contemporary rationalities and approaches to government for some time. And given that risk circulates within and frames broader governmental assemblages, it is not surprising that risk has forged connections within, and permeates other governmental assemblages for example health promotion (Peterson & Lupton, 1996; Peterson, 1997), education (Hay, 2009) and youth studies (Kelly, 2001). The dominance of risk within the broader governmental assemblage, and thus in turn school based health education assemblages, means that teachers not only come to understand the purpose of health education as being inextricably linked to risk, but it permeates the various ways teachers describe what health education can do in response to risk. For example the age old mantra of providing students with knowledge and skills that has long circulated within official curriculum discourse is reconfigured by risk. By this I mean that the development of knowledge and skills within the contemporary context becomes infused with the idea that all young people are at risk, and that the possession of certain knowledges and skills will enable young people to better mediate risk. The combination is a potent one in that it dramatically shaped the beliefs of teachers,
and in turn the translation work of teachers. Teachers’ risk saturated beliefs influenced their decisions about the kinds of programs they developed, and the ways in which they went about scaffolding teaching and learning opportunities in their lessons. I will discuss how programs were developed in light of risk in the next section. The following chapter explores risk as a rationality of government in more detail, as I consider the pedagogical assemblages of health education.

**Teachers translating**

Overall the teachers’ hopes for health education and its benefits mirrored those hopes being espoused in official curriculum documentation, and in turn the broader assemblage of health education. As a result there appears to have been very little slippage between the official hopes of health education and those posited by teachers. All of the teachers in the study mobilised an array of available dominant discourses of risk, health, health promotion and public health as they spoke about health education’s purposes and practices. This finding is not unique to my research and has been found to be the case in a number of other studies (Kehily, 2002; Lupton, 1999b; Rich, 2010a; Vander Schee, 2009a; Wright & Clifford, 2010). Although some studies reveal that teachers report a feeling of confusion and concern by the apparent presence of contradictory aims and practices of health education, this was certainly not the case in my study (see for example Cliff & Wright, 2010; Vander Schee, 2009a).

Rather, teachers exuded unbridled enthusiasm for the project of health education. As they recited its various long held mantras they almost bubbled over with excitement. Written quotes taken from interview transcripts fail to capture these affective responses from teachers as they spoke about health education. Their voices and bodily disposition indicated that they were passionately attached to the work that they did and the promise of health education. Such fervour is not unique to the teachers in my study, as Vander Schee (2009a) has identified health related zealot like behaviour amongst teaching staff in schools. The high hopes that teachers have for a health education that offers skills and knowledge, and their passionate attachment to that project reveals them as what Burchell (1996) refers
to as necessary voluntary accomplices of neo-liberal government. If government is to be translated effectively at a distance, then it requires its accomplices to translate its hopes into practice. Teachers here are integral to the assemblage, as they are true believers in what health education promises to do for young people.

Given that teachers act as a central mechanism for the translation of official curriculum into school programs and classrooms, their beliefs and understandings are vital to the flow of imperatives in the assemblage. As teachers go about their assemblage work, they forge linkages and connections between discourses within the assemblage that allows governmental imperatives to take practical form in the extremities of education. Their hopes and beliefs are crucial here as they make decisions regarding the content and approach of their programs. In doing this teachers work within the assemblage to forge certain alignments, and ignore others. Given that risk was pivotal to teachers’ beliefs about young people and the role of health education, it is not surprising then that it influenced program decisions. I want to now turn to consider the programs that teachers developed in each of the three schools.

**Curriculum assemblages**

As I mentioned earlier in this chapter, the health education curriculum programs that had been developed in each of the three schools were remarkably similar. I was genuinely surprised by this for no good reason other than I had thought that three different schools, with very different teachers and contexts, might make for some interesting and different program offerings. What also added to my surprise was that I expected much more messiness, due to the fact that I had been reading both Rose (2000) and Dean’s (1999) discussions of the fragmented nature of contemporary attempts to govern. At the level of program planning though, there was no sign of obvious mess. Popkewitz (1999) would suggest that the reason for the lack of mess at this level is because the very nature of curriculum programming involves the rational ordering of curriculum knowledge (Popkewitz 1999, p. 75). So at the level of programming, teachers worked to assemble
timetable structures, class timings and sizes, curriculum objectives, key learning focus areas, standards, topics, resources, textbooks, suggested activities and assessment ideas to scaffold programs that make good educational sense. And good (health) educational sense looked very similar in all three schools. This mirroring across the three schools can be evidenced in an overview of each school’s program offering in Table 3 below.
Table 3: Overview of health education offerings in three sample schools

<table>
<thead>
<tr>
<th>Year 7</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wattle Secondary College</strong></td>
</tr>
<tr>
<td><strong>Referred to as...</strong></td>
</tr>
<tr>
<td><strong>Nature of offering</strong></td>
</tr>
<tr>
<td><strong>Classes per week</strong></td>
</tr>
<tr>
<td><strong>Topics</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 8</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wattle Secondary College</strong></td>
</tr>
<tr>
<td><strong>Referred to as...</strong></td>
</tr>
<tr>
<td><strong>Nature of offering</strong></td>
</tr>
<tr>
<td><strong>Classes per week</strong></td>
</tr>
<tr>
<td><strong>Topics</strong></td>
</tr>
</tbody>
</table>
### Year 9

<table>
<thead>
<tr>
<th></th>
<th>Wattle Secondary College</th>
<th>Ash Secondary College</th>
<th>Paperbark Secondary College</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referred to us...</strong></td>
<td>Health Fair Day</td>
<td>Health Education</td>
<td>Mind your own body</td>
</tr>
<tr>
<td><strong>Nature of offering</strong></td>
<td>One day of presentations</td>
<td>One year (36 weeks)</td>
<td>One semester</td>
</tr>
<tr>
<td><strong>Classes per week</strong></td>
<td>One day only in the year</td>
<td>Two (45 mins each – total of 90 mins)</td>
<td>Two per two week cycle</td>
</tr>
<tr>
<td><strong>Topics</strong></td>
<td>Health information and Resources</td>
<td>Community health services</td>
<td>Contraception Fitness Decision Making Sexually transmitted diseases Stress</td>
</tr>
<tr>
<td></td>
<td>Safe sex</td>
<td>Substance Use – focus on alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Illicit drug use</td>
<td>Power and control in relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relationships</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal health plan</td>
<td></td>
</tr>
</tbody>
</table>

### Year 10

<table>
<thead>
<tr>
<th></th>
<th>Wattle Secondary College #</th>
<th>Ash Secondary College #</th>
<th>Paperbark Secondary College</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referred to as...</strong></td>
<td>Health Education</td>
<td>Health Education</td>
<td>Being fit for life</td>
</tr>
<tr>
<td><strong>Nature of offering</strong></td>
<td>Two terms</td>
<td>Two terms</td>
<td>One semester</td>
</tr>
<tr>
<td><strong>Classes per week</strong></td>
<td>Two - offered as a double (80 mins)</td>
<td>Two - offered as a double (90 mins)</td>
<td>Two per two week cycle</td>
</tr>
<tr>
<td><strong>Topics</strong></td>
<td>Community Health Project</td>
<td>First Aid</td>
<td>Drugs – Illicit</td>
</tr>
<tr>
<td></td>
<td>Sexual health</td>
<td>Food</td>
<td>Nutrition</td>
</tr>
<tr>
<td></td>
<td>Goal setting</td>
<td>Road Safety</td>
<td>Personal Goal setting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>and fitness planning</td>
</tr>
</tbody>
</table>

*Not offered in Year 8  # Elective only*
Across the three schools, health education was offered as part of the HPE KLA. And although considered to be one KLA there was a formal division made between health education and physical education. This was described in the following way by Ms Hill as ‘students have a double prac class and a theory class’. Theory was the term that was often used to talk about health education in relation to timetabling. In all cases students received more physical education than health education. The major differences across programs relate to the way health education was programmed. For example each school programmed health education differently across each of the year levels. In addition to this there were variations in the amount of time dedicated to health education, as well as whether or not health education was considered core, or an elective. These kinds of differences were not unexpected, as programs need to take into consideration the local context, competing timetable demands and broader school curricula architecture to name just a few.

As I have mentioned I was initially surprised about the similarities across programs (though I am no longer). On the whole each school health education program placed a great deal of emphasis on sexuality education, drug education and food and fitness education. When I asked the KLA managers about why they focussed on those topics their replies were unanimous, in that they were the things that posed the most risk to the students. And given this, they needed to occupy significant space within the curriculum. Teachers ensured they differentiated topics across the year levels. For example Ms Perry said ‘well we start of with a focus on personal development stuff in year seven, and then we hit them a bit harder in year eight and nine’. I asked why the need to hit them hard, and Ms Perry replied ‘that is when they need it most, as they get older the risks get bigger don’t they?’

Ms Perry’s sentiments were echoed by each of the KLA managers, and thus influenced how programs were scaffolded across the year levels. It was in this way that teachers attempted to tailor their programs according to perceived changing student need. The assumption underpinning this here was that in the
early years the focus should be on personal development and relationships. Then as students got older, the more programs needed to focus more on risk. Knowledge and skills were considered to be central components within and across every topic. In the topics aimed at cultivating personal development, programs were directed towards students getting to know themselves, developing self esteem, and developing good relationship skills. Topics that were oriented towards risks associated with sex, drug use and road safety programs were directed towards (older) students developing an understanding of the various risks via the acquisition of knowledge, and then aimed towards the development of key skills to enable students to manage the risks. The scaffolding utilised by teachers reflects the developmental lines that are present within official curriculum scaffolds, as well as those provided in the various resources and texts teachers drew from.

There were more consistencies, than inconsistencies, in the programs produced by teachers across the three schools in this study. Each of the programs developed in each of the schools all stayed true to the official hopes of health education. The various programs that were developed, although varying in structure, worked to turn the hopes of health education into plans for enacting those hopes within classrooms.

**Conclusion**

In the dynamics of translation, alignments are forged between the objectives of authorities wishing to govern and the personal projects of those organizations, groups and individuals who are the subjects of government. It is through translation processes of various sorts that linkages are assembled between political agencies, public bodies, economic, legal, medical, social and technical authorities and the aspirations, judgements and ambitions of formally autonomous entities, be these firms, factories, pressure groups, families or individuals (Rose, 1999, p. 49).

