Mind the Body

A Genealogy of Danish Preventive Health and Health Promotion in the Interwar Period and Turn of the Millennium

PhD dissertation by
Naja Vucina Pedersen

Department of Society and Globalisation
Roskilde University
March 2014

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Cover illustration: Wyndham Lewis, "Two Mechanics", ca. 1912.

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PREFACE AND ACKNOWLEDGEMENTS

This dissertation is the outcome of a number of digressions, inconsistencies and coincidences arising out of my attempt to pursue particular interests while adapting to a more or less defined project. The project was made possible through a grant from the Danish Sports Organisation (DGI). In the initial framing of the research field an emphasis was placed on the DGI's role as a volunteer organisation and its involvement in preventive health and health promotion through private-public partnerships. As I became affiliated with the project, it subsequently underwent a number of transformations. The French post-structuralist Michel Foucault's work played a central role in adjusting the research field, as I wanted to unfold his theoretical and methodological trajectories. The adaptation of a Foucauldian genealogy meant that the framing of the research field went from having the DGI and its organisational development as the point of departure to instead adding weight to health government as a particular way of nurturing healthy objects and subjects; however still integrating the DGI within the field of research. As a consequence, the project transformed from a concern with offering some solutions to the increasing challenges within health administration and the volunteer organisations' role in this respect, to instead aiming at analysing the emergence of particular problematisations and technologies embodied in specific ways of governing human beings and administration along the lines of health.

Well aware that I undeniably will disappoint some readers, my gambit, then, is less a matter of solving current problems of health or coming up with suggestions for political strategies. Rather, I am concerned with questioning how health government engenders specific modes of engagement in the quest for health while at the same time excluding other. Having the prerequisite for exploration in place, the next task was to demarcate a field of research; one that was central within public health government and at the same time linked to some of the DGI's campaigns. The choice fell on the fight against obesity targeting children and young people. The general emphasis on the serious nature of the rise

of obesity among not only the Danish population but worldwide was also reflected in some of the DGI activities targeting obese children and their families. Moreover, the fight against obesity seemed a relevant case for exploring more thoroughly how people are governed and govern themselves along the lines of prescribed norms of health. However, in the course of investigating the DGI's involvement in public health campaigns, it turned out that I could extract value from particular projects' ways of governing not only obese children, but also administration. The projects targeting obese children were primarily initiated through partnerships between the DGI, local and public authorities, and other private actors. It seemed that this particular administrative structure in itself was an interesting avenue to explore ways of governing not only individuals but also administration. Subsequently, a central concern became how particular problematisations of obesity informed specific modes of governing both obese children and government.

By adding a historical dimension I saw an opportunity to place under scrutiny not so much the historical background of obesity or fighting it, but rather the mere fact that a particular physical characteristic and condition (i.e. obesity) in the process of becoming a public health concern seems more or less explicitly linked to a particular inner condition; a way of thinking and feeling about oneself (i.e. an obese person suffers from low self-esteem). This concern with how a link was established between an inner and outer condition allowed for a broadening of the historical dimension to take into account areas of preventive health or health promotion where a relationship was established along the lines of physical appearance and an inner condition. Whilst this adapted focus broadened up the field of research – and allowed for new empirical avenues to be scrutinised – it also caused a somewhat blurry focus. The historical dimension can be criticised for extending an already broad research field with too many themes in the foreground. Regardless, the result indeed is a rather odd coupling of an analysis focusing on a campaign against obesity in the decades before and after the turn of the millennium, with the DGI as the point of departure, and an analysis of the first half of the twentieth century's

eugenics and promotion of a physical culture. I sincerely hope that this odd coupling will turn out less odd as the reading proceeds. Nonetheless, this does not counterweigh the fact that what the report has gained in adding a historical dimension to an already opaque analytical point of departure might have been lost in terms of keeping a comprehensible and straightforward focus, which can only be ascribed to the limits of my intellectual capacities – not to the coupling itself.

With this short preface in mind, I would like to express my sincere gratitude to the people whose academic support has been inestimable during the many stages of creating this dissertation.

Special thanks must go to my supervisor Peter Triantafillou at the Institute of Society and Globalisation, Roskilde University, whose persistence and encouragement cannot be overemphasised. The many years of stimulating feedback, along with his acuteness in sharpening the arguments, particularly with regard to adapting and unfolding a Foucauldian analytics, have been indispensable and will be greatly missed.

I owe my external supervisor Signild Vallgårda at the Department of Public Health at Copenhagen University a debt of gratitude for her critical and incisive observation. The interwar chapter has benefited tremendously from Vallgårda's extensive knowledge of the field, not to mention her insistence in taking seriously the task of engaging in a historical undertaking.

The writing of the dissertation would not have been possible without a generous grant from the DGI. Warm thanks must go to consultant at DGI Bo Fisker for providing valuable assistance throughout the process of collecting data, helping me to gain access to crucial information and enabling me to establish contact with key people. These include a number of persons affiliated with the DGI Funen campaign *Seize the Chance* and the *Overweight Association* at DGI Greater Copenhagen respectively, who have been extremely helpful, giving me important

material and allowing me to participate in meetings, evaluations and work in the field.

A special mention must be made of professor Nikolas Rose for providing important critique of my project and for making my stay at the centre of BIOS in London School of Economics and later King's College extremely fruitful and fulfilling.

Not least, I am indebted to the researchers at the Centre for Democratic Network Governance at the Institute of Society and Globalisation, Roskilde University, for providing a lively and broad-minded academic environment. Research seminars, work-in-process meetings and exchanges with PhD colleagues as well as the manifold experiences with teaching and supervising, have significantly nurtured my academic training, and this project could not have been completed without it.

Naja Vucina Pedersen

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ABBREVIATIONS

AI: Appreciative Inquiry.

BMI: Body Mass Index.

DFIF: Danish Association for Company Sports ("Dansk Firmaidrætsforbund").

DGI: Danish Gymnastics and Sports Association.

DIKE: Danish Institute for Clinical Epidemiology.

DSAF: Danish Association for Adiposity Research ("Dansk selskab for adipositaforskning").

GP: General Practitioner.

KRAM: A contraction of the first letters in Danish of *Diet* ("Kost"), *Smoking* ("Rygning"), *Alcohol* ("Alkohol") and *Exercise* ("Motion") and regards the overall focus areas of the health campaigns promoted by public authorities.

NC: Network Collaboration.

RSD: Region of Southern Denmark.

SPFF: Sports Political Forum Funen

WHO: World Health Organisation

1. INTRODUCTION

Is inferiority a human condition or a feeling?

The question was raised in 1930 in a correspondence in the Danish weekly medical journal *Ugeskrift for læger*, initiated by Doctor Paul Rubow. He expressed his disbelief in the transpiring use of the term 'inferiority' ("mindreværd"),[1] designating a feeling, the feeling of inferiority (Rubow, 1930: 110). Physician and medical psychologist Oluf Brüel also warned against employing the term to denote a subjective state of mind, like in 'inferiority complex' (Brüel, 1930d: 996; Rehfeld, 1939: 324-25). He emphasised that a medical expression had to be based on a purely objective judgement, dissociated from an individual's own sense of inadequacy. Therefore, inferiority had to be applied to someone who, in the view of normal members of society, was of lower worth or socially inadequate (Brüel; 1930b: 1075; 1930c: 1165; 1930d). However, Brüel maintained that Dr. J. Fog's use of 'low value' ("værdiringhed") was too bleak and Dr. Jacobsen's suggestion of 'substandard' ("underlødig") too peasantish ("landsmålsagtigt") (Ibid, 1930a: 1055). Dr. Lis Jacobsen blamed psychoanalysis for the inappropriate use of inferiority as an emotional condition (Jacobsen, 1930: 1183) and advocated the term to express a medical diagnosis of the absence of a particular quality (Ibid: 1184). Doctor Fog responded that the problem came down to finding an name suitable for an individual whose abilities did not reach the average, hence, a second-rate individual (Fog, 1930: 1033).

The participants involved in the debate summarised above on the proper use of inferiority are all in favour of the at the time prevailing use, as indicating a human condition, and simultaneously discrediting a more modern use, one that refers to feelings and opinions. By ascertaining the

[1] Please note that the material is mainly extracted from Danish texts and the quotes are my own translation into English. Material from the archives has been a challenge to translate, as it often entails archaic expressions, and thus had to be translated into similarly archaic English. When in doubt of the correct translation, I have written the original Danish word in parenthesis.

difference between appointing particular individuals as *being* inferior and individuals *feeling* inferior, the debate anticipates the introduction of subjectivity – feelings and self-reflection – as a medical concern; a concern which I will demonstrate in the following pages, is a crucial means in today's fight against obesity.

Preventing the occurrence and spread of obesity has increasingly become an integral part of public health efforts in Denmark. We have seen a rise in a new awareness and in new ways of addressing the relationship between the psyche and cognitive skills on the one hand, and the body and physical constitution on the other. Likewise, obesity is addressed by various health promotion campaigns as a health problem that can cause medical conditions such as diabetes type 2, cardiovascular diseases, stroke etc. Simultaneously, it is viewed as a physical state that is associated with, or even directly related to, a particular psychological profile. The attention in contemporary health practice given to the relationship of mind and body may be regarded as a particular way of carving out a space for governing individuals and groups through their ability to master their own health. While this type of health practice directs a particular approach to the human being, it simultaneously coincides with particular ways of administering public health. Following the implementation of the Structural Reform in 2007, and the ensuing strategic changes in the management of public health, municipalities are now required to implement citizen-oriented health promotion. The intention behind the structural changes to the public administrative landscape was to emphasise the relevance of external actors. A number of measures have been taken to encourage the direct involvement of private actors in the implementation of policies. Within the last decade Danish health management has witnessed an expansion of network collaboration (NC) and private-public partnerships,[2] along with new ways of conceptualising these new forms of bureaucratisation processes;

[2] The results of a questionnaire that I sent to all 98 Danish municipalities show that 74% of the participated municipalities have engaged in one or more partnerships, of which 55% have been with sports associations, whereof 60% have been directed at obese adults and 45% at obese children (cf. *Enclosure*).

i.e. network governance theories or governance network theories (Sørensen & Torfing, 2008).

Preventive health and health promotion targeting obesity reflect an area of public health where the individual is targeted as the ongoing object of transformation, and the rise of NC seems to play a key role. While it provides an answer to the structural challenges of preventive health and health promotion – non-hierarchical, local, democratic health services – at the same time it provides an answer as to how to govern human beings in order for them to make healthy choices. NC offers an administrative basis for constant transformation and reflection. It also engages a number of actors surrounding the one targeted, from family members, school and pedagogical institutions to GPs, health visitors, health centers, and sports associations. In other words, CN make possible a kind of health promotion that renders the human surroundings conducive to health. Not only are partnerships set on health and individual transformation with the overall purpose of making a healthy choice an easy choice. Seemingly the facilitators themselves have become the target of these facilitating technologies. Public health, then, is a kind of governing through which not only human transformation is addressed, but also administrative conduct. If NC reflects a neoliberal mode of governing, it might be due to exactly this pairing of freedom and the effort towards a kind of incorporating totality. It promotes health through human transformation and non-hierarchical administration, set on governing through the freedom to live and administer a healthy lifestyle through a transformation of the body and the mind, while at the same time securing an enabling environment as a constant reminder of the prescribed norms of health.

1.1. FIELD OF INQUIRY

This dissertation opens with reflections on how the notions of choice, self-steering capacities, self-esteem and empowerment are called upon when engaging in preventive health and health promotion. Serving as means and ends, such notions are reified and taken for granted, and thus rarely become the objects of inquiry. These reflections form the basis for a two-pronged investigation of preventive health and health promotion practices in Denmark. On the one hand the focus is on the 1920s and 1930s, or what I shall call the interwar period, and the ways of thinking and acting upon health as a matter of securing the quality of the human race and proper hygiene at the time. On the other hand the investigation takes us to the era from 1980 to 2010, or what I shall call the millennial period, and focuses on the fight against obesity among children through NC.

While the object of analysis varies in the two periods under investigation, the emphasis on the governmental aspect of the two areas of – and eras in – public health enables a fruitful comparison. The two settings share a number of similarities in terms of the technologies and analytical classifications employed in the promotion of health and human improvement. Further, the general transformation of public health in the interwar period and the creation of what today is considered the modern Danish welfare state – marked with the social reform of 1933 – allowed for new ways of addressing and problematising preventive health and health promotion; ways that show interesting parallels with today's preventive health program.

Drawing from Michel Foucault's conceptual guidelines and genealogical method, I examine preventive health practices as ways of governing and administering both human and administrative beings. A leitmotif of the thesis is the relationship between two aspects of government: on the one hand problematisations and technologies put forth to transform individual conduct; on the other, problematisations and technologies launched to attend to the population and social space. The relationship between these two modes of government will be displayed conceptually,

methodologically and empirically with a view to analyse the intimate relationships between power, ethics, and subjectivity.

In comparing health management in interwar Denmark with contemporary preventive public health measures, I illustrate how the population, the individual and the environment have been informed by these interventional efforts. I illustrate ways of governing individuals by virtue of their being part of a human totality as well as through their corporal and internal realities, placed as they are within particular human exteriorities. In investigating how human beings are informed by preventive health and health promotion, I suggest that a relationship is established between the mind and the body. Tracing back historically this relationship between human corporeality and human interiority, I illustrate a mode of governing human beings through and by virtue of an external as well as a corporal and internal reality. Moreover, in locating bureaucracy within the sphere of government, I elaborate on its recent efforts to inform the population and impact the immediate environment. This is paralleled with an interrogation of how the notion of exteriority was integrated within public health campaigns during the 1920s and 30s.

1.1.1. RESEARCH QUESTION

The following research question guides the two analyses:

How were human exteriority, corporeality and interiority governed through preventive health and health promotion in the period from 1920 to 1940 and from 1980 to 2012?

With the research question, preventive health and health promotion are placed within a government framework inspired by Michel Foucault's power analytics. A twofold health notion and practice is addressed: on the one hand *prevention* as a means to secure health and on the other *promotion* as a means to create healthy people. However, today the concepts are often merged or interlinked (Vallgårda, 2009).

Torben K. Jensen and Tommy J. Johnsen (2000) elaborate on the distinction between preventive health and health promotion as follows: preventive health is about keeping people healthy by avoiding disease. It is rooted in biomedical and social-medical explanations, and draws from experts and a top-down perspective based on risk calculation. Health promotion, on the other hand, according to Jensen and Johnsen, operates from the bottom up. It is directed at increasing particular emotions, such as feelings of cohesion, motivation, happiness and a sense of abundance and meaningfulness in everyday life. In other words, the focus is on enhancing people's wellbeing rather than avoiding what makes them unwell (Jensen & Johnsen, 2000: 6). Finn Kamper-Jørgensen and Gert Almind (2005) make a similar distinction between preventive health – which they divide into primary, secondary and tertiary prophylaxis (Kamper-Jørgensen & Almind, 2005: 18) – and health promotion. In health promotion, they argue, the attention is less on disease and more on health, less on risk and more on resources and possibilities of action (Ibid. 20-21). In directing health efforts at mobilising abundance and increasing people's skills in coping with everyday life's stresses, health promotion is based on a dynamic mindset, one that stresses individual experience and feelings of cohesion and meaningfulness (Ibid. 21). Hence, health promotion is a question of enhancing the quality of life. From this perspective, health is about the resources in one's surroundings and inside oneself that enhance the quality of life (Ibid. 52). In a nutshell, the intervention is about augmenting wellbeing (Ibid. 68). The National Board of Health defines preventive health the following way: health related activities that aim at hampering illness, psychosocial problems or accidents and thereby promote individual and public health (Sundhedsstyrelsen, 2005: 14). Health promotion on the other hand is about creating health promoting policies and nurturing environments with the intent to achieve health (Ibid. 5).

I suggest envisaging preventive health and health promotion as two distinct governmental technologies linked to the overall public health concern of how to govern human beings and their surroundings in order to secure health. Accordingly, in the interwar analysis the distinction is

explored as connected to the eugenic concern with the quality of the population, while in the present-day analysis the distinction is explored as connected to a concern with human conduct. This involves both interrogating the rationalities, i.e. types of *problematisation*, identifying some aspects of human life to be prevented and others promoted, on the one hand, and on the other, exploring techniques and practices, i.e. *technologies*, through which something/someone is either prevented or promoted in order to secure health. The question is how these areas of health concern are *governmentalised*, i.e. incorporated within governmental programmes and campaigns. Equally, preventive health and health promotion regard an area within public health that is not about curing illness but about taking steps so that illness does not appear or taking steps to decrease the occurrence of illness as well as taking steps to put forth particular ways of being and acting healthy.

1.1.2. SUB-QUESTIONS GUIDING THE INTERWAR ANALYSIS

1. **How were human exteriority, corporeality and interiority rendered a problem through preventive health and health promotion efforts in the period from 1920 to 1940?**

2. **How were human exteriority, corporeality and interiority informed by technologies of preventive health and health promotion in the period from 1920 to 1940?**

1.1.3. SUB-QUESTIONS GUIDING THE MILLENNIAL ANALYSIS

3. **How were human exteriority, corporeality and interiority rendered a problem through preventive health and health promotion in the period from 1980 to 2012?**

4. **How were human exteriority, corporeality and interiority informed by technologies of preventive health and health promotion in the period from 1980 to 2012?**

The two sub-questions guiding each analysis reflect the aim to provide an analysis of government by unfolding the *problematisations* connected with identifying those targeted and the *technologies* put forth for ameliorating the ills of those targeted. In other words, the investigation seeks to unpack how the targeted groups and individuals are problematised vis-à-vis particular notions of health, preventive health and health promotion as well as the solutions put forth for adjusting to the prescribed norms of health.

The following literary review serves as a point of departure for elaborating on the sub-questions and thus establishing the particular gaze this interrogation places upon this relatively narrow field of public health.

1.2. LITERARY REVIEW

The historical period selected for the investigation of preventive health and health promotion – the interwar period – is already well explored, both generally and in a Danish context. This also applies to the social reform of 1933 marks the founding of what today is referred to as the modern Danish welfare state. Simultaneously, it is a period known for the promotion of eugenics,[3] providing – with hindsight – rather controversial means. Likewise, several scholars have explored gymnastics and physical exercise in the period, along with hygienic movements. The following outline of other's research, therefore, serves as a delimitation of the field of exploration in this dissertation.

[3] Eugenics, translated literally from Greek as "well born" or "good breeding", is the study of hereditary improvement of the human race by controlled selective breeding developed by Francis Galton during the middle of the twentieth century based on his studies of heredity. In the interwar analysis I elaborate further on the topic.

The analysis centres on three areas of research: the first is the formation of a social space through preventive health and health promotion efforts facilitating the social reform of 1933.[4] The second focus is on the ways in which preventive health hinged on a vocabulary and practice of eugenics. Thirdly, I examine the role sports and gymnastics played along with a promotion of a body culture centred on physical and mental strength. The three areas of concern were all characteristic of exactly this period, and are the object of inquiry in a number of historical studies, which have both guided the analytical findings of this thesis and formed points of departure for it.

Providing an overview of Danish health policy from 1708 to 2002, Viggo Jonasen (2003), argues that the work of the Swedish couple Alva and Gunnar Myrdal are central to the theoretical background of the welfare reform in the 1930s. The Swedish welfare theorists were preoccupied with the problem of a decrease in the birth rate among the middle class; a class that was considered a stabilising factor in society. This notion, according to Jonasen, carved out the foundation for eugenics and its project of preventing deterioration in quality of the population. Although eugenics fell out of favour after the Nazi regime's use of its central ideas, Jonasen argues that the ideas nevertheless had a huge impact on Danish social legislation at the time (Jonasen, 2003: 97) and caused heated debate on issues like sexuality, contraception and abortion (Ibid. 114). This is also the case with the social reform in 1933 (Ibid. 110). Jonasen's argument regarding the relationship between eugenics and the Danish welfare state corresponds with the findings in the first part of the interwar analysis, where I investigate problematisations that lend themselves to a pairing of rationalities concerned with the quality of the race and those concerned with welfare state economics on the one hand, and a pairing of eugenic means and the initiation of social services on the other.

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[4] It is worth noting that the 1933 social reform, as the name indicates, is a *social* reform that implied a number of initiatives regarding social benefits, pensions and the like. Already in 1890, with Estrup's social reform, public health care was expanded (Bonnevie, 1958: 4). Nonetheless, as I elaborate on the interwar analysis, the 1933 reform also involved rearranging and expanding areas concerned with public health.

Lene Koch (1996, 2000) adds further validity to this point. Koch illustrates how means were put forth to prevent the procreation – and thus eventual existence – of physically and mentally deficient individuals, first and foremost sterilisation but also abortion and control of marriage contracts. Additionally, Koch identifies a law passed in 1935 as a decisive factor in carrying out sterilisation for eugenic considerations (Koch, 2000: 207). In her book on forced sterilisation practices in Denmark, she sheds light on how particularly the feebleminded – as a consequence of the eugenic procedures – were segregated from the rest of the population and divided according to their level of intelligence (Ibid. 89).

The argument substantiated in the interwar analysis, that a direct correlation exists between social politics and eugenics during the 1920s and 1930s, is thus not an original point. However, the analytical endeavour that formed the basis for this finding differs from both Jonasen's and Koch's research. I illustrate how both epistemologically and technically, welfare services and eugenic practices were aligned. In doing so, the accent is rather on how this relationship informed particular ways of addressing and approaching the population at large, the individual in body and mind, and the environment in which they were placed. Unlike Jonasen and Koch, in staking out these claims, the analysis does not provide a detailed account of the pairing up of welfare and eugenics. Instead, it illuminates how this relationship nurtured and ministered human exteriority, corporeality and interiority.

Historical accounts that focused on eugenics or aspects of eugenics have been useful for placing my findings within a broader context. For this, Lene Koch's overview of eugenics and sterilisation practices within both Danish and international contexts has indeed sharpened the analytical points in this investigation, in particular her account of negative eugenics, which targeted the feebleminded (Ibid. 264). Koch illustrates the dual nature of eugenics, in other words, its believed ability to either improve or impair racial qualities of future generations (Ibid. 1996: 16). Negative eugenics typically concerns the fertility of unwanted individuals. Positive eugenics, in Galton's definition, and in the way

Koch refers to it, is the more controversial part of hereditary science, namely the part concerned with actively trying to improve the population's quality by advancing the fertility of desired individuals (Ibid. 27): a strategy that did not find much support in Denmark, where the focus was on negative eugenics. The interwar analysis, on the other hand, envisages positive eugenics as de facto practices, and, in doing so I suggest that some areas of health efforts in fact fed into also positive eugenics. Regardless, Koch's thorough account of eugenics and sterilisation practices has been useful for filling out gaps of information and some of her findings are therefore also integrated in the analysis.

Birgit Kirkebæk's examination of eugenics in an international and Danish context takes its point of departure in one group that was particularly targeted through eugenics, namely physically and mentally deficient individuals (Kirkebæk, 1993). Kirkebæk examines the eugenic movement as a health reform movement (Ibid. 1) set on combating degeneration, in particular masturbation as it is considered a symptom of a weak will. Consequently, prevention efforts were aimed at fighting masturbation among both tainted individuals and other groups (Ibid. 85-86). The first part of the interwar analysis takes into account Kirkebæk's particular focus on deficient individuals. However, the gambit is not to pay particular attention to some groups over others, apart from children and young people. Although accounts are made that focus on efforts targeting deficient individuals, mostly a more generalised account is given of the fact that a number of groups and individuals were regarded as unsuitable to breed. The term 'tainted' is used to refer to the variety of individuals in this group.

Sniff Andersen Nexø has focused her investigation of eugenics on one central eugenic means, namely abortion practices in the period from the 1930s to the 1970s (Nexø, 2005) which, Nexø argues, were based on eugenic considerations (Ibid. 99-107). This point is also made in the interwar analysis, although abortion as such is not elaborated. Again, the point has been to focus on eugenics as related to particular problematisations and technologies, not to elaborate on particular means over others.

Other aspects that are unpacked in the interwar analysis are gymnastics and the promotion of physical culture, as well as hygienic installations. Again, the crux of it for me has been to place these endeavours in relation to ways of targeting the population as a whole and the individual through his/her corporeality and interiority. To establish a hinge between these concerns, the analysis has taken into account other research.

Lars-Henrik Schmidt and Jens Erik Kristensen make a historical inquiry into the notion of social hygiene. Going back to Johann Peter Frank's programme for state regulation of public and private health (Schmidt & Kristensen, 1986: 27) and Edwin Chadwick's sanitary reforms in England in the eighteenth century (Ibid. 50), they identify how preventive measures find ground in Europe as a means to secure a healthy population. Whereas the fight against filth, bacteria and stink constitutes one aspect of preventive health measures, and targets the physical environment (Ibid. 48-50), preventive actions targeting the physical body constitute another aspect (Ibid. 89). In the interwar account of gymnastics and hygiene, the target on the physical environment is only briefly touched upon. In the course of my argument on hygiene, I shall touch on how bodies and homes were secured against dirt and disease, in other words the hygiene of the body and the immediate environment.

Ove Korsgaard outlines (1982) a number of events within the last 200 years illustrating major developments and transformations in the perception and outlook of bodily exercises. Korsgaard suggests that gymnastics, already from its introduction in the eighteenth century within certain groups in favour of a Danish agricultural reform, was perceived as a pedagogical means to further a proper development of body and soul (Korsgaard, 1982: 27-29). Korsgaard maintains the focus on physical exercise as a disciplining technique, which was further accentuated in the 1920s with the gymnastic pedagogue Niels Bukh, who strove for bodily perfection and believed the body posture was an indicator of one's character (Ibid. 231-234); a point also made by Per Jørgensen (Jørgensen, P. 1993: 51). Korsgaard asserts that a central

source of inspiration was the so-called Ling gymnastics, developed in the nineteenth century and named after the Swedish gymnastics pedagogue Pehr Henrik Ling (Korsgaard, 1982: 233; Nielsen, N., 1993: 11). The interwar analysis does not elaborate on the historical development of gymnastics, but instead directs attention to the influence of gymnastics on how bodies were disciplined and nurtured by Bukh among others. Rather than focusing on particular movements and the like, Korsgaard's overview of the disciplinary and pedagogical aspect of gymnastics has provided background information for the interwar account of how a relationship between corporal and mental health was put forth along the promotion of what I regard as a physical culture, promoting the means to strengthen not only the human physique but also the mind.

