Abstract

On February 27th 2007 the Daily Mirror, one of the UK’s popular tabloid newspapers reported the case of an ‘overweight 8 year old, weighing 218 pounds’, purportedly ‘four times the weight of a ‘healthy’ child of his age’, whose mother feared she might lose custody of her son unless he lost weight and was allowed to keep the boy after striking a deal with social workers to safeguard his welfare. The child was in danger of being placed on the child care register, or in care, simply it seemed, for being ‘too fat’. That there can be serious discussion about state intervention and regulation on the scale of removing children from loving families is in itself deeply disturbing, raising issues of social justice and personal rights. But it also reflects the fearsome (medico research informed) authority that ‘obesity discourse’, and those who espouse it now possess, to define how populations should ‘read’ illness and health, and if they do not accept its messages, be rehabilitated. We examine the inexorable rise of health as a regulative discourse, while highlighting its class and cultural dimensions with reference to the policy content of recent obesity reports.
The Four Fat Fabrications of Obesity Discourse

This paper broaches the above issues with reference to the main conclusions of research which over five years has explored the relationships between education and the development of eating disorders amongst young women (Evans, Rich, Davies and Allwood, 2008). We refer to ‘four fat fabrications’ each representing a particular aspect or ‘effect’ of obesity discourse, identified from data derived essentially (but not exclusively) from the analysis of policy texts and the opinions of some 40 young women (aged 12-21) as they have reflected on the part played by education in the development of their disordered relationships with their bodies and food. We won’t dwell on the methodology of the research here, or detail all our findings but foreground the two ‘fabrications’ concerning the interests stated in the abstract above.

It was our intention in this paper to concentrate on the social history of the ‘child saving movement’ in order to demonstrate how contemporary health discourse around obesity is mere reflection of earlier (18th and 19th century) child saving crusades, albeit in much altered form. Those earlier crusades, like their modern variants, were attempts to regulate the deviant behaviours of working class men and women, using ‘panics’ to either establish new, or re-instate fragile, social norms, while leaving untouched underlying socio-economic structures, the primary determinants of their ‘discordant’, damaged and ‘unhealthy’ lives. But as is often the case when working in a fast changing, policy saturated field one is often overtaken by events and during the writing of this paper yet another obesity report was released in the UK, Foresight, (2007) which is of such significance we feel, that it perhaps warrants more attention than the intended trip down memory lane. In our view the Report is important not only because it will not only define thinking and practice on obesity issues for some years to come in the UK but elsewhere, once recycled globally through obesity networks, advocating and sanctioning unprecedented levels of monitoring and surveillance, from cradle to grave. We will try, then, to refer to contemporary child saving crusades as exemplified in Foresight, (2007) while also offering a little social history, taking a short trip down Gin Lane. In the process we will see that, whereas issues of social class and gender featured explicitly in early versions of child saving, they are an absent (or rather a more subtle) presence in recent variants of the crusade (e.g., the Report).
Fabrication 1. There is a Crisis (for health, science or truth)?

We began the project with modest aspirations, simply wanting to better understand the lived experiences of children and young people. In particular we were concerned with relationships, if any, between their expressed ‘private troubles’ in relation to their bodies’ size shape and weight and contemporary ‘public issues’. The latter has been noisily framed in popular discourse as a global rising tide of obesity, a primary antecedent of ill-health. As parents, educationalists and researchers working in body centred trades (PE, Sport and Health) we found ourselves increasingly in contact with students and children who seemed to be ever more dissatisfied with their bodies. Some were so deeply disaffected as to be taking drastic, even dangerous, actions in relation to exercise and weight loss. We were concerned as to the potential saturation of popular culture by images celebrating slenderness and alarmed at the way in which contemporary discourse around obesity seemed to be normalising and making a virtue of the slender body morph. There seemed to be little investigation of, or dialogue between, medical discourses of ‘overweight’ and ‘underweight’ and little documented critical reflection within the health community on prevailing orthodoxies. Given these circumstances, we set out to investigate currently dominant assertions of bioscience around health discourse and explore their refractions in popular culture and school policies and pedagogies. If nothing more we hoped to illuminate processes by which young people learned about their bodies and health and whether current health discourse had anything to do with their body disaffection or problematic relationships with exercise and food.