In contemplating how governmentality is put into motion at the level of schools, Rose (1999) directs us to consider the dynamics of translation. In this chapter I
have attempted, following Rose, to locate the various translation mechanisms of school based health education. This chapter took as its focus the extremities of curriculum, where governmental imperatives are put into motion via the enactment of curriculum at the level of the school. Drawing on official curriculum documentation and data collected across the three schools, I considered how the hopes of Health Education make their way into the lives of teachers and at their end point programs for students. The chapter illustrated that translation mechanisms are central in the functioning of the governmental assemblage of health education. The chapter also highlighted that there are a multitude of translation mechanisms involved in the translation of governmental health imperatives at the school level. Translation mechanisms are built into the official curriculum documentation provided by governments, as well as within the provided supporting documentation. In addition to this, the various resources and text books that teachers draw from all serve as mechanisms for curriculum translation. Upon examination, each of the translation mechanisms within the assemblage work to reinforce the dominant discourses of individual responsibility for health. There are few competing or alternative discourses available which teachers can draw from, to challenge the dominance of neo-liberal versions of health education. Whilst it appears that governmental translation mechanisms regulate curriculum possibilities quite tightly, teachers are assembling agents and act as central translators themselves. In saying this though, none of the teachers involved in this study talked about alternative approaches to health education. In fact their beliefs strongly aligned with neo-liberal imperatives. As key translators of curriculum at the level of the school, teachers’ beliefs were central to the enactment of, or resistance to, prevailing governmental imperatives. Teachers’ beliefs, as well as the hopes and practices advocated in the various ‘translation’ documents available to teachers resulted in school based programs that were on the whole very similar in their approach to health education, and largely directed at ensuring the production of healthy citizens who know themselves and can manage various risks. In the next Chapter, I consider how programs are or were enacted, or translated into the classroom, and thus into the lives of students.
Chapter Five: Risky pedagogical assemblages

Introduction

In the previous chapter, I began an exploration of how the governmental hopes of health education are translated into school programs. The programs that teachers assembled together in each of the schools had at their very core a desire to shape the health[ly] conduct of young people. This chapter extends on that analysis and considers how the hopes of health education enshrined within school programs are translated into classrooms. In particular the chapter is interested in examining what governmental rationalities and devices are deployed as teachers work to shape the healthy[ly] conduct of young people, and thus provide an examination of how the governmental hopes of health education are enacted. Drawing on classroom observations this chapter explores then extremities of governmental, via an analysis of practical government at the level of classrooms. In essence I am interested in examining the ‘contact point’ where technologies of power and technologies of the self interact (Burchell, 1996) to explore how young people are invited into entering processes of governmental self-formation (Dean, 1995).

Analyses revealed that risk discourses saturated health education classrooms. This is not a surprising finding given that risk permeates broader governmental assemblages, official curriculum and the various translation mechanisms. However what was surprising were the ways in which risk was mobilised within the various pedagogical assemblages I observed. In the first section of this chapter I briefly overview the two units of work that provided the basis for my classroom observations Being Fit For Life (Year 9) and Mind Your Own Body (Year 10). A central hope of each unit was to ensure that students came to understand that they were at risk. Once that was established the hope then was attached to ensuring that students had the appropriate skills to manage their risk. The second section of the chapter explores how those hopes were enacted within the various classrooms. Specifically I consider the various techniques that were deployed to ensure young people understood that they were at risk. My discussion here considers the various
roles of expert risk knowledges within pedagogical assemblages and in turn their relationship to contemporary approaches to government.

**A risky subject**

*Being Fit For Life* (Year 9) and *Mind Your Own Body* (Year 10) and were specific units of work developed at *Paperbark Secondary College*. As I have discussed in the previous chapter, the units were developed as part of a curriculum renewal process associated with the arrival of the ‘new’ CSF II. A central factor in the development of the units was the notion of risk. Teachers at *Paperbark* were of the belief that as their students moved into the later years of their lives they became even more at risk of being at risk. But the teachers at *Paperbark* are not on their own in thinking along these lines. As Kelly (2003, pp. 166-167) suggests the notion of young people at risk is pervasive, and yet not necessarily new. He believes that:

...a major problem for young people today is that they increasingly cause adults anxiety. This anxiety translates into a raft of responses that have young people as their targets. At the same time, these ‘systems of thought’ reflexively constitute our understandings of Youth – as a population/historical figure. These imaginings reflect and constitute a range of anxieties about the dangers posed by some people, or to some young people, and how these risks might be economically and prudently managed.

The adult anxiety of which Kelly speaks is evident within teachers’ talk about young people and health (see Chapter Four). It is also present in official curriculum structures, and many of the translating mechanisms associated with health education. In following Kelly’s (2003) argument, how we imagine the intersections of youth, risk, health and education dramatically influences the kinds of responses possible. In the case of the teachers at *Paperbark Secondary College* their response was to create two units specifically targeted towards understanding and reducing risk. *Mind Your Own Body* and *Being Fit For Life* were Level 6 units assembled together by teachers at *Paperbark*. The naming of the units is interesting in and of itself, as the titles effectively reveal governmental intent. As
Miller and Rose (1990) suggest ‘technologies’ do not simply come into being as the result of power, but are developed with a specific purpose in mind. The units were explicitly designed with the purpose to assist students to *Mind Their Own Body* and *Be Fit For Life*. More specifically, units were designed so that students would come to know the various risks and then develop the key skills to manage these, effectively enabling them to *Mind Their Own Body* in order to then *Be Fit For Life*.

*Being Fit For Life* was a unit of work developed for Year nine students. Within this unit students studied a range of topics including contraception, sexually transmitted diseases, decision-making, fitness and stress. The topics were divided up into Health Education related topics and Physical Education related topics. The Health Education topics were deemed to be contraception, sexually transmitted diseases and decision making, and were taught in the classroom. Fitness and stress on the other hand were considered to be topics that lent themselves to being taught either in the gym or on the oval (although stress did get some classroom time at the end of the unit via a 100 minute class on alternative therapies). *Mind Your Own Body* was developed along similar lines. Drugs and nutrition were considered to be topics for the classroom and personal goal setting and fitness planning were considered to fall into the realm of Physical Education. It is interesting to consider teachers’ attempts at integration across the curriculum area here. Although they make attempts to align topics under a title that has a wide appeal, it is still difficult to break down the clear subject boundaries that exist between Health Education and Physical Education. In this chapter I am interested in exploring the following questions proposed by Dean (1999, p. 32) as he discusses the ‘subject’ of contemporary government. He asks:

What forms of person, self and identity are presupposed by different practices of government and what sorts of transformation do these practices seek? What statuses, capacities, attributes and orientations are assumed of those who exercise authority (from politicians and bureaucrats to professionals and therapists) and those who are to be governed (workers, consumers, pupils and social welfare recipients)? What forms of conduct are expected of them? What duties and rights do they have? How are these capacities and attributes to be fostered?
How are certain aspects of conduct problematized? How are they then to be reformed? How are certain individuals and populations made to identify with certain groups, to become virtuous and active citizens, and so on?

Within the subject area of Health Education, risk is central to how young people are imagined, and thus acted on in health education classrooms. The following discussion considers how the idea of the risky subject permeates the pedagogical assemblages of health education.

**Constituting and protecting the at risk self**

According to Rose (2000, p. 323) contemporary approaches to shaping conduct involve various programmatic attempts ‘to foster and shape such capacities so that they are enacted in ways that are broadly consistent with particular objectives such as order, civility, health or enterprise’. As I have argued throughout the thesis, health education is one of many sites that seek to cultivate young people’s capacities so that they align with [healthy] governmental imperatives. Within contemporary times, risk is central to this work. And as an approach to government, it is not unique to health education. In fact risk discourse permeates the assemblages of youth studies (Kelly, 2001, 2003; Tait, 1995), health promotion (Lupton, 1995; Peterson, 1997; Peterson & Lupton, 1996), health (Fox, 1999; Turner, 1997) and education (Hay, 2009) and governmental assemblages more broadly (Dean, 1999b, 2010; O’Malley, 1996, 2000, 2004). Given that risk saturates the assemblage, I am interested to consider how risk imbues health education classrooms to produce particular kinds of pedagogical strategies.

A key function that health education plays within broader governmental assemblages is to alert young people to the fact that they are at risk. This move is an essential step if youthful subjectivities are to be successfully folded into the governmental process. Once students understand themselves as being at risk, health education then aims to provide the means by which they can voluntarily and prudently manage their [health] risks so that they can live healthy happy and productive lives (see Lupton, 1995, 1999; O’Malley, 1996; Tait, 2000). How the
governmental imperatives play out in classrooms though is not as straight forward as what is suggested above. Much goes on in what Probyn (2004) refers to as the ‘hurly burly’ of the classroom. I turn to now consider this ‘hurly burly’, and the various practical strategies and techniques that were called upon by the teachers in this study to fold students into and through the assemblage of governmentality.

**Expert risk knowledges**

Foucault (1991) considered expertise to be central in shifting forms of government, and thus approaches to government. According to Rose (1993, p. 298) expertise is central in advanced liberal democracies because the formula of rule:

...is dependent upon the proliferation of little regulatory instances across a territory and their multiplication, at a 'molecular' level, through the interstices of our present experience. It is dependent, too, upon a particular relation between political subjects and expertise, in which the injunctions of the experts merge with our own projects for self-mastery and the enhancement of our lives.

In relation to health, expert risk knowledges have come to shape how we think about health, and more significantly how we come to think about conducting our lives (Lupton, 1995). Within health education, expert risk knowledges are central to governmental work in that they establish firstly that young people are at risk, and then inform approaches to helping ensure young people can mediate their risk. As I discussed in Chapter Two, health psychology knowledges have been central in determining various formulas to guide approaches to health education and health promotion (see also Peterson & Lupton, 1996). The formula that privileges the combination of knowledge and skills finds support from various health psychology models, whether they be the Stages of Change model or the Health Belief Model. And within the contemporary context that formula has been heavily influenced by risk.

The following excerpt from *Being Fit For Life*, highlights one of the ways in which health education attempts to constitute the at risk subject, so that they are
ripe for intervention. The strategy I describe below was used as an introductory activity. The teacher walked in and said ‘good morning’ and got herself organised ready to start. She told the students that the topic for the day and for the next few weeks was going to be ‘Sex Education’. Then she started the activity:

Ms Hill: Okay now, can I get every fifth person to stand up. [class experiences a few difficulties with counting, where does the count start, what happens when you get to the end of the row]. That is near enough. Now look around the room, that is how many of you will get pregnant [teacher pauses to perhaps allow for reflection on that fact. Some girls have a look of horror, one girl standing sits down, another girl is staring out the window, some shake their head] Now you sit down and can the person on the right of you stand up [chairs and tables move, groans from some girls]. Right now this lot will get a sexually transmitted infection. Does anyone know what that might be?

Class: [shouting all at once] AIDS, Crabs, Syphilis.

Ms Hill: Well it will probably be Chlamydia. Now let’s look at that shall we? Get your text books out and start reading about that and take some notes.