In *Sports History Yearbook VIII, 1992* (1993), Johnny Wøllekær's linking of nationalism and the gymnastics movement has been useful for contextualising the second part of the interwar analysis. His elaboration on the gymnastics' influence and the promotion of a body culture envisages the nationalist and patriotic tendencies in gymnastics in the first half of the twentieth century as an outcome of its relationship with the rifle movement in the mid-nineteenth century. The two organisations were conjoined until 1929 and particularly the Danish defeat to Prussia in 1864, which lead to Prussia's conquest of the southern part of Denmark, according to Wøllekær fuelled nationalism and the blossoming of the rifle movement (Wøllekær, 1993: 9). I add weight to how exactly preventive health and health promotion feed into a relationship between the human body and mind through a promotion of body culture.

As with the interwar analysis, a central concern in the millennial analysis is to look into an area of public health as a governmental type of problematisation and technology informing the population, human corporeality, interiority and exteriority. However, the point of departure differs from the interwar analysis, and its focus is on the fight against obesity, the ways it is problematised by public authorities, and the way it is made technical through NC initiated by the Danish Gymnastics and Sports Association (DGI).

In contemporary public health initiatives, emphasis is often placed on how preventive health and health promotion is individualised, targeting individuals' abilities to transform themselves into healthier beings. One aspect of this individualisation is the entrance of lifestyle into public health campaigns. Signild Vallgårda (Vallgårda, 2009) has made this point, holding that Danish policies regarding lifestyle diseases have focused on individual choice of diet, smoking, alcohol and exercise. In this way, Vallgårda argues, Denmark differs from the other Nordic countries and England, which take into account other individual factors such as sexual habits, sleeping habits, cultural experiences and experiences in nature as well as work environment, pollution, social networks, discrimination and marginalisation (Ibid. 12). Lars Thorup Larsen has provided an overview of the major developments of lifestyle politics internationally and in Denmark (Larsen, L. 2010). Larsen identifies how a politics has emerged since the 1970s that prioritises preventive efforts (Ibid. 1) focusing on individual risk factors such as smoking, drinking alcohol and sedentary ways of life (Ibid. 7). He holds that in Denmark there is a marked focus on lifestyle and individual responsibility, and he identifies the onset of this emphasis as the *Government's Prevention Programme* in 1989 (Ibid. 16-18), inspired by the so-called *Ottawa Charter* at the World Health Organisation (WHO) conference in 1986; a charter that continues to inspire Danish health policy today, as is evident in the Danish Programme published by the Ministry of Health in 1999 (Ibid. 22). Both Vallgårda and Larsen's research informs the millennial analysis with an overview of preventive health aimed at lifestyle transformation and its integration into Danish health politics.

Along with the pursuits to transform individual lifestyle, the millennial analysis is also concerned with shedding light on preventive health and health promotion that targets human surroundings with attempts to mould them according to prescribed norms of health. Human surroundings, however, can both be physical and social. Jens Troelsen's investigations illustrate that since the late 1980s, Danish as well as international preventive practices targeting the environment have been particularly focused on fighting obesity: a focus that within a Danish

context was earnestly put forth with the establishment of the *Ministry of Health and Prevention* in 2007 (Troelsen, 2010b: 13) and the *Prevention Commission* in 2008 (Ibid. 14). Troelsen illustrates how, as in the case of sanitary installations, the creation of physical milieus is a passive type of intervention that is, at first, hidden to the individuals it targets. In other words, urban planning and architecture may be installed as preventive means during our daily lives without us noticing it as such (Ibid. 27).

The focus in the millennial analysis is not on the physical environment but rather the social. I propose a view on NC as particular workings on and through human exteriority. However, unlike the physical structural intervention that Troelsen is concerned with (parks, playgrounds and the like), I envisage NC as a type of socio-structural intervention, which operates by activating individuals and administrative units. The same point can be made as to the DGI's involvement in NC.

Bjarne Ibsen (2006a; 2006b; Ibsen & Eichberg, 2006; Ibsen, Boje & Fridberg, 2008) has provided an insight into voluntary organisations in general and the DGI in particular and the latter's transformation from an organisation that offers play and social interaction at the heart of its activities to one that is directly engaged in public health campaigns by initiating NC and emphasising health as motivation for its offered activities; a tendency followed by other voluntary organisations. Ibsen argues that sports organisations are challenged, partly due to the fact that the population engages in other kinds of exercise and there is increasing competition among various exercise and sports facility providers (Ibsen, 2006b: 4). This pressurises the DGI to take up new activities and to take into consideration a health perspective on the various sports activities (Ibid. 5). Moreover, municipalities increasingly make demands in return for providing the sports facilities for DGI branches to make use of (Ibid. 40). These factors have instigated a change in the organisational structure of the DGI around accomplishing specific health tasks (Ibsen, 2006a: 14). Tina Kryger Mondrup (Mondrup, 2005) points to a similar tendency within voluntary organisations, namely an increasing demand for them to ensure quality,

accountability and efficiency (Ibid. 54). Consequently, both the DGI and other voluntary organisations now have to adapt to a new role and new types of knowledge, which go beyond traditional association work and activities (Ibid. 49). Various evaluation reports have been published about the DGI and other sports organisations' engagement in public health efforts. University of Southern Denmark published a number of these. One evaluation illustrates how collaboration between voluntary organisations and municipal organisations is promoted, due to the fact that voluntary organisations are used to relatively non-committal partnerships and are now being forced to formalise their organisational structures (Støckel, 2008: 20). Another evaluation report illustrates a similar challenge on behalf of the voluntary organisations, namely a formalisation of the organisation, rendering it more professional and in tune with the private sector (Høyer-Kruse, 2008: 5).

While the above-mentioned contributions on the DGI and NC focus on diagnosing NC as an administrative challenge for volunteer organisations, a number of scholars have analysed network governance and partnerships between public bodies, private organisations and other non-public actors as the reflection of a whole new way of organising administration and government. In crudely parsing out the analytical specificity of these contributions, I see four general tendencies.

One type of analysis is a functionalist one, which is apt to see the rise of NC as abiding by the complex nature of present-day administrative practices. In other words, the increasing fragmentation of society and its complex nature calls for more flexible administrative tools (Sørensen & Torfing, 2008: 5).

> The central decision makers in public and private organisations at different regulatory scales tend to see the new forms of interactive networks as the most suitable answer to the challenge posed by increasing societal fragmentation, complexity and dynamism (Ibid. 5-6).

Another central account of NC adds weight to the participatory nature of this kind of administration, and thus its democratic potential.

> Obviously there are no guarantees, but since networks often include actors from outside the established set of political actors, such networks are likely to increase the democratic learning of those involved (Dreyer Hansen in Sørensen & Torfing, 2008: 254).

Thirdly, we see a hollowing out of the state argument, the point being that the state does not encompass modern health promotion and cannot reach target groups in the same manner without the involvement in partnerships (Bevir, 2010: 3).

Finally, we have the best practice argument: NC is the best means for meeting the demand for public health efforts. Høyer-Kruse et al. come up with a number of suggestions for how to engage in partnerships in order for it to work adequately. They define a partnership as a structured, reciprocally obliged and dialogue based form of cooperation between different sectors by combining their resources and competences in order to solve concrete problems and develop processes and/or new activities (Høyer-Kruse et al., 2008: 5).

Attempts have been made to integrate a power element, that is, a more critical account of NC (i.e. Koopenjan in Sørensen & Torfing, 2008: 133-66). Mark Bevir suggests that social science itself is to blame for the lack of critical analyses of NC, as social science has led policy actors to turn to social scientific expertise. One effect is that, rather than presenting a diagnostics, these experts become both referees and players on the field (Bevir, 2010: 3).

> Social science appeared to provide a neutral expertise that might guide policymaking. Social science could show us what policies would best produce whatever results or values our democratic representatives decided upon. Modernism thereby helped sustain the now classic distinction between politics and administration (Ibid. 34).

Taking my cue from Bevir's suggestion, I propose to take this argument even further. One might say that subjectivity and self-objectifying technologies are now integrated within administrative practices. The millennial analysis sheds light on how NC, apart from furthering a particular administrative reality, also furthers a particular way of

governing administrators while concurrently introducing a particular way to make intelligible a social environment: a point that will be elaborated through the findings in the analysis.

In summary, I have provided an outline of the scientific contributions that have either inspired the analytical endeavour of this dissertation or differ significantly from it. The object in question has first and foremost been the empirical foundation, as the selected literature more or less touch upon or bear a resemblance to the field of research. Establishing empirical similarities between this dissertation's field of research and others turned out to be a comprehensive task and includes areas that in themselves are wide-ranging, i.e. eugenics, the social reform of the 1930s, gymnastics and sports, obesity and NC.

While the above literature has qualified the empirical limitations of the field of research, the mode of accessing the field has been limited to Michel Foucault's power analytics serving as the conceptual and methodological prerequisite. Additionally, the conceptual framing, the methodological guidelines and the analytical strategy, along with the two analyses, draw heavily from a wide range of Foucault's writings. While Foucault's archaeological endeavours are taken into account only to a small extent, as the analysis is limited to a genealogical undertaking, a concern has been to extract from his writings how to make intelligible for analysis concepts of power, knowledge, ethics, freedom, subject and government, on the one hand, and, on the other, how to methodologically encompass these notions by means of genealogy. Foucault scholars' contributions, although extracted in a rather fragmented and superficial fashion, have provided guidelines for the carving out of the dissertation's mode of intelligibility. Contributions that I draw from include the work of Nikolas Rose, Mitchell Dean, Paul Rabinow, Hubert Dreyfus, Colin Gordon, Peter Miller, Ian Hacking, Alan Petersen and Peter Triantafillou.

1.3. HOW TO CRITICISE?

With the two parallel studies the dissertation aims to make intelligible preventive health and health promotion as modes of governing human beings and administration. It thereby contributes conceptually, methodologically and analytically to Michel Foucault's vast work on modern government. The inquiry is thus a critical interrogation into modern health policies in an attempt to question existing power relations and contribute to their reversibility. Now, what does this imply?

While analyses of public health interventions in general are far from short of evaluations of their intended effects, the indirect effects, or side effects of such interventions, often seems to evade the analytical gaze. 'Did the health intervention succeed in what it set out to do?', 'How effective was it really?', 'How healthy are those targeted since the intervention compared with before?', 'What should be done to make the health intervention more effective and more in tune with the needs in society?' and so forth are evaluative questions aimed at enabling either support of the intervention or criticism of it. From this vantage point, one can either look out for errors: 'Preventive health does not provide health!' or one can provide an account of what could be done in order to provide health. In both accounts, the premise – does health intervention provide health? – stays unaltered.

On the other hand, criticism of public health within prevailing sociological analyses tends to be preoccupied with health intervention's repressive and stigmatising characteristics, in the same manner as Ivan Illich in the 1970s identified "*the medicalisation of life*" (Illich, 1976: 8), by investigating medical practice as a monopoly that interferes with human integrity and social life (Ibid. 90). These types of criticism fall short of the possibility that public health interventions, while impacting upon human integrity and social life, simultaneously play a part in constituting them. More importantly, this very criticism in fact seems to direct public health intervention. In Dybroe & Kappe's critique of health promotion (Dybbroe & Kappe, 2012: 40-53), they emphasise social

inequality as both a consequence of public health campaigns and a reality people from the lower end of the social spectrum are faced with when in need of health promotion. However, as I show in the millennial analysis, inequality in health is also a central concern for both public authorities and private actors when engaging in health promotion campaigns; a point also made by Signild Vallgårda, who shows how, in connection with the foundation of a council for prevention in 1980, inequality was put on the public health agenda (Vallgårda, 2003: 124). Indeed the argument of inequality in health is a crucial factor for establishing the epistemological grounding for an intervention. Hence, addressing inequality in health cannot be regarded as an alternative perspective to health intervention as it constitutes a central allegory for supporting the very way health interventions are operationalised. One may say that health intervention, to a certain degree, has integrated the critique of inequality in health and allowed it to form an epistemological basis exactly for health intervention.

In a similar manner, Ditte-Marie From (From, 2012) argues that an effect of health promotion campaigns targeting obese children is that the children are addressed as lacking in particular characteristics: which From asserts affects the children's self-esteem negatively. She proposes a social-constructionist view on obese children; one that rather than focusing on lacks instead views the targeted children as active and empowered and thus in fact healthy. The crux of it for From is that if approached with a positive attitude, obese children are more likely to show competences for transforming themselves into less obese individuals. What From disregards, is that a positive and acknowledging attitude already is a central point of departure in the campaigns directed at obese children. Additionally, a concern in the analysis has been to place these *positive* appeals for individual transformation within a government framework, arguing that power is also at work when health interventions target obese children in a playful and light-hearted manner. One may even claim that Danish health government today has incorporated prevailing criticism of suppression and stigmatisation by directing its vocabulary and practice towards creating a positive transformation of the objects targeted; a point elaborated by Niels

Åkerstrøm Andersen (Andersen, 2009). Andersen identifies how play is turned into a power technology aiming at nurturing self-concepts of individuals and organisations as self-steering, adaptable and capable entities, and thereby reorganising power as directly linked to empowerment (Ibid. 9, 11). Government thereby operates through "*an ethics, in a Foucauldian sense, by producing the means by which subjects assess their own desires, attitudes and conducts in relation to those set out by health promotion expertise*" (Coveney, 1998: 459).

Going back to the question of how to criticise, I argue that when too preoccupied with identifying power in health as suppressing and stigmatising, one misses out on the critical endeavour of placing also positive health interventions within a power analytics. Drawing on Michel Foucault's analytical apparatus, the promotion of health, in my opinion, has more subtle effects than wrongdoings, mistakes and suppression. It creates a vocabulary, a mind-set and norms of behaviour for us to regard ourselves and lead our lives as particular kinds of beings and at the same time nurtures qualities that allows for specific modes of doing. Foucault compared himself with a crawfish that advances sideways (Foucault, 2009), and this might be a way to describe a kind of critical scrutiny that explores a given object by acknowledging its effects but nonetheless disregards its premise. In other words, the way this dissertation poses a critique is by acknowledging the truth claim found in the preventive health and health promoting practice I analyse, while at the same time robbing it of its evidentiary status.

1.4. CONTENTS AND ORGANISATION

In the course of my argument I shall explore the conceptual, methodological and analytical requirements for engaging in this mode of critique and unfold it along lines of the following chronology:

The succeeding chapter 2 works towards establishing the conceptual framework. This includes elaborating on Michel Foucault's concepts of power, freedom, knowledge and problematisations and outlining the

conceptual premise for analysing human exteriority, human corporeality and human interiority.

Chapter 3 offers reflections on the methodological bearings of undertaking the genealogical method provided by Foucault and the subsequent history of the present. This implies clarifying the use of genealogy as a historical method in comparison to Quentin Skinner's conceptual history. It also implies elaborating on the methodological implications of analysing problematisation and technology respectively.

Chapter 4 outlines the data used for the analysis. It includes first, the selection criteria guiding the data collection, and secondly, considerations with regard to the temporal and spatial delimitation.

Chapter 5 makes up the analytical tactics for analysis. It follows the sub-questions' division of problematisation and technology respectively and outlines how human exteriority, corporeality and interiority are turned into objects of inquiry in the two analyses.

Chapter 6 is the interwar analysis of the period from 1920 to 1940. Emphasis is placed on how eugenics and hygiene, as well as the promotion of a body culture, inform preventive health and health promotion while simultaneously directed at the human environment, human bodies and minds.

Chapter 7 makes up the millennial analysis of the period from 1980 to 2012. Particular attention is placed on the fight against obesity targeting children and young people. The chapter parses out how preventive health and health promotion render obesity a problem and additionally how it is objected to government technologies. Likewise, a concern is how specifically human exteriority, corporeality and interiority become amenable to government.

Finally, Chapter 8 offers a summary and some conclusive remarks of the analytical findings followed by a discussion of the dissertation's contribution to biopower analytics and its relevance today, elaborating on the criticism offered.

2. CONCEPTUAL FRAMING

2.1. INTRODUCTION

Central to this dissertation is to critically address preventive health and health promotion by placing them within an analytics of power and ethics. This involves investigating ways in which they work on the population and the ways in which human beings exercise their freedom to attain health through self-government. The question guiding this chapter is how to adapt notions of power and freedom, biopower and governmentality to the specific geo-political settings of preventive health and health promotion during the 1920s and 1930s on the one hand, and from the 1980s to 2012 on the other. Preventive health and health promotion can be viewed as particular engagements of various medical branches along with other branches, which conjoin with political strategies in the overall quest of providing health for the population; what Michel Foucault has described as the fusion of medical practices and the political need for social control (Foucault, 1980b: 176-77). Such a power analytics can be seen as an attempt to encompass power in its modern form, in other words power that does not centre on repressive means but rather operates through an array of relations between people and their relation to human space.

2.2. POWER

Foucault identified three modalities, or characteristics, of modern power. They can also be seen as phases in the evolution of power, operating first through sovereign rule, next through disciplining of bodies and third through governing and managing people in their relations.

Foucault's characterisation of sovereignty as the king's right to kill may serve as an allegory for a power that is primarily suppressive, one that says *no*: prohibits, suppresses and is adjacent to force; a modality of power that today takes a juridical form. In contrast to a power characterised as 'the right to kill', is one that emerges through a

manifold nurturing of human vitality "*to invest life through and through*" (Ibid. 1990: 139). It concerns forms of knowledge, political interventions, and technologies that seek to know, organise and control the ways in which humans behave (Ibid. 1980a; 1990: 139; 2003b: 239-264). Biopower is a name for these technologies directed at human beings through and by virtue of their vitality. Foucault's argument that power has become 'materialistic' alludes to these strategies, which target the living being so that life itself has become the object and means of power (Ibid. 2007b: 159). It concerns the preservation of human vitality through an array of emerging bodies of scientific knowledge – of which medicine is a central one – and the regulating concerned with the quantity, quality, procreation and wellbeing of vitality. Hence, it is a characterisation of a power that allows *the living* to be a central object of intervention (Osborne, 1997: 173-89). This investment of life finds two particular ways of operating: through *discipline's* individualising technologies and *government's* fusion of individualising and totalising technologies. Discipline evolved with the development of the eighteenth century's disciplinary institutions such as the school, the military and the like, as the epitome of power over individualisation. It operates precisely through the double meaning of the term discipline: specialisation of knowledge on the one hand, and authoritarian training and schooling of individuals on the other. While sovereign rule demands the obedience of subordinates – which today finds its echo in the penal system – disciplinary power introduces a power-knowledge relationship. Central is the idea that gaining knowledge about individuals is a prerequisite for utilising their capacities. Accordingly, the disciplines specialising in knowledge about the human being (biology, medicine, anthropology, sociology and the like) are correlated with a political concern to utilise a human workforce. It is power that primarily targets the human being through his/her individuality (Foucault, 2007a: 146-47; Driver, 1999: 116), directed first and foremost at disciplining the body. Hence, with discipline, the body became "*a privileged object for intervention*" (Raffnsøe, Gudmand-Høyer & Thaning, 2008: 202) and is materialised through a "*body politics*" (Gastaldo, 1998: 115).

> Mastery and awareness of one's own body can be acquired only through the effect of an investment of power in the body: gymnastics, exercises, muscle-building [...] all of this belongs to the pathway leading to the desire of one's own body, by way of the insistent, persistent, meticulous work of power on the bodies of children or soldiers, the healthy bodies (Foucault, 1980a: 56).

Discipline, as a variety of individualising technologies, evokes a bodily economy through exercise, precision, order and clockwork monotony concerned with "*[h]ow to oversee someone, how to control their conduct, their behaviour, their aptitudes, how to intensify their performance, multiply their capacities, how to put them in the place where they will be most useful*" (Ibid. 2007b: 159). Parallel to the individualising modality of discipline, Foucault identifies *government* as first and foremost a totalising modality of biopower, concerned not with individuals but with the population in its totality. With government, administration of the human species and management of human relations become incorporated in political practice (Ibid. 2000b: 207), not through discipline but through regulation (Ibid. 2003b: 246). Thus, government evolves through biopolitics, which is concerned with regulating the population at large, as a race, a sub-population and a group; as well as the environment as a socio-biological whole. This totalising and regulatory aspect operates through the vitality of the whole and encompasses various governmental strategies aimed at optimising, controlling, and mapping the processes that sustain life (Ibid. 2000g: 125; Dean 1999: 99). They address "*a multiplicity of men, not to the extent that they are nothing more than their individual bodies, but to the extent that they form, on the contrary, a global mass that is affected by overall processes characteristic of birth, death, production, illness*" (Foucault, 2003b: 242).

The role of medicine as a power technology is central; not as a symbol of power, nor as an ideology, but as a *practice* concerned with transforming human spaces and human beings, and therefore should in fact be regarded as a *social* practice. To identify modern medicine as social is to identify its role in *government,* emphasising how it evolved through a biopolitical concern with the living and thus is linked to political and social practice (Rose, 1999b: 55). As Rose argues, to say

that medicine is social does not mean that it should be understood in a social context. Nor does it mean that medicine is subject to social influence or socially determined. Instead, it means that the very idea of society has been brought into existence as an organic form and thought in medical terms. "*From the moment that European political reason came to assume its modern governmental form, it had a medical dimension: the administering of life*" (Ibid. 54). In other words, medical undertakings inform not only a biological reality but also a social reality (Foucault, 2004: 13). Put differently, social medicine is the effect of medical intervention at the biological level. Accordingly, the "social body" became a field for medical intervention (Ibid. 2000a: 134).

> Society, as it is historically invented, is immediately accorded an organic form and thought in medical terms. As a *social body* it is liable to sickness: that is to say, it is problematised in the vocabulary of medicine (Rose, 1999b: 54).

From this vantage point, medicine can be seen as a biological-social practice (Foucault, 2003b: 61-62), as it takes hold in and addresses a social space: the surroundings in which humans live. The point is that as medicine paired up with a political concern for the living, it simultaneously assumed a 'normalising' function, offering a vocabulary and a practice to distinguish the normal from the abnormal, the healthy from the sick and so forth (Ibid. 2004: 13). Hence, as medicine transformed from being essentially clinical to being essentially social, it became a body of expertise in normativity, entailing a capacity to promote and impose new norms (Osborne, 1997: 180). With this follows medicine's role in informing *dividing practices* (Foucault, 2000b: 208; Rose, 1999b: 50-52): segregating individuals and groups from the rest of the population along lines such as mad or sane, sick or healthy, normal or abnormal (Foucault, 2000e: 326). These objectifying practices also concern the "*lines of differentiation*" which target groups as suitable for medical intervention, while others are not (Rose, 1999b: 57).

In addition, government, while operating on a different level than discipline, can be said to have integrated an individualising modality. Individualisation has materialised through various techniques, of which Jeremy Bentham's architectural *Panopticon* was a central one; a flexible

surveillance technique that evolved at the turn of the nineteenth century and can be applied in psychiatric institutions and prisons just as easily as schools and hospitals (Foucault, 2000f: 70-73). Panopticism can be seen as an allegory for an individualising power that not only objectivises human beings through their individual bodies, but also works upon an interior space, i.e. human subjectivity. It evokes an anonymous surveillance – as the guard overseeing inmates, psychiatric patients, schoolchildren and so forth hides in a central tower and cannot be seen – while simultaneously being unverifiable: the inmate/patient/pupil never knows when he/she is being watched over. In effect, a kind of self-surveillance is installed in the individual, a constant awareness of the possibility of surveillance: an awareness that at the same time gives incentive to self-discipline. Foucault's point then is that this "*inversion of spectacle*" (Ibid. 72) as an individualising technology is in fact a technical installation, evolving through a disciplining power that enables a particular relationship of the individual with himself/herself as the object of government and self-government (Ibid. 70-73; cf. Driver, 1997: 113-31). Likewise, a modality of individualisation is at stake that does not primarily target the body, but instead a human interiority: *superego*, self-reflection, emotions, dreams and the like. One may say that discipline developed and materialised first and foremost through the economisation and utilisation of the human body; in effect it gave way for an individualisation that targets instead the individual's relation to himself/herself.

While Foucault maintains that medicine is paramount to the ways in which biopolitical regulation of social space has been carried out particularly at the turn of the twentieth century, he also asserts that medicine has gained prominence vis-à-vis the individualising aspect of biopower with regard to the moulding of human bodies and beings. In this way, medicine has been influential in the shaping of the *social* – the human environment – and at the same time a crucial technology for the nurturing of healthy individuals. The term *Governmentality* takes into account this dual operationalisation of biopower: on the one hand totalising technologies that work upon the population and human space,

and on the other hand individualising technologies that target an individualised body or inner reality; the point being that this inner human reality has been rendered technical (Foucault, 1990: 163). Hence, rationalities or mentalities of government today concern a manoeuvring between power and ethics (Ibid. 2007c: 154-55), i.e. the twofold undertaking of governing other and oneself. Government thereby accesses an advanced liberal imperative to govern over free subjects. Freedom, then, is a space left to resist power: the ways individuals – as particular subjects – govern themselves (Triantafillou, 2005: 16), and, thus, freedom presupposes the active participation of the individual. Ethics then refers to the kind of freedom exercised by those governed, i.e. the individual's freedom to become a subject.

While encompassing an advanced liberal mode of governing, governmentality simultaneously is an attempt to make intelligible how administration of the population has become a state concern. As Mitchell Dean and Kaspar Villadsen argue, the concept of governmentality is in fact a means of analysing the state (Dean & Villadsen, 2012: 28); not the state as a repressive force but the state as a number of relations between various interactions directed at enabling particular qualities and beings to come to the fore. Hence, the term governmentality encompasses those secular modes of governing the population and individuals, which have become a state concern.

Foucault argues that all three facets of power – sovereign rule, discipline and government – are indeed at play in the operationalisation of modern power, but that government has gained prominence (Foucault, 2000b: 207). It is in this light that the formation of the Western welfare states can be seen: a concern with on the one hand securing the whole – society, the race, the population and the like – and on the other hand providing welfare for each and everyone (Ibid. 2000c: 302-3, 307). This twofold problem of the modern welfare state – of both the whole and the individual – is what Foucault has described as a tricky combination of the city-citizen game and the shepherd-flock game (Ibid. 311).

Having outlined a concepts guiding a Foucauldian power analytics, below I apply this general framework to the analytical trajectory of this dissertation. This includes elaborating on knowledge-power-ethics relations and the notion of problematisation. I also outline the theoretical premise through which human exteriority, corporeality and interiority are analysed.

