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Health invaders in New Zealand primary schools

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Abstract

Escalating concern over childhood obesity rates, children's eating habits and their physical activity regimes has fuelled the development of multiple health policies and resources. Many of these are reaching into primary schools, contouring pedagogical opportunities and influencing how young people may come to understand themselves as healthy (or not). In this paper, we map the health policy/resource context in New Zealand emergent over the past two decades, examining the form and content of health messages circulating and their incursions into primary school environments. We also consider the potential effects for teachers and students of enduring health 'invasions' in the primary school space.

Keywords

Health policy, primary schools, children

Introduction

There are few that would contest the fact that New Zealand primary schools and the teachers and children that inhabit them are currently embedded in a complex health policy and resource environment. Programmes offered by corporate organisations are also increasingly reaching into schools, further complicating what is already a messy assemblage of policies, initiatives, and practices that schools and teachers are dealing with (Petrie & Lisahunter, 2011). Indeed, on some levels, the proliferation of health policies and resources in schools can be likened to an 'invasion'. People and agencies



with seemingly benign desires to prevent illness and alleviate the spread of risky behaviours in young people, are working with students in ways that are not necessarily aligned with Health and Physical Education (HPE) curriculum premises (Burrows & Wright, 2007; Dinan-Thomson, 2009; Macdonald, Hay, & Williams, 2008; Rich & Evans, 2009). They are also wittingly (or not) transmitting messages about 'health' that yield narrow and potentially unhelpful understandings about who and what counts as 'healthy' in contemporary New Zealand. Many of these health messages are premised on notions of children as 'at risk' of ill-health, on assumptions that knowledge about healthy foods and fitness will yield changes in children's behaviour, and that teachers are ideally positioned as conduits for health promotion remits by virtue of their pedagogic relationship to children. While these notions have a common-sense appeal, they simultaneously generate conundrums for teachers, for students and for schools as learner-centred institutions. In particular, these kinds of assumptions raise questions about what drives teaching and learning in schools (see Burrows, 2010a; McDermott, 2012; Rail, 2009), and questions about what 'teaching' and 'learning' actually mean in school environs.

The New Zealand Curriculum, as the mandated national document for all New Zealand schools, should presumably be the key driver of teaching and learning programmes in schools. While others have ably described the specific ways in which Health and Physical Education are envisaged in this curriculum (e.g., Burrows, 2009b; Cassidy & Ovens, 2009; Culpan, 1996/97; Tasker, 1996/1997; Tinning, 2000), it is worth rehearsing two of its key tenets here, if only to afford some context for the disquiet we later express about the scale and impact of the 'health invasions' we signal in this paper's title. First, the HPE curriculum is underpinned by a holistic definition of health. Social, emotional, spiritual *and* physical matters are accorded equal weighting in any consideration of a young person's health status, and teaching resources aligned with the curriculum (see for example Ministry of Education, n.d.) urge teachers to convey to students a sense that health is far more than a mere absence of disease and more than a corporeal matter (Sinkinson, 2011; Sinkinson & Burrows, 2011). Second, the HPE section of the curriculum embraces a desire to foster young people's capacity to critically engage with knowledge about health and physical education (Gillespie & Culpan, 2000). The motive is an educational one, to assist students to think critically and creatively about their own and others' well-being. In other words, the goal is not to fix up young people's health problems, but rather to equip them with the resources (both conceptual and practical) to understand and address well-being issues, foster resilience and the capacity to interrogate the health knowledge they receive in relation to their own lives and contexts (Robertson, 2005; Sinkinson, 2003). We argue that both of the aforementioned emphases are sidelined in a context where multiple vested public, private and popular health interests are at play in the primary school space. In so saying, as Luke (2010) attests, there is not necessarily a "direct 'hypodermic' effect between the official curriculum and the enacted curriculum" (p. 60).

Drawing on newspaper articles, government policy reports, public health promotion resources and health and/or physical activity-related websites, we map developments in the health policy/resource context in New Zealand in the recent past. We include documents and policies dating back to the early 2000s in an effort to illustrate both the shifts evident in the broader health context and the enduring nature of some of the claims being reiterated contemporaneously. A wide array of government documentation, including strategic visions, implementation plans and articulations of

‘priorities’ for child health was unearthed. There is certainly no shortage of information and guidance available for those wishing to secure ‘healthy’ and ‘positive’ futures for young people. We do not attempt to map the entire terrain but rather endeavour to paint a picture, partial as it is, of the substance and form of the contemporary and recent past health context.