Health Crusades

We set out first to deconstruct current bio-scientific wisdom, investigating core beliefs and assumptions around the antecedents and consequences of ‘obesity’ and ‘overweight’, appraising the knowledge that now passes for the orthodoxy which we referred to as ‘sacred health knowledge’ in public and personal discourse on health. We found much wanting. Belying the authoritative confidence of the claims being made in this field, the more we searched for knowledge certainty backed by research evidence that would legitimise contemporary emphasis on weight loss, exercise and fat, the less we found. If there was crisis it seemed to lie more with bioscience’s reluctance to either demur from or debunk its own core assumptions and ideals or reflect explicitly on the morality of its practices and strategies than with population weight gain and associated ‘ill-health’. The ambiguities, contradictions and uncertainties that riddled the knowledge base of the primary research field (see Gard and
Wright, 2005) pointed to the first fabrication now embedded in the policies and the practices of schools - *that there is an obesity crisis to be found.*

Foresight (2007) constitutes a paradigm shift on earlier explanations of the ‘obesity crisis’ and a step change in thinking on ‘intervention’. Released in October 2007 by the UK Government’s long established Foresight programme (the aim of which is to ‘create challenging visions of the future to ensure effective strategies now’ (Foresight, 2007: 5) ‘Tackling Obesities – Future projects’, the Report made headline grabbing news with the claim that

"Obesity as bad as climate risk" and "50% of population obese in next 24 years" (BBC News 24).
The official Report, which had been leaked prematurely to the BBC, confirmed that,

‘The rapid increase in the number of obese people in the UK is a major challenge. This analysis by the Government’s Foresight programme shows that nearly 60% of the UK population could be obese by 2050. The economic implications are substantial. By 2050, a seven-fold increase in the direct healthcare costs of overweight and obesity is anticipated, with the wider costs to society and business reaching £45.5 billion (at today’s prices).1,2’

The size of the problem is such that in the UK,

"Professor Klim McPherson, of Oxford Uni, and Tim March, of the National Heart Foundation, predicted that within 15 years 85% of men will be overweight - but not necessarily obese - and within 20 years, 70% women'. (BBC News 24 14/10/2007; http://news.bbc.co.uk/1/hi/health/7043639.stm).

A ‘crisis’ of such magnitude clearly threatens not only individuals’ ‘health’ as well as their economic prosperity and wealth. ‘In the UK the cost is put at £45 billion a year by 2050 if the epidemic is not brought under control’, exhorted The Guardian (2007), lauding the sentiments of the Report (1).

The merits of these claims are not the subject of this paper but we should note that the assertion that half of the British population will be clinically obese in 25 years ‘assumes, without any empirical evidence, that every overweight child will become and overweight adult and that every overweight adult will progress to obesity’ (Feinham, 2007: 10). Few self respecting statisticians or econometrists would make such cavalier predictions over 20, let alone 40, years. Without due caution (i.e., some expression of ‘confidence levels’), such claims are to be considered en par with those derived from reading tea leaves, tarot cards, or polishing one’s crystal balls. Furthermore, given that ‘overweight’ populations tend to be healthy populations and that the thresholds now used for women are so low that a BMI of 25 is normative and largely meaningless as an index of ill health, a rather different story could be told to the one spun in TV media and popular press worldwide.
That such fat fabs can be spun on prime time National BBC News without any accompanying voice of caution or allusion to the veracity of the statements made is itself quite disturbing and further evidence of how powerful medical orthodoxy around weight has become in the UK, as elsewhere. It is also testimony to how expert proponents of obesity discourse have become in making their voices heard. Taking a leaf out of Tony Blair’s book of ethics and propriety, it seems that obesity proponents have learned that when dealing with the politics of the unpalatable it is time for – spin, policy spin. This surely was a zenith for obesity discourse but nadir for impartiality, objectivity and disinterest, the virtues by which good science and democracy are practised and formed. We might also note that whereas even ‘global warming’ is acknowledged to have alternative and contrary viewpoints (albeit usually marginalised as irrational renegades), in obesity discourse no such space is afforded counter positions – there is no alternative (TINA) it seems, to the orthodoxy of obesity discourse and its inherent assumptions, incontrovertible facts, assumptions and ideals.