(Field notes, year 9 HPE class)

The students got their textbooks out whilst Ms Hill wrote up the relevant page numbers on the board. Ms Hill directed the students to read the sections she had indicated and take relevant notes. As the students began to read, she wrote down the following points on the board and as she did this she asked students to keep them in mind as they were reading and taking notes:

- What are the main dangers?
- Who is at risk?
- What are the consequences?
The students spent approximately 10 minutes reading and making notes. Ms Hill stood up toward the end of the 10 minutes and went to the board to draw a diagram. The lesson continued in the following way after she had drawn the diagram below on the board:

![Diagram of at risk vaginas on the board]

**Figure 1: Ms Hill’s diagram of at risk vaginas on the board**

**Ms Hill:** [Pointing at vagina on the left] Now [getting everyone’s attention standing at the board] the penis that was in this vagina last night [pointing to the vagina on the left of the board], was in this one last week [pointing to the middle vagina] and was in this one the week before that [pointing at the third and final vagina] If a boy wants to have sex with you, make sure you use one of these [waving a condom around] and some of this [picking up a pack of lubricant]

(Field notes, year 9 HPE class)

Ms Hill then set about organising the class into small groups and distributing condoms, lubricant and carrots. Reactions were mixed amongst the girls. Some were clearly amused and playing with what Ms Hill had left on the table for their group (although they had been advised not to). Others were looking slightly terrified, whilst others were sitting patiently waiting to be told what to do next. Ms Hill told the students to all have a turn at putting the condom on the carrot, making sure that they used lubricant.

The classroom excerpt above reveals that in this particular class, a range of strategies were utilised to ensure that the girls in the class understood that they
were at risk of pregnancy and sexually transmitted infections. Ms Hill utilised an interactive activity in the first instance to firmly establish that the students recognised that risk was everywhere, in fact it could be sitting right next to them. Drawing on expert statistical knowledges, Ms Hill applied the statistic of 1 in 5 to the class of girls via encouraging every fifth person to stand. I would suggest that potency in the strategy had much to do with the standing up aspect incorporated into the strategy. In fact it was instrumental in the process of interpellating youthful subjectivities into being at risk. The very act of standing up, or having people in the class stand up, was an attempt to make the statistic real and to suggest that it could (and would) happen to them (if they failed to mind their own body).

Once Ms Hill had worked to establish that understanding, she then asked the students to refer to the textbooks so as to ensure that they understood more about the risk associated with sexual activity. Having worked to instil the idea that the students were at risk, Ms Hill then turned to educating the girls about how to reduce or eliminate the risk of pregnancy and/or sexually transmitted infections. Before doing this though, she reiterated the risk posed by sex. Using the diagram of vaginas on the board, she highlighted that the penis that was in ‘you’ last night had been in multiple vaginas before you. Thus setting up the imperative to have safe sex. The strategy was an adaptation of media scare tactic campaigns that have been circulating since the 1980s and the rise of AIDS. The recruitment of broader Public Health pedagogies here provides a good example of how teachers assemble together classroom pedagogies by drawing from ‘other’ pedagogic assemblages, thus providing a contact point or an avenue whereby public pedagogies can infiltrate school pedagogies (Rich, 2011a, 2011b). As a pedagogical strategy it attempted to reiterate risk and to set up the importance of condom use (with lubricant). As an assemblage of strategies, the risk imperative was clear in that everyone was at risk, and everyone should use a condom if a boy wanted to have sex with them. And it is within this moment that the discourses of the neo-liberal healthy active citizen collide with discourses of gender and sexuality. Within this pedagogical moment, the available dominant discourses on gender and sexuality
do not sit comfortably, or at all, alongside the hopes for the neo-liberal subject. On one hand health education would have that we are all responsible for making informed decisions about our lives, and thus be entrepreneurs of ourselves. But on the other hand health education finds it difficult to acknowledge that girls might desire sex, and be the ones in this scenario wanting sex (Fine, 1988, Harrison, 1995, Kehily, 2005). So within that one moment agency is acknowledged but then disavowed. It is an impossible and undesirable practice that has been in scholars sights for sometime now (see Harrison & Hillier, 1999; Kehily, 2002; Kehily & Nayak, 2000; Tolman, 2005). Within this particular pedagogical assemblage the frictions that emerge around agency, autonomy, gender and sex are not easily reconciled. They are not merely discursive frictions, as Hillier, Harrison and Warr (1998) point out. Their research explored young people’s condom use and revealed that young girls were particularly concerned about the risk of developing a ‘sullied’ reputation if they carried condoms. In a sense then the solution that Ms Hill proposes to the students in her class, possibly sets in motion another set of risks for young women. As a strategy too, it serves to reinforce dominant notions of penetrative heterosex as the only kind of sex.

Throughout the various classes I observed teachers drew from expert statistical knowledges as a means to help students learn the facts about risk. Teachers would weave statistics into various teaching and learning strategies with the deliberate aim to work to ensure students understood that they were at risk. This then set up a pressing need for students to learn strategies and develop skills about how to mediate those risks. Statistics were either covered explicitly, via the recounting of numbers in discussions or research reports, or via stand up activities where students could see the ‘real’ effects of risk statistics in action. But there were other ways expert risk knowledges worked in the classroom too. In the following excerpt Ms Hill’s strategy was informed by expert risk knowledges, though statistics were not explicitly in the mix here. Ms Hill used a brainstorm about parties, as an introductory activity for the lesson. Before the students had arrived she had written PARTY on the board in big red letters. Once the bell had rung and the students had come inside and settled she then turned to ask the students:
Ms Hill: What might happen at a party you go to?

Class: [silence]

Ms Hill: Cathy, what might happen at a party?

Student 1: Nothing Miss

Ms Hill: Well, what else might happen at a party?

Student 2: You could get drunk and get pregnant?

Ms Hill: [nods head agreeing and writes on board] What else?

Student 3: You could get an STI

Ms Hill: Good one. [turns and writes on board]

Student 4: Oh, you might feel guilty about sex and get depressed

Ms Hill: [adds it to the list on the board] What can happen then?

Student 5: Get a reputation

Class: [a number of students start to call out at once] parents find out, you get kicked out of home, you have an abortion, you feel depressed, you are homeless, suicide

Ms Hill: [nodding head quickly writing the suggestions on board, she finishes the list] well look what can happen if you go to a party.

(Field notes, year 9 HPE class)

The objective of the activity was to get students to understand that attending parties was risky (and potentially a deadly slippery slope). The imperative to
ensure students understood this impacted significantly on how Ms Hill facilitated the discussion, and thus what responses made their way onto the board, and those that were left off. When Ms Hill first posed the question about what can happen at a party, the first response solicited from a student of ‘nothing’ failed to make the list. Rather Ms Hill posed the question again looking for other responses. The very idea that going to a party might not pose a risk to young people ran counter to the necessity of constituting young people at risk, in this instance, by going to parties. And as a result the response was rendered redundant. This action had a significant impact on the direction of the discussion from that moment on. The student who was of the opinion that nothing might happen, pulled a face, shook her head and opened up her school diary and started doodling. Other class members however seemed to take the lead, and began to offer up the more appropriate responses that Ms Hill expected, and thus they found their way onto the board. The end point of the discussion, and thus the list, was that you could effectively die if you went to a party. Once the discussion had found its way to suicide, Ms Hill asked students to jot the list on the board down in their books. Once students had recorded the risks, Ms Hill then asked ‘Well what are we going to do about this?’ She then put on a DVD from the Rethinking Drinking resource (Youth Research Centre, 1997). The clip that Ms Hill showed was a scenario that depicted a teenage girl who was at a party. She gets drunk and sleeps with an older boy (who was depicted as preying on her vulnerability). The clip then turns to explore how the girl deals with the various consequences the next day. Effectively the DVD reinforced the content of the previous brainstorm, although the girl had not died by the end of the scene (though it loomed in the background as the girl was struggling to deal with the repercussions of her actions at school the next day). The DVD and its risky content is an exemplary example of how risk permeates the transulatory mechanisms of health education. The combination of the brainstorm and the DVD were utilised to ensure that the students understood that they were at risk. Once that had been achieved, Ms Hill then went on to set up another activity that was designed to get students to develop strategies to help them avoid the risks at the party. She got students in groups to consider one of the
many risks that parties posed, and to list down a range of strategies to help manage the risks. Toward the end of the lesson, Ms Hill suggested that students make sure that they remember what they had learnt in the lesson, and that the strategies that they had thought of today could save their lives. The bell went and students packed up their books and left.

In another classroom, students were constituted as being at risk via a pedagogical strategy that involved personal scrutiny of their diets. The following excerpt from the unit *Being Fit For Life* was an introductory lesson to the topic of nutrition. The focus on nutrition was intended to complement the topic of fitness which they were studying in Physical Education. The common thread that ran through the topics was personal action plans (for fitness and nutrition). To make learning meaningful, and thus to inspire action, students were required to scrutinise their current health status in light of ‘expert’ knowledges related to fitness and nutrition. In Physical Education students, according to Ms Murray had just been ‘put to the test’. In other words students had undertaken a range of fitness tests, and then were required to ‘write up’ their results and compare their scores to normative fitness scales. Once students got a sense of their deficiencies they were to adopt a plan of action, and embark on a fitness program to get fit. In Health Education, students were required to engage in a similar process, though the self-scrutiny this time was aimed at students’ diets. And so the lesson began:

Ms Murray: Okay today we are going to be looking at nutrition, and I want you to write everything down that you ate yesterday and today already

Class: [General groan]

Ms Murray: Now once you’ve done that I want you to go through and make a note of the following things. I’ll put them on the board and go over them in a minute. Start writing down what you ate, and be honest with yourself. Be sure to note quantity.
Class: [Another groan]

Ms Murray: [turns to the board and writes down the following list: Fibre, Calcium, Cholesterol, Salt, Sugar.]

Can I have your attention for a moment please? Now this is for when you have finished noting down what you have eaten. I want you to go to your text and look up each of these on the board [points to board] and find out what they do for you or to you and make some notes. Um, I want you to focus on the following [writes on the board as she is talking]. What is the RDI [Recommended Daily Intake]? Are you eating the RDI? And what will happen if you don’t eat the RDI? [stops writing]. So girls, basically the consequences of not eating properly, eating the things that you should be eating. So what are the risks to your health? So whether it be related to cancer, CVD [Cardio Vascular Disease] [asks question] Who knows what CVD is? [no one answers] Mmm, well it is in the book. So you might want to organise it under some goals for yourselves like this in your books, like this [compiles the following list on the board]

Goals

Reduce fat intake

Problems which may occur if this goal is ignored:

My personal goal:

I will lower my fat intake by...

[turning back to the class] So if you can do that for the others here [pointing to the list]. You can see why you might need to change your eating habits, if you can see what the risks are to you, yeah?

(Field notes, year 10 HPE class)

Effectively the class was aimed at encouraging students to self-monitor their food intake via the documentation of their diet over the last two days. They then used expert knowledges on nutrition to make a judgement on whether they were eating ‘well’ or not via the use of the RDI tables provided in the textbook. Students were
Chapter Five: Risky pedagogical assemblages

then directed to ‘learn’ about the risks associated with their current diet, and then directed to develop an action plan to alter their behaviour. The potency, supposedly, within the strategy here is that by becoming aware that your diet was ‘problematic’ and as a result you risked disease, then you would set goals to alter that behaviour. Risk is reinforced in the strategy via the direction for students to consider what they risked if they ignored their goal. This sequence of activities relies on a complex assemblage of governmental pedagogical techniques that rely heavily on expert knowledges. The teacher combines the confessional with strategies that require students to self monitor and plan for action.