To begin we briefly address what is arguably the most enduring and pervasive concern addressed by governmental policy and instantiated in health promotion resources—obesity. We then track some of the big picture and school-based health and physical activity initiatives introduced over the past two decades, before considering what all of this might mean for students and teachers in New Zealand primary schools.

Obesity

Unsurprisingly popular, professional and political media during the past decade has been replete with information about obesity (Burrows, 2009a; Gard, 2010; Gard & Wright, 2005). Across all of the document categories we analysed a remarkably consistent picture emerges about what the obesity ‘problem’ is and what needs to be done to solve it. In its most simple enunciation the obesity ‘story’ features the following key points. Obesity is a global phenomenon caused by over-consumption of high-density foods, too little exercise, a proliferation of audio-visual and internet technologies and a generalised disposition on the part of a consumerist over-indulged society towards ‘sedentary lifestyles’. While some commentators point to the importance of creating ‘environments’ conducive to healthy eating and physical activity practices (e.g., through legislating against ‘bad’ food advertising, creating more spaces ‘to move’ and encouraging walking and cycling), the premise that obesity is largely attributable to poor nutrition and/or a failure to move one’s body usually remains in such arguments. One of the most pervasive themes across most of the reports we analysed is the notion that controlling weight gain is a matter of balancing energy in (i.e., food one eats) with energy out (i.e., amount of energy expended through physical activity). While many of the resources promulgated to assist young people to achieve this balance responsabilise young people themselves (e.g., through getting fitter, eating better food), a discernable trend in newspaper reporting of late is a move towards positioning families, and parents in particular, as culpable for the expanding waistlines of their progeny. Hailed as a ‘breakthrough’ in obesity knowledge are claims such as “expectant mothers’ diets could be creating a time-bomb for their unborn children” (Johnston, 2007).

Obesity is regularly conflated with ‘overweight’ in the statistics deployed to point to the incidence and prevalence of the problem (Evans, Rich, & Allwood, 2005) and crude and widely contested measures of both (e.g., BMI) are employed to describe the percentages of populations digressing from ‘ideal’ bodily norms (Campos, 2004; Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006). Children (and increasingly babies) are cast as both the ‘hope’ for and the ‘risk’ to the future with even pregnant mum’s being instructed to take action (e.g., prenatal exercise and dietary monitoring) to prevent chubby, dimply babies being born. Finally, obesity is either represented as a risk factor for a variety of non-communicable diseases (e.g., Type 2 diabetes, cardiovascular disease, arthritis) or increasingly, as a ‘disease’ entity in its own right (Campos et al., 2006; Jutel, 2000). In 2012, this kind of ‘picture’ about obesity is remarkably unchanged from that prevailing in the early 2000s.

Several incisive critiques have been mounted against the evidence upon which the aforementioned claims are based (e.g., Aphramor, 2005; Campos, 2004; Evans et al., 2005, 2006; Gard, 2010; Gard & Wright, 2005). Gard (2010) for example, has disputed the existence of an obesity epidemic, drawing on volumes of so-called ‘scientific’ evidence, to suggest that, if there ever was an obesity crisis, it was put out to pasture at precisely the time proponents suggest it arose. Campos (2004; Campos et al., 2006) has similarly drawn on the empirical evidence accumulated by biomedical scholars to point to serious flaws in obesity arguments. He suggests that contrary to popular and professional opinion fat is not a predictor of mortality but rather a protective factor. Aphramor (2005), Evans et al. (2005), and Ross (2005) agree. Simply put, what this cadre of scholars suggests is that firstly, the scale and proportion of the obesity crisis has been wildly exaggerated, and secondly that the ‘solutions’ advanced from the scientific community for curing an obesity problem (should it exist) rest on shaky foundations. In particular, these scholars contest the notion that balancing energy in with energy out to regulate fat works and point to the ways factors other than individual choice (e.g., ethnicity, class, genetics) impact the capacity of any person to lose the weight ‘experts’ suggest they should.