2.3. KNOWLEDGE-POWER-ETHICS

An examination of power in social scientific analyses often reveals an emphasis on power as one person or group's interest (Lukes, 1976: 34) or power as a repressive entity (Horkheimer & Adorno, 1944/1993: 179; Dahl, 1991: 46). However, keeping in mind the above outline, the governmental aspect of power as one that engenders rather than restrains can be seen as an attempt to provide an account of power which side-steps the *repressive hypothesis* (Foucault, 1990): the tendency within social and political analyses to make power and repression of a piece. It is not a question of denying the existence of repression – the modalities of sovereignty, discipline and government are all at work – but rather of looking for the more silent effects of power: "*Power 'produces reality' before it represses. Equally it produces truth before it ideologises, abstracts or masks*" (Deleuze, 2006: 25). Put differently, power gives way for room to resist, claiming one's being and the like. Thus, instead of addressing power as repressing human beings, I identify how power invests in – and works through – the repression hypothesis: the ongoing fight against a repressive power (see examples of this in the Introduction). Hence, power is a name given to a kind of intervention that operates without physical coercion or restraint (Foucault, 2010: 42), but is exercised over free individuals within a regulated space (Ibid. 2000b: 221). The relation to freedom is central, not so much as a rejection of domination, but as a matter of sharpening the analytical focus by placing attention on the 'positive' aspect of power rather than envisaging it as a negative force.

By linking power and freedom, I argue that preventive health and health promotion can be seen in relation to an advanced liberal pursuit to govern through self-regulating capacities, i.e. ethical practice. Ethical government then concerns technologies that address the targeted individuals through and by virtue of their ability to reflect upon their problem and come up with solutions (Dean, 1994: 177). The millennial analysis, for example, unfolds how health intervention addresses obese children as active and responsible beings in a way that intimately links government and self-government. Accordingly, the individuals subjected to health intervention should not be seen as either suppressed or corrupted by medical power or public health intervention, but are exercising their freedom within a regulated space (Foucault, 2000b: 221). Government as a particular conjunction of power and freedom is a matter of presupposing the active participation of the individual targeted by medical or public health intervention. Ethics, then, concerns how human beings govern themselves.

The term 'power-knowledge relations' refers to a mode of intervention that is inherently linked to, on the one hand, knowledge about the governmental target and on the other hand the ability to direct its cause (Ibid. 214). However, the relationship between knowledge and power – modes of knowing and modes of doing – is a tricky one. When Vivien Schmidt, analysing political institutions, places emphasis on discourse (Schmidt, 2010: 3), she suggests that ideas and discourses stemming from individual actors within institutions make particular institutional actions and sometimes change (Ibid. 2008: 2). She thereby establishes a causal relationship between what is said and what is done (Ibid. 2, 9). My gambit is to establish a link between what is said and known (knowledge) and what is done (power/ethics) without establishing a causal relationship between the two. In other words, the one cannot be reduced to the other (Triantafillou, 2012: 11). The point instead is to illustrate how particular modes of knowing inform particular modes of doing and thereby give way for "*this murmur without beginning or end*" (Deleuze, 2006: 8). Utterances, language and discourses are placed under scrutiny to the extent that they either inform government in some way or the other, or they offer a limited space of freedom to resist power

and thereby are activated through ethical practice. Knowing the target of preventive health is an activity that simultaneously constitutes and moulds that target.

Linked to knowledge are problematising (Osborne, 1997: 174): the way in which things and humans are rendered a problem (Foucault, 2007c: 141) through processes of problematisaton (Raffnsøe, Gudmand-Høyer & Thaning, 2008: 333) or, science understood as a problem (Nietzsche, 1887/1998: 112). The millennial analysis, for example, sheds light on how preventive health and health promoting practice direct attention to obesity and obese children by firstly problematising these phenomenon along lines of health, social placement and self-esteem. Put differently, a prerequisite of government is that something or someone is regarded as a problem that has to be solved (Dean, 1994: 195-96), or, one may say, the way in which a phenomenon is rendered a problem in need of political intervention (Triantafillou, 2012: 20). In the subsequent chapter, I discuss more thoroughly my use of the notions of knowledge and problematisation, i.e. the methodological implications of these concepts.

2.4. HUMAN EXTERIORITY, CORPOREALITY AND INTERIORITY

The following pages elaborate on the theoretical premise guiding what I in the research question and related sub-questions refer to as *human exteriority*, *human corporeality* and *human interiority*.

2.4.1. HUMAN EXTERIORITY

Human exteriority refers to the biopolitical management of the milieu in which people live, in other words their surroundings (Foucault, 2003b: 245). Foucault offers clues to envisage human exteriority as in fact a medico-political working on the environment as a biosocial body. Public health, for example, can be regarded as a technique for controlling those elements in the environment that are regarded as either harmful or as promoting health (Ibid. 2000a: 150-1); hence the

division between preventive health and health promotion. Sex, sexuality and the sexual urge were special targets for biopolitics, particularly during the first half of the twentieth century. At the level of the population, especially perverted sexuality was linked with heredity and degeneracy (Ibid. 2003b: 252). "*[L]ocated at the point of intersection of the discipline of the body and the control of the population*" (Ibid. 2000b: 125), sex offered itself as a concern for both individualising and totalising technologies. Accordingly, sexuality made up a principal reference for biopower to spread (Dreyfus & Rabinow, 1983: 140). Taking into account this analytical prerequisite, in the interwar analysis I illustrate how the 'sexual question' raised by medical and related expertise both concerned how to prevent tainted individuals from procreating and simultaneously targeted children through a disciplinary practice, as I elaborate on below. In the millennial analysis, however, sex and sexuality do not seem to be a concern for preventive health and health promoting practice, on the level of either human exteriority or human individuality.

Another aspect of the conceptualisation of human exteriority is how the family is targeted and rendered amenable to government. According to Foucault, this can be seen in the light of hygiene, which at the turn of the twentieth century evolved as a specialised branch of medicine. Concerned with illnesses prevalent in the population, medicine came to be a kind of public hygiene (Foucault, 2003b: 243) through which families were targeted as a "*hygienic machine*" (Rose, 1999b: 51). Jacques Donzelot elaborates on this phenomenon, suggesting a governmentalisation of the family as in fact the attempt to create the "*smallest political organisation possible*" (Donzelot, 1979: 48). In the light of the biomedical concern with physical and moral decay in the population, the family became a direct political instrument (Rose, 1999b: 56). Additionally, a "*hygienist norm*" (Ibid. 57) penetrated the home and rendered particularly maternal means a safeguard from racial decay. In effect, the medico-hygienic practice upon the home offered women in the household an increased autonomy and thus authority: an authority quite distinct from patriarchal authority (Ibid. 56-58). Taking into account this analytical framing of the family, the interwar analysis

sheds light on how problematisations of the hygienic state of the families also informed particular technologies for governmentalising child rearing, nurturing, diet and cleanness within the family. Likewise, in the millennial analysis, I investigate how parents of obese children were targeted in the attempt to turn the homes into healthy units.

While the above conceptualises human exteriority as a biosocial body, in the millennial analysis I also take into account NC as a particular kind of work upon human exteriority. This calls for a theoretical pursuit that takes into account the nitty-gritty techniques and practices related to administration in health promotion. From this perspective, the notion of *exteriority* does not concern only the biosocial body but also administration, in other words it also encompasses a socio-administrative body.

Taking his cue from Foucault's diagnosis of the 'governmentalisation of the state', Mitchell Dean introduces the term 'governmentalisation of government'. He thereby suggests that new forms of government have taken up the practice of reflecting on government itself – i.e. a 'reflexive government'. Dean asserts that this style of government is expressed in the employment of democratic, accountable and transparent institutions, public bodies and the like, in constant questioning and problematisation of the government of government (Dean, 1999: 193).

> Societal transformation is at the heart of reflexive government. However, it seeks to achieve this transformation no longer through the government of processes but through the government of the mechanisms, techniques and agencies of government themselves (Ibid. 196).

Dean holds that reflexive or self-reflecting government – i.e. governmentalisation of government is operationalised through "*technologies of agency*", that is, through freedom, agency and choice (Ibid. 195-96). In establishing a hinge between these concerns, I suggest placing NC within a governmentality framework as a technology through which intervention takes place on the basis of a calculated probability that an undesirable behaviour may occur, and can therefore be prevented (Petersen, 1997: 195). Health administration then, with the

introduction and spread of NC, is both a matter of regulating public health and of regulating the very regulation of public health. Consequently, the management and administration of health promotion are more than merely a bureaucratic means to promote health. They express a particular instalment of power exerted upon the very body of government and administration. The phenomenon may be conceptualised as *governmentalisation of administration*, which is centred on informing an "*ethics of administration*", to use Alan Petersen's wording (Ibid. 196), making self-regulation imperative. Thus one may argue that NC operates through a bureaucratic ethics, that is, government's constant self-reflection and self-regulation:

> Network governance then could be regarded as an instance of this conception of neo-liberal government. From this point of view, we could broadly characterise network governance as the diverse governmental rationalities, technologies and norms that seek to govern by promoting the self-steering capacities of individuals and organisations (Triantafillou, 2004: 11).

From this standpoint, governmentalisation of administration encompasses both the totalising and individualising aspects of administrative endeavours, holding that this type of empowerment of the administration works at different levels and each administrative unit is to be empowered and self-regulating. As Petersen argues, the administrators are themselves engaged in ethical and self-reflecting government. Health promoters are helping to forge a new conception of the political and see themselves closely allied with the new social movements in their concern to 'empower' citizens (Petersen, 1997: 196). In addition, NC alludes to ethical working not only of administrative units but also of the administrators themselves. In the millennial analysis I unfold this conceptual prerequisite at length by placing under scrutiny a selected NC between DGI, public bodies and private organisations that target obese children with the aim of increasing their ability to make choices that will lead to a healthy life; the point being that these administrative practices can be seen as a particular way to ameliorate the social space in which obese children lead their lives.

2.4.2. HUMAN CORPOREALITY

How does Foucault's concept of a disciplinary power targeting human bodies and individualised beings translate into an analysis of preventive health and health promoting government?

Foucault characterised power over bodies from the eighteenth century as particularly concerned with children's masturbation practices (Foucault, 1980a: 56, 58) and in effect a general sexualising of children's bodies (Ibid. 2000e: 21). This concern was less a moralisation than a somatisation (Ibid. 2003a: 237) in that it became a medical concern and was linked to a number of both physical and mental illnesses. Moreover, masturbation was seen as causing bodily decay, leaving children pale, weak, crooked and without a clear character (Ibid. 238-39). At the level of human corporeality, the problem with sex is less a problem of procreation – as it is at the level of human exteriority – as it is a problem with an undisciplined body (Ibid. 2003b: 252). Adding further validity to this point, David Armstrong suggests that the body of the child was turned into a medical object through the notion that bodily exercise benefits both the mind and the body (Armstrong, 2009: 914). During the early 1920s, Armstrong argues, a number of techniques were deployed around the behaviour of children that aimed at the 'whole' child (Ibid. 915). In staking out these claims, in the interwar chapter I illustrate how the 'sexual question' that was raised among medical experts concerned questions about how to discipline and keep in check the masturbating practices of children and the youth. In the millennial analysis, this is of no concern whatsoever.

According to Foucault, the mid-twentieth century marked a transformation in medical health practice from aiming at providing the nation with a strong and clean race to adding a new concern, namely somatic reality (Foucault, 2004: 16). In addition, medical practice was characterised as a particular mode of "*somatocracy*", in which corporeal health had become a statuary concern (Ibid. 7). Nikolas Rose (Rose, 1997) developed the idea that biomedicine increasingly related to the human being as a "somatic" individual whose identity was grounded in

our corpus: "*our corporeality, now at the molecular level, is the target of our judgements and of the techniques that we use to improve ourselves*" (Ibid. 26). As Alan Petersen puts it, the present day's "*cult of body*" is promoted in terms of the risks of selfhood, which requires a constant monitoring of the body (Petersen, 1997: 200). In reference to this standpoint, in the millennial analysis I investigate how obese children were worked upon to bring about a transformation of their corporeal reality from an obese and unhealthy body to a fit and healthy body. However, while this transformation was physical, the means was to a large extent mental in that they targeted a human interiority instead of corporeality.

2.4.3. HUMAN INTERIORITY

> The entire inner world [...] has spread and unfolded, has taken on depth, breadth, height (Nietzsche, 1887/1998: 57).

In his earlier writings, Nikolas Rose used the prefix *psy* (Rose, 1998) to designate those sciences that target the human being as a psychological subject (e.g. psychology, psychiatry, and psychoanalysis): an individual with a particular psychological makeup. This includes the ways in which health promotion is put into operation by targeting different personalities linked with certain psychological attributes (Ibid. 9). Moreover, it includes the ways in which individuals act upon their individuality as ethical beings. These types of governmental technologies, which work through and by virtue of beings as the centre of their own experience (Coveney, 1998: 465), address the human mind and its thoughts, morality and ability to engage in self-reflection and know itself (Fox, 1998: 36). This carving out of an inner reality can be seen as an ethical practice: a kind of freedom through which individuals engage actively in their own self-understanding (Cruikshank, 1999: 41), make choices, have feelings, and reflect upon themselves according to their autonomous nature; in other words, "*the ways in which we recognise ourselves and others as particular kinds of selves*" (Owen, 1995: 500).

Technologies targeting human interiority seem, in Rose's account, to have "*flattened*" and have lost their depth (Rose, 2007: 15; 26). Analysing the somatic emphasis in current human technologies, Rose notes the somewhat superficial humans who arise and come to be the target, means and end of the work on themselves; what he calls a "*somatisation of ethics*" has taken hold (Ibid. 26, 83). Whereas most of the twentieth century dwelt on a deep inner reality, such as the Freudian subconscious, human technologies now operate directly on the surfaced body and corporeal existence (Ibid. 26). Hence, Rose argues that contemporary biopolitical workings have loosened the grip on human interiority, suggesting a 'neurochemical self' has inhabited the once deep human interior. This new technology of the self is characterised as focusing on the chemical responses of the brain rather than the hidden figures inhabiting the psyche (Ibid. 187-88).

I take a rather different tack on the notion of human interiority. In the interwar analysis, I illustrate how although human interiority constituted an end of health promoting government, it was only addressed indirectly. Instead, transformation of human corporeality was the central mode of intervention. In contrast, in the millennial analysis I illustrate how human interiority has indeed become a direct object of transformation. Whether this interiority is flattened is not a concern. However, rather than making use of the term 'neurochemical self' to account for a characteristic of human interiority today, I envisage the fight against obesity as giving incentive to a flexible and self-reflecting individual.

2.5. SUMMARY

The above makes up the conceptual framework guiding the two analyses. I have elaborating on the characteristics of power within a Foucauldian power analytics as engendering human capacities rather than repressing these and hence, working through and by virtue of free individuals. I have showed how power operates through knowing the object targeted while at the same time problematising it. In relating to the analytical objects of inquiry that are framed by the research question, I have

outlined the concepts of human exteriority, corporeality and interiority. Human exteriority regards the conceptualisation of an area of public health that govern the surroundings in which individuals live. It both entails medico-biological operationalisation upon human space as a socio-biological whole and hygiene's aim at creating health within the families. Moreover, it regards the administration of health through NC and the particular way a socio-administrative space is targeted and ameliorated. Human corporeality regards the conceptualisation of those preventive health and health promoting efforts operating upon human bodies with a view to transform these into healthier bodies. Finally, human interiority regards those preventive health and health promoting efforts targeting a human space within through self-reflection, feelings and dreams.

3. METHODOLOGICAL FRAMING

3.1. INTRODUCTION

> I adopt the methodological precaution and the radical but unaggressive scepticism which makes it a principle not to regard the point in time where we are now standing as the outcome of a teleological progression which it could be one's business to reconstruct historically: that scepticism regarding ourselves and what we are, our here and now, which prevents one from assuming that what we have is better than – or more than – in the past (Foucault, 1980c: 49).

If the power-analytical undertaking provided by Foucault entails a methodological as well as an ethical shake-up, this pertains not only to social scientific methods but also to historical undertakings. This dual ambition can be boiled down to one central purpose: to reveal and problematise the effects of science (Ibid. 1980e: 83). In both his archaeological and genealogical writings Foucault seeks to place under critical scrutiny those sciences that have the human being at the centre of attention, that is, the human sciences (Dreyfus & Rabinow, 1983: 26-27). Likewise, a central concern in this dissertation is to illuminate how the human being is constituted and constitutes itself as an object and subject of knowledge, and how this is connected to ways of being human and acting accordingly (Foucault, 1998b: 444-45). What follows is an account of the methodological implications of such an endeavour.

Firstly, I account for the central methodological implications upon the object of inquiry of adopting Foucault's genealogical method and history of the present. Secondly, I elaborate on genealogy as a historical method by comparing it to Quentin Skinner's conceptual history. Although not directly inconsistent with genealogy, Skinner might serve as a reference point for clarifying the particular genealogical undertaking provided in this dissertation. Finally, I explore the genealogical attitude towards knowledge and problematisation on the one hand and power and ethics on the other. I thereby account for the methodological implications of providing an analysis centred on investigating the relationship between problematisations and technologies.

3.2. GENEALOGY AND HISTORY OF THE PRESENT

> Biopower is the increasing ordering in all realms under the guise of improving the welfare of the individual and the population. To the genealogist this order reveals itself to be a strategy (Dreyfus & Rabinow, 1983: xxxvi).

What is the price of knowing, being, and acting upon oneself and others? These are central questions found in Foucault's historical undertakings. To get a grip on these questions one should study "*discourses, (archaeology), practices (genealogy) and their effects*" (Gordon, 1980: 246).

Archaeology deals with how scientific discourses (modes of knowing) struggle over truth; i.e. struggle to become scientific. The preoccupation with rationality in archaeology takes its point of departure in the mere fact that things have been said. The archaeological historian seeks to establish the epistemological breaks occurring within a given time span and the conditions for such epistemological formations and splits (Foucault, 2002: 42). The emphasis is placed on investigating the relationship between science and truth, that is, how modes of knowing are connected to truth-claims (Ibid. 2006; Foucault in Dreyfus & Rabinow, 1983: 237). Words were spoken and things took place, not as causalities within a larger coherent picture, but due to the immanent presence of conflict. Likewise, statements are uttered as candidates for being true or false, and as possible objects of knowledge (Hacking, 2002: 46). While it is not a concern in this dissertation to provide an archaeological undertaking, a central cue from Foucault's archaeological studies is adopted, namely the bearing upon (scientific) knowledge. The interest lies not in the formation of knowledge as such, but rather in investigating how particular kinds of knowledge enter a relationship with particular kinds of government, producing particular effects, i.e. segregating the healthy from the sickly. The focus on knowledge, then, is not only at a discursive level, but also on the ways in which human beings and their surroundings are rendered into a technical and practical reality by means of science; a point I elaborate on below.

Genealogy in this dissertation is applied as a method for analysing both historical and contemporary events. Either way, it provides what can be termed a history of the present (Gordon, 1980: 241) or effective history (Foucault, 1998a: 380; Dreyfus & Rabinow, 1983: 110). The methodological implications, strictly speaking, are the same, regardless of whether the object of analysis is from the past or the present. On this score, the interwar account is also a history of the *present*, as it provides a particular gaze upon contemporary problems, untangling their normative effects. In the same way, the contemporary analysis is also a *history* of the present as it seeks to disengage the object of inquiry from the normative notions upon which they are bound, and, thus, causing estrangement on the object of inquiry, as if it is from a distant past. From this standpoint, the analysis of preventive health in the 1920s and 1930s offers a perspective upon the campaign against obesity at the turn of the millennium by means of questioning its inevitability, just as the millennial campaign provides a frame of reference for the power-knowledge relations from which it emerged. In both cases an attempt is made to create a *verfremdungseffekt*, in other words, creating a distance from the object of inquiry by disturbing the seemingly obviousness attached to these workings.

To engage in genealogy as a history of the present, one needs to view the object of analysis as if it is unfamiliar. That is to say, although it seems to be an outcome of a particular logic and order of things, the genealogist's task is to show its incongruity (Foucault, 1998a: 372). In the interwar analysis I place under scrutiny how a relationship was formed between a welfare rationality and eugenics, not to get to the bottom of the inherent logic in this relationship – I do not argue that they are intrinsically bound together – but to show the contingent nature of this conjunction; not wrong or illogical but contingent. Despite the arbitrary nature of historical events, they nevertheless inform human ontologies – ways of being human according to a given nature, actions, feelings and everyday lives (Ibid. 1980c: 39): "*Nothing in man – not even his body – is sufficiently stable to serve as the basis for self-recognition or for understanding other men*" (Ibid. 1998a: 380). While archaeology's aim is to reveal rationality as informed by practices of segregation through

modes of knowing, genealogy's aim is to shed light on the relationship between science and subject-formations; formations that are themselves informed by practices of segregation, that is, the ways in which individuals and groups are divided (power) and divide themselves (ethics) according to specific norms of health.

Related to the incongruity appeal in genealogy is the attempt to break with the idea of historical analysis as a matter of looking for invariables throughout history, or, put differently, avoid taking the effect to be the cause (Nietzsche, 1887/2007: 51). For example, in investigating the campaign against obesity in the millennial era from a historical perspective, it might seem evident to investigate the past to discover when obesity became a problem that had to be prevented. Accordingly, one may conclude that obesity posed itself as a problem in relation to a general increase in income combined with less physical labour and more office work. The problem with this thread, however, is that in engaging in a historical account that basically says that because people become obese, obesity is regarded as a problem, is that one thereby creates causality. Consequently, a coherent picture of the historical phenomenon is presented through which intervention and transformation take place as a response to an inevitable necessity. Genealogy's claim, however, is that if a logic can be extracted in an interventional practice, it is not found in the object of the intervention itself: obese children do not naturally call for health intervention; or as Nietzsche states in presenting the genealogical method that inspired Foucault: "*Questions of origin and purpose are to be separated*" (Ibid. 1887/1998: xxiv, 25). Instead, I have chosen to look into a period in time – the first half of the twentieth century – where obesity was not considered a major problem. In fact the opposite was the case: underweight related to lack of nutrition, tuberculosis and poverty posed itself as a problem. However, while underweight does not merit attention in the analyses, so do eugenics and the promotion of physical culture. The crux of it is that, although one can trace back a place in time where the notion of obesity came to the fore as a public health concern, long before this, weighing techniques and systems of classification – along with other ways of addressing human beings through their bodies

– had been governmentalised. I illustrate how particular technologies (weighing, measuring and the like) and practices (gymnastics and the like) inform the ways people govern their bodies and beings in the fight against obesity. The gambit here is, that by avoiding the fixation of origin, i.e. establishing the starting point – *ursprung* – of particular ways of knowing and being (Foucault, 1998a: 372-73), I also avoid establishing a causal relationship between today and before. In this regard, the displacement of the analytical object of investigation serves the present by creating an effect of alienation vis-à-vis the ways people govern themselves and others: "*There are no constants for the genealogist*" (Dreyfus & Rabinow, 1983: 110).

3.3. GENEALOGY AND SKINNER'S CONCEPTUAL HISTORY

A kind of materialism is at stake in genealogy: not in the sense of relating things back to something like an economic basis, but rather in an attempt to relate things back to the effect of power on bodies and beings. It is concerned with the practical and technical effects of science and the moulding of human beings. Moreover, it entails the imperative that power and freedom are of this world as they inform the ways people think, act and relate to themselves and each other (Foucault, 1991: 79).

In emphasising the materialist imperative of genealogy, I relate the genealogical approach to Quentin Skinner's conceptual history (1988, 2002).[5] While Skinner's historical account of the development of concepts offers an alternative to a history writing that looks for origin and causality, it does not provide a firm grip on the production of truth as a thing of this world, i.e. it does not, as Foucault's genealogy does, offer a materialism. In staking out these claims, I compare the notions of utterance and language in Skinner's conceptual history with a Foucauldian genealogy. At the same time, Skinner's use of key

[5] The account draws from an earlier publication in which a similar comparison was made (Vucina, Drejer &Triantafillou, 2011). However, this shorter account offers a slightly different angle to the comparison of Skinner and Foucault by focusing on two specific areas of concern: how to incorporate a notion of rationality without losing the grip on power and how, methodologically, to avoid regarding the subject as transcending history.

individuals as bearers of history provides a platform for illustrating how to avoid the pitfall of what Foucault has identified as the 'empirico-transcendental double' (Foucault, 1970).

Skinner draws from Reinhart Koselleck's conceptual history in which language and utterances are considered crucial elements for making up history. This recognition of language as constitutive of reality is partly regarded as an epistemological condition, and one that every historian is faced with: it is impossible to identify what *really* took place in the past, because the only way to understand the past is through language (text). A historical analysis cannot make a clear-cut distinction between an event and different testimonies and descriptions of the event (Koselleck, 2002: 27). According to Skinner, it is the revelation of the shifts in conceptual possibilities that constitutes the way history unfolds, rather than the historical events in and of themselves (Skinner, 2002: 4, 87, 125). In this perspective, a historical undertaking is less a matter of identifying reality as such than a way to examine the discourses drawn upon and the utterances used by historical actors within a given context. Rationality is historically relative, in other words although thoughts from the past may seem, from a present-day perspective, unscientific or irrational, they are nevertheless rational from the perspective of their own historical context (Ibid. 1988: 243):

> We need to begin by recreating as sympatically as possible a sense of what was held to connect with what and what was held to count as reason for what, among the people we are studying (Ibid. 244).

Like Skinner's analyses, we also find a bearing on rationality in Foucault's analytics. This is particularly present in his archaeological writings through which spoken and written texts, i.e. discourse, make up the objects of inquiry (Foucault, 2002). Foucault maintains that rationality is not the rewarded outcome of some enlightened human beings, nor the end of a long journey where people are finally able to see ourselves as they really are (Ibid. 2007c: 59). Instead, going about the notion nominalistically, rationality is the type of knowledge that is identified and recognised as resting on a scientific foundation: that which is widely accepted as science (Donzelot, 1979: 99). For instance,

the millennial analysis illuminates how medical and political expertise identifies obesity through demographic and statistical surveys as a national and international health risk that threatens the general public health; a rationality that informed a number of interventional practices aimed at fighting obesity among children. Thus, genealogy offers tools to explore truth-statements, i.e. forms of veridiction (Foucault, 2010: 41-42), in order to analytically expose the relationship between types of expertise such as medicine and political practice (Rose, 1999b: 55). The human sciences play a central role in the various ways people know, relate to, identify, shape and govern themselves and others as human beings. Thus, in analysing a field of inquiry in which the human sciences feed into government technologies, one seeks to draw attention to the human sciences' normative effects on the ways people conduct themselves and others (Owen, 1995: 495). A primary prerequisite is that the areas worth investigating are the ones that seem common, natural, obvious and inevitable, because these areas are often where the effects are the most profound. In other words, the exploration of rationality is a concurrent exploration of power and ethics. Unlike Skinner's focus, the struggles taking place are not within a linguistic field but reflect a relation of power (Foucault, 1998a: 387): "*The history which bears and determines us has the form of a war rather than that of a language: relations of power, not relations of meaning*" (Foucault in Hacking, 2002: 83).