Throughout the various classes that I observed there were variations made to this assemblage. For example in other classes students were asked to keep food diaries for a week (as well as exercise diaries). They then used the data, as a basis to develop insights into how well their diet and activity levels matched those prescribed in the textbooks and what the associated risks were currently, and also in the future. Regardless of class or teacher, the assemblage of strategies utilised relied on expert risk knowledges, self surveillance, regulation and monitoring. As an approach to delivering health education, it certainly is not unique to the classrooms I observed in this study. The strategies appear consistently throughout many of the translatory mechanisms of health education, for example text books, web sites and resources both in Australia and more broadly (see Burrows & Wright, 2007; Wright & Dean, 2007). Expert risk knowledges are central features throughout the various pedagogical assemblages, and they appeared in a myriad of forms including health statistics, dietary guidelines and benchmarks, biomedicine and disease, health psychology models and risk factors. Risk knowledges were utilised by teachers deliberately to ensure that young people came to understand that they were at risk. Once students understood this, expert knowledges helped frame approaches to taking action so young people could develop effective plans and strategies to mediate their risks. And although risk expertise is central to contemporary rationalities and practices of government (Lupton, 1999b; Rose, 1993; Turner, 1997) and within health education curricula and pedagogy there were also other kinds of risk knowledges at play.
Hybrid risk knowledges

Moore and Valverde (2000) suggest that when it comes to risk, governmentality scholars need to look beyond the deployment of expert rational and objective risk knowledges. They state that:

...scholars working in the loosely defined field of governmentality studies have by and large focused on formal systems of governance that use ‘rational’ techniques such as statistical correlations, bureaucratic measures, and managerial business plans. It is thus not surprising that most of these studies neglect the non-rational (including moral) dimensions of governance that tend to be the domain of anthropologists, cultural studies scholars, and specialists in moral panics. But we would like to suggest that there is no need to debate whether risk governance is rational or not, since there are many different domains and techniques of risk governance (Moore & Valverde, 2000, p. 515).

In discussing various dimensions of risk governance, they suggest that we consider other forms of risk knowledges that might be involved in governing conduct. They refer to such knowledges as ‘hybrid risk knowledges’. They argue that such knowledge formats often combine scientific knowledges with other melodramatic and mythical narratives to do governmental work. These knowledges were a feature of many of the health education classrooms I observed. In particular, they were a feature of classes dedicated to the topic of drug education, though they were not just contained to drug education. Hybrid risk knowledges worked in similar ways to expert risk knowledges, in that they were recruited by teachers to produce an at risk subject. But what was interesting was that hybrid risk knowledges were more often than not ‘constructed out of pedagogy itself’ (Gore, 2002, p. 4). By this I mean both teacher and students were involved in the creation of hybrid knowledges. For example in a discussion about illicit drugs a student commented:

Student: I know a friend who brought some cocaine that had glass in it and it was in there so it tore up the stomach so the drug got into the blood stream more quickly
Ms Woods: Well yes that is one of the dangers of buying illegal drugs

(Field notes, year 10 HPE class)

The story that the student told about her friend is a story that also circulates more widely in popular media and popular discourse. A commonly held belief is that cocaine is cut with bits of glass so it makes cuts in the nose as it is inhaled and thus enters the bloodstream more quickly. The story is a melodramatic one that combines scientific information, albeit flawed scientific information with storytelling. Ms Woods seizes on the story, not to correct the student about the fact that cocaine is often snorted and thus wouldn’t be in the stomach, or suggest that the story might be a popular urban myth. Rather Ms Woods uses the dramatic story to reinforce the risk of using illicit drugs. The hybrid risk knowledges were produced by the student in this instance, and Ms Wood’s discursive manoeuvring ensured that those knowledges were put to good use. In another class, a similar scenario unfolded. The discussion below occurred after students had been working on their illicit drug research project in class. Ms Murray began a discussion in an attempt to explore some of the student findings around the risks of illicit drug use. Just after a student had talked about their project on LSD another student commented:

Student: Two girlfriends were in bed and they were on LSD and one of them bit her girlfriend’s nose off she was so out of it and scared. And then she went to the bathroom because she thought that dragons and things were coming out of her back. And she picked up a slinky, you know those wiry springy things and she started scratching her back with it trying to get rid of the dragons and she sawed her head nearly off. It was hanging on by a thread.

Ms Murray: It is one of the risks you take isn’t it with illegal drugs? You might consider that to be an extreme story and does that make you think that when you use drugs, well that won’t happen to me?

(Field notes, year 10 HPE class)
Again it is the student who produced hybrid risk knowledges via the use of a melodramatic and fantastical story line peppered with some science and some loose facts about LSD. In this instance Ms Murray acknowledges that the story is perhaps extreme, but nevertheless goes on to ensure that the story can still be put to good pedagogic use via the reinforcement that it could happen to them.

In both of the above examples, expert truth knowledges about drugs and the body find themselves displaced or re imagined by other risk knowledges. However, hybridised expert drug knowledges were not always pivotal in producing risk in classrooms. In the following discussion, gendered risk comes to the fore. The students were discussing the risks of going to parties, which was prompted by the teacher. And although I have already discussed the dangers associated with parties in this example, the following excerpt captures yet another way students are encouraged to think about the risks of parties, and in turn the risks to them. In the middle of the discussion about things that could happen at parties a student said:

Student one: Well yeah this there? was this girl who had her drink spiked and she had no idea where she was.

Student two: Yeah people spike your drinks and make you addicted and so you have to buy drugs from them.

Ms Woods: Yes people try to get you while you are vulnerable.

Student three: Well my best friend’s friend is addicted ecstasy because her boyfriend gave her some and now she can’t get off it.

Student four: That often happens, girls use drugs because their boyfriends do.

Ms Woods: Why do you think that is? Girls trying to impress their boyfriends?
Student five: Well I know this Turkish family in Broadmeadows right and they were pretty religious and everything and the daughter left home and she was in a nightclub and she got raped by her brother because he was on drugs and afterward he killed himself because he didn’t know it was her. He had never seen her uncovered.

Student six: I don’t believe it … how come the brother was there if they were so strict?

Ms Woods: We are going to have to finish up soon, there has been some good discussion and we’ll follow it up next class with thinking about some strategies.

(Field notes, year 10 HPE class)

The various discussion points raised by the students mobilise commonly held beliefs about drug use and addiction. They also mobilise beliefs about gender, ethnicity, religion, drug use and agency. In this case the discussion reinforces the idea that girls only use drugs because their boyfriends do. Ms Woods takes full advantage of the student comment here, by picking up on it to facilitate some more discussion about why girls use drugs. In particular she seems to want the students to consider the idea that girls use drugs to impress their boyfriends. But her bid here fails to generate any discussion about that as a student introduces another story into the mix. The story combines a potent cocktail of risk, gender, race and religion that ends in rape and death. That story elicits a response from a student, but Ms Woods did not explore the issues any further. This might have been because the bell was about to go. Or it might have been that it became impossible for Ms Woods to isolate the risk message in the story that was applicable to the whole group without unpacking the racism or questioning the veracity of this story. Regardless though, the stories told in the above excerpt move from one gendered risky problem to the next and according to Moore and Valverde (2000) this creates amorphous risk amalgams. They go on to suggest that as amalgams emerge ‘each set or conglomerate of risks is thought to be
naturally governable through some more or less intuitively chosen set of risk management strategies: the ‘party safety tips, the trusted friends etc.’ (p. 528). In the case of this particular class, students were going to have an opportunity to develop a range of risk management strategies the following week to respond to the gendered risks associated with going to parties.

**Disgusting pedagogies**

Expert risk knowledges and hybrid risk knowledges were integral to the health education pedagogical assemblages I observed. Teachers deliberately interwove risk knowledges with various pedagogic techniques to produce pedagogical strategies that would mean that young people would understand themselves as being at risk. As a first step in what Dean (1999) refers to as the process of governmental self formation, understanding the self to be at risk is essential if one is to utilise the raft of risk minimisation strategies, to manage risk. However expertise and hybrid risk knowledges are only part of the picture, albeit a very significant part. To consider other forces at play within health education, I turn now to a vignette. The story, as you will see is real, and lifted from my field notes. As a research moment it provided a breakthrough, and the insights gleaned here shape the remaining analyses in this chapter.

*In my data collection days I went about immersing myself in the broader field of school based health education. Part of my reasoning was based around the idea that I wanted to get to know health education well, if I was to write about it. So I attended workshops, professional development seminars, research seminars across youth studies, adolescent health, education and health promotion. Effectively I was exploring what was going on in the broader assemblage of school based health education. Upon completion of my year of fieldwork, I took up a position as Lecturer in Health Education at Deakin University, and I began to be invited to present workshops and seminars on Health Education. I remember getting myself organised to present my workshop on the topic of ‘Health Promoting...*
Schools and its impact on Health Education’ and another presenter came up to me to ask me what I was doing. And so I told her. I then asked politely what she was going to be doing. And she told me something about primary health education and drug education, along the lines of strategies for drug education. I nodded. She then told me she had a fabulous strategy. And so I asked what it was. The strategy involved calling all of the students into the centre of the room around a single table with a plate in the centre. The teacher then needed to have a can of dog food behind their back (they should have prepared the can so that it was open already). Once the students were around the table and you had their attention you were to upend the can of dog food on the plate, whilst at the same time asking the questions; ‘Now would you eat that? Then why would you use illicit drugs?’

The scenario I describe above had me literally stumped for days (as well as feeling very concerned about what was happening in drug education). I wondered about whether the implication was that illicit drug users were dogs? (and weren’t dogs man’s best friend and very likeable)? Or perhaps dogs used illicit drugs? Or was the implication that if you ate dog food you used illicit drugs? Or was it if you were foolish enough to eat dog food, you would use illicit drugs? Or maybe it was the opposite to that, in that if you didn’t eat dog food then you wouldn’t use illicit drugs? But the strategy itself via the deliberate gathering of students around the table, and the placing of the upturned tin of dog food under their noses was pivotal in the strategy mix.

From all accounts, governmentality theorists had not (and possibly still haven’t) ever discussed the role of dog food in drug education prevention programs. But the use of dog food in the strategy reminded me of some of the stories being told by students in the classrooms. For example the idea of a dog food injecting drug user reminded me of various pedagogical strategies that had included a Turkish brother raping his sister, or the crazed LSD user who had her head hanging on by a thread. There were no expert discourses at play, and I am not even sure I could
suggest there were hybrid risk discourses that morphed expert knowledges present. But risk knowledges were at work, just differently. The attempt to sway children away from the dangers of drug use via the use of dog food was not about providing students with expert knowledges so they could make a rational decision not to use drugs. Rather the strategy was based on the expectation that students would be repelled by the smell and look of the dog food in front of them. The presenter was deliberately trying to mobilise an affective response from the children and recruit it to do governmental work by associating disgust and repulsion towards the use of illicit drugs. I am uncertain as to how often this strategy is used (or if it was). If it was used, one can only imagine the kinds of understandings that children might have walked away with, and the various associations they might make between disgust, illicit drug use and users and dogs. But as an approach it left me feeling quite worried. And although the worry has not ever subsided, that particular moment was a turning point in thinking about governmentality and how health education operates as a key site of government.