Despite the aforementioned critiques of obesity knowledge and the implications that flow from it, a plethora of interventions and resources designed to ameliorate obesity have been promulgated. Schools, as holding pens for large numbers of children, are unsurprising sites for the spread of these resources. Premised on an assumption that ‘early intervention’ is best, primary and intermediate schools are particularly favoured venues for the introduction of health initiatives. In the following section we examine some of the key health and physical activity policy statements related to obesity concerns that have surfaced in the past decade.

The policy context

A raft of policy initiatives from New Zealand’s Ministry of Health, Hillary Commission and Ministry of Youth Development was introduced in the period 1997–2002 (e.g., Hillary Commission, 2001; Ministry of Health, 1997, 1998a, 1999, 2000, 2001, 2002a, 2002b; SPARC, 2002). Chief among these was the release in 2000 of the New Zealand Health Strategy, which identified 13 priority population health objectives. The release in February 2002 of the draft Healthy Eating, Healthy Action: Oranga Pumau—Oranga Kai (HEHA) strategy signalled a strong Ministry of Health commitment to addressing three of those objectives—that is improving nutrition, increasing physical activity and reducing obesity. Generated largely as a result of research indicating that obesity rates were rising in New Zealand (Ministry of Health, 1998a, 1998b, 1999; Russell et al., 1999; Swinburn et al., 1997) and derived from an assumption that physical activity and nutrition are the key mitigating factors in both alleviating current obesity problems and preventing the emergence of more (Ministry of Health, 2001), the HEHA strategy “called for a more integrated approach to physical activity, nutrition and healthy weight. It also called on the health sector to reorient its funding and delivery of services to strengthen and create intersectoral links and partnerships”.

This emphasis on intersectoral links and partnerships paved the way for outside agencies (e.g., the National Heart Foundation, Public Health Units, Māori providers, Pacific providers, regional sports trusts, the Cancer Society, Agencies for Nutrition Action & Watties) to justifiably expand their work into and around schools. While

healthy eating and healthy action were clearly identified as things that required collaborative efforts, schools were understandably viewed as key sites where initiatives flowing from this strategy (e.g., fruit in schools) could be implemented. Food and nutrition guidelines for healthy children (Ministry of Health, 1997) and healthy adolescents (Ministry of Health, 1998b) had already been prepared, yet with the advent of HEHA, a strategic framework (Ministry of Health, 2003a) and a comprehensive implementation plan (Ministry of Health, 2004) for achieving nutrition, physical activity and obesity objectives were generated. Ministry of Health brochures for parents and teachers like *Eating for Healthy Children Aged 2 to 12* (Ministry of Health, 2002a) were produced and by 2002, internet sites, sponsored by both government and non-government organisations (e.g. Agencies for Nutrition Action, Ministry of Education, Heart Foundation) focused on food, nutrition and physical activity had proliferated. In 2007 HEHA remained a pivotal arm of the government's Mission-On project to stem the tide of childhood obesity in New Zealand. A total of 87 initiatives focused on healthy eating and healthy action were rolled out over the next few years, including a \$3 million annual fund over four years to "help schools and early childhood communities become eating environments that deliver consistent, positive messages about healthy eating" (<http://www.moh.govt.nz/healthyeating/healthyaction>, accessed 8 July 2007).

Coupled with the HEHA initiatives (see <http://www.moh.govt.nz/healthyeating/healthyaction>), the Hillary Commission (and latterly Sport and Recreation New Zealand and now Sport New Zealand) and district health boards were also pivotally involved in generating campaigns to increase physical activity in the early 2000s. The Ministerial Taskforce on Sport, Fitness and Leisure published its findings in January 2001. Three of these are particularly relevant for any consideration of physical education and health in school environments. Firstly, the taskforce said it was "appalled at the state of physical education, physical activity, movement and recreation and sport education in New Zealand" (Ministerial Taskforce on Sport, Fitness and Leisure, 2001, p. 54). The taskforce claimed that evidence had been provided to them "showing classes going for weeks without organised physical activity or physical education" (p. 54) and that, in their view, the education sector's approach to physical activity, recreation and sport was grossly inadequate. Secondly, it claimed that participation levels are too low and that many New Zealanders are unable to fully participate in recreation and/or sport, and finally it called on government to provide sufficient direction and resources to address the problems identified by the taskforce. Schools providing more effective prescribed time for physical education, recreation and sport was one of its key recommendations. As the taskforce put it, "lifelong involvement in physical activity is best learned in an education environment" and "this will require restructuring of the school timetable and major resourcing" (Ministerial Taskforce of Sport, Fitness and Leisure, 2001, p. 53). Minister of Education at the time Trevor Mallard later put this view into action by proposing new national education guidelines and national administration guidelines specifying that priority must be given to physical activity in primary schools (Mallard, 2004).