A central objective for genealogy, then, is the determination to disrupt the effects of the human sciences in their discursive and/or non-discursive form, the point being that these effects have a firm grip on current thought: "*One must confront what one is thinking and saying with what one is doing, with what one is*" (Foucault, 1984b: 374). This involves shedding light on how people (including most historians) *'loop'* (Hacking, 1995) the symptoms of the human sciences. These symptoms are an illustration of the pitfalls that, fallen into, preserve a certain image of the era and of how Western Europe has become what it is; i.e. the tendency to provide a neat picture of causality and the inevitability of human progress, making "*the historian [...] insensitive to all disgusting things*" (Foucault, 1998a: 383).

> Humanity does not gradually progress from combat to combat until it arrives at universal reciprocity, where the rule of law finally replaces warfare; humanity installs each of its violences in a system of rules and thus proceeds from domination to domination (Ibid. 378).

Thus, what is at stake is to question the ways people know themselves and others and act upon themselves and others by means of scientific knowledge.

Despite Skinner's efforts to propose a historical understanding detached from a grand narrative that looks for epochs, revolutions, war and the like, his analyses nonetheless do rely on grand individuals, that is, historical key figures, as he attempts to stay loyal to the historical person whose statements and thoughts he is investigating. Skinner proposes a kind of scientific tolerance or scientific relativism that is linked to his attempt to avoid the deadlock of historical *presentism* (Skinner, 1988: 243), that is, analysing historical accounts and events through the lens of contemporary norms (cf. Dean, 1994: 24-28). Instead, Skinner places emphasis on the intentions behind a given utterance in the context of the time in which it was uttered. In other words, he offers a hermeneutic approach. For Skinner, while intention is not necessarily expressed directly in language, the utterance should nevertheless be examined at the level of language, for instance by investigating displacement of meaning or conceptual changes (Skinner, 2002: 98).

In genealogy, paying attention to the looping effects of the human sciences entails both a methodological and an ethical imperative. Genealogy thus shares Skinner's attempt to break with presentism (Foucault, 2009: 17). Additionally, Foucault illustrates how historians impose on history a normativity, which is rooted in ideas of progression (Gordon, 1980: 242). However, Foucault goes much further, claiming that presentism in fact is an effect of the human sciences, and that the fallacy of progression nurtures a valorised interpretation of historical events. From this vantage point, hermeneutics is a kind of distrust of what is said without being said (Foucault, 1998: 286): "*If interpretation were the slow exposure of the meaning hidden in an origin, then only metaphysics could interpret development of humanity*" (Ibid. 378).

The genealogical task thus is to illuminate the effects of the human sciences, first and foremost by breaking with hermeneutics.

While genealogy resorts to break with hermeneutics, it concurrently sidesteps what Foucault has termed the empirico-transcendental double (Ibid. 1970). This entails avoiding a common pitfall in historical endeavours and contemporary analysis, namely viewing the subject as the a-historical bearer of the historical events one is analysing. For instance, when Skinner accounts for his historical analyses with the following statement: "*Historians have no option but to begin by assuming that what people actually talk about provides us with the most reliable guide to their beliefs*" (Skinner, 1988: 255), he emphasises exactly this focus on the subject as the bearer or the prime mover in history, and thus fails to take into account that the subject, too, is historically bound. When I analyse how children and young people are governed and govern themselves through preventive health practice, it is to emphasise how they and their actions are bound to historically variable power-knowledge relations. The methodological point is that when placing subject-formation at the centre of an investigation with a view to detecting effects of power-knowledge relations, it does not make analytical sense to place the subject exactly at the centre of events. The subject of crucial events is not merely a mediator of them, but is also transformed and becoming through them. In other words, an attempt to break with the deadlock of the empirico-transcendental double is an attempt to avoid looping an effect of power-knowledge relations that locates the subject at the point of departure of his/her experiences and thoughts (Foucault, 2000g: 118).

From this perspective, the difference between Skinner's attempt to detect true discourse according to the speaker's context on the one hand, and the genealogical attempt to establish forms of veridiction according to power-knowledge relations on the other, is the difference between the phenomenological or hermeneutic attempt to extract the meaning-giving activity from an autonomous subject (Dreyfus & Rabinow, 1983: xxiii) and the genealogical attempt to place knowledge within a governmentality framework. In the genealogical pursuit to connect

power and knowledge, the claim is that the effects of knowing what people know and doing what they do are physical in a very concrete way: it shapes their minds and bodies; it makes them feel certain things and allows them to fight for certain things. In this way, genealogy offers a historical materialism that seeks to illustrate how the relationship between rationality and government of human beings manifests itself in their lives and in the ways they relate to themselves (Foucault, 1998a: 375-76).

In the previous chapter, the notion of problematisation was outlined along lines of its conceptual merit. Genealogy, however, asserts that the notion of problematisation can be unfolded in two ways: conceptually – which I have unfolded in the previous chapter – and as a methodological aspiration. As a methodological aspiration, it feeds into an ethical stance: experiences which endeavour political problematisations bear within them a potentiality to cause political change and thus must be deliberated from their subjugated fixed position (Ibid. 1984a: 384). As a methodological premise, it invokes a particular gaze placed on the investigated material, which may be termed *problematisation of problematisation*. It relates to the epistemological implications of genealogy as an effective history and as a method for problematising the present. Effective history places contemporary modes of government in a critical light in the sense of unpacking current ways of thinking of and acting upon individuals and groups. By drawing attention to the normative underpinnings of power-knowledge relations, genealogy seeks to unshackle the causality established between a particular problem (e.g. obesity) and a particular solution (e.g. health promoting technologies). Problematisation of problematisation, then, is a question of critically investigating the effects of preventive health and health promotion. In analysing how obese children are made into targets of preventive health, it merits attention to how they are problematised as unhealthy and suffering from low self-esteem. By exposing the problematisation directing preventive health intervention, I also expose the causal relations established between obese children and preventive health. In other words, analysing preventive health as a number of problematising activities, calls into question – and thereby also

problematises – the effects of the problematisations informing preventive health intervention. The genealogical take thereby serves as a problematising mechanism, in which a history of the past and present both helps to create distance from contemporary norms and at the same time illuminates how these norms evolved as particular ways of governing human beings through and by virtue of their health. From this standpoint, one may find at the heart of genealogy an emancipatory imperative. However, the emancipation does not offer a liberation of the human being. Instead, I argue, it is concerned with liberating knowledge from truth-claims, in other words, from its scientific hold (Ibid. 1980e: 84). Further, it is an emancipation of knowledge from human beings, that is, a break with the idea that the human being transcends knowledge. Finally, it is a freeing of history from human thought and intention; i.e. from a hermeneutical grip.

3.4. SUMMARY

While genealogy is a way of engaging in historical and contemporary analyses, it is equally a way to critically analyse present rationalities and technologies. This attempt requires a methodological stand to avoid falling into the pitfall of origin while at the same time avoiding a search for invariables and constants. Although a central prerequisite in genealogy is the contingency of events and behaviour, it nevertheless offers a materialism by emphasising the constituting effects of power-knowledge relations: they target bodies and beings and shape the ways people think, act and become. This is equally the case when applying it to present events – and thereby offering a history of the present – and historical events. Quentin Skinner's conceptual history, like Foucault's archaeology and genealogy, gives prominence to the role of knowledge and rationality while equally attempting to avoid the presentist trap in history writing, where history is written according to the norms of contemporary times. However, genealogy not only sidesteps presentism; it also breaks with the idea of the individual as a bearer and mediator of history. In engaging in a genealogical undertaking, I analyse how relations of power and knowledge target and minister to particular human beings through their bodies and minds. I do so by investigating

how these are rendered a problem and accordingly, how they are rendered technical through government technologies. Chapter 5 outlines more thoroughly on how I make this focus. First, however, an outline of the data used in the analyses.

4. DATA

4.1. INTRODUCTION

In line with the overall attempt in this dissertation, the data has been selected for its efficacy in placing preventive health and health promotion within a power analytics. More specifically, it has been analysed for the light it throws on public health attempts to render human exteriority, corporeality and interiority a problem and, as such, as candidates for preventive health and health promoting intervention. Additionally, the data is analysed as revolving around various focal points of power and ethics set in play by particular problems (Deleuze, 2006: 16).

What follows is an outline of the data used for analysis, which includes elaborating on first, the selection criteria guiding the data collection, and secondly, considerations with regard to the temporal and special delimitation. Accordingly, reflections are put forth as to validity and representation, including the general strategy for data collection followed by considerations of space and time as well as validity and representation. Secondly, the data outline is divided according to the two analyses and data for each analysis is presented along with the selection criteria guiding each analysis.

4.2. GENERAL STRATEGY FOR DATA COLLECTION

The first criterion for selection of data related to the two sub-questions guiding the interwar and millennial analyses, regarded what it added to the identification of *problematisations* of and *technologies* targeting human exteriority, corporeality and interiority, or, in other words, 'modes of knowing' and 'modes of doing'. As elaborated on in the previous chapter, this relationship is not a simple causal. While *problematisation* entails viewing rationalities as being connected to the identification of a public health problem, it also entails looking into the technologies of health attached to this problematising activity. Likewise, *technology* also entails ideas put forth for government.

Secondly, while taking into account both *preventive* health and health *promotion*, they are viewed as two separate government technologies of health. Although they are often intertwined – especially in the millennial analysis – by selecting data that reflects both modalities, an insight is provided into the dividing practices put forth in terms of the object of government: who and what qualities were targeted as eligible for prevention and who and what qualities were targeted as eligible for promotion.

Thirdly, in deploying genealogy as a method, the relationship between the two analyses is a somewhat tricky one, as I do neither a direct comparison nor a mapping out of the two periods. Instead, the interwar analysis serves the millennial analysis in two ways. A. It works as a differentiating mechanism, that is, as a way to distance preventive health in Denmark at the turn of the millennium from the norms and truths of the era. The findings from the interwar analysis guide the gaze placed on the millennial analysis: a critical gaze on the governmental effects of strategies for providing health. Hence, the interwar analysis can be seen as a *problematising* mechanism, set on causing an estrangement effect on present-day norms of health related to obesity. B. The interwar analysis provides a *genesis* of formations and reformations of specific fields of thought and intervention. In other words the selected data alludes to particular ways that preventive health at the turn of the millennium was carved out and presented as a particular answer to a particular problem in public health. On this score, in the data selection process, the genealogical premise evaded a focus on invariables in a general attempt to avoid causality between the past and the present; a prerequisite which is reflected in the inconsistency of data in the interwar and millennial analysis respectively. In the interwar analysis, the data centres on how medical, anthropological, hygienic, welfare-economic and nursing problems became a public health problem or how it did not become so. Contrary, in the millennial analysis, neither medical, anthropological, hygienic nor nursing data have a prominent role; in fact only medical data is drawn from and only to a minor extent. Instead, with the use of data from DGI, medical data and government reports, a central point here was to investigate how private or non-state

modes of administrating the population and individuals became a political concern. While medical expertise had a key role in this pairing of civil and state health concerns in the interwar era, by the turn of the millennium medicine's role seems less dominant. Indeed, the data illustrates how an expansion of health expertise had taken place, giving incentive to other relations of biopolitics to be formed. In the same vein, while data on obese children constitutes a key element in the millennial analysis, in the interwar analysis this is not the case. The point was not to trace back historically the government of obesity but to interrogate how problematisations and solutions put forth through preventive health and health promotion in the early twentieth century – some of which targeted children – show parallels with problematisations and solutions found at the turn of the millennium. Hence, while invariables are not found to connect the interwar investigation with the millennial, instead the two settings are bound by two overarching questions: how are preventive health and health promotion made epistemologically and technically possible through modes of problematisations and government technologies? And how are the human environment, human bodies and human minds targeted and ameliorated according to particular health norms?

The empirical foundation for comparing the two analyses then concerns the rationalities, techniques and practices informing preventive health. Likewise, the data's reliability is established not in relation to the strategies put forth – to achieving intended aims – but with reference to the modes of problematisation and modes of technology, regardless of ends.

4.3. TIME AND SPACE

The geo-political setting is Denmark. Therefore, I am not able to draw lines to preventive health and health promoting efforts outside Denmark. However, in the selected data, a number of references are made to other European countries as well as the US. Some of the Danish preventive health strategies draw explicitly from foreign literature. Accordingly, I account for preventive health practices and rationalities in

Norway, Sweden, Germany, the UK and the US to the extent that they explicitly inform Danish preventive health strategies.

The data is analysed from a variety of local settings. In the interwar analysis, a number of preventive health and health promoting debates and practices flagged the rural areas of Denmark as being of particular interest as the youth in the countryside were considered more in need of health interventions. However, the opposite was also the case. Problematisations concerned the upbringing of mainly urban children in larger cities, particularly Copenhagen, as areas where unhealthy habits thrive. In the millennial setting, the distinction between countryside and city is made to a lesser extent. The fact that the data from this setting for the most part is taken from the Southern region of Funen, apart from Copenhagen, is due to the campaign *Seize the Chance* ('Grib Chancen') from DGI Funen, which was set in motion at the time of the data collection. As the campaign took place in Funen, data from municipalities and associations in this region is overrepresented. In addition, attention has been placed on DGI Copenhagen's campaigns and at the time of the data collection, an overweight association was starting up, which allowed for data to be extracted also from Copenhagen. Thus, I do not consider the analysis to be representative of the whole of Denmark. Nonetheless, the data extracted from Funen and Copenhagen respectively, reflect a tendency, namely the increasing use of NC between private organisations and various public authorities.

As for the temporal aspect, the interwar analysis spans the period from 1920 to 1940. There are various reasons for choosing this particular period. First of all, as mentioned in the introduction, the social reform of 1933 marks a time where public health becomes a central state concern following a number of efforts to install new types of preventive health. The first half of the twentieth century had a profound impact on current preventive health practice and the outcome of the social legislation of 1933 to a certain extent still matters. Another reason for choosing this particular period is almost contrary to the first: the two periods differ sharply with regard to the way bodies and beings are addressed and transformed, although the influence of earlier welfare efforts can still to

a certain extent be seen in preventive health and health promotion today. That said, the above-mentioned reasons for choosing the interwar period were not clear before the collection of data. I started out with a broader time span but, guided by the data itself and secondary literature, made a decision to narrow it down. Nevertheless, the set time span is not always kept. Some sources extracted had their breakthrough before or after this period. Likewise, some data refers to and draws directly from literature from before the selected period. Thus, when relevant for the course of the argument, or in order to clarify a point, I take into account data from before and after the chosen period.

The later analysis focuses on the decades on either side of the turn of the millennium – the 1980s until 2012. The DGI has supported this investigation financially and has provided support for accessing data on the DGI and gymnastics movements in general. The organisation was selected, both when investigating campaigns targeting obese children and for exploring the promotion of collaborative partnerships. An aim was to select data that involved particular ways of putting into play bodies and beings. The fight against obesity therefore seemed fruitful to centre the interrogation on, as obesity is a bodily condition. Initially I mostly investigated material from the last five years of the period. It turned out that it drew mostly from certain data from earlier on, and therefore I expanded the timeframe backwards. As the campaign against obesity officially took off in the 1980s, 1980 was chosen as the starting point.

4.4. QUESTIONS OF REPRESENTATION AND VALIDITY

The point is not to provide a mapping of preventive health and health promoting practice. Neither is it to establish a chronology of health-related events from the beginning of the twentieth century to the end of it. Instead, the interrogation takes a sideways cut into a narrow area of government through preventive health and health promotion, leaving out a vast amount of other data. It is the premise for this kind of genealogy, and the reason that it is considered *a* genealogy out of other possible genealogies of government through preventive health and

health promotion. Linked to this is the question of validity granted to the selected data. While the data is selected for illustrating how particular forms of knowing and doing health become a government concern, it simultaneously provides an insight into how specific forms of truth-statements inform the ways people govern themselves and others (cf. Chapter 2). One focus is on how relations are established between rendering something a problem and rendering it a technical entity, and how each is rendered into relations of power. This does not, however, involve an evaluation of certain forms of strategies over others in terms of their truthfulness, accuracy or appropriateness. I thus refrain from providing normative evaluations that approve some power relations over others. It is not, for instance, the task of this dissertation to endorse some means of fighting obesity. In other words, while I do investigate the truth and power effect produced through public health government, the point is not to engage in those truth and power games. Thus, validity is indeed granted to the selected data, but strictly in terms of its relation to power and knowledge.

In the process of selecting data, particular importance was rendered to two types of data: scientific expertise and government documents. Scientific data refers to data from people granted the authority to speak the truth about health government (see an elaboration on the use of expertise in the analysis in Chapter 5). In the process of collecting data on millennial scientific expertise, I came across a challenge. Health professionals and less 'professional' expertise, such as that used by sports students and students of nutrition – all of whom were directly involved in campaigns against obesity – obtained very little written material on why obese children were targeted and what solutions were to be brought to bear in terms of health. A health visitor involved in the *Camp Fanø* for obese children, approached with a request for written material on their health strategies, did send me some, though it was not very detailed. However, she emphasised the importance of meeting obese children through a gut feeling, combined with the knowledge gained under training, rather than through schemes and steady procedures. Although many procedures do include schematic testing and the like, they were not necessarily carried out on the basis of clear

strategies and proceedings, at least not in writing. This dearth of hard copy for the millennial analysis, which certainly was a challenge with regard to establishing an empirical foundation for analysis, in fact became an analytical point: truth-telling is less a telling than a kind of unarticulated knowledge incorporated in everyday practice.

The data selected for the interwar analysis consists only of written material, which may seem an obvious thing to state when investigating a bygone era. The data for the millennial analysis, on the other hand, consists of written material, a few interviews with key individuals and notes taken during short stays at two health-promoting settings and during a number of meetings. Hence, written material makes up the majority of the data. Following a Foucauldian premise I avoid ranking data according to its closeness to the 'truth', or to exact events. From this perspective, information provided through personal accounts and encounters with people experiencing particular events is ranked, if not lower than, then at least equal to, say, government reports. The crux of it is that one does not necessarily get a more accurate, more comprehensive or more useful picture of events from an interview with an obese child about his or her involvement in a health campaign than from government documents. Instead, the concern is to steer clear of attempts to envisage the subject and his/her experience as the bearer of events, in other words to avoid the pitfall of the 'empirico-transcendental double' (cf. Chapter 3).

Below I provide a more detailed account of the data used in the interwar and the millennial analyses.

4.5. THE INTERWAR ANALYSIS

4.5.1. DATA SELECTION CRITERIA

As sub-questions 1 (*How were human exteriority, corporeality and interiority rendered a problem through preventive health and health promotion efforts in the period from 1920 to 1940?*) and 2 (*How were human exteriority, corporeality and interiority informed by*

technologies of preventive health and health promotion in the period from 1920 to 1940?) guiding the interwar analysis illustrate, a central concern has been to incorporate data dealing with both the *problematising* and the *technological* facets of government through preventive health and health promotion. Thus the data consists either of ways of identifying human qualities, relations and modes of behaviour as problematic in terms of health and disease, or of ways of coming up with solutions to problems of ill-health. Simultaneously, following attempts to put into play the relationships between human exteriority, corporeality and interiority, I needed to extract data that somehow related to workings upon human environments, human bodies and human beings. Finally, having in mind the millennial child obesity campaigns, a point was also to extract data that somehow found resemblances to this, either in terms of the individuals targeted (e.g. children) or in terms of types of rationalities provided and technologies promoted. That said, in order to avoid creating a chronology of events culminating in current health practice, apart from the above-mentioned, I was in no way loyal to millennial events and practices when selecting the data. In an attempt to avoid *presentism* (Skinner, 1988b: 242-45; Dean, 1999: 24-28; cf. Chapter 3), although *serving* the millennial investigation, the interwar investigation stands in its own right. I did, however, allow millennial problematisations and interventions to direct the general terms for selection, although without directly influencing the objects of interest. For instance, although the DGI is a central source in the millennial analysis, it was not a concern to trace back the development of the DGI or sports organisations as such to the interwar period. Instead, the promotion of physical culture merited attention. Likewise, although I investigate NC as a particular health administrative practice in the millennial analysis, in the interwar analysis I do not trace back when, how and why NC became a central administrative practice. Instead, I extract data that shows resemblances to similar modes of rendering human exteriority amenable to government. In other words, the interwar data has not been selected to serve the millennial analysis as a mapping or a chronological research into the development of preventive health. Instead, the interwar analysis serves the millennial

one in that it illustrates how preventive health and health promotion found a scientific ground for putting forth particular practices.

4.5.2. DATA SELECTION PRACTICE

Having the criteria in place, the data for the interwar analysis was compiled through the following areas of interest:

Firstly, priority was given preventive health practices that targeted children and the youth. Or, more precisely, in my initial data search I discovered that children and young people were one of the groups given particular attention. As my focus in the millennial analysis was on young people, I decided to integrate this focus also with regard to the earlier period as well.

Secondly, data on medicine and medical practice forms the central point of departure. Medical expertise in the 1920s and 1930s was a decisive factor, both in terms of identifying problems for preventive health and health promotion to deal with, and in coming up with solutions. Put differently, medical concerns correlated with welfare, economic and social concerns; medically identified problems were thus not only raised within a medical context but problems of public health, welfare and the economy too. In other words, to the extent that medicine went beyond the purely clinical aspects of disease and prevention, it informed preventive health in the 1920s and 1930s; hence its relevance as the central object of the analysis. It is important to note, however, that biomedical rationalities and practices correlated explicitly with, for instance, physical anthropology and nursing, and informed political rationalities such as welfare-economic rationalities. Consequently, if medically identified problems relating to preventive health did not link up with public health concerns, I did not take them into account. The crucial point was exactly this linking of the medical and the political (cf. Chapter 2 on governmentalisation), which gave way for particular rationalities concerning the health of the population and particular ways of governing it.

Thirdly, I wanted to localise data on preventive health and health promotion without relying on either the terms themselves or on their resemblances to contemporary practices. Instead, I wanted to address how medicine and related branches such as biology, anthropology and psychiatry identified, problematised and carried out preventive health and health promotion. This in turn made it possible to draw lines to sports science, gymnastics, nursing and welfare economics. Moreover, the initial data collection revealed that a variety of medical branches put forth broad notions of preventive health and health promotion, encompassing gymnastics, nursing, psychiatry, sociology and welfare economics. For instance, a central preventive means was eugenics. The expertise included GPs, biologists, eugenicists, gymnastics experts, nutritionists and heredity scientists. As for the gymnastics experts, for the most part they were in fact doctors specialising in gymnastics and body movements.

The medical data revealed how broad the field was on the theme of preventive health and health promotion and an eclectic picture slowly emerged of the research landscape through debates, articles and books. Some experts were often referred to and quoted, which directed me to read their own works and sometimes grant them central status within that particular debate, whether it was in gymnastics, heredity science or clinical medicine's take on preventive health. At the same time, reviews of journals and books led me to sports journals, journals for social issues, economics, nursing, venereal disease and many more, each of which in some way or another related to preventive health or health promotion. This wide-ranging approach provided many insights into the central problematisations and technologies led by medical science, as well as into how medicine paired up with other scientific branches. It also provided a platform to investigate how medicine informed the politics of preventive health and health promotion.

The interwar data collected for the most part deals with ideas, discussions and identification of a given event, problem and solution, including testimonies concerning what was actually done. Part of the methodological premise was to dwell less on what was actually taking

place than on strategies put forth, i.e. the rationalities and technologies that allowed a space for government to be carved out. That said, in dealing with the interwar data, it was a challenge to actually get hold of material that provided an overview of what had taken place. To give an example, a central concern in preventive health debates at the time was the low birth rate. A number of discussions took place about the issue, in medical journals and in other material dealing with public health issues. However, I cannot draw a direct line from these discussions to what was actually done to slow or reverse the decline. Instead, I was able to extract material that illustrated a number of intervention initiatives, and to investigate techniques and procedures put forth that were informed by the decrease in the fertility rate.

In order to heal an imbalance created by my emphasis on the problematising aspect, I have supplemented my own data with that of Lene Koch (1996, 2000). Her work on eugenics and sterilisation practices during the early twentieth century provides an overview and at the same time gives a thorough account of intervention practices.

4.5.3. SOURCES

Having described my selection criteria and selection practices, below I present the data used.

As for medical science, primarily data from the journal *Ugeskrift for Læger* ('Weekly Journal for Doctors', hereafter referred to as *Ugeskrift*) has been extracted. The journal was first published in 1839 and is focused mainly on findings within biomedical research. *Ugeskrift* is one of the most central medical journals in Denmark and it therefore seemed relevant to start here when looking into preventive health and health promotion. With the above-mentioned criteria for data collection in place I looked into all issues of *Ugeskrift* from 1890 until 1942, keeping the time span a bit broader than within the analysis in order to contextualise better. I collected everything related to preventive health and health promotion that had human beings as a central concern linked to a social and/or welfare perspective. The articles that I found relevant

came from a large range of medical branches that touch on preventive health and health promotion – from venereal disease, mental illness and intellectual incapacity to nutrition, eugenics, social care, hygiene, physical anthropology and, finally, gymnastics, physical exercises and sports.

The journal search led me to other sources through both references and reviews, for instance *Bibliotek for Læger* ('Library for Doctors'): the oldest still existing medical journal in Denmark and the world. *Bibliotek for Læger* has been published quarterly since 1809. My search in this journal was more sporadic. This was both due to the fact that I had already placed the main focus on *Ugeskrift*, but also due to the nature of the journal, which, at least in the first half of the twentieth century, is of a more general kind and less concrete in terms of actual debates and practices. I mostly looked into articles in *Bibliotek* from 1890 to 1900 that were referred to in *Ugeskrift*, and their main use was in contextualising debates and practices that fell within the decided time span.