Given that science is designed not to tell lies, Ball’s (2004: 153) reminder is timely; ‘fabrications’ are not untruths but ‘half truths or nearly truths’, ‘simply’ offering versions of reality which do not exist, in this case with respect to persons and their health. They are not:

‘outside the truth but then neither do they render simply true or direct accounts - they are produced purposefully in order ‘to be accountable’ […] Truthfulness is not the point – the point is their effectiveness’.

They characterise both the health ‘market’ where there is serious competition for scarce financial resources and schools where teachers have to meet the expectations of inspection and appraisal regimes. They work on persons and populations to achieve ‘their transformational and disciplinary impact’ (Shore and Wright, 1999; quoted in Ball, 2004, p. 152). To be audited a population or person ‘must actively transform themselves into an auditable commodity. Their existence impels us to ask a different set of questions of contemporary health discourse concerning its purposes and pedagogical ‘effects’. Amongst them, if crises have been simply ‘storied into existence’ what purposes do they serve (beyond turning populations or individuals into auditable commodities)? What is it that has to be solved?

*The Vocabulary of Crisis*

It is no accident that the Report articulates its message through a language and vocabulary of ‘global warming’. ‘Risk’ and ‘crisis’ narratives now have such familiarity they
immediately and easily resonate with the public psyche (if not altogether comfortably). And they are intended not only to scare populations (indeed, that may not be their primary purpose) but also rationalise and sanction new strategies, in this case involving unprecedented levels of intervention, surveillance, monitoring and control, reaching into every aspect of our private and public lives. To be sure, the Report represents a ‘paradigm shift’ in the conceptualisation of the ‘obesity’ away from allocating ‘individual’ blame toward ‘system’ blame for the crisis, and, concomitantly in the approaches to be taken toward its resolution. In its foreword, for example, it is emphasised that,

‘We must fight the notion that that the current obesity epidemic arises from individual over-indulgence or laziness alone’ […] The project’s findings, summarised here, challenge the simple portrayal of obesity as an issue of personal willpower – eating too much and doing too little. Although, at the heart of the problem, there is an imbalance between energy intake and energy expenditure, the physical and psychological drivers inherent in human biology mean that the vast majority of us are predisposed to gaining weight. It’s not surprising that the median body mass index in the UK is now above that considered to be in the ‘healthy’ range. We evolved in a world of relative food scarcity and hard physical work – obesity is one of the penalties of the modern world, where energy-dense food is abundant and labour-saving technologies abound’. (Foresight, 2007, Foreword, Sir David King) (our emphasis)

The Report proper states:

‘People in the UK today don’t have less willpower and are not more gluttonous than previous generations. Nor is their biology significantly different to that of their forefathers. Society, however, has radically altered over the past five decades, with major changes in work patterns, transport, food production and food sales. These changes have exposed an underlying biological tendency, possessed by many people, to both put on weight and retain it. Being overweight or obese increases the risk of a wide range of chronic diseases, principally type 2 diabetes, hypertension, cardiovascular disease including stroke, as well as cancer. It can also impair a person’s well-being, quality of life and ability to earn’

The pace of the technological revolution is outstripping human evolution and, for an increasing number of people, weight gain is the inevitable – and largely involuntary – consequence of exposure to a modern lifestyle. This is not to dismiss personal responsibility altogether, but to highlight a reality: that the forces that drive obesity are, for many people, overwhelming. Although what we identify in this report as ‘passive obesity’ occurs across all population groups, the socially and economically disadvantaged and some ethnic minorities are more vulnerable (Foresight, 2007:5).