For the first time, the role of schooling in fostering opportunities for physical activity and physical education was explicitly recognised as the taskforce sought "an education system that places value and emphasis on positive health, physical activity and physical education" (Ministerial Taskforce on Sport, Fitness and Leisure, 2001, p. 55). Although reducing obesity was not enunciated as one of the taskforce's aims,

subsequently many of the initiatives and strategies from its report *were* harnessed to an obesity reduction agenda.

Acting on the taskforce's recommendation, the government dissolved the former Hillary Commission, replacing it with a new Crown entity, responsible for the leadership and support of recreation and sport—Sport and Recreation New Zealand (SPARC). Not surprisingly, the volume and scale of social marketing and school-based resources generated from this new, rather more well-resourced government organisation increased considerably (e.g., sports co-ordinators in schools). While space prohibits a detailed analysis of all of the physical activity-related activities conducted under the SPARC umbrella, it *is* important to signal that 'push play' (the former Hillary Commission's initiative to get the nation more active) was one of its signature endeavours. The campaign was launched in 2000 and spawned a plethora of linked initiatives, including 'the activator', 'push play nation' and 'push play parents'. The message was simple—get active for at least 30 minutes (and latterly 60 minutes per day) in any way you can. As Burrows (2010b) found in her work with children in New Zealand schools, the push-play message appears to have particular purchase with children, many of whom are able to recite the push-play mantra, recognise its marketing symbols and rehearse its invocations to move in their schoolyard play. Further, in terms of its pedagogical implications, the 'push play' assignation of particular practices to families, to individual children and adults, and indeed, the nation, is interesting, effectively hailing **all** New Zealanders to take action now for the sake of their future health.

To accompany the New Zealand Health Strategy, a DHB Toolkit: Physical Activity was developed by the Public Health Directorate of the Ministry of Health to focus specifically on physical activity as a simple and cost effective intervention (Ministry of Health, 2001). Children and adolescents were identified as one of the priority groups to be targeted in new physical activity initiatives and as part of a strategy designed to reduce inequalities in health, attention to Māori, Pacific people and other ethnic groups was signalled as important. Physical activity was represented in the toolkit as not only a vehicle for reducing obesity, but also as something that could potentially serve to reduce the incidence of cardiovascular disease, the incidence and impact of diabetes, prevent cancer, and reduce smoking, suicide, alcohol use and mental illness. Drawing on findings from the US Surgeon General's report on physical activity and health (US Department of Health and Human Services, 1996), the toolkit specifies 30 minutes of moderate-intensity physical activity on most, if not all, days of the week as the goal to work towards for adults, and for children, an additional three 20-minute sessions of vigorous activity per week were suggested (Pate, Long, & Heath, 1994; Sallis & Patrick, 1994).

In 2001 the Hillary Commission developed the New Zealand Physical Activity Guidelines (Hillary Commission, 2001) for use within and outside of schools, setting targets that by 2010 75% of adult New Zealanders and 80% of children and adolescents should meet the above-specified goals. Among the specific physical activities emphasised in this strategy were everyday functional activities (including gardening, walking to the shop, doing the vacuuming) together with walking and cycling. Hillary Commission programmes like Kiwidex, KiwiSport¹ and Sportfit remained key school-based strategies for increasing physical activity, yet what the intersectoral emphasis did in the early years of the 21st century was raise awareness of the number and range of

'other' government and non-government organisations whose programmes and resources could be fruitfully employed within schools. As was the case with nutrition, a nationwide trend towards collaborative action meant that many more agencies were poised and ready to take a slice of the school-based physical activity 'pie'. The importance of this trend for schooling lies in a recognition that the HPE curriculum is by no means the only source of information children have available to them through which to make meaning about concepts like 'fitness' and/or 'play'. Rather the sheer magnitude and proliferation of resources about physical activity occurring in the early 2000s means children conceivably have absorbed messages about it from organisations as diversely positioned as the Ministry of Transport, the Arthritis Foundation, He Hotu Manawa Maori, ACC and the National Heart Foundation.