In going back to consider my data, there were several instances of where affect was central to governmental pedagogical assemblages. In these assemblages, affective risk knowledges worked alongside other risk knowledges to constitute risk to the subject. In the following health education classroom, students had been working on their nutrition eating plans. As a side discussion Ms Hill decided to introduce the concept of fitness as it was coming up next in their Physical Education class. To start the discussion Ms Hill posed a question:

Ms Hill: Okay what is wrong with being unfit?

Class: [all at once] You get fat, look like Homer Simpson, yuk, you could die.

Ms Hill: So well, if you don’t want to look like Homer Simpson it’s important to exercise to keep fit.

(Field notes, year 10 HPE class)
The starting point for the discussion is interesting in and of itself. The assumption is that being unfit is indeed wrong and in turn problematic. As a question it sets the class up to reply in ways that can only reinforce the idea that being unfit is wrong. Student responses combine a range of expert knowledges that rely on expert causal relationships that link being unfit to obesity to life threatening illness and ultimately death. But student responses also draw from popular cultural resources to suggest that one of the risks associated with being unfit might be that you could look like Homer Simpson. The response from the class here was to call out ‘yuk’. The students who did this were expressing disgust and repulsion at the idea of being fat like Homer Simpson. The teacher capitalises on the affective response of students and uses it to reinforce the message that exercising is important by suggesting that if they didn’t heed the message they could look like Homer Simpson. Ms Hill’s choice here to afford primacy to the risk of looking like Homer Simpson is an interesting one. Her words elicited the desired response from some of the students in that they pulled faces, recoiled their bodies in disgust and reiterated their disgust by uttering the words ‘ewww’ or ‘yuk’. It is hard to imagine the same kind of response would have been generated if Ms Hill said ‘well if you do not want to contract Type 2 Diabetes you should exercise’. In the above excerpt Ms Hill has the option to use expert risk knowledges by reinforcing that various risk factors associated with sedentary lifestyles can lead to long term health problems. But she chooses to ignore expert knowledges, and instead uses the threat of looking like Homer Simpson to try and entice students to establish healthy activity patterns.

In another classroom that was exploring the risks of drug use, and strategies that could be used to reduce risk, affect circulated potently to produce understandings of risk. When the teacher issued the invitation to consider drug risks, the responses from the students included both expert and hybridised risk knowledges. However, in this classroom, affective risk knowledges are primarily involved in establishing the risks of illicit drug use. In response to Ms Woods setting the task to highlight the ‘risks’ associated with the use of illicit drugs and develop some strategies that people could use to reduce risk the following discussion emerged:
Student: Well there was this guy right, and he was addicted to coca cola and he used to sell everything to buy coke.

Student: He is stupid.

Ms Woods: Well he doesn’t sound very intelligent [teacher directs the class to get back on task. They are analysing their media strategies for their effectiveness in drug prevention. They are television advertisements that depict the horrors of drug use. Ten minutes pass] Okay you have had enough time, they are good strategies aren’t they? Do they make you think ‘I won’t do that, I’ll develop a plan’.

Student: Well I work on Smith Street and I have seen them. They are revolting you know I would never want to be like that. They get acne and they look shocking. It is just so foul.

Ms Woods: I wonder if they can look in the mirror, if they know they look like that [pause]. They can’t can they? [looking to the class].

(Field notes, year 10 HPE class)

In the excerpt above, illicit drug users are considered to be stupid, ugly and disgusting. This belief is held by the students contributing to the discussion as well as by Ms Woods, and in retrospect it is a belief held by the dog food PD presenter. Ms Woods in this particular excerpt deliberately uses disgust to effectively establish the idea that drug users are not interested in hygiene amongst other things, and are in fact the abject other.

The abject other appears throughout many of the translation mechanisms of health education. Burrows and Wright (2007) for example identify a number of abject characters that feature throughout several health education resources. In the resource ‘Kids Life’ they draw attention to the image of a ‘sedentary, potato munching and coke drinking boy in an armchair accompanied by pictures of him
in his swimming costume replete with rolls of fact descending from the neck down’ (p. 8). They also discuss a school resource called ‘Healthy Bodies, Happy Kids’. They describe the main characters in the following way:

...Ollie Oil has a spotty face, appalling hair and is featured sitting down, not smiling and eating chips. Oilyan is a dripping viscous, gooey humanoid with one hooded eye while Oily Onlooker is a spotty kid with bad posture carrying a packet of chips with a pot of chips on his hat (p. 8).

Finally they describe a strategy that is recommended to teachers to assist students to develop a visceral response to fat, via watching butter getting dragged over lunch paper and observing the greasy trail it leaves. Further to this, teachers are encouraged to get students to feel the butter, to touch the grease. The kinds of strategies that Burrows and Wright (2007) describe are not that dissimilar to the strategies that I observed. At their core they rely on affective knowledges and responses as a mechanism to entice young people to look after themselves. The disgusting images and stories are utilised by teachers in classrooms to ‘show’ students what could happen to them if they do not take appropriate action. The risk that one could become abject, or the ‘unhealthy other’, is harnessed by teachers and various health organisations (see Burrows & Wright, 2007; Lupton & Peterson, 1996) as a means to entice students to behave in ways that are consistent with governmental health imperatives.

The abject other functions as a potent warning mechanism within health education pedagogical assemblages, and disgust is central to its production. Though there are other affects that are recruited too. For example Ms Woods suggests that the drug user who is covered in acne and foul couldn’t possibly look in the mirror. Here she is deferring to pride (or lack thereof) and conversely shame in order to further constitute abjectness. In addition to this the implication is that the abject other is stupid. As a constellation of affects they powerfully establish risk, and the risky other. The constellation also produces moralising forces, which according to several authors, apportion worth and blame (Cohen & Johnson, 2005; Hancock, 2004; Miller, 1997). This has implications for scholars interested in interrogating
how health education works to privilege and value particular subjectivities, whilst demonising ‘other’ subjectivities.

**Risky assemblages**

The various pedagogical assemblages detailed above are saturated through with risk. More often than not, the pedagogical force (Ellsworth, 2005) circulating through the assemblage was directed towards ensuring that young people understood that they were at risk. Establishing the ‘at risk’ subject was central to enlisting students into processes of healthy governmental self formation. Expertise, and in particular expert risk knowledges, were crucial within the various techniques called upon to do this work. For example, teachers utilised expert risk knowledges to actively constitute their students as being at risk. But within the assemblage other risk knowledges are recruited and produced. These included hybridised knowledges and affective risk knowledges. These knowledges are assembled together with a vast range of techniques including research, journaling, self surveillance, surveillance of others, self study, role play, discussion, story telling and media analysis.

The resultant pedagogical assemblages reveal that practical governmentality looks somewhat different than discursive governmentality. Much of the work on governmentality highlights the role of expertise in enacting government. This is not surprising given that the majority of analyses are conducted on policy or other documents. Official health education curricula is no different, it is saturated through with expertise and expert risk knowledges. However as curricula hopes are translated into classrooms, governmental work becomes messy as hybrid risk knowledges and affective risk knowledges are produced in the name of governmentality. At times the hybrid risk knowledges that students manufactured in discussion were factually incorrect, unrealistic and fantastical. For example, cocaine is not usually eaten and thus unlikely to tear up the stomach, glass or no glass. Nor would it be possible to saw through your own neck with a slinky to the point that it is hanging on by a tread (this after biting your girlfriends nose off).
Story telling in classrooms is common (Kehily & Nayak, 1996) and within the health education classrooms I observed they were a key pedagogic device that teachers and students co-created.

What is interesting, and at the same time alarming, is that teachers ignored expertise often to recruit the stories to ensure that they functioned to (re) affirm risk. In fact, from my observations it appeared that expertise might have gotten in the way of a good story, and thus denied the opportunity to reassert risk. The risk posed by halting the stories was perhaps too great for the teachers. Had they intervened in the story telling by saying ‘now that can’t be true’ or ‘that is actually a good example of many of the urban myths that circulate about drug use’ they may have effectively put risk, at risk. For teachers too, the idea of interrupting stories potentially put them at risk of contradicting students and thus would call into question their commitment to a student-centred approach. Ms Woods pointed this difficulty out to me after a class one day. She told me that she liked the students to contribute as it meant that they were sharing and being heard. After saying that she commented that she did not like to interrupt as she did not want to shut them down and that it was important that students felt comfortable to continue to contribute.

The assemblage of discourses here is complex. Such complexity can be difficult for teachers to negotiate. But at the end of the day, the message that students would have received via hybrid risk knowledges was that drugs were risky and that if you use them you risk terrible things. In addition to this they may have learnt that slinkies left around the house too, are dangerous, cocaine has glass in it and perhaps your nose leads to your stomach, or the main way people use cocaine is to eat it. Hybrid risk knowledges were significant in constructing risk in ways that may (or may not) have put students off the idea of using illicit drugs. Regardless though they were very much a part of enacting the hopes of a governmental project. In addition to hybrid risk knowledges teachers utilised affective risk knowledges. To date affect has largely been ignored in governmental analyses (Fullagar, 2009; Tamboukou, 2003) though interest has
been growing (Burrows & Wright, 2007; Leahy, 2009; Rich, 2011b). Within the broader education field too there are several scholars who have been interested in affect (see for example Albert-Crane Slack, 2007; Probyn, 2004; Watkins, 2006; Youdell, 2011). In relation to practical governmentality, affective knowledges and techniques are put to work in health education classrooms very deliberately. Following Ellsworth’s (1992, p. 6) idea that pedagogy is a ‘social relationship [that] is very close in. It gets right in there in your brain, your body, your heart, your sense of self, of the world, of others, and of possibilities and impossibilities in all those realms’. The recruitment of affective pedagogic constellations of disgust, repulsion and shame works to creep into students’ ways of thinking and being.