Heredity science was a central medical branch in the data from the two journals and the heredity approach to preventive health was represented by a number of key figures, whose publications I also draw from. These include plant physiologist and heredity scientist Wilhelm Johannsen's historical overview of experimental heredity science published in 1923 as well as his book on heredity and alcohol published in 1924. With these I was able to establish some of the key ideas behind heredity science at the time and how heredity concerns became crucial when debating the issue of preventive health. It also includes botanist and heredity scientist Øjvind Winge's work published by the *Carlsberg Laboratories* in 1921 and his work on alcoholism and heredity published by the *National Association for the Protection of Personal Freedom* ('Landsforeningen til den personlige friheds værn'). This association was established in 1918 as a reaction against the prohibition of alcohol and was dissolved in 1980 (http://dpfv.dk/index.php). Winge also published a widely cited anthology on heredity and race published in 1934 by the *Danish Association for Social Education* ('Dansk Forening for Social

Oplysning'), as part of *The Social Secretary* ('Det Sociale Sekretariat') and *Social-Political Association* ('Socialpolitisk Forening') which I also draw from. Social-Political Association was established in 1898, dealing with social issues (http://socialpolitisk-forening.dk). Among other journals the association published *Society's Demand* ('Samfundets krav'). Winge and Johannsen's work were regarded as central works of the time in heredity science, and as heredity was emphasised when debating the issues related to preventive health, I found both extremely useful.

Apart from heredity science, I draw from medical data with a psychiatric take on preventive health. A review in *Ugeskrift* on the psychiatrist August Wimmer's lecture on mental illness, heredity and eugenics held at Uppsala University led me to his Uppsala lectures, published in 1929. I also draw from his forensic psychiatry lectures on alcoholism, published in *Ugeskrift* in 1930. Moreover, I draw from Wimmer's contribution in Winge's anthology on heredity and race published in 1934, which provided insight on how psychiatry was preoccupied with issues relating to preventive health.

Along with heredity science and psychiatry, a sexual-administrative take on preventive health was reflected within medicine. Most of this data is from the *Danish Association for the Fight against Venereal Diseases* ('Dansk forening til kønssygdommenes bekæmpelse'). The association, which was founded in 1902, published a number of articles questioning whether to educate the youth in schools on the issue of venereal diseases. Articles from *Ugeskrift* include work by the physician and sexual reformer J. H. Leunbach. Heredity scientist and sociologist Tage Kemp's book on prostitution from 1935 was also useful.

For medicine's approach to nutrition, I draw from physiologist Johanne Christiansen's correspondence in *Ugeskrift* on the topic of child mortality in Denmark and Norway, and her article in the same journal on nutrition and the state of health in Denmark, both published in 1937. Another of her articles in *Ugeskrift*, this one on animal food and public health, was published in 1939. In the social journal *Society's Demand*

('Samfundets krav') in 1935, physiologist Ejnar Nyrop publishes the first in his series of articles about the relationship between income, nutrition and health, which I draw from. I also extract three other articles on the topic that appear in *Ugeskrift* during 1937.

Articles from *Ugeskrift* reveal an influence from physical anthropology on the matter of preventive health, especially *The Anthropological Committee*, founded by physical anthropologist and police surgeon Søren Hansen in 1904. Apart from various articles published by members of the Anthropological Committee, I draw from a lecture Hansen gave in 1912 at *National-Economic Association* ('Nationaløkonomisk forening'); an association for national economists founded in 1873) on the issue of eugenics, which was published in a special edition of *National-Economic Journal*, as well as an article Hansen published in 1917 in a special edition of *Biographical Journal* ('Personalhistorisk tidsskrift') that was first published in 1880.

Tage Kemp's reference to Gunnar and Alva Myrdal – he a sociologist and economist and she a sociologist and politician – in his lecture on the anti-social, which was published in *Ugeskrift*, led me to the couple's book on the population crisis published in 1935, and to Alva Myrdal's book on urban children published in 1936. Also, I draw from Gunnar Myrdal's lecture on the commonality crisis in 1935 and his book on value and social theory published in 1958; both illustrate how welfare services were seen as a crucial means for preventive health.

K. K. Steincke, who during the first half of the twentieth century served as the ruling Social Democratic party's minister of justice, minister of social affairs and later minister of justice again, is widely regarded as the chief architect of the Danish welfare state with his Social Reform Acts of the early 1930s. He was one of the contributors in Øjvind Winge's anthology on race and heredity published in 1934. I also draw from Steincke's lecture on social legislation and eugenics given at the Medical Society in 1928 and published in *Ugeskrift*.

Hygiene during the first half of the twentieth century is a term broadly used and covers various health-related areas, ranging from disinfection of buildings, installation of health facilities in schools, general practice and nursing to fighting tuberculosis and venereal diseases. In the analysis I take into account a few of these areas. I draw from articles published by the *National Association for the Fight against Tuberculosis* and representatives from the association, such as professor of clinical medicine Knud Faber, and his work with J. Ostenfeld published in the nursing journal *Sygeplejen* in 1924. I also draw from Faber's memories of health administrative practices in Denmark in a book published in 1939.

Data from the popular scientific journal *Healthy Lifestyle – Popular Journal for Nutrition and Hygiene* ('Sund levevis – Populært tidsskrift for ernæring og hygiejne') is also extracted. *Healthy Lifestyle*, first published in 1935, was also reviewed in *Ugeskrift* (Bie, 1935: 61). I draw from various articles in the period ranging from 1933 to 1938, most of them published by the chief editor Poul Freudenthal, a consultant in gynaecology and specialist in hygiene and nutrition as well as bodily and mental health.

Data on children and hygiene covers themes from physical issues in raising children and biometric investigations to discussions about school medical officers and schoolchildren's nutritional needs. I take into account the *Nordic Congresses for Physical Education, Children's Health and School Hygiene* ('Nordiske kongresser for legemlig opdragelse, børne- og skolehygiejne'), which took place monthly, quarterly, and annually in different Nordic cities from the early 1920s until the late 1950s. A Danish contributor at the congresses is the physiologist H. P. T. Ørum, who specialised in school hygiene, and schoolchildren's growth, nutrition and physical constitution in general. I draw from Ørum's accounts in *Ugeskrift* in 1924 and 1926, from a book (8. Nordiske kongres for legemlig opdragelse, børne- og skolehygiejne på Hindsgavl 1.-6. juli 1935, 1935) and from a summary of the eighth meeting in 1935, the latter published in *Ugeskrift* the same year. Also published material from the *Association for the Promotion of School*

Hygiene ('Foreningen til skolehygiejnens fremme') is extracted. A key source on the theme of school hygiene was L. S. Fridericia, a professor in hygiene and consultant at the National Board of Health.

The nurses' role in preventive health constitutes a relatively small part of the findings. In particular their new assignment as health visitors was widely debated, both by nurses themselves and by physicians, particularly as a means to fight tuberculosis and venereal diseases. I draw from some articles in the nursing journal *Sygeplejen*, the main publication of the *Central Association for Nursing Activities outside Copenhagen* ('Centralforeningen af Sygeplejevirksomheder uden for København') since its establishment in 1909. The issue of hygiene, although put forth in *Ugeskrift,* was more thoroughly debated in *Sygeplejen* among nurses, GPs and others, the one aspect of preventive health debates the journal covers. A few articles from the 1920s and 1930s are extracted.

Sports, gymnastics and physical culture were central topics in the debate about means for preventive health as promotion of fitness. In the early twentieth century, sports, gymnastics and physical culture were to a large degree a medical concern and were promoted and debated within areas of hygiene, general practice, clinical medicine and social medicine. In addition to a medical take on the issue of physical culture, I draw on a sports scientific approach to gymnastics, represented in the main by key scientists J. P. Müller, Captain Jespersen, Pehr Henrik Ling, Agnete Bertram, Elli Björkstén, Niels Bukh and Viggo Munck, particularly Ling and Björkstén, as well as extracts from J. P. Müller's *My System*, published in 1904, and from his book on sexuality and morality published in 1908. From the sports journal *Danish Sports* ('Dansk Idræt') I draw from a number of articles published during the 1930s. It covers the gymnastics and sports take on the issue of preventive health practices. Apart from gymnastics theories, many articles were in fact published by doctors.

Foreign sources of inspiration are German Ernst Kretschmer, American constitutional psychologist William Sheldon's 1940 book on the varieties

of human physique and Charles Stockard's work on the physical basis of personality, published in 1931, as well as his book on the difference between body and behaviour published in 1941.

A central source for establishing an overview of the preventive health carried out during the 1920s and 1930s was the former director of the National Board of Health Johannes Frandsen's memoirs of public health from the late 1920s. Frandsen headed the board from 1928 to 1961, and was chief medical officer of the board from 1932 (Frandsen, 1963). Frandsen's memoirs provided clues for material among policy documents.

I take into account the *Commission for Social Arrangements Towards Degenerate Persons,* established in 1924, which is also referred to as the *Sterilisation Commission*.

As for the work done by the Sterilisation Commission, I draw from a report published by the commission in *Ugeskrift* in 1927. I also draw from Lene Koch's account of the commission's work.

As the policy documents were difficult to track down according to my specific search for preventive health, the use of these documents has been rather sporadic. I draw from two ministerial reports published in *Ministerial Tidende for Kongeriget Danmark,* both from the 1930s. Moreover I take into account four documents published by the National Board of Health between 1920 and 1930 and the National Board of Health's annual report ('Sundhedsstyrelsens årsberetning') from 1932. I also take into account health interventions carried out by the Copenhagen medical county district, as well as ministerial work and interventions carried out by the National Board of Health. Finally, I draw from accounts on health services by medical consultants as well as an account in *Social Denmark – A Survey of the Danish Social Legislation* published in 1947. The latter includes K. K. Steincke's speech in Parliament in 1929.

4.6. THE MILLENNIAL ANALYSIS

4.6.1. SELECTION CRITERIA

Firstly, as in the historical chapter, the sub-questions guiding the millennial analysis illustrate the division into investigating the *problematising* facet of preventive health and health promotion, reflected in sub-question 3 (*How were human exteriority, corporeality and interiority rendered a problem through preventive health and health promotion in the period from 1980 to 2012?*) – and the *technological* facet of preventive health and health promotion, reflected in sub-question 4 (*How were human exteriority, corporeality and interiority informed by technologies of preventive health and health promotion in the period from 1980 to 2012?*). At the same time, an attempt was made to put into play the relationships between human exteriority, corporeality and interiority.

Secondly, in the initial data collection phase, it became clear that children and young people were of particular interest in campaigns fighting obesity and that many both privately and publicly funded projects targeted obese and/or inactive children. I therefore decided to narrow down my data collection to these. The nature of the preventive health target – obesity – moreover allowed me to analytically unfold an area of public health in which the body constitutes a central concern.

Thirdly, a part from investigating direct interventions, and strategies and campaigns involved in fighting obesity through preventive health, I wanted to include an administrative aspect, more specifically NC between public and private bodies. Along with my own survey (see Enclosure), public authorities confirm that forming partnerships has been placed on the agenda as an important way of dealing with public health issues of overweight and inactivity (Kulturministeriet, 2009b: 38-40; Sundhedsstyrelsen, 2007b: 40). One may argue against presenting NC as a new phenomenon, as public administrations to some extent have always engaged in collaborations with voluntary organisations and external actors. For instance, municipalities have long been obliged to

provide free facilities for sports associations (Ibsen, 2006: 40), and thus for many years they have provided at least the physical framework for sports associations' activities. However, as several commentators point out, a difference lies in the fact that the collaboration has increased, as has outsourcing of public services generally (See Høyer-Kruse, 2008 for an elaboration of this point). The spread of NC is one reason for my interest in investigating the phenomenon. A primary reason, however, has to do with the fact that central actors such as the National Board of Health, the Prevention Committee and the Ministry of Health and Prevention have emphasised NC as a central means for carrying out preventive health campaigns. I therefore found it relevant to add an administrative aspect to my investigation of government. Another reason is of a more theoretical nature. In the government literature, very few attempts have been made to investigate NC as a particular form of government.

Fourthly, a choice was made to allow DGI to constitute the central point of departure in my millennial investigation. Apart from the fact that DGI has funded the project, there are a number of reasons for this decision. Firstly, with the increased focus by the National Board of Health and the Ministry of Health and Prevention on preventing obesity among children in the first decade of the new millennium came a concomitant increase in the funds allocated to specific sports organisations (cf. Høyer-Kruse et al., 2008). As one of the most central sports organisations in Denmark, the DGI seemed like a relevant source. Secondly, in this same decade the DGI changed its profile with a new emphasis on sports as a health provider rather than merely a social and recreational activity. In the light of this change, it initiated a number of projects in partnership with public bodies and private organisations targeting obese children. Finally, I was interested in shedding light on both interventions targeting obese children and the NC involved in the intervention, and the DGI was a leader in both.

4.6.2. SELECTION PRACTICE

In presenting my main sources, I again divide the data into first that which was related to 'modes of knowing', that is, the rationalities, debates and problematisations of preventive health; and secondly, to 'modes of doing', or the interventions carried out and technologies for intervention. The idea has been to gain insight into the general preventive health setting in which the DGI navigated, both in terms of the strategies directed at obese children and those directed at the administration of preventive health. The link between the DGI and these documents is that they all in different ways relate to preventive health and for the most part preventive health aimed at fighting obesity among children and young people.

In order to provide a general introduction to the ways in which preventive health and health promotion were problematised in terms of fighting obesity, I draw on medical articles and documents from health institutions and government programmes. As for the medical articles, I present a rather sporadic introduction to how obesity was presented and problematised as a medical concern. Unlike the interwar chapter, the focus is not on medicine's role. Nevertheless I illustrate how obesity as a medical problem is intimately linked to obesity as a public health problem as well as economic and political ones. As for a health institutional approach to the problem of obesity I take into account publications from central health authorities such as the National Board of Health, the National Board of Nutrition, the Prevention Commission's report from 2009 and their affiliation with the WHO preventive health reports. Together these documents provide insight into how the problem of obesity came to be identified as not only a medical problem but also a public health problem, both nationally and internationally. As a public health problem, it became linked to broader socio-economic problematisations such as health expenses, demographic concerns and concerns related to the workforce as such. Finally, documents from public authorities include government documents detailing national strategies targeting obesity and municipal documents, mainly from the Region of Southern Denmark (RSD), as this is the location of the DGI

activities I focus on. The various documents of public bodies provide an insight into how obesity had become as much public health and socio-economic concerns as a medical one, and thus something that demanded political action both nationally and locally.

As for interventions directed at obese children, I take into account *Camp Fanø* for obese children connected to Odense municipality. Each year 40 overweight children attending fifth grade are offered a six-week stay in a camp on the island Fanø, as part of Odense municipality's preventive health strategy (Odense Kommune, 2010a: 2). When Odense municipality took part in *Seize the Chance*, *Camp Fanø* became integrated as part of the package offered to overweight children. The children enrolled in *Camp Fanø* are away from home from mid-May to the end of June. As part of the programme, they engage in different kinds of physical activities, eat healthy food and are taught about general health. Apart from activities aimed at changing the children's lifestyle, Danish classes, mathematics and English are also part of the everyday schedule. Six students from the Institute of Sports Science and Clinical Biomechanics at the University of Southern Denmark are in charge of the daily activities. Play, movement and active participation are key notions behind attempts to motivate the children to be physically active and develop healthy social competences. Moreover, a catering manager is in charge of food at the camp. The *Camp Fanø* data includes notes collected during my visit at the camp and during unstructured interviews with three health professionals connected to the camp from Odense municipality. Moreover, the data includes notes from the implementation of Grib Chancen by DGI Funen, from the initial meeting to the process of including various municipalities from the RSD along with the various sports associations associated to the municipalities. For this I draw from notes from meetings, interviews and written material.

I focus on two levels of preventive health targeting obese children. One deals with how to know obese children and intervene in their lives in order to transform them into healthier children. The other is about the administration of preventive health, that is, how to know administration of preventive health targeting obese children and intervene in it.

In terms of relating to the two research questions connected to the millennial analysis, I take into account various levels of data dealing with governmental strategies, either in the form of rationalities and ideas or in the form of technologies for interventions and strategies. In line with my conceptualisation of government as types of rationality and intervention that state bodies hinge on, I illuminate these levels of state government.

Firstly, I draw from a number of state institutions, mainly the Ministry of Health, later named the Ministry of Health and Prevention, which oversees state initiatives such as the Prevention Commission and the Committee for Popular Sports. I take into account the National Board of Health, the highest authority on health and prevention matters in general, the National Board of Nutrition and the Danish Institute for Clinical Epidemiology (DIKE), an institute under the Ministry of Health that monitors the state of health in the population and sub-populations. Secondly, I use data from municipalities. As stated above, I have structured my data collection around two specific DGI projects, one from DGI Funen in the RSD and, to a lesser extent, from DGI Greater Copenhagen. Therefore, I draw from municipalities connected to the DGI Funen project Grib Chancen, that is municipalities in the RSD, mostly from Nyborg and Odense municipality. Thirdly, as the DGI formed the central point of departure for my collection of data, I draw from both published data from the DGI headquarter as well as from specific data connected to either DGI Funen or DGI Greater Copenhagen.

4.6.3. SOURCES

The DGI is one of three main sports organisations in Denmark.[6] Its focus is on non-elite sports and 5100 individuals, mainly volunteers, run it. Its

[6] While Team-Denmark covers elite sports, apart from the DGI the two other main sport organisations are the Danish Sports Union ('Dansk Idrætsforbund' – DIF) – which covers 10.700 associations and is responsible for both elite and non-elite sport as well as the Danish

history goes back to the middle of the nineteenth century when the *Danish Rifle Association* was constituted in 1861. Data on the DGI includes a guide for development of associations, data on collaboration with municipalities, annual reports and strategy reports, as well as data on the DGI's role as a voluntary organisation.

As mentioned, focus was on two particular initiatives for fighting obesity, namely DGI Funen's campaign *Seize the Chance* and DGI Greater Copenhagen's overweight association. Therefore most of the material from the DGI is taken from these two local DGI associations and related partners. I draw on written material on the establishing of *Sports Political Forum Funen* (SPFF), notes from dialogue meetings, network meetings and an interview with the appointed organiser of *Seize the Chance*, and finally, an evaluation of the initiative by sports scientists from the University of Southern Denmark. There is also data on *Camp Fanø*, described in the section above on selection practice. The data includes a few written documents, notes from a short stay at the camp and an interview with a health visitor connected to the camp.

As for DGI Greater Copenhagen, data included a project description of the initiation of the overweight association, notes from my stay at a workshop for instructors involved in the association and material from a nutrition association that was connected to DGI Greater Copenhagen, an interview with a student from Suhr's school of diet, who was affiliated to the overweight association, as well as files on excess weight and DGI Greater Copenhagen's activities for obese children.

Like with the interwar analysis, I take into account selected medical data. As argued, a medical approach to the problem of obesity is not crucial in the millennial analysis: the point has not been to compare medical approaches over time. Nonetheless, it was useful to take into account some medical sources that view obesity as a lifestyle-related

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Olympic programme – and Danish Firm Sports Union ('Dansk Firmaidrætsforbund' – DFIF) which promotes sport in the workplace. The three organisations cover 14.900 sport associations in total, some of which are members of more than one of the three.

problem. For this I take into account a few selected articles from the medical journal *Ugeskrift for Læger*, a medical article from Bispebjerg Hospital and a few other medical articles and health reports by the State's Institute of Public Health.

Different research centres have – either in collaboration with public institutions or on their own initiative – contributed to identifying obesity in general and obesity among children in particular as a public health risk. I have drawn from a few, including the *National Centre for Social Research*, the *National Research Centre for Welfare* and the *Rockwool Foundation*: in all cases I draw from reports on excess weight and its social implications. Moreover, I take into account a number of articles from the *National Institute of Public Health* and the University of Southern Denmark that focus on obesity and public health.

In investigating the health administrative aspect of preventive health targeting obese children, I take into account a report by the *Prevention Commission*; a commission established by the government in 2008 with the purpose of investigating the central public health challenges occurring. In 2009 the commission published their findings, in which 52 proposals were given for future health intervention. I also take into account reports by the *National Board of Health*, which is concerned with public health issues such as preventive health, health promotion and treatment and sets the national public health strategy. Moreover, I take into account reports from the *Ministry of Health and Prevention*. The ministry was named the Ministry of Internal Affairs and Health until 2007, when its name was changed to the Ministry of Health and Prevention. In 2010 it was renamed the Ministry of Internal Affairs and Health until a government shift in 2011 restored its name to the Ministry of Health and Prevention. The ministry sets the government's aims and strategies within the area of health.

Another ministry I draw from is the *Ministry of Culture*. This ministry's field of responsibility includes sports and gymnastics, sports organisations, school sports and common sports.

I also take into account publications by the government concerning strategies on public health in general and children's health in particular.

Data from the *National Board of Health* includes guidelines for physical activity, initiatives for campaigns against obesity, material on citizen-aimed preventive health, material on the link between social inequality and health, guidelines for the establishment of a database on children, material on how to prevent obesity among children and finally a number of selected strategy reports.

Apart from state authorities, I draw from are municipalities. After the structural reform of 2007, local authorities were tasked with carrying out most of the nationally set preventive work directives. I draw from the Danish municipalities' interest organisation Local Government Denmark ('Kommunernes Landsforening'), KL; an interest organisation formed in 1970, which represents the 98 municipalities in the country. I extract strategies and health profiles published by the southern municipality Nyborg in Funen. I wanted to draw from municipalities that are related to the DGI project Grib Chancen, and Nyborg is considered the municipality in the RSD with the most ambitious health strategy. I extract data from the Ministry of Culture's strategies for how to increase collaboration as a means to encourage children and the youth to engage in sports activities. Accordingly, I take into account a report published by the so-called *Commission for Popular Sports* ('Breddeidrætsudvalget'). The commission was appointed by the Minister of Culture in 2007 and consists of representatives from various sports associations, municipalities and ministries. The commission published its report in 2009, listing 42 suggestions for how to strengthen sports organisations and encourage the Danish population to engage more actively in sports.

As a supplement I take into account the government's presentation of a national health plan for 2002 to 2010, in which collaboration is a central priority.

Finally, I take into account the World Health Organisation to the extent that Danish government strategies draw directly from international strategies for fighting obesity put forth by the organisations. This particularly includes the *Ottawa Charter*.

4.7. SUMMARY

The above chapter has outlined the central strategies guiding the collection of data used for the two analysis and has presented a list of the data used. The data used for the two analyses are reciprocally different. In the interwar setting, a majority of the data is extracted from medical or related expertise while a majority of the data extracted in the millennial setting is institutional reports and DGI reports. Apart from the fact, that the two periods differed with regard to the authorities engaged in public health, the reason for this dissimilarity has to do with the genealogical imperative to avoid creating causality between two settings. Instead, two distinct empirical foundations make up the two analyses, and what connects them is the focus on problematisations and technologies with regard to preventive health and health promotion and the objects of inquiry which are human exteriority, corporeality and interiority.

5. ANALYTICAL TACTICS

5.1. INTRODUCTION

In presenting the analytical tactics guiding the two analyses, I lay bare the focal points around which to orient the data used for analysis with a view to unfold preventive health and health promotion in both their regulating and their individualising facets. This is related to an overarching aim to place public health within the realm of government and to cast a critical gaze on preventive health and health promotion, not because they are bad but because they inform how humans live their lives and the surroundings in which they live. In addition, to place preventive health and health promotion within a power analytics is to emphasise their practical undertakings.

The interwar and millennial analyses are both divided according to the two sub-questions guiding the interrogation. I account for the central objects of analysis – human exteriority, corporeality and interiority – as well as for the central mode of analytically unfolding the two cases. This includes elaborating on central notions such as problematisation, rationality and expertise – i.e. 'modes of knowing' – and technologies, tactics and strategies – i.e. 'modes of doing'.

5.2. HUMAN EXTERIORITY, CORPOREALITY AND INTERIORITY

To unpack the relationship between the biopolitical *government of human exteriority* and the *government of subjectivity*, I follow Foucault's identification of two components of biopower: regulation of the population and social space on the one hand, and the individualisation of the body and mind on the other. On this score, I explore preventive health and health promotion as activities concerned with, on the one hand, administration and regulation of public health targeting the population and social space, and on the other hand, those concerned with disciplining and ministering to individuals. Additionally, under the pretext of governmentalisation, I examine the relationship

between governing humans through their environment and governing them through their bodies and minds.

In the interwar analysis I explore the government of human *exteriority* as a particular socio-biological space. Here I assess how problematising the quality of the population informs totalising technologies for regulating the human environment into a socio-biological whole. Likewise, different procedures, strategies and practices concerned with how to prevent or promote particular qualities through processes of segregation (Rose, 1999a: 51) are scrutinised. In the millennial analysis, on the other hand, I analyse how obesity is rendered problematic as affecting the population as a whole and how this informs totalising technologies of NC, which I term government of administration or ethico-administrative government. I thereby investigate how NC as a health promoting strategy was put forth as a particular way to create an institutional environment. Thus, a central aspect of *government of human exteriority* is to do with the regulation of people's relations.

In terms of conceptualising the individualising aspect of biopower, I explore ways of objectifying and subjectifying individuals, i.e. how individuals are rendered as objects and subjects. Objectification refers to how particular individuals are constructed as endowed with particular characteristics, for instance a degenerate person or an obese child. Subjectification, on the other hand, refers to how individuals are either encouraged to address themselves as particular subjects or in their own manner claim their subjectivity. This often involves self-reflection and self-government, for instance when obese children are encouraged to reflect upon their obesity in terms of their feelings about being obese or living a healthier life. I thereby seek to illustrate a mode of intervention that operates not against human ontology but through it, provided that individuals are given room to be, in other words, the norms and style of governing (Osborne, 1997: 175-76). Hence, subjectification is either a process of subjectifying someone else or it is one "*that [ties someone] to his own identity by a conscience or self-knowledge. Both meanings suggest a form of power that subjugates and makes subject to*" (Foucault, 2000e: 331).

In analytically framing human *corporeality* I encompass those governmental workings that are directed at human – particularly children's – bodies. I investigate the type of knowledge that identifies the human body, or human physique. My focus remains on how the body was targeted: in the interwar era through the promotion of gymnastics and physical culture and in the millennial one through the promotion of exercise and diet. The linking of bodily exercise and selfhood will be further examined in the millennial chapter. Human corporeality, then, is analysed as linked to technologies of health promotion and prevention that aim at transforming individuals by making their physiques stronger and healthier.

Government of *interiority* is an attempt to analytically encompass those governmental rationalities and workings that address the human being from within. Unlike government of corporeality, these workings carve out and take hold in an internal space, the mind, the morality and the psyche. In parsing out the government of human interiority I lay bare the ways in which an inner reality within the human being is carved out through technologies of the self: self-reflection, self-government and the like. In the interwar chapter, human interiority is not directly targeted through health government. In the millennial chapter I investigate how obese children are addressed as self-reflecting and self-governing beings whose health relies on their own ability to govern themselves into healthier and more responsible beings.