Together with the Ministry of Health, Hillary Commission (SPARC) and Ministry of Education input into strategies and policies around nutrition and physical activity for young people, the Youth Development Strategy Aotearoa was launched in February 2002. The strategy consists of a vision, principles, aims and goals, and suggests actions that can be taken to support the positive development of young people. Goal 3 of this strategy specifically focuses on "creating opportunities for young people to actively participate and engage" through equipping them with the skills and knowledge to make choices regarding how they will live their lives

It is important to signal this involvement of the Ministry of Youth Affairs in the ongoing intersectoral collaborations that are so much a feature of our contemporary health and physical activity policy context. Indeed, the Aotearoa/New Zealand Health Promoting Schools framework specifically suggested that schools and other agencies involved in promoting physical activity and nutrition align their strategies with YDSA principles together with National Education Goals (NEGS) and National Administration Guidelines (NAGS).

Amidst a landscape inundated with health and physical activity, the development of Mission-On in 2007/2008 signalled a recognition that perhaps current initiatives were not working and a more concerted intersectoral approach was required to address the nutritional and physical activity habits of young and old alike. In both its far-ranging formally enunciated objectives and in its annexing of these to popular cultures, familial obligations and educational missives, Mission-On sought a veritable territorialisation (Rail, 2009) of 'youth health' as a terrain. That is, in Deleuzian terms, the programme sought to enact a wide range of strategies to reach diverse young people, to capture the market (youth), spread the message (health) and maximise impact (the production of healthy youth).

There is considerable debate about the best way/s to actually make a difference to childhood obesity and the resources and packages gifted to schools often embrace widely divergent strategies. Some, like the Heart Foundation, just provide information about the wonders of the food pyramid and foods with a healthy heart tick, while others seek to engage children through appeal to sporting idols and other constituents of popular culture. As signalled above, the Mission-On creators seemed to be endeavouring to cover all bases, using everything from print and media campaigns, the recruitment of lifestyle ambassadors and the provision of nutrition guidelines in schools, to exercise prescribing doctors, community get it up campaigns through to the development of interactive websites. What most of these strategies implied was a commitment to the notion of a subject who can, with a little 'help' choose to make the

‘right’ choices. This is a familiar trope and one regularly cast by educational researchers as reflective of neoliberal political intent. As MacDonald et al. (2008) attest, “Neoliberalism can be understood as an approach to governing society in such a way as to reconfigure people as productive economic entrepreneurs who are responsible for making sound choices in their education, work, health, and lifestyle” (p. 6).

Indeed, as the prime minister of New Zealand at the time, Helen Clark, put it:

Mission-On will give young Kiwis and their families the tools to improve their nutrition and increase their physical activity ... with the right resources, young people their families, and their communities can act together to make healthier choices. (Clark, 2006)

Mission-On comprised a package of 10 initiatives,ⁱⁱ each foregrounding eating and/or physical activity as the primary practices through which a healthful self could be achieved. The now familiar ‘energy in’ versus ‘energy out’ equation (Wright & Dean, 2007) infused each of the initiatives, with good health invariably being represented as a matter of balancing inputs (food consumed) with outputs (energy expended through deliberate or everyday physical activity). Under Initiative 1 (improving nutrition within the school and early childhood environments), for example, new regulations controlling what foods were permitted in schools, when, and in what quantities were enacted. Pies in canteens, sausage sizzles and chocolate sales as fundraisers were discouraged and foods available on school premises were compartmentalised into three groups—sometimes, everyday or occasional. Under Initiative 3 (lifestyle ambassadors) popular Kiwi icons explained through school visits and media shows (television and radio) the perils of eating unhealthy foods and the health advantages to be had through “pushing play every day” (i.e., exercising regularly). Under Initiative 8 (television and radio), shows designed especially for young people offered instructions on how to prepare healthy meals and engage in regular physical activity, often drawing on the experiences of icons of youth culture to assist in conveying the message. Under Initiative 4, a suite of age-specific websites offered children and young people opportunities to win prizes for achieving particular nutrition and/or physical activity ‘goals’. The sites provided ‘body coaches’ and personal trainers to kick-start presumed uninformed subjects on the road to good health. Under Initiative 2 (student health promotion) large sums of money were allocated to schools prepared to engage students in designing ‘health-enhancing’ environments, with food and physical activity taking centre stage in most of these student-led projects.