This makes for fascinating reading; bye, bye free will and agency, it seems, in this carefully framed version of environmental and biological determinism. In an ‘obesiogenic environment’ ‘we’ are biological retards, ‘passively obese’, fat by default; though the
‘alone’ (in the above extract) is telling; for while we are all decreed innocent of the bad/fat state we are in, ‘the socially and economically disadvantaged and some ethnic minorities are (deemed) more vulnerable’ because of ‘their’ circumstances. Their habits, induced by their social biology, make them more culpable and, therefore, needing special attention/intervention to get them to eat better and lose weight. We return to this below.

Faced with a crisis on the scale of global warming, piecemeal action is deemed futile. Only cradle to grave intervention into the actions of communities, families, parents, pupils, teachers, and the practices of food producers and advertisers, etc., etc., in effect reaching into every aspect of our private and public lives will correct our bad behaviours and alter the state we find ourselves in. Nothing short of totally pedagogised societies, totally pedagogised communities and totally pedagogised schools and a future in which ‘weight’ features in the mind-set of everyone, everywhere, as cradle to grave concerns, will save us and miserant others from dying prematurely before being globally warmed.

**Figure 4.1: Critical opportunities for intervention during an individual’s life course.** It is critical to note that there is no one point in the life course where intervention is particularly successful but that progress through life offers a number of naturally occurring opportunities such as metabolic plasticity or behaviour change. (Foresight, 2007 p.63)

**Progress of sorts?**

Acknowledging environmental complexity and the significance of ‘systems’ and structures in weight issues might be considered progress of sorts, an advance on earlier blame the individual/victim thinking. But this narrative, especially its use of the decidedly reductive term ‘obesiogenic environment’, not only sanitises the text of anything like serious analysis of the political economy of health and of cultural (ethnic and gender) issues; for example, as to why some people (because of their ethnicity or religion) may ‘chose’ to be fat, or why others may rationally lead lifestyles considered ‘unhealthy’ - exercising little and eating ‘bad’ food because they have no ‘real’ alternative, so very little ‘choice’. It also creates the impression that the Report serves no vested interest and represents no particular values and that it is speaking dispassionately on behalf of everyone’s concerns. These lacunae (discursive gaps) are important for a number of reasons. In failing to adequately acknowledge that ‘health’, weight and shape are cultural as well as socio-economic categories, the Report facilitates not only the celebration of a particularly narrow set of corporeal virtues - slenderness and the relentless pursuit of ‘being thin’, a vision endorsed in subsequent Health Reports (see The
Telegraph, 2007) - but also implicitly endorses the view that bad biology, bad psychology, bad habits, resulting in too little exercise and over indulgence in the pleasures of readily available, cheap, bad food, can be apportioned disproportionately to particular categories of the population, thereby, perpetuating a culture in which selected individuals (and their families) can be singled out and held ultimately responsible for not achieving these ideals. (2)

Fabrication 2: Your health, your responsibility; only YOU are to blame (and shame)

Despite the attention given in the recent Foresight Report to ‘systems’ and ‘environments’, its discursive gaps around culture and class provide ample space for the perpetuation of another fabrication. It insists that ultimately individuals rather than other antecedent or contingent socio-economic factors are the primary resource for the resolution of health problems and associated risks. These spaces provide opportunity for the more rabid voices within popular culture (TV and other media) and amongst conservative politicians, to remind the lay public that ‘bottom line’ fat is an individual issue, a consequence of irresponsible behaviour, expending too little energy and eating too much bad food

‘Listen up fatso – we are letting you off far too lightly’ (Portillo, 2007:17)

Historically the most invidious feature of obesity discourse, endemic in media reporting and implicit in policy texts, is that health problems are essentially the fault of individuals, especially females, or the ignorant, or poor, misguided working class. It is not dissipated by the more all-inclusive narratives of the Foresight report which, like others, barely begins to address the complexity of health issues or the specific social and economic conditions, over which individuals may have little or no control and which structure and set limits to people’s lives. In passing we might note the following commentary by Routledge (2007: 31) on statistics released in the UK by the Office of National Statistics:

The great Victorian statesman Benjamin Disraeli coined the term “Two nations” to describe a Britain he saw as cruelly divided between rich and poor. That was in 1845. But you could still say the same thing today. Despite 10 years of Labour Government, the UK is still split between a healthier richer South and a less healthy impoverished north. In the dockside Middlehaven area of Middlesbrough, healthy life expectancy – the age people can expect to reach before ill-health sets in – is 24.9 years In the Ladygrove neighbourhood of Didcot, Oxfordshire, people can expect healthy lives until they reach 86 – more than three decades longer. The other social indicators tell the same story of divided Britain. In Middlehaven, only 29 per cent of adults are in
work. Didcot boasts 86 per cent. Up north, 27 per cent are owner occupiers, Down south, 66 percent. Car ownership – 94 percent for the richer folk, and 29 per cent for the poorer people. These figures are taken from the first detailed survey of the north-south divide carried out by the Office of National Statistics. The report makes grim reading. Nine out of the worst districts for early onset of ill health are in northern cities. And nine out of 10 places with the longest healthy lives are in the south. Disraeli spoke of two nations “between whom there is no intercourse or sympathy, who are as ignorant of each others habits, thoughts and feelings, as if they are dwellers in different zones, or inhabitants of different planets.” More than 160 years later, these nations-within a nation do live in different places. And they might as well be on different planets.

Social class is not simply a discursive artefact, a category, or construction of either Governments’ or academics’ classificatory schemes. It is a visceral reality, constituted by a set of affectively loaded, social and economic relationships that are likely to strongly influence, if not determine and dominate, people’s lives (Evans and Davies 2007). These involve dynamic processes within and across many social sites or fields of practice (Bourdieu, 1986), particularly in families and schools. These are not just contexts in which orientations to the body are nurtured, expressed, some rejected others assimilated, affirmed and endorsed but locations of opportunity and cost where physical and intellectual capital is distributed and legitimated and sometimes withheld. Rarely are such matters given attention either in official Reports or in media reporting of obesity and health. As Peter Marsh (15th March 2004, Social Issues Research Centre) has observed;

‘Unlike the alleged effect of food advertising, the impact of social inequalities on levels of obesity can be measured, and it is very substantial — the largest single factor that has so far been identified. Despite this, it receives scant attention in the media. The graph below demonstrates dramatically how little we seem to care about this issue.
The data that are illustrated in the graph are derived from SIRC’s analysis of 12,902 British national and major regional newspaper articles that focused, to some degree at least, on obesity since 1998 [...] The bottom line of the graph shows the number of articles in which attention was paid to issues of poverty, low-income families, social deprivation, etc. The graph speaks for itself. The real roots of obesity, that are conveniently hidden away from the chattering classes who wield disproportionate influence when it comes to developing ‘popular’ solutions to societal problems, are not things that the media wish us to read about. And because they are rarely headline news, government departments and agencies seem to have little cause to pay them much heed — especially when they are uncomfortable reminders that New Labour has not yet quite delivered the New Britain’.


Child Saving?

In certain respects none of this is new but merely represents an extension, perhaps a new, high point, of earlier, 18th and 19th century child saving crusades (Anthony Platt, 1969: 97) which were also characterised by a ‘rhetoric of legitimisation’ built on ‘traditional values and imagery’, such as notions of ‘the good life’ uncontaminated by the pathologies of urban environments. They also borrowed images of pathology, disease and treatment from the medical profession, as well as ‘from the tenets of Social Darwinism pessimistic views about the intractability of human nature and the innate defects of the working class’. To these were added ideas about the biological and environmental origins of ‘crime’ attributable to the ‘positivist tradition in European criminology and to anti urban sentiments associated with the rural Protestant ethic’ (ibid: 96). In the early 20th century, especially in the USA and the UK, there were policy shifts concerning delinquency ‘from one emphasising its criminal nature to the ‘new humanism’ which spoke of disease, illness, contagion, and the like’, then, as now,
representing essentially a shift from legal to medical emphasis. Anticipating consequences that seem particularly redolent today, Platt (1969: 102-3) pointed out that:

‘the emergence of a medical emphasis is of considerable significance, since it is a powerful rationale for organising social action in the most diverse behavioural aspects or our society. For example, the child savers were not concerned merely with ‘humanizing’ conditions under which children were treated by the criminal law. It was rather their aim to extend the scope of government control over a wide variety of personal misdeeds and to regulate potentially disruptive persons. The child-saver reforms were politically aimed at lower class behaviour and were instrumental in intimidating and controlling the poor’.

We can read, then, obesity discourse as a latter day version of the ‘child saving’ crusade goal not only to rescue a child population ‘at risk’ but to regulate ‘deviant’ populations by announcing and (re)establishing acceptable social norms. Allusion to the child saving crusades of the nineteenth and early twentieth centuries highlights how the medicalisation of social policy served certain socio-political purposes and to sanction ever more intrusive and ubiquitous control over working class people’s lives. Then, as now, crusaders were driven by far more than concern for children’s ill-health; they were also seen to be addressing the risks posed by inadequate or irresponsible working class behaviour to the wider social order. Health messages traded moral and social as well as health/medical codes in establishing new norms around a range of ‘correct’ behaviours. Such crusades, like those of the eighteenth century, were not only focused on the misuse of food. Borsay (2007) observed how other cultural malaises of this period, such as binge drinking, street anarchy, parental neglect and a government in denial, all familiar tropes of contemporary political and media discourse, would have been familiar to mid eighteenth century London cultural commentators, as illustrated by Hogarth’s painting of ‘Gin Lane’.
Media constructed panics characterised both periods and symbolised not only their obvious signifiers or tropes, such as over-drinking or overeating but wider anxieties about social breakdown and disorder. In the 18th century, as now, ‘problem drinking’ was one of many behaviours described as out of control and illustrative of a broken society in media driven moral panics where reforming campaigners played leading roles in elevating problems to crisis status. In contemporary context, health agencies, government spokespersons and popular experts take on such reform roles. In Borsay’s terms it is not bad diets or ‘binge drinking’ that merit comparisons across these periods but the moral panics fuelled by pressure groups and the media, amid perceptions of Government complacency, that characterised them. Of particular significance is that in all these episodes women’s behaviour and family breakdown are focuses of attention. As Borsay observed, the women portrayed in ‘Gin Lane’ are not 18th century ‘ladettes’ but wives and mothers seen to be sacrificing their children’s
welfare to Mother Gin. Problem drinking, like the problem feeding or eating with which we have been concerned, is depicted as both a public and urban phenomenon. But whereas in the eighteenth century young people were depicted as the victims of their binge drinking parents’ neglect, today their own binge drinking is the main focus for concern. In contrast, in contemporary discourse over problem eating, both parents (especially single ones) and children tend to be held to blame. And it is not just a case of the rich taking the credit (for good child rearing practices, healthy diets and conserving the earth’s resource) while the poor that gets the blame for doing none of these decent things. Fractions of the middle class are also held culpable, where single parent women serving their selfish interests in going to work are deemed to provide the wrong family structure and too little time for structured meal times and serving good wholesome food, their ‘crime’ essentially reflecting the malpractices of the irresponsible working class.

**Fat: a middle-class issue**

**Unprecedented study by Great Ormond Street Hospital says mothers who work risk their children becoming overweight**

Roger Dobson and Susie Mesure

[http://news.independent.co.uk/health/article2790964.ece](http://news.independent.co.uk/health/article2790964.ece)

**Class and Gender Matter**

The similarities between earlier and current moral panics concerning binge drinking or the misuse of food are, on balance, quite striking. They become disturbing when encoded in policy texts and school social relations bearing on the lives of young people as they categorise and stigmatise fractions of their populations with the ‘wrong’, while privileging others with the ‘right’ attitudes and predispositions. Warin, Turner, Moore and Davies (2007, p.12) have pointed out that, in their society, as illustrated in *Healthy Weight* (2008) and *Australia’s Future* (2003) or the UK in *Every Child Matters* (2003), even when the macro environment, health promotion focus is targeted at children from an early age, young people and their families:

‘it is women (as primary school teachers and child care workers) and particularly mothers, who are the forefront of such strategies […] as they are the household and community members who are most actively engaged in and organising the day today nutrition and activities of young children’.
They also point out these strategies do not impact all women in the same way, for people’s daily lives are shaped not only by gender but social class. Class based aspects of habitus, such as employment have powerful bearing on understandings and decisions around food. In their study they found working class women shocked to think that they might be called obese, at odds with their own experiences of body size and weight. They recounted experiences of food insecurity, poverty and neglect that profoundly affected the ways in which food and nurturing featured in their own families. Low priority assigned to weight loss was not only related to their gendered but differing class habitus. Middle and upper class women did not recount biographies of food insecurity but lifestyles in which attention to the body was much more salient, with constant discussion of the need to modify it through dietary and exercise regimes, such as trying a range of diets or attending diet and other, including gym, groups. With similar tendencies evident in the UK it is hardly surprising that the middle class young women in our study refracted such ideals, defining ‘health’ as the desire to be, or display, being thin as not only a moral responsibility but a social virtue and, at least to begin with, something of a personal crusade. If regulation and disciplining of populations and individuals rather than amelioration of their ‘health’ is the underlying or accompanying, unintended goal of obesity discourse, the intense pressures and anxieties experienced by young people are unlikely to dissipate and their seemingly ‘private’, though publicly induced, ‘health problems’ will neither recede nor go away.

Where does this leave us in our analysis of ‘obesity and health? Well, with Warin, Turner, Moore and Davies (2007 p, 11) we would suggest that a ‘gendered and class analysis of health issues and obesity discourse would provide a very ‘different entry point for examining “obesiogenic environments” (Egar and Swinburn, 1997) by pointing to how social meanings and practices (around health) are embedded and reproduced in everyday lives’ (our parenthesis), including those of middle and working class young people in communities and schools. Indeed, without a better understanding of the way in which class, gender and ethnicity are culturally inscribed in educational and health practices we are unlikely to set meaningful and realistic agendas either for research or policy and practice in schools. Like Warin, Turner, Moore and Davies’ (2007, p. 1) we are concerned to both understand and enhance the health of populations and individuals, entailing that we have to:

‘problematise the universality of health promotion messages and highlight the integral role that a critical theory of ‘habitus’ (or ‘lived experience’ and the ‘corporeal device’) has in understanding the embodiment of obesity’.
and various forms of resistance to it. Understanding how people’s lives are shaped by gender, culture and their social class must, then, constitute a vital element in any strategy that addressed health issues. We are under no illusion as to the serious limitations of our data where there are notable lacunae in the narrative, particularly with respect of the voices of males, working class females, the ethnically diverse and the ‘disabled’. Yet, if we are to stand any chance of explaining why some of the kinds of behaviours and exchanges around health entailed in formal learning are so lacking in meaning to certain sections of the population (for example, some working class boys, their parents and ethnic fractions), we first need to understand what is meaningful to those individuals about their own participation amongst peers in school and community contexts, particularly in relation to their understandings of their bodies and health. Moreover, like Warin, Turner, Moore and Davies (2007, p. 11), who argue that popular discourses continue to privilege and validate the slender female body, we would emphasise that even where there is a focus on ‘gender’ in popular culture and academic literature it is often simply equated with girls or women, despite there being a growing literature on relationships between men and their bodies highlighting some clear differences in their gendered consumption and embodiment of food and shape (Monaghan, 2005, 2006). A clear message emerges. We are unlikely to either appreciate or understand the nature and development of corporeal disorders or, more broadly, the aversions young people develop for certain aspects of education, including those designed to enhance involvement in physical activity and health, unless we embrace class, gender and ethnicity in both our analyses and the strategies we devise to resolve these things.

Where next?