Having established the objects of analysis, below I explicate certain stances taken in the analyses.

In addressing problematisation and technologies when investigating the effect of preventive health and health promotion upon human exteriority, corporeality and interiority, I analyse government as a dual endeavour of epistemologically and technically carving out a governmental space. The analytical division between problematisations and technologies made in the two analyses does not correspond with the division into 'modes of knowing' and 'modes of doing'. Although the exploration of problematisation entails *knowing* the objects of

preventive health and health promotion, it equally entails strategies of intervention to the extent that they link up directly with types of problematisation. In the same vein, the exploration of technologies, including techniques and practices of intervention, also entails modes of knowing to the extent that they concern solutions to a problem rather than identifying the problem.

The term *modes of knowing* refers to how particular individuals and groups are identified, problematised and sought transformed according to the diverse forms of legitimacy that different types of expertise have claimed or been accorded (Rose, 1999a: 51-52). I single out systems of expert knowledge as specific ways of appealing to preventive health and health promotion through knowledge about it. This involves investigating the deployment of diverse forms of *expertise*: all the various types of knowledgeable individuals who have made disease their business and made a business out of sickness and health (Ibid. 51). Expertise is a broader term than expert as it refers less to a person's title – e.g. a medical practitioner – than to the knowledge he or she makes use of in order to claim authority on the basis of science. It is a matter of shedding light on investigating how a scientific basis for intervention is established. On the one hand, the expertise has broadened since the 1920s and 1930s and include a much more eclectic range than simply the medical, anthropological and welfare-economic disciplines. At the same time, however, the definition of experts in health has expanded to include not only those granted authority to administer public health programmes but also the objects of the campaigns, for instance obese children. However, as the field of expertise has broadened since the early twentieth century's preventive health and health promotion, truth-telling related to accessing expertise has become a somewhat hazy enterprise, in relation to both the *problematising* activities and the *technologies* put forth. Thus certain forms of knowledge are considered authoritative within a given period in terms of coming up with ways of problematising a given object and providing solutions to the problem. In the interwar chapter particularly, examining the various types of expertise involved in problematising particular groups and individuals is central. A point has been to illustrate the ways in which a field of

government was carved out by science, in turn producing particular effects on how preventive health and health promotion were accessed in the first half of the twentieth century, and to place alongside this a genealogy of knowledge related to the preventive health and health promotion practices targeting obese children that had emerged five or six decades later. I thereby merit attention to how, for example, medical practitioners draw from biological, social, and psychological disciplines in promoting preventive health and health promotion. In the millennial analysis, for instance, social workers use physiological, pedagogical and psychological knowledge in their interventions.

When analysing *modes of doing*, I investigate how preventive health is put forth as a technology, entailing a number of practices, techniques and tactics (Foucault, 1980b: 115). Rather than emphasising what was actually done, the point is to explore how government is in fact a technicalisation of means. I am interested in the technical aspect of government, or the procedures and technologies of government (Ibid. 2010: 42). This involves the technical assembly of means (Rose, 1999a: xi). It entails an array of technologies that are in the background of the identification of particular problems (Ibid. 52). In the interwar analysis, for example, I identify how welfare technologies and medico-genetic technologies are deployed together in the assessment of eugenic means. Related to technologies, I investigate also the strategies put forth as solutions to problems of preventive health and health promotion (Ibid. 52-53). It follows that health intervention is acted out according to a particular rationality and this acting out entails rules of conduct (Foucault, 2000d: 229; 2000e: 346). For instance, in the interwar era the strategies were aimed at preventing the deterioration of the human race. In the millennial era the aim was to prevent the spread of obesity. In other words, strategies refer to the rationalities designed to achieve certain ends; "*it is a question of the means destined to obtain victory*" (Ibid. 2000e: 346).

5.3. SUMMARY

I have provided a tactics for analysis that takes into account my overarching attempt to place under scrutiny preventive health and health promotion as particular ways of governing human beings and their surroundings. Within that, according to the two sub-questions guiding the interwar and millennial analyses, I investigate the effect of government in terms of human exteriority, corporeality and interiority. Moreover, I view government as a relationship between 'modes of knowing' and 'modes of being'. While 'modes of knowing' encompasses problematisation and the variety of expertise identifying the objects of health intervention, 'modes of doing' refers to the technological and strategic aspect of governing through health.

6. INTERWAR ANALYSIS CLEANING AND CONTROLING SOCIAL AND INDIVIDUAL BODIES

6.1. INTRODUCTION

> The more effort I put into becoming "a whole human being", the more I see how long the road is ahead of me (Gymnastics theorist P. Müller, 1897).

This chapter explores the ways in which preventive health and health promotion were problematised and rendered technical in the name of public health from the beginning of the 1920s until the end of the 1930s. The chapter is structured as follows: The first part explores how a field for intervention was epistemologically carved out for the quality of the race and hygiene to become preventive health concerns within various branches of medical science and biology as well as anthropology and welfare-economics. The second part concerns the technologies put forth for intervention. It includes examining those public health practices that were put forth as ways of preventing the race from deteriorating and those practices that directly aimed at creating a strong race by targeting children and the youth through physical culture.

6.2. PROBLEMATISATIONS OF HUMAN EXTERIORITY, CORPOREALITY AND INTERIORITY

6.2.1. KNOWING AND SEGREGATING

In 1904 physical anthropologist and police surgeon Søren Hansen founded the Anthropological Committee with the purpose of carrying out anthropological examinations and collecting biometric data on the Danish population in order to "*elucidate the connection between the population's living conditions and their build*" (Den Antropologiske Komite, 1911: ii). It included studying the distinct characteristics of the Danish population and schoolchildren's growth patterns. In the committee's wording, the goal was to:

> [P]rovide knowledge that was hitherto lacking of people's bodily build and other physical conditions by means of mass investigations [...] The aim of this work is purely social, as it strives to disentangle the connection between the population's environment and physical health (Ibid.).

Hence, a concern was to provide knowledge about both the physical constitution of the Danish race and the external factors affecting this constitution. While Sweden and Norway on the one hand and Germany on the other had for some time been undertaking extensive anthropological measurements of their populations' racial characteristics, Denmark had remained an anthropological "*terra incognita*" (Steensby, 1911: 114). Holding the idea that "*95 percent of Europe's population is characterised as distinct bastards or curs*" – that is to say that not one single individual can be said to be thoroughbred (Ibid. 85-86) – Denmark's placement as a racial purlieu between the North and the rest of Europe called for a Danish racial anthropology, which included a mapping of the racial traits of the Danish population and its placement within the so-called Nordic race (Ibid. 106). A Danish racial anthropology was to be launched by drawing from already established racial theories, such as Carl Von Linné's distinction in the eighteenth century between a European, an Asiatic, an African and an American human shape (Ibid. 95), Anders Retzius' lecture on 'The Shape of the Nordic People's Cranium' held in Stockholm in 1842 (Ibid. 106), A. M. Hansen's racial distinction among the Danish population of the dark short-headed 'Alpine' race and the blond long-headed 'Aryan' race (Ibid. 113-14) as well as the American William Z. Rimpley's racial taxonomy (Ibid. 126).

In the first part of the twentieth century, the Anthropological Committee instigated a number of measurements of the Danish population in carefully selected areas. Physical anthropologist H. P. Steensby collected data among 500 inhabitants of the small parish Skamby in the southern island Funen, identifying the dispersion of what he regarded as the two primeval races in Denmark, the obvious 'Nordic' and the obvious 'Alpine' type. Through measurement techniques and registration of eye and hair colour among other techniques, Steensby surprisingly found that the

majority of the individuals did not live up to the standards of the primeval races (Ibid. 121-22). Other members of the Anthropological Committee also began collecting data. K. S. Bardenfleth made a number of measurements of the population of the island Samsø, including height, leg length (Bardenfleth, 1932: 7-11), arm width (Ibid. 15-19), foot length (Ibid. 7-11), head and face length and width (Ibid. 22-36) and the colours of the hair and the eyes (Ibid. 36-48). Søren Hansen initiated a number of investigations of the size of the head of men and women in Denmark (Hansen S., 1911b: 159-60) and of the Danish population's hair and eye colour (Ibid. 1911a: 285-307): the latter had already been investigated among schoolchildren in 1893 by Copenhagen University's Statistical Laboratory (Ibid. 288). This mapping of the racial characteristics of the Danish population as a whole with geographic varieties corresponded with the overall concern with the quality of the race. Along these lines, the measurements aimed first and foremost to investigate physical appearance and bodily characteristics, and in this way make human corporeality an object of scientific analysis and intervention.

Along with the general physical characteristics of the population, data on the feebleminded was gathered. Already from the beginning of the twentieth century, the Anthropological Committee had collected data on this sub-population, including their family circumstances (Smith, 1932: 91-92). Using the Anthropological Committee's databank – and the assistance of Søren Hansen – the doctor Jens Christian Smith initiated an examination of sets of twins, one of whom was considered feebleminded. With 6700 cases of feeblemindedness at his disposal, Smith used case records, correspondence with relatives and personal investigations as the basis for his study (Ibid.). The idea was to collect knowledge about twins, whose genetic material was considered alike (Ibid. 89). Concurrently, the feebleminded – whose characteristic of low intelligence was of interest – were classified and grouped along these lines (Ibid. 91). For this classification practice, Smith drew from a taxonomy developed by psychiatrist at the Keller Asylum for the feebleminded, H.D. Wildenskov, in which the feebleminded were ranged from the lowest types, referred to as 'asylists' ('asylister'), to the least

feebleminded. Accordingly, 'idiots' were identified as having an intelligence quotient (IQ) of 0 to 30, 'imbecile' an IQ of 30-50, 'debile' 55-75 and 'backwards' ('sinker') 75-90. A normal IQ began at 90 (Ibid. 109).

Lene Koch describes how during 1939, after the founding of the *Institute of Human Genetics and Eugenics* in 1938 funded by the *Rockefeller Foundation*, a number of inquiries were undertaken by the institute at hospitals, municipalities, institutions, prisons, police, archives and ministries, as well as with individual doctors, requesting co-operation in the construction of a heredity hygiene register. Respondents would contribute with detailed information about individuals and their relatives, including death certificates from the Danish National Archives, birth certificates from the Ministry of Ecclesiastical Affairs, tax information, and police information (cf. Koch, 1996: 192-193).

Apart from the general population and the feebleminded, another group selected for extensive mapping and knowledge collection was children and young people.

> Obtaining exact knowledge about the youth's bodily development [...] ought to be an obligation for every cultivated people who have a sense for social undertakings. Knowledge about these matters is a necessity in order to monitor the stock's bodily condition, its progress and regress, the sufficiency of ordinary nursing ["den almindelige Forplejnings Tilstrækkelighed"], the effect of various social conditions and measures; for no other age group equally reflects the evil and the good, the damaging and the useful, as childhood and youth (Hertz, 1911: 321).

The quotation pinpoints an area of concern that this section explores more thoroughly in the following paragraph, namely the concern with objectifying human bodies through biometric techniques: techniques that – as we shall also see in the millennial analysis – allowed for the establishment of a bodily norm through and by virtue of human corporeality.

Danish authorities had been noting the height of conscripts since 1774. Edv. Ph. Macherprang used these statistics to show that an increase in

their average height over 50 years was concomitant with an improvement in economic conditions. Based on this data he concluded that a correlation existed between increase in bodily height and favourable economic conditions (Macherprang, 1911: 46). In a similar vein, longitudinal studies were carried out on schoolchildren, for instance the height of a particular group in a particular school was followed over ten years (Dalmark, 1923: 771-73). Concurrently, the Anthropological Committee initiated a number of projects taking measurements of children. These included collection of data on infants' weight and an additional overview of the disparity between illegitimate children's weight and the weight of children born in wedlock (Hansen, H. J., 1920-1928a: 2-109). Some investigations aimed at measuring the weight and height of children, particularly in their primary school years (Hansen, S. 1929-1932b: 59-69) but also at secondary school (Ibid. 1929-1932a: 71-82). Søren Hansen set up a number of studies of schoolchildren's growth patterns in Copenhagen (Den Antropologiske Komite, 1928, 1932). In total 54.643 schoolchildren were subjected to the following measurements: weight while stripped, height without footwear, height from bottom to top while sitting, circumference of the breast at deepest inspiration and expiration, expansion of respiration, and width of the arms (Hansen, S., 1920-1928b: 207-8). The data collected was worked up with the help of the Anthropological Institute in Zürich (Lendorff-Kugler, 1929-1932: 393).

Schoolchildren in particular, then, were subjected to data gathering exercises by means of systematic weighing and measuring (Møller, J. S., 1935a, 1935b; Møller, N. 1937: 176-77; Andersen & Schaumburg-Müller, 1936: 882-83), intelligence tests (Simonsen, 1936: 354) and general health examinations (Gotfredsen, 1937: 352; Christiansen, 1937c: 687) including health cards listing the individual's history of illnesses and weaknesses (Ugeskrift for Læger, 1924d: 128-29). In 1882 the School Commission had already set up an investigation of schoolchildren that was the most comprehensive of its day. According to the Anthropological Committee, however, the focus was primarily on sickness while health and development were secondary factors. It therefore set up a project that placed health at the centre of attention. Accordingly, 1035 school

children dispersed across 20 schools in mid-Jutland underwent a measuring of their physical proportions under the supervision of the committee's S. H. A. Rambush (Rambusch, 1911: 173-89). In working up the data it was discussed how to establish a numeric expression – i.e. a norm – for a healthy body and a corresponding one for a sick body by taking into account the proportions between height and weight. Søren Hansen, who was in charge of working the data, expressed reservations as to the prevailing idea that if the weight deviated notably from the height it was an expression of sickness and conversely, that a lack of deviation was an expression of health. Hansen argued that health might occur at both extremes of a range of weights (Hansen S., 1929-1932c: 373). The commonly used numeric indexes within school hygiene were the Rohrer index, by which weight was put in relation to height in the third power, referred to as W/H3 ('V/H3') as well as the Kaupsk index by which weight was put in relation to height in the second power, referred to as W/H2 ('V/H2') (Ibid. 380).

Above I have explored a type of preventive practice that entailed a mapping and measuring of children and the youth. We see how human bodies were subjected to intervention practices and how measuring techniques, statistics and demographic surveys targeted children and young people, whose physique was the central object of knowledge. In providing a norm for physique among children and young people, a different perception was put forth than in the case of establishing the degree of abnormality among the feebleminded. The difference between categorising along lines of abnormality and along those of normality is the difference between objectifying particular groups and objectifying potentially everybody. A health norm is a positive notion which in principal everyone – and in this case all children and young people – can strive toward, whereas categorisations of the feebleminded – identified according to their lack of intelligence – is a categorisation of what is considered an abnormal state, which continues to be abnormal. The objectifying biometric techniques directed at the feebleminded informed their placement on the outskirts of normality. On the contrary, the objectifying biometric techniques directed at children and young people informed their potential placement within normality.

6.2.2.THE PROBLEM OF RACIAL QUALITY

Along with establishing the racial identity of the Danish population, a general concern with the quality of the Danish race was expressed. This concern fed into the problem of a drop of the fertility rate among the general population, the spread of tainted individuals and the problem of neonatal deaths.

In 1912 Søren Hansen had already addressed the decrease in the fertility rate, as evidenced by a lecture on the relationship between the improvement of the stock and the decreasing birth rate (Hansen S., 1912: 28). Several articles were to follow on what he regarded as the deteriorating quality of the race. Some were based on investigations indicating that the first-born child is of lower quality than the second-born, which together with a low fertility rate could affect the general quality of future generations (Ibid. 1920-28a: 148). Adolph Jensen, also from the Anthropological Committee, merited attention to the crucial effect of the changes in the fertility rate along with the mortality rate: effects which, he argued, would mark the future with regard to the population's vitality (Jensen, A., 1920-1928: 309, 318).

The Swedish Myrdal couple – sociologist Alva Myrdal and sociologist and economist Gunnar Myrdal – also warned against the catastrophic drop in the birth rate in their influential book *Crisis in the Population Question* (Myrdal, A. and G., 1935: 10). The couple's writings came to mark the onset of a widespread and detailed investigation into how to prevent the fatal drop (Boje, 1935: 104). Advocating for a strong welfare state coupled with eugenics, their work influenced Danish welfare ideas and policy. Alva Myrdal elaborated on the theme of the drop in the fertility rate in her book on urban children's living conditions (Myrdal, A., 1936: 7), warning against what she referred to as the increasing number of sterile and semi-sterile families among the healthy part of the population, which she saw as a consequence of the poor conditions for bringing up children in the city (Ibid. 9).

While the drop in the fertility rate regarded the general population, another type of problematisation linked to the overall concern with the quality of the race focused on the spread of tainted individuals. The tainted individuals were given many names[7], ranging from the degenerates, the anti-social, the non-valuable elements, the bad quality and so forth. As presented in the editorial in the sports journal *Danish Sports* ('Dansk Idræt'):[8]

> There are three classes: those who are maintained by others, those who can maintain themselves and finally, the ten thousands of negative classes (H., 1932: 262).

A decline in the number of fit members of the race and an increase in the number of tainted members correlated in the sense that the tainted were considered more fertile, more uncontrolled sexually and less moral than the fit and healthy members. Tainted elements were seen as posing an overall risk to society and the general fitness and strength of the population (Smith, 1928: 1205-6, 1929: 571-72).

Doctor Harald Okkels emphasised the problem with deficient individuals due to their hyper-sexuality and improper sexual practices such as masturbation. Apart from deficient individuals, the group included nymphomaniac women, homosexuals with criminal tendencies and mentally ill people (Okkels, 1940: 291). The tainted group also included the feebleminded (Smith, 1932) and criminals (Aggebo, 1940; Sund levevis, 1938b) as well as prostitutes and the sexually perverted (Kemp, 1936; Gammeltoft, 1936). What bound these anti-social, degenerate, or tainted groups together was the problem of sexuality, and the characteristics often mingled. Prostitutes for example were

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[7] I do not present a thorough account of the various groups identified as posing a threat to the population as a whole, as this is not the focus of the analysis. For the sake of simplicity, I use the term 'tainted' to account for the group in general.

[8] 'Danish Sports' was published from 1930 by what at the time was called 'Danish Riflemen, Gymnastics and Sports Organisations', and today is 'Danish Gymnastics and Sports Organisations' ('DGI').

considered to be (more or less) feebleminded, sexually perverted per definition, and they would often also be criminals (Kemp, 1936). In 1937, reporting on the 'Social Summer Meeting' in an article in *Ugeskrift for Læger*, biologist, heredity scientist and sociologist Tage Kemp[9] posed the question: "*Who are the anti-social individuals?*" (Ibid. 1937: 1009). Taking his cue from the Myrdals, Kemp placed emphasis on the problem of prostitutes, which was also the central concern in his book *Prostitution – An Investigation of its Causes, Especially with Regard to Hereditary Factors* (Ibid. 1936). Other concerns were raised underscoring the dangers of uncontrolled sexuality. In the nursing journal *Sygeplejen* district medical officer and hygienist F. Ingerslev and hygienist Lomholt argued for the necessity to identify transmitters of venereal diseases, the typical groups being prostitutes, mistresses, unfaithful husbands and returned sailors and soldiers (Lomholt, 1926: 48).

Additionally, it was held that some of the characteristics of the tainted individuals could (potentially) develop in all individuals, almost as a contagious illness or a virus one might contract. In the wording of the physiologist Poul la Cour: "*The one from whom coarseness emanates exposes others to physiological and psychological contagion*" (la Cour, 1924: 255). That is to say, the problem with the tainted part of the population was a problem of risk: bad, unhealthy elements had the potential to infect the greater whole; i.e., society at large, the race in its entirety, or the whole individual. The extent of the danger society or the race was in correlated with the number of prostitutes, deficient individuals, criminals and the number of individuals who were partly tainted. As to the risk put on the individual, the bad traits, whether internal or external, could constitute a threat to that individual's general state of health. These bad traits, which were perceived to pose a threat to

[9] Tage Kemp was an internationally recognised heredity scientist. During the 1930s, he was the Rockefeller Foundation's European connection, carving out the scientific ground for the foundation's launch of *A New Science of Man*. In 1938 he was a central figure in the founding of the Department of Human Biology and Eugenics at the University of Copenhagen where he was also appointed Department Chair (cf. Koch, 1996: 161, 168).

the individual, more or less explicitly concerned the intensity or direction of his/her sexuality and sexual urge.

In 1934 a number of Danish key figures within medicine, biology and politics contributed to a book called *Heredity and Race* (Winge, et al., 1934). One of the contributors was Karl Kristian Steincke, who during the years under the Social-Democratic government held the post as Minister of Justice and later Minister of Social Affairs, and today is considered the architect of the modern Danish welfare state. In his contribution to *Heredity and Race*, Steincke posed the following question: "*How can society protect itself against the increasing degeneration?*" (Steincke in Winge, et al. 1934: 91). His main argument was that Denmark's developed social legislation opened up for a situation in which the hereditarily tainted individuals – those who in a more primitive society would succumb – were kept alive, thereby causing hereditary defects to be carried on to the next generation (Steincke, 1930; Steincke in Winge, et al. 1934: 95). Another contributor in the debate was a controversial figure, physician and sexual reformer Jonathan Høegh von Leunbach, who provided free contraceptive tools for the underprivileged and carried out illegal abortions in his clinic; the latter for which he served some time in prison and was deprived of his civil rights for a five-year period. A declared socialist, von Leunbach emphasised the necessity of sexual education of the common people. He maintained that the intelligent members of the population would naturally limit themselves in terms of procreation, while the less valuable part would propagate rapidly (Leunbach, 1926: 1016; 1933: 925).

In summary, I have showed how a scientific setting was formed in which various branches of expertise addressed a public health concern with the quality of the race through a physical anthropological take, a hygienic take, a welfare-economist take, a nutritional take, a nursing take, a socio-medical take and a sexual reformist take. The problematisation of the quality of the race found scientific support by pointing to a demographic discrepancy of the population. This was expressed in a general decrease of the fertility rate combined with the apparent

demographic disparity, namely a general decrease in the fertility rate combined with indications that the fertility rate among the tainted was either constant or increasing while it was decreasing among the healthy. From this vantage point, it was argued that the increase of tainted elements was attributable to limited access to contraception and a general lack of education. These types of problematisations thus were directed at the population as a whole. While the above-mentioned problematisations were directly linked to a concern with the quality of the race, the discussion below arises from a preoccupation with the problem of a filthy environment and filthy bodies.

A concern was expressed with the relatively high number of infant deaths. The physiologist Johanne Christiansen, who specialised in nutrition as a prophylactic means, regarded the problem of child mortality a result of poor diet (Ørskov, 1939: 469), particularly overconsumption of meat (Christiansen, 1935, 1936, 1937a, 1937b, 1937c, 1939a, Ugeskrift for læger, 1939). The physiologist Ejnar Nyrop, who advocated a medico-sociological focus on the relationship between poverty and nutrition, also warned about the high number of neonatal deaths. In a series of articles under the headline 'Income-Nutrition-Health' published first in the social journal *Society's Demand* ('Samfundets krav'), and then in *Ugeskrift for Læger*, Nyrop explicitly linked the problem of child mortality to poverty and poor diet (Nyrop, 1935, 1937a, 1937b, 1937c). Likewise, other doctors paid attention to the relationship between bad hygiene, poverty and poor diet (Jürgensen, 1926: 667-68; Jensen, Aa., 1936: 1-3; Bredsdorff, Lundsteen & Lund, 1943).

Poul Freudenthal, a consultant in gynaecology and specialist in hygiene, nutrition and bodily and mental health, as well as the editor of the popular hygiene journal *Healthy Lifestyle* ('Sund Levevis'),[10] linked the

[10] "Sund Levevis – Populært Tidsskrift for Ernæring og Hygiejne" ("Healthy Lifestyle – Popular journal for nutrition and hygiene"), first published in 1935, was also reviewed in *Ugeskrift for Læger* (Bie, 1935: 61). The journal, whose contributors ranged from physicians and hygienists to gymnastics theorists, addressed topical issues of health, eugenics, hygiene and the like often with a somewhat reactionary take. Apart from healthy menus, a series of articles

increase in the infant mortality rate to poor hygiene and malnutrition, particularly in rural areas (Freudenthal, 1935b: 52; 1940b: 1369). Also in the journal *Nursing* ('Sygeplejen'), the relatively high number of neonatal deaths was put on the agenda, seen as a problem particularly in rural areas (Frandsen, 1932a: 387-91, 1932b: 416; Johannesen, 1939: 548).

Apart from the problem of infant deaths, another general concern raised was tuberculosis. In 1901 the National Association for the Combat of Tuberculosis was founded with the hygienist and professor in clinical medicine Knud Faber as a central figure (Frandsen, 1963: 74-75). During the 1920s Faber, together with the hygienists J. Ostenfeld and F. Ingerslev, published a number of articles in *Ugeskrift for Læger* raising the question of how to improve general hygiene standards in order to avoid tuberculosis (K. Faber & Ostenfeld J., 1924; Ingerslev, 1920, 1924a, 1924b). Faber emphasised that the cause of tuberculosis was bad hygiene and particularly two areas were at stake as potential breeding places for tuberculosis: the family and the school, the main culprits being lack of light and fresh air, untidy rooms, and filthy bodies due to lack of soap and water (K. Faber, 1928: 891).

Bad hygiene thereby was linked to the relatively high number of infant deaths attributed to malnutrition (West, 1940: 1276), poverty and bad housing, particularly in the rural areas of Denmark (Metz, 1932: 161-63). The concern with the immediate environment was also expressed with regard to tuberculosis (Ugeskrift for Læger, 1923, 1924c; Ørum, 1925; Larsen, A., 1928: 40-42; Chrom, 1927: 1217-18).