In 2009 the incoming National government instigated a review of Mission-On, encompassing a re-assessment of each of the initiatives that fell under its umbrella. The mandatory food and nutrition guidelines were revoked, the Mission-On website disassembled and several of its key initiatives disbanded. Furthermore, the New Zealand Health Strategy removed obesity action as a priority population health objective. Despite the absence of Mission-On, governmental and health promotion messages emphasising a need to change the physical activity and nutrition practices of young people persist. With or without the prior government’s Mission-On campaign, the mission is clearly still one of interest to many. SPARC, for example, has multiple initiatives designed to promote physical activity in schools and communities (e.g., Active Schools Toolkit, Developing Fundamental Movement Skills, Kiwidex Manual, Activating Communities through Active Schools, Kori ki te kura) and is increasingly commissioning research to investigate the facilitators and constraints to participation in

sport and physical activity amongst particular groups of young people (personal communication with Grant McLean, 2011).

In 2007 the Ministry of Education's publication of *Physical Activity Guidelines for Healthy Confident Kids: Guidelines for Sustainable Physical Activity in School Communities* further signalled a clear commitment to the role of schools (teachers, in particular) in boosting children's physical activity levels. Research consulted in preparation for these guidelines predominantly includes large-scale population studies that sought to measure population physical activity levels, or assess the effectiveness of physical activity or health interventions using Likert scales and other quantitative measures (e.g., Bauman, Bellew, & Booth, 1996; Carr, 2001; Keays & Alison, 1995; Ross & Gilbert, 1985). Very few of these kinds of studies are explicitly focused on children and, as yet, there are few standardised tests or measures of physical activity that have been applied cross-culturally to yield an understanding of how New Zealanders stack up alongside other nation states with regard to physical activity levels. Nevertheless an assumption that young New Zealanders are more sedentary than they used to be prevails in public and professional parlance (Ministry of Health, 2001, 2004).

SPARC also devised physical activity guidelines for assorted aged groupings in December 2007, with the specifications for children aged 5–18 reading as follows:

New Zealand children and young people should

- do 60 minutes or more of moderate to vigorous physical activity each day and be active in as many ways as possible, for example through play, cultural activities, dance, sport and recreation, jobs, and moving from place to place.
- be active with friends and whanau, at home, school, and in the community.
- spend less than two hours a day (out of school time) in front of television, computers and game consoles. (<http://www.sparc.org.nz/en-nz/young-people/Guidelines--Resources/>)

Accompanying these guidelines were a range of resources designed to facilitate schools' capacity to promote physical activity and sport (e.g. Active Schools Toolkit). Further, a recognition that schools are pivotal sites for the inculcation of physical activity habits also prompted a range of school-community partnership policies and guidelines including *Activating Communities through Activating Schools* and *Territorial Authority/School Facilities Partnerships: A Guide*.

The Ministry of Health has also commissioned multiple research projects geared towards identifying barriers to healthy eating and physical activity amongst young people and has sponsored a plethora of initiatives aiming to improve the physical activity levels and nutritional habits of young people. For example, the Active Families Pilot project was launched in April 2005, providing resources and support to general practice teams for obese children and their families, A Family Lifestyle Coach (FLC) project designed to work with children (5–12 year olds) and their families to encourage healthy active lifestyles was launched together with an initiative devised to provide easy access to a free culturally appropriate, youth-friendly school-based health service for young people who do not access healthcare elsewhere. Anti-smoking initiatives and plans to tackle unhealthy food environments in schools were included as potential health targets here. It is worth noting that many of these initiatives appear to focus explicitly on Māori and Pacific families who have children identified as overweight and/or obese.