‘You will never understand how it feels to live your life […] without meaning and control […] with nowhere left to go […] You’ll never live like common people, never do what common people do […] You’ll never fail like common people […] you’ll never watch your life slide out of view […] and you’ll dance and drink and screw cos there’s nothing else to do’ (Jarvis Cocker, Common People, Pulp, 1995).

How are we to recognise and discuss the effects of poverty, culture and class without patronising ‘working class’ interests or pathologising quite rational attitudes and actions toward exercise and food? Reading ‘obesity’ like anorexia and other forms of serious body disaffection as discursive and material practices that are both self-productive (pleasurable) and self-destructive may tell us something significant about viable options for gaining control over one’s identity in communities and schools. The actions of the middle class young women in our study highlight a perform active culture endorsed in school which builds pressure for perfection and performance, often in forms which are undesirable or impossible to achieve.
How much greater this gap for the working class poor, between their lives and the promises of wealth, slenderness, recognition, independence, work satisfaction, traded in popular culture, obesity reports and the curriculum of schools? What future, pleasure and gratification is there for the 40% of young people who continually fail in schools? Far from empowering individuals, health practices and social practices induced by contemporary education and health policy may leave young people, including the middle class young women in our study, feeling powerless, alienated from their developing bodies and reaching towards starvation diets and obsessive exercise as means of regaining control over the base elements of their lives. Eating ‘bad’ foods whether of necessity or for visceral pleasure may in effect serve similar ends. The social injustice of placing such moral obligation and blame on individuals for their health problems in ways which depoliticise the roles school and other social influences play in people's lives should be a major concern.

In a fast changing, postmodern world schools will have to address new expectations, new opportunities and gender relations and more attention will need to be paid to the micro-politics of power which are as significant as macro-formations. What is clear from the stories of these young people is that the complexity of social interaction in schools belies any simple notion of gender socialisation or reform strategy, such as critical literacy or health promotion strategies geared towards the treatment of single factors, such as weight or exercise bearing on their lives. If nothing else, the data presented here should warrant a fundamental critique of any discourse that reduces the contribution of education to a trivium of food (diet), exercise and weight management or generates social practices in which children or young persons are reduced to ‘bodies’, not persons whose circumstances need to be understood if their health and educational requirements are to be met. To accept that there is no alternative to contemporary discourse of health or that there is and can be nothing new is, as Fitzpatrick (2000, p. 160-161) has observed, a recipe not only for ineffective health measures but also the stagnation of society and diminished expectations for the future:

‘If collective aspirations are no longer viable, then the scope for individual aspirations is also reduced. The contemporary preoccupation with the body is one consequence of this […] If people’s lives are ruled by the measures they believe may help to prolong their existence, the quality of their lives is diminished. The tyranny of health means the ascendancy of the imperatives of biology over the aspirations of the human spirit’.
This places educationalists and health educationalists in something of a conundrum. Critical pedagogues do need to engage with the changing world in which health discourse is configured; it is not enough to criticise, explain or understand it. We have to engage with the paradox of wanting to utterly reject the performative values in health and education that are driving social change in a context of global capitalism while at least considering that there also might be an immediate problem to deal with in the form of poor diets, too few opportunities for play and exercise and ill health and their origins in the social conditions of peoples lives. Critical pedagogy does not occur in a vacuum; as Apple (2005) reminds us, unless we honestly confront neo-liberally inspired market proposals and purposes and think tactically about them we will have little effect either on the creation of counter hegemonic common sense, in this case around health, or on the building of counter hegemonic alliances. Certainly our analyses have, as Apple implores, to be sufficiently connected to the ways in which conservative modernisation has altered common sense, including that around health and transformed the material and ideological conditions surrounding schooling. It also has to be aware of alternative belief systems and conceptions of ‘health’ and strategies for effecting the latter that might be drawn on while contesting the current orthodoxies of health policy and school pedagogic modalities. In view of this, to suggest that we reduce our analysis of ‘health’ to weight and exercise issues is at best limited at worst patently absurd.
References


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