To sum up, two modes of problematising human exteriority were at stake: problems concerning the social body as a whole and problems

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were published in all volumes under the two headlines 'The Woman – The Mother' and 'The Child'. In the former, editor Freudenthal expressed his resistance to abortion, which he termed "embryo killing," and his general discontent with the idea that women should decide over their offspring (Freudenthal, 1935e). The latter article series centred on providing tips for child rearing (Ibid. 1935a, 1935b).

concerning the immediate environment. As to the former, medical concerns as well as anthropological and welfare-economic ones about public health linked up to a general problematisation of the quality of the race. These concerns centred on the drop in the fertility rate and the spread of tainted individuals. As to the latter, socio-medical, nutritional and hygienic expertise expressed concerns over the relatively high number of infant deaths on the one hand and tuberculosis on the other, both of which were regarded as consequences of bad hygiene. On the one hand, the race was addressed as a biological entity, whose vitality depended on the sum of the small elements. These smaller entities were various groups' strength and fitness and the subsequent danger posed to the whole by the tainted individuals. However, while tainted elements constituted a risk to the race as a whole, it was first and foremost due to the hereditary nature of their fit and tainted qualities respectively. On the other hand, the immediate environment was addressed as posing a threat to individual health. Thus, while the problem of racial quality was posed through an overall concern with the population as a whole, the problem of bad hygiene was posed through an overall concern with the family, school and home environment.

6.2.3. THE PROBLEM OF A WEAK PHYSICAL AND MORAL CONSTITUTION

In what follows, I show how various medico-scientific authorities, in their overall quest to improve the quality of the race and general hygiene practices, tapped into both a notion of heredity and a notion of physique as an indicator. In staking out these claims, I focus on how a relationship was established between the individual's corporeal reality and his/her interior reality as well as his/her relation to the immediate environment. The point then is to shed light on how a space for transformation was rendered possible not only by segregating specific individuals, but also by establishing a link between the individual's bodily and moral constitution: a relationship that I argue allowed for direct intervention upon the body and through the body.

As early as the end of the nineteenth century Søren Hansen proposed that the population's average height might be an indicator of the general health of the stock (Hansen S., 1892: 387-91). Moreover, data from the Anthropological Committee revealed how hereditary factors played a central role with regards to cases of feeblemindedness. Committee member Dr Jens Christian Smith's study of twins in which one twin was feebleminded led him to conclude that physical deviations were accompanied by psychological deviations (Smith, 1932: 95). He also concluded that severe types of feeblemindedness were more likely to occur as an effect of external factors, whereas the more mild types in most cases were passed on from generation to generation (Ibid. 107).

The physical anthropological take on inheritance evolved along the lines of B. A. Morel's degeneration theory[11] (Hansen S., 1917: 2). Morel stated that degeneration comprised "*a morbid deviation from the normal human type which remove the subsequent generations from the norm*" (Morel, cited in Hansen S., 1917: 4). The degenerative point of departure presented by Hansen's physical anthropology was based on an already known biological-genealogical study of the German noble family Habsburg. Considered a typical case of inbreeding, the stock's physical features, which included a protruding chin, had been identified as being passed on from one generation to the next. Søren Hansen dismissed Morel's idea of 'total degeneration' (Hansen, S., 1917: 2), and maintained that when the progeny came out less fortunate in appearance, it was almost never a direct consequence of actual inheritance, but more often a complex effect of poor upbringing and other conditions such as the parents' previous sins, e.g. syphilis, gonorrhoea, blindness or chronic alcoholism (Ibid. 6). Hence, the quality of the race would, to follow Hansen's wording, depend on its vital necessities (Ibid. 15). In turning

[11] B. A. Morel was the founder of the degeneration theory from 1857. Degeneration was considered a result as much of hereditary traits of external factors and social evils, such as alcoholism, tobacco, unhealthy work conditions, tuberculosis, and miscegenation. The commonly identified signs of degeneration were a small skull, harelip, abnormal ear shape, extra fingers or toes, clubfoot and dwarf stature. Classifications were made according to bodily appearance and behaviour (cf. Koch, 1996: 30-31).

down the idea of total degeneration, Hansen's physical-anthropological take on heredity opened up for the constant possibility for degenerate individuals to regenerate themselves by means of external influences. The question posed by various scientific branches of the relationship between hereditary and non-hereditary factors on individuals and the population as such gave way for a linking of societal, bodily and moral constitutions. The idea that corporeal strength could affect morality and vice versa, that a strong morality would manifest externally as a strong body, and that these individual traits were influenced by the individual's immediate environment, and were on a large scale also influencing the population as a whole, turned out to become related to questions about how to overcome the problem with the quality of the race.

Biology also contributed to the heredity debate, drawing from two central theories at the time, 'Mendel's law' and the Galton eugenics.[12] In questioning the impact of heredity and to what extent human beings were determined by their progenitor or by their surroundings (e.g. upbringing and familial condition), notions were put forth of the relationship between appearance and temperament. In 1937 Øjvind Winge[13] presented the following argument in his book on heredity: due to the impossibility of subjecting human beings to genetic experiments, we still lack information about the relationship between bodily height,

[12] Gregor Mendel was an Austrian monk and the founder of heredity biology in the 1860s. Based on experiments on plants and animals, and analyses of particular cases, Mendel's law is based on the idea that unchangeable hereditary units determine the organism's traits. Heredity scientist Wilhelm Johannsen later named these units genes (Koch, 1996: 29). Francis Galton is considered the founder of eugenics, inspired by his uncle Charles Darwin's natural selection theory. Galton was interested in exploring how particular human qualities would be inherited from one generation and passed on to the next. In identifying hereditary traits, Galton's theory would point to a connection between physical appearance and mental predisposition. While the Galton eugenicists make use of statistics as their main research method, Mendelism is based on experiments and unique cases (Ibid. 66).

[13] A botanist and a heredity scientist who studied both plants (Winge, 1919) and human beings (Ibid. 1921), Øjvind Winge was considered one of the key figures within the Danish scientific environment in the first half of the twentieth century (Kemp, 1945). In 1938 Winge was appointed leader of one of the research units at *Carlsberg Laboratories*, a scientific institution established in 1875 by the founder of the beer brewing company Carlsberg.

bodily curves, skin colour, hair colour, hair structure, growth of beard, facial expressions, and their effect on the human psyche (Winge, 1937: 406). Nonetheless, Winge argued, statistics and scientific studies had proved that these characteristics were hereditary and that they not only affected the physical appearance of the individual but also his or her psychological constitution (Ibid. 409). "*In reality*", he maintained, "*any psychological flaw is rooted in a bodily abnormality*" (Ibid. 1941: 22). For example, the link between heredity and alcoholism, according to Winge, should not be explained by stating that alcoholism per se was the determining factor that caused the progeny to be less valuable. Rather, it was the alcoholic person's lack of grit that was passed on to the children (Ibid. 24).

The effect of alcoholism was also debated within psychiatry. The psychiatrist August Wimmer, specialising in the impact of alcohol on the human constitution, had appointed the hereditary factors related to alcoholism (Wimmer, 1911, 1930). Wimmer argued that a clear relationship existed between internal and external states; a swollen, blotchy face and slack facial expressions correspond well with the alcoholic's spiritual characteristics (Ibid. 1930: 308, 312). Wimmer furthermore made an allusion to the genetic causes of mental illness by establishing a relationship between physical appearance and heredity (Ibid. 1929: 14), but nevertheless dismissed the popular idea presented by Morel of 'total hereditary taint' (Ibid. 29): "*In the eugenic paradise, there should be room for bohemians and artists*" (Bateson cited in Wimmer, 1929: 83). It is worth noting that alcoholism, in this case, referred less to a practice, a conduct of the individual, than to a condition – a psychological and mental condition – which was partly hereditary. The alcoholic individual, then, was less an active contributor to alcoholism, than determined by it through his/her ancestors' hereditary traces (Wimmer, 1929, 1937, 1941). This way of addressing alcoholism and the alcoholic individual illustrates how physique was regarded as a symptom of a particular mental makeup, and hence the degenerate individual could be identified with the naked eye. Although the view on degeneration was a rather deterministic one – in that the body was seen as a symptom of internal flaws, and flaws of the mind

(mental illness, amorality and the like) – regeneration was still considered a possibility; degenerate traits could be restored over time and with the help of upbringing and the immediate environment.

The plant physiologist Wilhelm Johannsen took his point of departure in Mendel's heredity law in his own recognised distinction between genotype (predisposition) and phenotype (appearance) was remarked internationally (Johannsen, 1923, 1924, 1927). Genotype, in Johannsen's view, had a bearing on the unchangeable and thus determining factors within the individual, both with regard to the individual's outer (physical) and inner (spiritual, moral) constitution. Phenotype, on the other hand, was partly determined by the genotype, and partly open for transformation through upbringing, environmental factors and other external conditions. In other words, phenotype was the part in the individual that was open for change given the proper external conditions (Johannsen in Winge, 1941: 10). Unlike Winge and Wimmer, Johannsen challenged the idea that nonphysical traits were manifested directly on the body, and thereby he also challenged the premise of a Galton inspired eugenics. The clear correlation made by Galton eugenicists between physique and mind – and the view that the physical body was an external expression of a mental condition – was, according to Johannsen, irrational and lacking in scientific evidence. On the other hand, according to Johannsen's heredity take, the Morel inspired optimism towards the degenerate individual as susceptible to change also had to be dismissed, given the determining factor of heredity. In opposing Morel's theory of degeneration, in which degenerate individuals were endowed with the potential to regenerate, Johannsen argued that inherited predisposition to disease was fixed and thus immutably passed on from one generation to the next. Thus, Johannsen made a clear distinction between hereditary and acquired characteristics. Although circumstances and nurture, from this perspective, played a relatively small part, Johannsen nonetheless stressed the importance of a good upbringing (Johannsen, 1923; cf. Koch, 1996: 32-33). Refusing the idea of breeding super humans, regarding it as unwarranted, he held that instead one should take

seriously the task of avoiding the determining human flaws (Johannsen, 1923: 321-22).

The physiologist and pathologist Oluf Thomsen[14] argued for the unalterable nature of genes – physical appearance, on the other hand, was mouldable (Thomsen, 1934: 143) – and accordingly he emphasised the common correlation between bodily and spiritual characteristics (Ibid. 144). However, he dismissed the notion of degeneration and the idea of a pure race. The latter, the argument went, only exists in the world of plants and to transfer this idea to the world of human beings was devoid of objective reasoning (Ibid. 159).

Both Johannsen and Thomsen's heredity take and the degeneration take presented by Søren Hansen's physical anthropology and Wimmer's psychiatry upheld the idea that within the individual existed both elements open to transformation and elements that the individual was determined by. While the former opened up for means to improve individuals through their surroundings, the latter, that is the determining aspect, opened up for means to arrest these determining elements.

To sum up, I have illustrated how various branches of medicine and science were preoccupied with the question of heredity's impact on human appearance and conduct in contrast to that of external factors. Notions of degeneration paired up with heredity in explaining this relationship. Two points can be made in order to draw lines to the overall framing of the analysis. Firstly, the heredity debate illustrates how a relationship was established between individuals' physical characteristics and their morality; that is, human conduct was correlated with human physique and general appearance. Physique was considered an indicator – a symptom – of an individual's moral constitution and his/her ways of behaving. Secondly, although heredity's determining effect was acknowledged, emphasis was nevertheless placed on the

[14] Oluf Thomsen was acknowledged for his work on the hereditary aspect of syphilis, and in 1935 he founded the Department of Eugenics at the University of Copenhagen.

environment's effect. Heredity science thereby opened a space for improving either the human environment or human beings. In this regard, an exit was created out of the deadlock of a hereditary determinism and room was left for health promoting means and modes of government, such as physical exercises and body culture; means that will be investigated more thoroughly in the following pages. In other words, by acknowledging that heredity did not completely determine the individual's being, a space was carved out for improving human beings through their bodies and their surroundings.

While the notion of heredity linked corporeal reality with interior reality, a step further was the notion of human physique as an indicator of interiority.

6.2.4. TAXONOMY OF HUMAN PHYSIQUE

In 1938 the popular health journal 'Healthy Lifestyle' ('Sund Levevis') published two articles from the Norwegian journal *Liv og sundhet* on the issue of female categories. Different types of women were listed and their physiques were identified as correlating to their personalities. For instance, the curvaceous woman was also mentally round and soft in the sense of being loving and considerate, enjoying her domestic role as a housewife. In contrast, the slim type – apart from having an interest in the arts – was said to be somewhat cold. She typically regarded a man as a competitor or a friend rather than a potential husband (Havin, 1938a: 181-83), but in her favour she had a graceful figure and was stylish (Ibid. 1938b: 208). Notwithstanding this popular take on the relationship between the body and the mind, soma and psyche, it nevertheless illustrated a central idea, namely the idea of the body as a symptom of the mind. Below I show how this relationship evolved through a debate about external and hereditary factors' influence on human health, conduct and morality.

In spite of the fact that phrenology[15] was rarely mentioned in the debate about the relationship between psyche and soma, the notion of the body as a symptom of an internal condition did prevail. The major sources of inspiration were the German Ernst Kretschmer (1931a, 1931b) and the American Charles Stockard (Stockard, 1931, 1941). Kretschmer was acknowledged for his outline of the so-called constitutional types (1931a, 1931b),[16] in which he proposed a link between character and physical appearance. His taxonomy of human beings – ranging from the slim so-called 'leptosome type' to the rounder so-called 'pycnic type' – found a number of proponents within Danish medical circles (e.g. A. Faber, 1933b; Thomsen, 1934; Aggebo, 1940; Døssing, 1947). Charles Stockard's *The Physical Basis of Personality* (Stockard, 1931) in a similar manner – as the title indicates – put forward a link between an individual's physical appearance and mental constitution. By arguing in favour of a correlation between human freaks and dogs (Ibid. vii), Stockard warned against leaving it up to phrenology and, as he put it, fortune-tellers to establish a connection between physical type and psychology (Ibid. 279). He identified two main categories of human beings. One was the 'linear type', who was characterised as being faster growing, having a high metabolism and being slim. The other was the 'lateral type' who was slower to mature and of a stockier and rounder build. Each group was further divided into minor groups, each with their particular psychological characteristics (Ibid. 285). Stockard also found spokesmen within Danish medical circles. In *Ugeskrift for Læger* H. Dragehjelm for example, reviewed a measuring map developed in the US by the Philadelphia School Board based on Stockard's types, recommending the practice to be used within the Danish school system (Ugeskrift for Læger, 1925: 1019).

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[15] The German physician Franz Joseph Gall developed the theory of phrenology in 1796 stating that particular components of the brain correspond to particular mental traits within the individual.

[16] In particular Ernst Kretschmer's *Körperbau und Charakter – Untersuchungen zum Konstitutions-Problem und zur Lehre von den Temperamenten* from 1931 was influential. Here he argued for the physical body's correspondence with mental character traits.

Some years later, the American William Sheldon (1940) developed a typology of three general human somatic types, also referred to by Danish medical experts (Brüel, 1939; Christensen, 1949). In 1939 physician and medical psychologist Oluf Brüel published a lecture held at the Danish Military Society on constitutional types among conscripts. Here he referred to Sheldon's classification system and Stockard's linear and lateral types as well as Kretschmer's human taxonomy; the latter he found most useful (Brüel, 1939: 383). He also referred to a study showing that in 87 percent of the studied cases, a correlation was found between build and psychology (Ibid. 392). In a similar manner Geert-Jørgensen drew attention to the correlation between corporeal and interior constitution. In his acknowledgement of Wilhelm Johannsen's distinction between genotype and phenotype, Geert-Jørgensen underscored phenotype and the environment's effect on the mental constitution of the individual. As he put it: it is in the constitution that the disease is hidden, which is expressed in the build and the mental life (Geert-Jørgensen, 1942: 4). Likewise, Carl Clemmensen drew attention to psychiatrist and psychiatric consultant Ib Ostenfeld's book on the thyreofile type (Clemmensen, 1942: 757-58). Inspired by Ernst Kretschmer, Ostenfeld was acknowledged for his writings on mental cases among authors and their build. He argued that a diagnosis could be made on the basis of heredity, personality and type (Ostenfeld I., 1942: 13) and that an individual's hair in particular showed a clear affinity to their personality (Ibid. 14). A similar relationship between outer and inner constitution was at stake in a review in *Ugeskrift for Læger* of a biographical book on Martin Luther, in which a connection was claimed between Luther's build, character and psychosis (Strömgren, 1942: 69).

In summary, causality by some medical doctors was posited between human corporeality and interiority: physical appearance and physique were regarded as symptoms of an inner human reality, namely the psyche and the moral indications attached to this. As in the case of the hereditary way of addressing this relationship, the state of the human constitution was rooted within the individual, his/her psyche and

morality. However, it was the body that revealed this inner constitution through an outer expression: physique and bodily characteristics.

The following pages illustrate how the overall concern with the quality of the race and the subsequent concerns with degeneration, bad hygiene, the spread of tainted individuals, the drop in the fertility rate, infant deaths and the concern with tuberculosis linked up to a general concern with the physical and moral strength of children and the youth.

6.2.5. THE PHYSICAL AND MORAL CONSTITUTION OF CHILDREN AND THE YOUTH

In 1892, the renowned writer and doctor Hans Kaarsberg (1892a, 1892b) drew attention to the problems of children and the youth's sexual practice in his popular lectures on 'Our children, their upbringing, health and the most common diseases'. He claimed that lack of bodily discipline during the child's upbringing would cause two problems: women being deflowered too early, and the spread of masturbation like the dry-rot fungus (Kaarsberg, 1892b: 39). Physical laziness, Kaaarsberg argued, was often symptomatic of low morals (Ibid. 19). Kaarsberg posited a clear connection between bodily characteristics and personal character, that is, corporeal and moral constitution, as I outline below.

In 1906 U. H. Wöldike from the Association for the Combat of Venereal Diseases, in a lecture held at the higher common school's ('højere almueskoler') teacher's meeting, expressed his concern with schoolchildren's masturbation practices. He maintained that the issue was intimately connected to factors such as upbringing, morality, health, happiness and welfare (Wöldike, 1907: 1). Wöldike asserted that the evil should be removed before the school was turned into a hotbed for hatching bad instincts (Ibid. 13). Children, according to Wöldike, needed to understand that immature sexual excesses would eventually harm their bodily health, as the immature body was not equipped to handle such practice. The problematisation of masturbation practices was related to the individual and the race's constitution. Masturbation was

seen as both a symptom and a cause of a weak bodily and mental constitution, which in turn would affect future generations (Ibid. 16).

"*Only very rarely does one see a young harmonic body*" proclaimed *Healthy Lifestyle* editor Poul Freudendal (Freudendal 1935b: 52). He published a number of articles about "*the fight for mental hygiene*", warning against what he identified as the youth's retrogression of mental health and strength of character (Ibid. 1936c: 1-2, 1936d: 1, 1937b: 33-37, 1938a: 173-79; 1940a: 1308). The result, he explained, was an increasing number of unhappy individuals, inharmonious marriages and spiritually deleterious conditions for children within families as well as hospital admissions (Ibid. 1936d: 1). Freudenthal outlined the purpose of the journal with the rhetorical question: "*Has the spiritual and bodily upbringing managed to develop the spirit and the character in each individual? No!*" (Ibid. 1935a: 6).

In general, medical scientists found themselves preoccupied with the physical constitution of children and the youth; a tendency that was also reflected in *Ugeskrift for Læger* in 1931. The point raised here was that children were underdeveloped with regard to their physical strength and intelligence (Alstrup & Bøgelund, 1931; Schlanbush, 1931; Rohleder, 1931) and that the physical habitus of children and the youth was declining (Alstrup & Bøgelund, 1931; Freudenthal, 1933; Osier, 1933; Garde, 1934). Causality was established between the present state of children and the youth and their effect on the future race: the point being that strength as well as weakness, good and bad morality could be passed on from one generation to the next, to a certain extent. Linked to this notion of heredity was the notion of constitution, both physical and moral. Arguments put forth illustrate how a relationship was established between how children and young people looked – that is, their physical appearance – and how they acted and were, that is, their morality and conduct. Additionally, external causes were seen as affecting children and young people's corporeal and mental constitution (Ringsted, 1934; Heiberg, 1925, 1934, 1936).

District medical officer Joh. Lunddahl warned against the grave consequences of a weak youth. Denmark's future was at stake, he argued, and, in the name of hygiene, health needed to be put at the top of the agenda (Lunddahl, 1926: 1037; 1934: 905). Physician, politician and co-founder of the National Association for the Fight against Tuberculosis, Holger Rørdam called attention to the problem of rachitis, caused by lack of light and fresh air as well as bad nutrition (Rørdam, 1934: 878). In a similar manner, Johanne Christiansen identified a general lack of proper diet in the population (Christiansen, 1940a: 1170-71; 1940b: 141; 1940c: 628-29), particularly among young people in the countryside (Ibid. 1934: 879). Likewise, P. Sørensen problematised the youth's physical appearance, stating that particularly in the rural areas young people displayed deformities (Sørensen P., 1934: 878). H. Tvedegård agreed on the problematic youth in the countryside but explained it as a consequence of walking in natural surroundings: one needed to look down to avoid tripping over stones and so on, and this resulted in a crooked posture (Tvedegård, 1934: 878-79). Underweight children's weak physical constitutions were to a certain extent linked to a weak mental constitution (Garde, 1934: 1016-20); a relationship that was generally upheld when problematising children and the youth as lacking the necessary strength to secure the future (Ugeskrift for Læger, 1927: 1163).

Above I have shown how the overall concern with the quality of the race and low standards of hygiene gave way to children and the youth being identified as jeopardising the population as a whole and the future state of the race. The problematisations of children and young people were put forth along the lines of their bodily as well as their moral constitution. A relationship was established between this particular group's weak hereditary constitution, their physical constitution and their moral constitution in such a way that their bodies equally indicated their hereditary constitution, their problematic conduct (masturbation) and their morality. In addition, this relationship between the body and the mind was again related to the immediate environment's influence as well as the hereditary influence.

To summarise the chapter so far, I have shed light on the epistemological foundations for some of the expertise put forth by particular branches of science in the interwar era including medicine, physical anthropology, heredity science, psychiatry and welfare-economic science. More precisely, I have illustrated how the quality of the race, bad hygiene and the moral and physical health of children and the youth were carved out not only as medical problems, but as public health problems through concerns with the drop in the fertility rate, infant deaths, the spread of tainted individuals and tuberculosis. Moreover, these overall concerns with the quality of the race and bad hygiene were put forth as inextricable from issues of heredity and physique. While particular groups in society were identified as tainted – such as prostitutes, the feebleminded and criminals – and as posing a threat to the race as a whole, children and the youth were identified and problematised as lacking physical strength and moral grit.

In relating to sub-question 1, I have showed how within medicine and biology as well as branches of expertise related to anthropology and welfare economics, an overall public health concern regarded the deterioration of the race. In unfolding what I have conceptualised as the dual nature of biopower, this concern followed two main paths. One was related to biopolitical problematisations of the population and the social body as a biological whole, expressed through medico-biological, physical anthropological, welfare-economic and psychiatric rationalities. The idea put forth was that tainted elements in society – identified as prostitutes, feebleminded, mentally ill people and criminals – were spreading while the healthy elements were decreasing, causing a lowering of the racial quality. The other was related to what I have conceptualised as the individualising aspect of biopower, that is, problematisations of the individual, his/her body and mind, first and foremost expressed through hygienic, gymnastics and medico-physiological rationalities. The tainted groups were identified as affecting social space as such, segregated as symptomatic of a bad racial constitution. In the case of children and the youth, their symptoms were identified not in the population but on the individual body, but nonetheless still affecting the social body as a whole, the point being that

the flaws in their physical and mental constitution were jeopardising future generations. Problematisations of tainted individuals and a drop in the fertility rate on the one hand, along with problematisations of the weak bodily and mental constitution of children and the youth on the other hand tapped into a general notion of the social body as a biological entity. In parallel, problematisations of tuberculosis and neonatal deaths along with poverty and lack of proper hygiene in the schools and within the family tapped into problematisations of the immediate environment as a potential breeding place for disease. These two distinct ways of epistemologically addressing a public health concern – with the quality of the race and hygiene standards in general – informed what I suggest to be two modes of governing the population: preventive means for the purpose of cleansing social space and health promoting means aimed at transforming the home and school environment and strengthening human bodies and minds. In the following pages, this point is elaborated.

6.3. TECHNOLOGIES TARGETING HUMAN EXTERIORITY, CORPOREALITY AND INTERIORITY

In 1883 Francis Galton, the founder of eugenics, defined the study of eugenics as:

> [T]he study of the agencies under social control which may improve or impair the physical or mental quality of future generations (Galton (1883) in Johannsen, 1923: 319).

The quote indicates two forms of eugenics: that which is concerned with how to avoid impairing the physical and mental quality of future generations and that which is concerned with improving them. Heredity scientist Wilhelm Johannsen advocated Galton's principle of birth control based on the idea that a society should only have as many individuals as it is able to provide for, and that those individuals should be of the best stock possible (Johannsen, 1923: 319). Quoting Galton, Johannsen elaborated: "*The first task is to impede the birth frequency among the weak*". The next step, he continued, would be to improve fertility among the fit individuals through early marriage and health care

for their children (Ibid.). Hence, Johannsen held on to a health practice that combine negative and positive eugenics: a distinction that will constitute the following examination of how eugenics came to be presented as a solution to the problems of the quality of the race and bad hygiene by avoiding threatening elements while simultaneously nurturing fitness and the fit. These two modes of securing health through eugenics will be related to technologies of preventive health and health promotion respectively. Moreover, we shall see how they were carried out along the lines of welfare services and thus how a link was established between medical practice and welfare-economical practice.

While the first half of the chapter shed light on rationalities and problematisations raised – the 'modes of knowing' – the following pages explore the technological facet of governing human beings by virtue of their exteriority, corporeality and interiority. My concern is less with what was actually done than with the technologies put forth through preventive health and health promotion. By investigating these two different modes of public health interventions, a link can be established to the *problematisations* analysed above; not a causal link – i.e. I cannot argue that particular ways of identifying and addressing a problem led to particular actions. Rather, preventive and promotion technologies are regarded as being informed by the problematisations and related to the overall concerns with the quality of the race and bad hygiene.

6.3.1. EUGENICS AND SOCIAL CONTROL

In 1908 the celebrated gymnastics theorist J. P. Müller gave prominence to two important aspects of what he referred to as an ethics of sexual life, namely, the individual's satisfaction of his/her sexual urge, and reproduction of the stock. In relation to the former, Müller argued, quality and quantity were important factors to take into account (Müller, 1908: 91). In relation to the latter, Müller suggested that the following moral law be used as a litmus test: it is unethical to have children if 1) True love between potential parents is not present, 2) When one suffers from an inherited physical or mental illness or in any other way may damage the offspring, and 3) When it is unlikely that the child will be

brought up under favourable circumstances (Ibid. 98). In Müller's sexual ethics we find suggestions of how to secure the quality of future generations. Thereby he anticipated what in the following years was put forth as part of the solution to the question of racial quality in terms of *avoiding* particular elements, individuals, groups and modes of conduct.