Conclusion

This chapter took as its focus the extremities of curriculum, where governmental imperatives are put into practice in health education classrooms. Drawing mostly from classroom observations I considered how the hopes of Health Education make their way into the classrooms, and what they mean for classroom pedagogy. The concept of pedagogical assemblages is central to my analyses, as it permits an understanding of pedagogy that captures the multiple and complex discourses and techniques that are at play within classrooms. The chapter revealed that risk was central to health education pedagogical assemblages. Health education classrooms, I argued, were largely directed to ensuring that young people understood that they were at risk. Once students understood this, health education classes then were directed towards helping young people develop life skills and strategies to manage risk. Expertise in the form of expert risk knowledges, and approaches to understanding health action planning were significant in achieving this end. The dominance of risk and expert risk knowledges, in and of itself, I suggest was not surprising given that risk and expertise are central in broader governmental assemblages and health curricula assemblages. However the pedagogical assemblages of health education were permeated by other risk knowledges. As my discussion reveals hybrid risk knowledges and affective risk
knowledges circulated within the pedagogical assemblages to constitute the at risk subject as well as to entice young people into entering into their own projects of [healthy] governmental self formation.

The resultant pedagogical assemblages reveal much about how health education functions as a governmental site. In particular close analyses of ‘practical’ governmentality provide insights into the minutiae of classrooms, and thus insights into the micro practices of governmentality. At the level of the classroom expert, hybrid and affective risk discourses are folded through various pedagogic techniques in deliberate attempts to individualise risk and in turn responsibilise risky subjects. This chapter revealed that process in motion, as well as shedding light on some of the messiness that characterises pedagogy. This messiness, as I have discussed was particularly evident at the intersections of gender, sex and agency. The health education classrooms I observed in my study were saturated by risk. Teachers used health education classrooms to continually assert that young people were at risk. As a subject whose very reason is imbued by risk, interrupting risk in any of its forms is risky practice. The following and final chapter reflects on this in more detail as I consider the various elements that make up the governmental assemblage of health education and the various rationalities, techniques and notions of subjectivity that circulate within the assemblage.
Conclusion

On commencing this study, I felt uneasy about the political work that was being ‘done’ in the name of Health Education. In responding to my ‘ethics of discomfort’ I set about interrogating Health Education, its politics and subsequent practices in an attempt to better understand its ‘critical’ possibilities and limitations. Drawing from Foucauldian and post Foucauldian theorisations of governmentality, the thesis has developed a governmental analysis of School Based Health Education in Victoria, Australia. In seeking to understand how School Based Health Education operates as a site of governmentality, I employed a qualitative multi method research strategy that involved a consideration of policy, official curriculum, school curriculum, teacher beliefs, curriculum support materials and classroom practices. The combination of discursive and practical governmental analyses in this thesis has been valuable as it enabled me to trace governmental rationalities and their associated techniques in policy, and also as they were put into motion. Such insights and perspectives are rare in the field of governmentality studies, and in Health Education scholarship.

This concluding chapter is organised into three main sections. In the first section ‘Assembling Health Education’ I revisit my initial research questions to weave together ‘governmental’ insights contained throughout the various chapters of this thesis. In this section I also offer a reflection on the usefulness of governmentality as an analytic. In the second section I attempt to offer some preliminary ways forward for researchers and educators. In doing this though I am mindful that one could spend an entire life, and build a career around critically interrogating attempts to work ‘educationally’ with young people around health and wellbeing related issues. And whilst I believe this is necessary work, I also believe that we urgently need to re-imagine Health Education, consider its’ edutopias and set about enacting new possibilities where we can (see Ellsworth, 2005; Peters & Freeman-Moir, 2006; Youdell, 2011). In recognition of this, I tentatively offer some thoughts on different tactics for Health Education. Finally, the third section considers the newly released Draft shape of the Australian curriculum: Health
and physical education paper (ACARA, 2012). The paper was published just over a month ago, and although it is not the final paper nor curriculum, it does provide us with some insights as to what official versions of Health Education might look like in the future. In many ways it is a fitting end to this thesis as it offers up (yet) another beginning.

Assembling health education

School Based Health Education, has at its very core, the desire to shape the health[y] conduct of children and young people. As a school subject, it functions as a ‘contact point’ whereby governmental health imperatives get to meet their target population. Health Education is but one site within a myriad of governmental sites that include school subjects, community agencies, institutions and organisations. As I have discussed in this thesis, these sites have emerged over time, in an attempt to regulate the lives of people, or in other words enact government at a distance (Miller & Rose, 2008). In deciphering how government sites operate as mechanisms of regulation in modern times, Miller and Rose (2008, p. 32) suggest that we require:

...an investigation not merely of grand political schemata, or economic ambitions, or even of general slogans such as ‘state control’, nationalization, the free market, and the like, but of apparently humble and mundane mechanisms which appear to make it possible to govern ... the list is heterogeneous and is, in principle unlimited’.

To grasp governmentality then, is a complex business and requires an analytics that can span history, and reach across macro and micro contours to trace various linkages and connections forged between governmental rationalities, techniques and practices. Throughout this thesis I have utilised the concept of governmental assemblages as an analytical device that I believe can assist us to comprehend the complexities that confront those interested in how a specific site functions in its governmental role. I would also suggest that for scholars interested in understanding contemporary attempts to govern, it is important to utilise ethnographic methods to consider practical governmentality (McKee, 2009). As
Tamboukou and Ball (2003) suggest the value in combining methods, and using ethnography as well as discursive analyses lies with the potential to ‘make it possible for previously unthought connections to occur in research and theory’ (p. 4). So in utilising governmental assemblages as the key analytic, I was able to establish some key questions that provided the direction for this thesis. I now return to those questions to summarise my responses, and revisit the major arguments I have developed throughout the chapters of the thesis.

1. What elements make up the assemblage of school based health education?

According to Dean (1999, p. 29) the practices of government:

...cannot be understood as expressions of a particular principle, as reducible to a particular set of relations, or as referring to a single set of problems or functions. They do not form those types of totalities in which parts are expressions of the whole. Rather they should be approached as composed of heterogeneous elements having diverse historical trajectories, as polymorphous in their internal and external relations, and as bearing upon a multiple and wide range of problems and issues (Dean, 1999, p. 29).

Following Dean’s lead, I conceptualised Health Education as a governmental assemblage as an analytical starting place. In my attempt to understand how Health Education functions in its governmental role, it was necessary to tease apart the assemblage in order to determine the elements that make it up. In essence assemblages and their elements forge connections with and rely on linkages to other assemblages. Thus there are numerous trails one could follow, and numerous elements to consider. In teasing apart the Health Education assemblage though, I identified what I believed to be the key elements. They were the official curriculum, school adaptations of official curriculum and classrooms. Each of these elements can be understood to be assemblages in and of themselves as they are made up of a variety of rationalities, techniques and conceptions of the subject. They also are key spaces where other elements forge links and so they provide ample opportunity to consider Health Education, its rationalities and techniques. There are a myriad of other elements, and assemblages that link to Health Education that this study was not able to consider in any real depth, or at
all. For example it might be that Health Education is conducted in Pastoral Care in schools, or by a range of outside organisations. It might be that Health Education is delivered as a one off ‘Health Fair Day’ assembled together by a host of community organisations and speakers. In addition to this there are a range of professional associations that reach into Health Education in various ways. They might do this by developing classroom resources, offering professional development and/or developing scope and sequence curriculum charts. Further, the academic and practical fields of Physical Education, Health Promotion, Wellbeing, Positive Psychology and Resilience, and their associated frameworks, link into Health Education and shift existing assemblages. The shifts to which I refer to here are already in motion. For example in The Melbourne Declaration of Educational Goals for Young Australians, MCEECYDA (2008, p. 13) states that the curriculum ‘will also enable students to build social and emotional intelligence, and nurture student wellbeing through health and physical education in particular.’ This call provides evidence of a shift in language, and the recruitment of ‘new’ ways of talking about Health Education, and perhaps doing Health Education.

Teacher education and ongoing teacher professional development, teacher standards, and teacher professional accreditation mechanisms are also part of the assemblage. Depending on the school, its location and moment in time, there will be other elements that make up the broader assemblage that seeks to shape the health[...] conduct of children and young people. And last, but certainly not least, in a long list of elements that make up the assemblage of Health Education, are the very targets of the governmental assemblage: the young people themselves (and their families). They are all elements that have diverse historical trajectories, internal and external logics and intersect in consistent or precarious ways. What is interesting though is, that despite the numerous governmental elements at play in the governmental assemblage of Health Education, the assemblage remains relatively intact. I want to consider the stability of the assemblage as I turn now to consider the various rationalities, techniques and subjects that make up Health Education, and how they are put into motion in practices of curriculum making.
2. What are School Based Health Education’s rationalities, techniques and subjects and how do they come together in settlements of curriculum and pedagogy?

This study considered three main elements of the School Based Health Education assemblage: official curriculum, school adaptations of official curriculum, and classrooms in an attempt to develop a governmental analysis of the various rationalities, techniques and conceptions of the subject that are forged together within contemporary assemblages. The analysis of curriculum, both official and enacted and classrooms revealed that School Based Health Education is, and always has been, about shaping the health[y] conduct of young people. My analysis of the ‘official’ curriculum context revealed that neo-liberalism has dominated official Health Education curriculum making for over thirty years. And although we have witnessed shifts in the assemblage, for example curriculum architecture and language, the aim has largely remained the same. My analysis of curriculum and classrooms revealed that neo-liberalism produces particular versions of Health Education. Within neo-liberalist governmental assemblages, Health Education operates as a key site for enacting government at a distance by working to facilitate the shifting of responsibility for health from the State to the individual. In essence Health Education provides a contact point whereby the political, social and economic health goals of the day can be woven into and through the choices of individuals. These neo-liberal intentions saturated the contours of the Health Education assemblage and worked as a congealing agent that augmented discourses and practices within the assemblage.

Risk, and expertise, also works potently alongside neo-liberalism in the assemblage to render the problems of government both thinkable and calculable, and in turn, practical. In a sense risk provided neo-liberalism with a technical form in Health Education. And although risk did not necessarily feature much by name within the various official curricula assemblages, it nevertheless dominates the Health Education assemblage as well as other related assemblages. Much of the impetus for Health Education within the contemporary context is derived from
the fact that ‘young people’ are considered to be at risk, and that Health Education can do something about this, whether they are at risk from date rape, sexually transmitted infections, obesity, suicide, pregnancy, road accidents, poor self esteem, low levels of resilience, poor social skills, poor relationship skills, bullying, the perils of illicit drug use, alcohol related violence and abuse and the list goes on. These are the governmental problems that Health Education is charged with solving. And within neo-liberal times I revealed that the curriculum sets about solving these problems by developing a schema that determines the various skills and knowledges that individuals will require to remedy such problems. The assumption that runs throughout the assemblage is that young people are rational, autonomous, health seeking subjects who can take responsibility for their and others’ health. But such qualities need to be taught. And thus a whole series of techniques, or pedagogic strategies are developed in order to cultivate the self-regulating capacities of young people. Health Education does this by ‘teaching’ students how to make decisions, problem solve, communicate, use condoms effectively, develop safety strategies, seek help, reflect on their decisions, analyse their diets, analyse their fitness levels, respond to scenarios, make judgements about good and bad behaviours and plan to make changes to their health related behaviour.