Together with this saturated and complex health policy/resource environment, with the election of a National government in 2009 came an increased emphasis on the role of sport in young people's lives. Funding for sports programmes and equipment in schools was re-jigged under the 'Kiwisport' banner and from government officials emerged messages like "a kid in sport stays out of court" (Key, 2008). These signalled a renewed emphasis on grassroots sport and physical activity, not necessarily attenuated to health outcomes, but rather as a way of moulding productive citizens. The success of these programmes seems to be increasingly measured by the numbers of young people participating in sport, with league tables displaying percentage of student population engagement in sport published in the *Education Gazette* (e.g., 2010). This emphasis on quantity of student engagement rather than the quality of a student's experience of sport is important to note.

In summary, the context within which children play and study is one characterised by intense governmental interest in promoting healthy eating, increasing levels of physical activity and reducing obesity rates among New Zealand's children. Regulations about physical activity and provision of healthy food have now been mandated (e.g. NAG 1 (iii) giving priority to regular quality physical activity that develops movement skills for all students, especially in years 1–6 Ministry of Education, n.d.); and NAG 5 (b) promote healthy food and nutrition for all students, and the level of 'interest' in the health and physical activity behaviours and dispositions of children and young people is exceedingly high.

Health resources in schools

Given this albeit brief review of some of the key messages embedded in government policy, it is no surprise that multiple agencies have developed resources tailored to the primary and intermediate school populations. Among these, LIFE education, in particular, retains a visible presence in those primary schools able and willing to afford it. LIFE education provides a mobile classroom in the form of a big bus with a LIFE education mascot, Harold the Giraffe, on board. As LIFE education Otago co-ordinator Megan Gallagher puts it, LIFE education's mission statement is "to give the young people of New Zealand, through positive health-based education the knowledge and skills to raise their awareness to live a fulfilling and healthy life" (2007). The vehicle through which this knowledge is delivered is Harold, a puppet that "embodies everything that LIFE education is about" (Gallagher, 2007). Harold and a LIFE educator visit over 225,000 primary and intermediate school children throughout New Zealand each year. As its promoters claim, "We go into schools by invitation, not by right. We are linked into the school curriculum" (<http://www.lifeeducation.org.nz/>). Well-articulated links to the New Zealand Curriculum have become a stand-out feature of most health-related packages marketed to schools currently and analysis of LIFE education resources confirms that many of the themes Harold the Giraffe introduces to children match those encouraged in the HPE curriculum. In the most recent re-working of those resources, explicit links to the New Zealand Curriculum (Ministry of Education, 2007) are drawn, in particular to the key competencies and values embraced by that document. It appears that LIFE education remains a major contributor to health education in schooling for the junior years (Burrows, 2010c). In so saying, LIFE education is by no means the only resource primary teachers have at their disposal.

Other resources include, but are not limited to, a raft of food and physical activity initiatives:

- The Heart Foundation cache includes resources like Heart Start; Food for Thought; Physical Activity Programme for a Healthy Future; Healthy Heart Awards; Jump Rope for Heart; advice on how to incorporate health and nutrition into key learning areas; tips on analysing children's food consumption; a tick box shopping guide, and Sore Throats Aren't Cool!—a resource particularly targeting Māori and/or Pacific children;
- The New Zealand Police youth education programmes (e.g., DARE, Kia Kaha, Keeping Ourselves Safe, Road Safety);
- Family Planning (Preparing for Puberty and the Sexuality Road);
- Waikato District Health Board (Project Energize)—e.g., flyers such as 'Veg It Up!'; 'Kids Love to Play!'; Summer Family Fun (dodgeball); Winter Warm-up; Healthy Lunch);
- the Millenium Institute and Nestle ('Be Healthy Be Active' programme);
- Scholastic Book Club resources (e.g., a racing game; the pirate ship game) focused on food and physical activity;
- The New Zealand Food Safety Authority's 'My Cool Lunch Box' tips, Kleenex and the Ministry of Health's 'Sneeze Safe Lesson Plan';
- The NZ Food Safety and Initial Healthcare publication *Wash and Dry Your Hands*.

So what for schools?