My research suggests that these are, and have long been, the official hopes and techniques of Health Education. My analysis reveals that the hopes and techniques saturated the curriculum, school based curriculum programs, teachers’ beliefs about Health Education and in turn Health Education classrooms. They also saturated the various governmental translation mechanisms that support the enactment of curricula hopes including curriculum support materials, textbooks, resources and websites.

As mentioned earlier in the thesis, according to Rose (2000, p. 322):

…current control practices manifest, at most, a hesitant, incomplete, fragmentary, contradictory and contested metamorphosis, the abandonment of some old themes, the maintenance of others, the introduction of some new elements, a shift in the role and functioning
of others because of their changed places and connections with the ‘assemblage’ of control.

Throughout the thesis there is certainly evidence of this, as official curriculum changes over time, as Health Education as a subject area tries to affirm self esteem and body shape while it tries to contribute to the obesity prevention agendas, or while it tries to pay homage to critical theory, while remaining faithful to individualism, or as teachers mobilise some aspects of the curriculum and not others. Yet the assemblage manages to stay relatively intact. In the ‘hurly burly’ of classrooms, where fantastical stories, affective knowledges and hybrid risk knowledges were introduced, where even slinkies became the risk object, and expert risk knowledges were no where in sight, the assemblage could have fractured. In hindsight there were many occasions where I thought this would be the case. And yet on the surface at least, it was able to ‘continually and consistently draw its scattered components back together seamlessly without evidence of its fractures and fault-lines’ (Youdell, 2011, p. 140). In contemplating how the assemblage manages to convert itself, over time and across spaces, in very similar ways, I want to suggest that neo-liberalism and its educative accomplices operate as congealing mechanisms within the assemblage. Thus enabling the fractures and fault lines to be traversed, to ensure the work of Health Education continues to flow.

3. What are the implications for the subject of health education itself, and in turn its subjects?

At the very heart of neo-liberalism is an imagined subject. That is, neo-liberalism needs and wants citizens to be autonomous, health seeking, enterprising, rational, choice-making individuals. And as I have discussed Health Education is one space that seeks to cultivate and enlist its subjects in processes of governmental self formation via its various ‘citizen forming devices’ (Rose, 1999, p. 46). The dominance of neo-liberalism though has dramatic effects on official versions of Health Education, and its educational practices. For those of us who take the term
‘education’ seriously, we need to look very carefully at the pedagogic work that Health Education is doing, in the name of good health.

Neo-liberal approaches to Health Education ‘teach’ young people that they are entirely responsible for their health. At times, though Health Education might teach students about the broader effects of class, gender, geographical location, age, ethnicity, race, environmental, political and economic conditions that impact on health, inevitably contemporary practices render these understandings redundant. The acknowledgement of the broader health determinants is one such instance whereby neo-liberal governmental assemblages become precarious and at risk of fracturing. But not for long, as inevitably the class is swung back by the force of neo-liberalism and the associated pedagogic ‘push’ for students to improve their health via the acquisition of knowledge and skills. This has been a feature throughout past curriculum assemblages and it is going to endure into future assemblages (see Sinkinson, 2011).\(^\text{13}\)

Health Education does powerful politically infused pedagogical work. As Dean (2010, p, 19) suggests:

\[\begin{align*}
\text{...the rational attempt to shape conduct implies another feature of this study of government: it links with moral questions. If morality is understood as the attempt to make oneself accountable for one’s own actions, or as a practice in which human beings take their own conduct to be subject to self-regulation then government is an intensely moral activity ... It is a moral enterprise as it presumes to know with varying degrees of explicitness and using specific forms of knowledge, what constitutes good, virtuous, appropriate, responsible conduct of individuals.}
\end{align*}\]

Health Education ‘teaches’ the very lessons in morality that Dean refers to above. It teaches students time and time again that they can and must make choices related to improving their health. This on its own is not necessarily problematic as we all make choices everyday as we carve out our existence. But Health

\(^{13}\) I discuss this in more detail in the final section of this chapter when I consider the draft Shape paper.
Education teaches students that choices are unlimited and unbounded, and that they are made rationally. This in turn sets up some students and people ‘as less capable, disciplined, intelligent and civilised, even psychologically ill or underequipped to act in ways that ‘rational’ decent people’ know is good for one’s health’ (Evans et al, 2011, p. 339). If achieving health is as simple as acquiring knowledge and having the appropriate skills, then this renders those who aren’t healthy as defective citizens who have failed in their moral duty to be well (Greco, 2003). This morally corrupt ‘unhealthy other’ circulates within the Health Education official curriculum assemblages, in between and behind the curriculum lines. In my analysis of official curricula and school curricula however, they were never mentioned. They are what Walkerdine (2009, p. 205) refers to ‘as the unspoken other to the subject of biopower’. And whilst the unhealthy remains unspoken in curricula assemblages, ‘they’ are brought to life in the Health Education classroom in a variety of ways.

In my analyses of Health Education classrooms, students were taught that drug users are stupid, ugly, disgusting and barely human, and overweight people are lazy and revolting. They were taught that ‘these’ people are irrational, that ‘they’ have no regard for themselves or others, and they are not decent people. Admittedly Health Education is not on its own in reinforcing such messages as they have long circulated in public pedagogies (see Rich, 2011b). Within the Health Education assemblages that I examined there were few if ever any instances of counter discourses that young people could engage with, to begin to think critically about the project of Health Education, and in turn their own, or others, lives. Rather there was, as Burrows (2011, p 349) states, ‘an unending cacophony of messages telling them (students) to shape up, get off the couch, eat better, exercise better and shed those youthful fat rolls’. And as Wright, O’Flynn and Macdonald (2006) suggest, this is problematic because in the absence of critical counter discourses related to health, the body and responsibility the potential for stigmatization and moral evaluation based on simplistic lifestyle criteria can remain unchecked.
One of the most significant elements missing from this study is students’ responses to their ‘Health Education’. In retrospect I wish I had talked with students about their responses to the Health Education lessons they were being subjected to. On one hand we know from research that has sought to explore children and young people’s perspectives on health that, more often than not, their understandings match those that are being privileged in Health Education (see Burrows, 2010; Rich 2011a; Wright & Burrows, 2004; Wright, O’Flynn & MacDonald, 2006). However, research too has highlighted that children and young people do critically interrogate and challenge the dominant discourses that are being fed to them consistently (Burrows, 2011; Rich 2011a; Vander Schee, 2009b). What this means is that we cannot necessarily know or predict the ways in which the lessons of Health Education will resonate with young people, how they might be taken up, rejected, interpreted or re-construed. This by no means lets Health Education off the hook though and I now turn to discuss the possibilities for Health Education and research.

Where do we go from here?

This section is divided into two. In the first section, I offer up some future prospects for research in the field. This appears to be customary at this time, and a mandatory requirement for conclusions. Whilst I do think there are some exciting possibilities ahead within the discipline, I find myself including a second section that explores some other possible directions for Health Education.

Future research directions

Julie McLeod (1995, p. 267) suggests towards the end of her thesis that ‘over the length of writing a thesis, … certain ideas and arguments once compelling, can become seen as problematic and new ways of interpreting incidents can emerge’. For me, over time, I have found myself becoming more and more immersed in governmentality studies. The field continues to produce interesting and exciting takes on discursive and practical approaches to government. But in saying this, I
believe if we want to continue to interrogate the politics of health education and to understand how political imperatives play out across the macro and micro levels we need to draw on other theoretical resources. Admittedly my use of the term assemblages signals a theoretical shift, and I acknowledge this in Chapter Two of the thesis. Both Nikolas Rose (2000) and Mitchell Dean (1999, 2010) borrow from Deleuze and Guattari’s (1987) concept of assemblages to conceptualise approaches to contemporary government, and thus the term governmental assemblages emerges. But throughout my thesis I have found myself drawn more and more towards Deleuze and Guattari’s concepts as I have struggled to make sense of the complexities educational assemblages present us with. As Youdell (2011, pp. 45-46) suggests:

Deleuze and Guattari use notions of ‘ensembles’, ‘arrangements’ and assemblages to think about the multiplicity of diverse elements that combine to form a field of understanding and activity. The key insight offered by this idea is the recognition that the economic, political, institutional, social, linguistic, semiotic, representational, discursive, subjective and affective are all potentially implicated in the assemblage, and so all are potentially significant in our analysis.

Youdell (2011) goes on to say that although some of the discursive matrices and disciplinary technologies that can be found within the assemblage are reminiscent of Foucauldian inspired scholarship, there are a multitude of other elements present that are not often foregrounded in Foucauldian work. In many ways my attempts to grapple with affects in the classroom point to perhaps a ‘weak spot’ in governmental studies.

Walkerdine (2009, p. 201) tells us that critical work has perhaps relied too heavily on discourse, and that the relation produced between knowledge/power is perhaps too simple and that we need to be more attuned to how governmental imperatives affectively circulate through pedagogical assemblages. Perhaps Deleuze and Guattari’s concepts promise some greater analytical potential? Several scholars in health and education have turned to Deleuze and Guattari already (see for example Fox, 2011, Hickey Moody & Crowley, 2011; Honan, 2001; Rich, 2011b, Ringrose, 2011; Tamboukou, 2008; Youdell, 2011). Increasingly I have come to
think that this approach may be fruitful in order to try and make sense of the political project of Health Education and how it is enacted within complex classroom assemblages. In saying this though, I am not advocating one theorist over another, rather I suggest that interdisciplinary perspectives have much to offer, especially when questions related to the politics of schooling continue to trouble us in the ways that they do.

And questions of politics do still trouble us. Just last month a special issue of Critical Studies in Education was published titled Rethinking educational, systems, policy and schools. In the editors’ introduction, they argue for ‘the need for new ideas to assist in the creation of a new social imaginary post-neoliberalism to frame rethought educational systems, policy and schooling. This is an attempt to reclaim progressive, democratic and social justice purposes for schooling well beyond dominant human capital renditions’ (Thomson, Lingard & Wrigley, 2012, p. 1). Further to this, Youdell’s (2011) recent book School trouble: Identity, power and politics in education starts with the premise that schools are ‘implicated in the making of particular kinds of subjects and in the making of educational and social exclusions and inequalities’ (p.1). Although this is not new, she, like others, are turning to a different set of theoretical resources that may enable a different ‘take’ on the problems of, and possibilities within, neo-liberal educational assemblages. But she also states that schools are significant places for the establishment of a counter politics that can continue to trouble schools and their politics. In following this lead, I would argue that we need to continue to trouble Health Education and re-imagine what it might look like. I am not sure we necessarily need more research on how ‘healthism’ continues to permeate policy and practice. We know this, we have mapped it, and it is without question that it is a force to be reckoned with, both theoretically and practically. I am well aware we could spend more time on exposing the finer nuances of this, and interrogate the various ways this works. And I do think there are some new semi explored theoretical horizons that can offer us new ways of rethinking and renegotiating the contours of a ‘Healthist’ Health Education differently. Though for me I think the urgency in all of this is for critical scholars to become entangled with practice. I
was at a seminar recently and on suggesting this I watched as the very idea of such an enterprise rippled through the group. Clearly for some, this work holds little interest, but for others it seemed to strike a chord. I believe it is imperative that we develop what Youdell (2011, p. 17) refers to as ‘new tactics for political practice’. Thus my thoughts for further research become necessarily entangled with my thoughts for future practice. And just as we need a more complex theoretical repertoire from which to draw in order to understand this field, we more than ever need a more complex repertoire for practice.