Our intent in this paper has not been to deride all outside attempts to influence health outcomes for young people, nor to suggest that all of the missives rest on unpalatable premises. Rather, we have canvassed health initiatives and policies in New Zealand's recent past because attending to the form and content of health messages circulating is a matter of ongoing relevance to researchers, teachers and students in the primary school locale. This is especially so, when recent research points to the ways both teachers and students are acutely aware of health messages circulating in popular and professional culture (Burrows & McCormack, 2012; Cosgriff, Burrows, & Petrie, 2013; Rich, Evans, & De Pian, 2011). While awareness of broader messages does not necessarily mean these are uniformly taken up as pedagogical priorities, they nevertheless serve as cultural resources available to young people and teachers to draw on in their day-to-day activities. They also afford mandates for the retention or rejection of specific pedagogical practices in schools, influencing institutional ethos and impacting on what it is possible for students to experience and understand about their own and others' health and physicality.

In terms of content, the sheer volume of messages relating to health in general, and children's health in particular, is of note. So too, is the commensurability of the message across commentary from agencies ranging from government health departments to sport agencies and those concerned with marketing educational and/or health products, and the re-presentation of health concerns as straightforward and uncomplicated matters (e.g., a matter of eating better and exercising more). In terms of form, exploring the ways health messages are (re)presented in policies, media articles

and resources is important. For example, at times health messages convey a single finding, with an attention-grabbing heading, yet fail to discuss the 'finding' in any depth. Further, the style of health-related knowledge in particular is often highly prescriptive rather than commentary-based, and unsurprisingly opinion pieces carry some pretty hefty moral charges for people that fail to take up those prescriptions.

There are three cautionary issues/questions we wish to end with. First, for some young children, an excessive focus on healthy eating and exercise can evoke feelings of guilt, worry and anxiety, exacerbating concerns about body weight and size (Burrows, 2012; Rail, 2009; Rich et al., 2011). Subjecting some of the health messages and policies that are reaching into schools to critical scrutiny, asking questions about how and why they are taken up and/or negotiated in school settings and with what implications for what takes place in the name of health and physical education would be a useful exercise for not just teachers and administrators in primary schools, but also for young students themselves. Inquiry and curiosity are values underpinning the New Zealand Curriculum. Both could be fruitfully fostered through examining the connection between the broader health context and school-based learning in health and physical education.

Secondly, as Crawford (1980) and numerous others since have suggested (e.g., Colquhoun, 1990), there is scant evidence to support the notion that information necessarily changes individual disposition nor behaviour, even if the kinds of claims about food and exercise that undergird most policy and resource initiatives could be verified as 'truths'. Further, despite the extent of public and professional concern about children's dietary and exercise regimes signalled in this paper, there is precious little research that would substantiate the claim that children are more sedentary or fatter than they have ever been. Indeed, as Gard and Wright (2005) suggest, most of the evidence to date points to children living longer and healthier lives now than at any other point in history. Given an extraordinarily cramped curriculum, pressures to adhere to national literacy and numeracy standards, and the contradictory yet mandated injunction to provide a curriculum attuned to developing life-long, connected, critically minded learners, one wonders whether schools in general, and teachers in particular, are necessarily ideally positioned to address national health agendas in the ways they have been encouraged to do.

Finally, even if there is some substance to the claim that teachers should be a front-line defence against childhood illness, how and why should primary school teachers incorporate the plethora of resources provided by multiple outside agencies? Variable in quality and barely recognisable as 'educational' in terms of their contribution to student learning, should teachers take on these resources, re-fashion them to fit with their own curriculum imperatives or simply 'bin' them? The answers to these questions will inevitably vary across and within particular schools yet the sheer range and volume of policies and resources circulating will ensure that the need to continually reflect on what is permitted to fly in the school gates, how and with what effect for student learning is a shared one for New Zealand primary schools.

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ⁱ This version of KiwiSport should not be confused with the 2009 initiative of the same name.

ⁱⁱ The 10 initiatives specified under the Mission-On umbrella are:

Initiative 1—Improving nutrition within the school and early childhood environments.

- Initiative 2—Student health promotion.
- Initiative 3—‘Lifestyle’ ambassadors.
- Initiative 4—Youth-branded websites.
- Initiative 5—Government ‘walking the talk’.
- Initiative 6—Television and computer-free time.
- Initiative 7—Controlling advertising.
- Initiative 8—Using television and radio to encourage change.
- Initiative 9—Health impact assessments.
- Initiative 10—Expanding the green prescription.