**Pedagogical possibilities**

In order to imagine other possibilities I have to necessarily step outside of the usual ‘orbits around curricular goals and objectives, as well as measurable, verifiable educational outcomes’ (Ellsworth, 2005, p. 5). I, like many others, think such mandates get in the way of what might be more interesting and exciting possibilities for learning. In fact curricula goals and standards, as they are currently assembled, are implicated in the production of the problematic pedagogies I discussed throughout Chapter Five of this thesis. On a very simple level, I wonder about what other pedagogical spaces are available for educators to offer a different type of Health Education. How might issues that relate to drug use, sex and sexuality, relationships, mental health, food and the body be addressed differently in the pedagogical spaces of English, Drama, Humanities and Media for example? Could these educational spaces work to scatter risk and neo-liberalism and offer up opportunities to convert the educational assemblage into useful and valuable ‘places of learning’ (Ellsworth, 2005)? And what about virtual worlds, and digital gaming? Do such places provide us with the opportunity to ‘throw a monkey wrench into a system of knowledge that perpetuates such perspectives’ (Evans et al, 2011, p. 339)? Could we rethink how we prepare Health Education Teachers? If we want counter discourses to be able to circulate in places of learning, we need to conceptually and practically resource teachers to do this work, so that they might be able to work to actively scatter the assemblage rather than race to seal over the fissures that begin to appear. And
fissures do appear. They appear when discourses collide in policy and in curriculum, and in classroom moments. They are an unavoidable product of any attempt to govern in the present. As Rose (2000, p. 322) suggests:

…current control practices manifest, at most, a hesitant, incomplete, fragmentary, contradictory and contested metamorphosis, the abandonment of some old themes, the maintenance of others, the introduction of some new elements, a shift in the role and functioning of others because of their changed places and connections with the ‘assemblage’ of control (2000, p. 322).

If we take Rose seriously, and understand that the project of Health Education can only ever be this, perhaps we can start to exploit the fissures and the ruptures, so that classrooms might prompt ‘new ways of knowing that also transform knowledge, self-experience, awareness, understanding, appreciation, memory, social relations and the future’ (Ellsworth, 2005, p. 37). I do not want to suggest that classrooms can ever fall outside of governmental education assemblages, but we do need to consider other possibilities.

While reflecting upon the possibilities for this, I have been inspired by both Ellsworth (2005) and Youdell (2011) who have moved into thinking ‘otherwise’ about education. Ellsworth’s (2005) thoughts are peppered throughout my discussion above. But now I turn to Youdell (2011) who draws from Foucault’s (1967) concept of heterotopias to acknowledge that there are real possibilities for counter spaces in the present. Youdell (2011, pp. 143-144) describes the kind of edutopia she imagines:

While I want to avoid a blueprint or check-list of ‘must have’ elements of an ‘edutopia’, I do want to suggest some of the practices, forms, subjects and feelings that might help to create education spaces of possibility. Based on what we know about schools and schooling as it stands, building on the heterotopias that can already be glimpsed in contemporary education spaces and pursuing the promises of the radical politics that I have been exploring, the education space that I imagine does seem to be underpinned by some contingent certainties. It is a semi-formal space that is physically accessible, welcoming and comfortable; it is a space of listening, exploration and openness; it is a space of dialogue where consensus and disagreement are both important, where uncomfortable truths are spoken and where the
intolerable is named and responded to; it is a space where there is time for and interest in children’s and young people’s lives, ideas, experiences, feelings, imaginings and hopes; it is a space where trust circulates; it is a space where feelings of all sorts, whether thought through and translated into the language of emotions or in the form of flowing affective intensities, are not simply allowed but acknowledged as a vital part of living and learning; it is a space where both engagement and disconnection are valid and where participation is elective; it is a space that is interdisciplinary, where learning moves from children and young people’s pressing concerns, where teachers map connections to existing knowledges as well as the gaps in this, and where the possibility of new ways of knowing and new knowledges is real; it is a space where identifications and subjectivities are heard, explored and offered recognition, even as this recognition includes critical interrogations and problematizations; it is a space where tests, performance indicators, league tables and the terrors these bring with them are insignificant; it is a space that is recognised as being deeply political and deeply significant. It is a classroom I have seen glimpses of in my own research and has been documented elsewhere. In this sense it is a heterotopia. It is a classroom that I would like to teach and learn in.

And it is a classroom that I would like to teach and learn in too. It is by no means a classroom that falls outside of politics, but it is a classroom that might enable different types of learning in Health Education. And yet as I make the move to consider other possibilities and new places for learning, the Draft shape of the Australian curriculum: Health and physical education paper (ACARA, 2012) brings me back into the orbit of the governmental imperatives of Health Education. And in reaching an ending, it is rather fitting that I turn to consider, albeit briefly the brave new world of Health Education.

A brave new world?

Throughout the thesis I have alluded to the fact that we are on the verge of a curriculum change, brought about by Australia’s move to a National curriculum. Last month (March, 2012) ACARA released the Draft shape of the Australian curriculum: Health and physical education paper (ACARA, 2012). This draft version:
...provides [the] broad direction on the purpose, structure and organisation of the Health and Physical Education curriculum. It is intended to guide the writing of the Australian Health and Physical Education Curriculum from Foundation Year to Year 12 (ACARA, 2012, p. 1).

The Shape paper as its title suggests, it is in draft formation. ACARA has opened up a consultation period and they have invited teachers, parents and stakeholders in the HPE field to comment on the draft paper by filling in an online survey. Within the draft paper the writers argue that:

Health and Physical Education is uniquely positioned to provide opportunities for students to adopt lifelong healthy, active living. The knowledge, understanding and skills taught through Health and Physical Education provide a foundation for students to enhance their own and others’ health and wellbeing in ever-changing contexts (ACARA, 2012, p. 2).

This of course is not a new hope for Health Education. As a broad statement, it has over the years been slightly adapted and reconfigured to state the same things. What is interesting however in the draft document is that there is some recognition that Health Education cannot necessarily guarantee ‘results’. The paper states:

For some years, there has been increasing pressure for the Health and Physical Education curriculum to be the cure-all for a range of public health concerns about children and young people. It should be recognised that although the curriculum will support the development of the knowledge, understanding and skills students need to make healthier and safer choices, it cannot be expected that the curriculum will fix all of the social problems and other issues that may contribute to young people’s health and wellbeing (ACARA, 2012, p. 4).

This recognition is significant, as it discursively at least, brings into relief the neo-liberal imperatives that have long saturated and shaped curriculum discourse. In many ways, the recognition given here to the social problems and the complexities involved in making healthier and safer decisions speaks that which neo-liberalism usually cannot bear to name (Walkerdine, 2009). The document
goes on to further consider the complex social and political factors that impact on health and wellbeing by stating that:

Health and Physical Education also addresses how factors such as gender, sexuality, culture, ethnicity, socio-economic status, environments and geographical location influence the health, wellbeing and physical activity patterns of individuals, groups and communities. In turn, it provides opportunities for students to develop the skills, self-efficacy and dispositions to advocate for their own and others’ wellbeing thereby making a positive contribution to the future for all (ACARA, 2012, p. 2).

But instead of simply being able to learn something about the complex and diverse factors that impact on health status and wellbeing, the curriculum wants to interpellate the good neo-liberal subject into developing skills, self-efficacy and dispositions to ‘do something about it’. Whilst advocating for social change is certainly a feature of my edutopia, and it has been an appealing feature of critical education from moments gone by, the curriculum here fails to name the possibility that such an enterprise is not necessarily straightforward, and that in some cases could fail. It is a classic case of governmentality’s eternal optimism (Miller & Rose, 2008), albeit a missed opportunity for students to engage with the complexities attached to thinking about social change and enacting it.

Perhaps the most interesting crack to appear in the draft paper can be found in the following statement:

Traditionally, Health and Physical Education curricula in Australia have adopted a risk-based model focusing on when and how young people experience risky health behaviours and exploring reasons why and how they could change these behaviours. The emphasis on risk factors and groups at risk (for example young people, Indigenous Australians, ethnic minorities) has been widely criticised for unnecessarily alienating young people, and frequently laying blame on them for their failure to meet expectations of self-management. By taking a strengths-based approach the Australian Curriculum: Health and Physical Education will prioritise the questions what keeps people healthy? and what helps people to be active? inviting students to build on their resources and competencies consistent with a preventive health agenda (ACARA, 2012, p. 3).
The recognition that risk has been a problematic element throughout the Health Education assemblage here offers up an opportunity to convert the Health Education assemblage in ways that can take us beyond risky discourses and risky pedagogies. In reflecting back on the ways in which risk dominated teachers beliefs about Health Education, and in turn their practices, the call to erase risk here brings a great deal of joy to me. And if only for a moment, it is something to be celebrated. It is a crack, and an official one at that, and it creates some space within which critical scholars can begin to inhabit to rethink Health Education. In true assemblage form though, as one element loses its place, another one comes to prominence, in the form of a Strengths Based Approach. This approach, its historical trajectory and its emergence in the Health Education assemblage will need to be closely analysed, discursively and practically, in order to determine if it effectively displaces risk. And in true assemblage form, contradictions emerge in relation to the call to remove risk. As one reads further through the document, we see the following:

Students will investigate a range of health issues relevant to young people including mental health, sexual health, healthy eating, personal safety, body image and behaviours associated with substance use. As they do so, students will develop knowledge, understanding and skills (such as early help seeking strategies, assertive behaviours, conflict resolution, emergency care and first aid management skills) to appropriately respond to a range of situations where their own or others' wellbeing may be at risk.

Risk re-emerges several times throughout the document, despite its earlier disavowal. It is not surprising though, that the writers have not been able to dispose of it. It is after all a dominant technology of contemporary governmentality. It will prove tricky to remove from the contours of Health Education given that it saturates teachers’ beliefs, and the various translation mechanisms that support teachers as they develop and implement Health Education. But as one crack appears, and it is allowed to endure, it offers I believe the potential for counter discourses to at least come into the frame. There is much more to be said about this draft document, but that can wait for another time. We also need to wait to see what elements of this draft paper make their way into the
official document, and how those elements are given form in the final curriculum documentation. As Health Education gets re-assembled, there are stirrings at least, that there is some space again for critical scholars and educators to inhabit as we work to assemble a health[y] subject. And although everything is dangerous, I am reminded of, and hold fast to, Foucault’s words spoken in an interview, that everything is not equally dangerous (cited in McLaren, 2002).
References


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