Negative eugenics during the 1920s and 1930s evolved from concerns about tainted elements of the population and their effect on the general strength of the race. The overall questions posed regarded firstly how to control the tainted groups and secondly how to impede their ability to procreate. In the following, I shed light on how these two concerns were expressed through different ideas and moreover, how they amounted to a number of governing practices. What we will see is how administration of the tainted groups came about through a pairing of eugenic practices and social politics. Welfare services were thus characterised by a tricky combination of, on the one hand, securing good conditions for deficient individuals, and, on the other, arresting and controlling deficiency in society.

Whilst advocating for social politics as a means to improve the quality of the human material (Myrdal, A. & G., 1935: 179), both Alva and Gunnar Myrdal expressed concern over the risk of taking eugenics too far. "*It is difficult*", they argued, "*to decide which individuals should be able to procreate*" (Ibid. 10). Yet they maintained that the best solution would be to erase all physical and mental inferiority, bodily diseases and bad character traits (Ibid. 10, 190). Reducing deficient individuals' freedom to procreate would ultimately serve the interests of society as a whole (Ibid. 196). The most effective and sensible way of doing this, they argued, would be sterilisation (Ibid. 191) and abortion (Ibid. 193). Recalling the findings in the preceding section, the way the tainted individuals were problematised rested on the assumption that by removing weak elements, society as a whole would be healed and the prosperity of the future race would be secured: "*The distant goal of welfare is to cure society from the burden of deficiency*" (Ingbøl, 1936: 1304), as Kaj Ingbøl explains. A social system was to operate upon the

population in order to clean it from tainted elements (Olsen, A. 1936: 906).

K. K. Steincke, who during the years under the Social-Democratic government held the posts of Minister of Justice and later Minister of Social Affairs, presented the following argument for the importance of social legislation:

> It is not easy to come up with good arguments for taking care of the bodily and mentally abnormal individuals. Thus, if society is not able to kill them, a minimum of social policy is crucial simply due to the fact that, in the long run, the existence of tainted individuals will deteriorate the fit, and, accordingly, the average intelligence of the population will decrease (Steincke, 1928: 1140).

Steincke stressed that anyone, simply by virtue of being alive, had the right to the greatest happiness possible and ought to be protected and cared for. Nevertheless, lending weight to the intimate connection between eugenics and social legislation, he argued that society was obligated to prevent the breeding of degenerates (Steincke in Winge, et al. 1934: 97). From this vantage point, eugenics depended on social legislation in that the social institutions that provided care for the degenerate also provided the knowledge about them. In other words, by caring for the degenerates, public authorities would simultaneously gain access to them and be able to gather detailed knowledge about them. Asserting the reciprocal dependency between social legislation and eugenics, Steincke argued that all legislation was social, because it dealt with social problems and the population (Ibid. 98).

Heredity scientist and sociologist Tage Kemp took his cue from Alva and Gunnar Myrdal in emphasising the necessity of breeding a pure and fully functional population that would be able to join the workforce; or, as he put it, to breed "*100 percent people*" only (Kemp, 1937: 1013). He asserted that a society ought to be devoid of antisocial elements. Prophylactic eugenics was to eliminate such elements through sterilisation and enlightenment of the population, diagnosing psychological abnormalities, providing special schools and correctional institutions, controlling poorly equipped children, and, finally, extending

social care for deficient individuals (Ibid. 1014). Heredity scientist Oluf Thomsen emphasised the necessity of a strong social legislative framework, warning against allowing nature to rule freely. Restraints were important in order to eliminate so-called unwanted material (Thomsen in Winge, et al. 1934: 7-8; Garboe, 1934: 580).

The combination of a strong state and eugenic means was informed by what in the first part of the analysis was referred to as the overall concern with the quality of the population; a concern that gave way for problematising the spread of tainted individuals. The above-mentioned proposals presented a way to arrest this development, namely by social control of the tainted individuals and by constraining their fertility.

A number of social laws corresponded to the procedures towards the tainted population. In 1922 an act prohibited marriage between mentally retarded individuals and mentally ill ones unless their deficiency was not considered at risk of being passed on to their children (Wimmer, 1929). For the first time, a marriage prohibition was based on eugenic considerations, the areas in question being inborn deafness, inherited blindness, mental illness, deficiency, epilepsy, alcoholism, tuberculosis, cancer and a number of congenital deformities (cf. Koch, 1996: 36).

In 1924, the new Social-Democratic government appointed a Commission for Social Arrangements Towards Degenerate Persons – referred to as the *Sterilisation Commission* – with Steincke in charge in his capacity as Minister of Justice (Krarup, 1927). The Commission published the following statement:

> Due to eugenic reasons it is an utmost necessity that all deficient children are immediately put under special care. This is also the case with the retarded and the substandard individuals (Den alm. danske lægeforenings hygiejnekomite, 1942a: 759).

The social reform of 1933 included a deficiency care act regarding the handling and control of mentally deficient individuals. Firstly, they were to be detected in schools, workplaces and the like. Secondly, they were to be segregated from the rest of the population and deposited in special

institutions. The Social Committee, appointed for the purpose, was instructed to report on all deficient individuals detected and municipalities were instructed to give a report when deficient individuals were identified (Social Denmark – A survey of the Danish Social Legislation, 1947; Olsen, A. 1936; Kemp, 1937; Den alm. danske Lægeforenings Hygiejnekomite, 1942b; Den alm. danske lægeforenings hygiejnekomites udvalg for svangerskabs- og børnehygiejne, 1937).

In summary, I have shed light on how medical, anthropological and welfare-economical problematisations correlated with a number of governmental technologies along the lines of securing the population from tainted elements. These included a prohibition on marriage for mentally deficient individuals; social legislation concerning the control and handling of them and sterilisation of so-called eugenically loaded individuals. Thereby, the overall problematisation of the quality of the race informed particular preventive health practices, which evolved around controlling the tainted part of the population. In reference to the conceptualisation of the biopolitical concern for the living, we see a kind of totalising technology aimed at cleansing the population from the dangers of bad elements. Preventive health in this context was a matter of controlling and limiting the spread of tainted individuals and their integration within the healthy part of the population.

What follows is an elaboration of a mode of preventive practice that was intimately connected to the administration of sexual life and sexual urges. I highlight how tainted individuals – the feebleminded, the mentally ill and the like – were targeted and subjected to preventive health practices with regard to their sexuality, which was considered problematic in two ways: first, in terms of their fertility, which was said to be increasing and, thus, allowing the taint to spread; and second in terms of the nature of their sexuality: tainted individuals' sexual urge was regarded as uncontrolled, strong and often perverted, which again linked up to the problem of the fertility rate. This problem – also referred to as the 'sexual question' – was raised within various scientific branches.

In his lecture series from 1912, Søren Hansen put forth arguments for restricting childbirth. Eugenics, he argued, is concerned with bettering the general health of the population. This would include preventing the mentally ill, deficient individuals, epileptics and other inadequate individuals from reproducing by sterilising them, and by preventing them from getting married (Hansen S., 1912: 29).

Doctor Harald Okkels argued for the necessity of castration. First, he acknowledged the change in the law in 1935, which made it possible to perform forced castration (Okkels, 1940: 287). Then, he suggested that this extension should include sterilisation of nymphomaniac women, homosexuals with criminal tendencies, mentally ill people and deficient individuals. It was necessary, Okkels argued, to eliminate crime at its root. Such methods could only be considered humane (Ibid. 291). The psychiatrist August Wimmer was also in favour of sterilising morally degenerate individuals, including the spiritually abnormal, the strongly erotic individuals, amoral individuals, deficient individuals, epileptics and drunkards. (Wimmer, 1909: 9, 1929: 84). Every humanitarian, he argued, must approve of eugenic efforts (Ibid. 1929: 81). The sexual reformer J. H. Leunbach also argued for obstructing the fertility of the tainted part of the population. On the one hand, Leunbach was a staunch supporter of human, and in particular female, autonomy in relation to reproduction (Leunbach, 1925a: 42, 1925b: 114). On the other, he viewed the spread of tainted elements as a serious matter. Consequently, he considered contraceptive techniques and abortion important means to secure the quality of the race. In Leunbach's wording:

> The necessary regulation of the birth number should be used in order to eliminate the sickly and the less valuable stocks and families, and thereby bettering the quality of humankind (Ibid. 1926: 1015).

During the 1920s and 1930s a number of practices were legislated that resonate with a negative eugenics approach to the 'sexual question', including sterilisation and abortion (Smith, 1929: 572).

The possibility of sterilisation came sharply into focus with the founding of the Sterilisation Commission in 1924 with K. K. Steincke in charge. It

was argued that sterilisation practices first and foremost should be directed at mentally ill individuals, epileptics, backward individuals, and, in some cases, also masturbators if they were regarded as suffering from their morbid propensity. The central question debated among the members was whether eugenic arguments should also be taken into consideration (Krarup, 1927: 262-63). The commission was represented by a variety of scientific expertise including law, medicine, psychiatry, heredity science, social care, prison service and women's societies (Ibid. 261). Members of the commission were divided into three groups: a juridical, a social and a medico-biological group.[17] Two aspects were taken into account for sterilisation to take place. Firstly, those dangers stemming from the individual that threatened the individual himself/herself or others. These include masturbators who were considered to be suffering from their sick inclination (Ibid. 261-62). Secondly, the nature and conditions in which the offspring was bred.

In 1929 Denmark, as the first country in the world to do so, introduced sterilisation. Up until then, sterilisation had already been practiced in one Swiss canton and in a number of states in the US. Danish sterilisation practice, however – unlike Sweden and Norway – was first and foremost consensual (Christiansen, 1939b; Okkels, 1940) (see Koch, 1996, and Kirkebæk, 1993, for a critical account of the voluntary aspect of the sterilisation procedures). In 1934 the sterilisation act was extended to include all those individuals who due to deficiency were unable to provide for their own children (Ingbøl, 1936: 1303-4).

In 1935 the sterilisation act was further expanded to include non-deficient individuals to be sterilised if they wished for it and/or if the social conditions in which they were placed called for it. A juridical

[17] Members of the medico-biological group included professor in heredity Wilhelm Johannsen, consultant at the Keller Institution Christian Keller, consultant at the Epileptic Home in Nyborg Laurits Christian Langkilde, doctor and chair of the National Board of Health Ludvig Christian Gabriel Tryde, Cand.Theol. and inspector at the Horsens' penal institution Johan Chr. Heugh Wandall, doctor and professor in Psychiatry August Wimmer, secretary for the Ministry of Justice, later to be judge of the supreme court, Otto Irminger Kaarsberg, and, finally, endocrinologist and later professor in medical jurisprudence Knud Sand (cf. Koch, 1996: 59).

opening was made for forced sterilisation of the following groups: rapists and other sexual offenders and some mentally ill, but the majority being disabled individuals, considered the most degenerate group in the hierarchy of degeneration (Social Denmark – A survey of the Danish Social Legislation, 1947).

The sterilisation practic proceeded in the following way: after the practitioner's report on those patients considered suitable for castration or sterilisation, the National Board of Health and the Medico-Legal Council made a recommendation to the Ministry of Justice who provided the licence to perform the procedure (Sundhedsstyrelsen, 1933b: 4; Ministerialtidende for Kongeriget Danmark for året 1940, 1941). The majority of the individuals subjected to sterilisation were mentally ill, epileptics or suffering from some form of psychopathology, including kleptomania and erotomania. Most of the individuals had been involved in criminal acts (Christiansen, 1939b: 1121). Also, the majority of the cases were identified as having an abnormal sexual urge, whose strength and direction had forced them to commit crimes (Wildenskov, 1933: 1223) as well as being deficient (Ibid. 1225).

The following account extracts the types of patients submitted to vasectomy, castration or sterilisation (Sundhedsstyrelsen, 1933b: 32-48). As we see, a description of the patient's characteristics as well as his/her family background formed a scientific basis for the final decision. One patient submitted to castration was regarded a late developer with a father who was a drunkard and a hysterical mother. He had been sent to an institution due to repeated rape attempts and indecent behaviour towards small girls (Ibid. 46). Another patient was characterised as constitutionally homosexual. It was noted that he showed no inclination towards sexual criminal acts or criminal acts in general. However, due to his sexual disposition, he was considered unable to focus on his work. In order to avoid disruption and to provide spiritual calmness it was recommended to subject him to castration (Ibid.). A third patient was described as slightly deficient, with gross, amoral character flaws, including indecent behaviour towards small girls. His father was a drunkard and the home was poor and miserable.

Another patient was described as coming from a poor home and being the result of bad upbringing. He was characterised as wild and intractable, showing a strong homosexual disposition and an intelligence quotient of 87 (Ibid. 46-47). Another patient had previously been convicted for acts of indecent behaviour towards small boys. He was characterised as homosexually attracted to small boys, psychologically degenerate with a strong sexual urge (Ibid. 48). Finally, a patient was described as a habitual masturbator who also engaged in several sexual relationships with women. He was characterised as partly impotent, psychologically childish and underdeveloped, but nevertheless intellectually well equipped. He was, it was reported, well aware of the moral reprehensibility of his actions but was not able to control his urge (Ibid. 47). Most of these cases for sterilisation were considered sexually problematic, either due to the direction of their sexuality or due to its intensity. The nature of their sexuality was such that it had to be arrested in order to secure the population's prosperity as a whole. What is also worth noticing is that the root of the problem of these cases was considered to be within the immediate environment, first and foremost the parents' sins, but also an outcome of external factors such as poverty and miserable life conditions.

To summarise, the cases above illustrate how sterilisations were carried out as a preventive health technique to keep the tainted population from increasing. We see how the majority of cases who were subjected to sterilisation had been identified as having a problematic sexual nature. Thereby the 'sexual question' was regarded as a social problem, which called for negative eugenics. In other words, a preventive health technology was put forth that operated through and by virtue of sexual life and sexuality. This was also the case with abortion, as I discuss below.

In 1937 the *Act of 18th May 1937 on measures in relation to pregnancy etc.* allowed for termination of pregnancy on the basis of eugenic indicators, that is, if the child was considered at risk of suffering from a mental illness. However, the patient had to take the initiative for the procedure (Frandsen, 1963: 121; Kemp, 1937, 1940a: 373; Social

Denmark – A survey of the Danish Social Legislation, 1947). In 1939, the act came into force and provided the possibility for legal abortion if it was indicated by any of the following factors: medical indication (risk to the mother's life or health), criminal indication (rape, incest, if the woman was unconscious at the time of the sexual act, if she was insane or markedly mentally deficient; when a child under 15 was made pregnant, or a young woman under 18 was grossly taken advantage of and seduced by the person who caused her pregnancy), or eugenic indication (if the child, as a result of hereditary disposition, was at risk of suffering from insanity, mental deficiency, other grave mental disturbance, epilepsy, or grave and incurable physical disease). The hereditary aspect corresponded with how – as we have seen in part 1 – the quality of the race was partly addressed through a notion of heredity. Heredity provided a risk both to the offspring and to the population as a whole – a risk of degeneration. As illustrated, the heredity approach took into account both a deterministic element and an element that allowed for transformation. Now, in the case of the tainted individuals, the risk of deterioration was considered more likely than the possibility of transformation – hence abortion procedures. The reverse was the case with the promotion of fitness among the youth, as we shall see later.

In summarising the whole section, the following points can be made: we have seen how medico-biological, physical anthropological and welfare-economical problematisations of racial quality informed a number of governmental technologies that aimed at protecting the population from tainted elements. Moreover, the preventive health practices were aimed at arresting the tainted groups' sexual life, sexual urge and fertility by means of two practices: sterilisation and abortion.

Along with the preventive practices aimed at securing the social body as a biological entity, technologies aimed at the human exteriority also targeted the immediate environment, i.e. homes and the families. These can be seen in the light of a number of campaigns aimed at human exteriority with a view to increase health. The National Association for the Combat of Tuberculosis, besides establishing policlinics and dispensaries throughout the country (Københavns Amtslægekreds, 1929:

26), provided free treatment and launched a number of hygiene campaigns, some of which were directed at schoolchildren (Faber, K., 1939: 62; Bergtrup-Hansen, 1939; Den alm. danske lægeforenings hygiejnekomite, 1943; Frandsen, 1963: 74-77; Sundhedsstyrelsen, 1924, 1926, 1927; Sundhedsstyrelsens medicinalstatistiske kontor, 1925: 196; 1926: 12; Ugeskrift for læger, 1926a: 229). Likewise, various vaccination campaigns were launched to prevent smallpox, polio and other contagious childhood diseases (Københavns Amtslægekreds, 1929: 18-19; 1930: 14-15; 1931: 27-30; 1934: 2; Sundhedsstyrelsens medicinalstatistiske kontor, 1925: 194). Moreover, the problem of nutrition called for vitaminisation of food (Frandsen, 1963: 108) and human beings – e.g. experiments with adding vitamins into schoolchildren's diet (Gudjonsson et al., 1935: 1158-62) – as well as heat treatment of milk as a means to avoid tuberculosis (Frandsen, 1963: 103-05). I will not elaborate on these campaigns but instead focus on the one particularly targeting homes and families.

In 1927 the League of Nations appointed a commission for investigating the different countries' preventive health procedures aimed at maintaining public health. The main themes presented were hygienic conditions for the sickly, care of mothers, babies, preschool children and schoolchildren (League of Nations, 1928; J. K., 1927: 335). The rationalities concerning the negative effects of family circumstances upon individual health and general constitution, elaborated in the previous section, gave way for health promoting means seeking to transform human exteriority into a healthier one. The problematisation of tuberculosis and other defects informed an exclusive focus on the schools. An important source of health expertise was the school practitioner, particularly as the school was seen as a breeding place for tuberculosis. This practitioner's task, argued several prominent hygienists (Faber, K. & Ostenfeld, J., 1924, Ingerslev, 1924a), was to gather information about the children's state of health (Ugeskrift for Læger, 1924b). According to Ingerslev, the school practitioner's job is not to cure, but to detect the weak pupils so that procedures could be taken in order to avoid diseases such as tuberculosis and defects such as impaired hearing and sight (Ingerslev, 1924a: 171). In his memoirs from

1939 the hygienist and influential figure in the Association for the Combat of Tuberculosis Knud Faber emphasised the necessity to manage not only sickness but also health, which includes epidemiological and bacteriological knowledge as well as hygienic expertise (K. Faber, 1939: 62; 1945: 1023).

The problematisation of infant deaths in particular informed a mode of health promotion operating through the home and the family. During the 1920s a new practice was taken in the public health efforts, namely health visits.[18] The health visitor was introduced to secure proper hygiene and child rearing in the homes (Lomholt, 1926: 48; Sygeplejen, 1926: 13-18) through systematic contact (Bergmann, 1926: 683-84; Den alm. danske Lægeforenings Hygiejnekomite: 1940: 876-78). It was argued that home visits made it possible to help people bodily as well as spiritually (Arffman, 1928: 141). In addition, healthy habits were to be worked in at home (Freudenthal, 1940b: 1369; Heuch, 1936: 825; 1939: 210). The GP Arne Johannesen added that, with the introduction of health visits, it was not only the individual homes that were advanced, but in fact the whole of society (Johannesen, 1939: 548).

In 1928, the head of the European division of *The Rockefeller Foundation* paid a visit to the Danish National Board of Health and the following year the foundation became involved in the Danish campaign against infant deaths. In 1929, the National Board of Health set up a pilot project of health visitors for a trial period of five years in three Danish districts: Copenhagen, Holbæk and Vejle respectively (Sundhedsstyrelsen, 1936: 43; 1937: 129). According to Johannes Frandsen, a key figure in the National Board of Health during the 1930s and 1940s, the initiative was the first of its kind. Unlike the effective

[18] It is worth noting that already in 1870 the *Deaconess Foundation* ('Diakonissestiftelsen'), together with the *Stefan Association* ('Stefansforening'), introduced the first 'home nurses' in the country by delegating deaconesses to poor neighbourhoods in Copenhagen (Dansk sygeplejeråd, 1941: 477). In 1916, the introduction of municipal home nurses was carried out in Copenhagen, first and foremost to relieve the pressure on hospitals (Ibid. 480). However, the above-mentioned account of health visitors illustrates a new nursing function.

Tuberculosis Acts from 1904 (Lehmann, 1906), this act legislated preventive health action in general without targeting specific diseases (Frandsen, 1963: 122). In light of the new priorities, the hygiene expert's title was changed from nurse, which had connotations with sickness, to health visitor (Ibid. 118).

The districts were divided into welfare authority units, each with an appointed health visitor (Social Denmark – A survey of the Danish Social Legislation, 1947). Her job was to visit families with newborn babies regularly during the first years of the child's life, providing expert advice on hygiene and child nursing, monitoring the child's weight and general health, and calling a doctor if she suspected a medical problem (Sundhedsstyrelsen, 1937: 129).

Along these lines, enhancing health became the health visitor's central concern rather than merely preventing disease or bad elements. Hygiene was thus occupied with promoting health, unlike the preventive technologies informed by negative eugenics seeking to diminish bad elements among the population as a whole. With health promotion seeking to establish a healthy environment inside the home and within the family, health as a norm was introduced into the human exteriority. And with this introduction families and homes were addressed as potential agents of health.

At the end of the trial period, the health visitor programme was considered a huge success. In Copenhagen, 85 percent of the homes offered the assistance accepted it and in the rural districts the number was 98 percent (Frandsen, 1963: 119). Moreover, according to statistics released by the National Board of Health, the infant mortality rate was reduced by 13 percent in 20 years from the turn of the twentieth century and was relatively stable in the period stretching from 1921 to 1931. The following years the mortality rate was even more reduced and in 1934 it was at its lowest point, namely at 6,4 percent. Numbers indicated that the mortality rate was halved among those children who had been under supervision of a health visitor by the introduction of health visits (Sundhedsstyrelsen, 1937: 130): numbers that in 1935 made the

National Board of Health provide the following account to the Minister of Internal Affairs Bertel Dahlgaard:

> [T]here is no doubt that it is possible not only to save the lives of many infants, but also to increase the health considerably among infants all over the country through educational work of mothers carried out by women particularly educated for the purpose, namely health visitors (Frandsen, 1963: 120).

The account was followed by an appeal to the Ministry of the Interiour to affirm legal authority to provide state subsidies to the municipalities that engage in a similar kind of hygienic work (Ibid.). This led to a bill for preventive health action, which gave authority to the municipalities. In 1937, after the five-year health visitor trial period, the act against infant mortality was upheld (Ibid. 121). State authorities could now grant aid for local bodies and other institutions to employ public health visitors for the purpose of keeping an eye on children in their first year (Social Denmark, 1947). The act also authorised the national administration to fund local authorities and other institutions to employ public health visitors (Ibid. 120-1; Social Denmark, 1947), prescribing that municipalities were offered grants from the state to cover half of their expenses (Ministerialtidende for Kongeriget Danmark for året 1937, 1938). The act was followed by the founding of the National Child Birth Trust ('Mødrehjælpsinstitutionerne') in 1939, also with a hygienic purpose aiming at children in mind (Gullestrup, 1948: 125-26).

In summary, we have seen how health promotion targeting families directly through health visitors was in line with the urgings of hygienist Freudenthal, the welfare theorists Myrdal and others, who emphasised the need for children's intimate environment to be moulded according to hygienic standards as well as spiritual ones. Human exteriority, then, was seen as both having an impact on hereditary factors and being a potentially nourishing environment for the proper breed of individuals through social legislation. In contrast, unrestricted procreation among the tainted members was a menace to society as it would result in a growing demographic inequality at the expense of the fit, and it was this idea that constituted the scientific basis for the use of eugenic practices. Taking my cue from Michel Foucault's notion of medicine as a bio-social

practice (Foucault, 2003b: 61-62), one may regard the negative eugenic notions and technologies as particular ways of making social space – and particular groups within this space – amenable to government and control. The population was addressed through biological, medical and social knowledge and accordingly targeted for interventions according to their risk to the greater whole – the race. What was at stake, in terms of preventive government, was that the medico-social concern for the quality of the race paired up with a welfare-economic pursuit of securing the population's prosperity. It was these two rationalities that informed the negative eugenic practices along the lines of arresting the spread of tainted elements. While medical, biological, welfare-economic and anthropological authorities found an epistemological basis for problematising the quality of the population, welfare-economics provided the means through which this problem could be solved, namely through negative eugenics. With the introduction of the health visitor and her role in securing a healthy immediate environment, the familial environment was also governed and subjected to preventive health procedures. Based on the voluntary engagement of the mothers, this type of intervention was less a matter of preventing particular conducts, as it was a matter of installing in the very heart of the families a preventive health unit.

While the above section illustrates a type of government aiming at part of the population as a way to protect social space, the following mode of government was directed at human corporeality.

6.3.2. AMELIORATING BODY AND MORALITY

"*Spiritual life should be reflected in the face and the body*" (Knudsen, 1930: 41), K. A. Knudsen, acknowledged gymnastics theorist and until 1928 leader of the *Department of Gymnastics* at Copenhagen University, claimed. The quote is quintessential for a kind of health promotion that in effect provided a fusion of the body and the mind: a point that is demonstrated in the following paragraph.

At the *Fourth Nordic Congress of Physical Education and Child and School Hygiene* in 1924, professor in hygiene L. S. Fridericia gave an account of the development of modern hygiene, which he divided into three periods. The first he called the miasma period related to the cholera epidemic in 1853, in which attention was directed at buildings, sewage and other exterior factors. Then, he explained, the bacteriological phase came, which allowed for a focus on exterminating the source of infection. Finally, he argued, in the present day, individual health was now at the centre of attention. Therefore, gymnastics played a crucial role (Fridericia L.S., 1927: 35), as did the measurement of and division according to body types of all schoolchildren (Ibid. 1942a: 765; 1942b: 766). Hygienist H. P. T. Ørum pursued a similar argument: healthy housing was important, but it was even more important that the individual was given responsibility for his/her own health and that the will to be healthy and to avoid immorality was strengthened (Ørum, 1924a: 908-10; 1926: 851; 1927: 603). Ørum further argued that what was previously known as laziness was in fact defective development and connected to bodily diseases (Ibid. 1927: 603). As he explained in *Ugeskrift for Læger*: the school practitioner's primary task was to combat epidemics, then to ensure proper school buildings. But the real task behind this was to transform the exterior school hygiene into hygiene aimed at schoolchildren and in this way focus on its social importance (Ibid. 1924b: 799). Physical upbringing was linked to this task and from this vantage point gymnastics, proper sleep, cleanness, and proper food was central (Ibid. 1924a: 908). The issue of individual behaviour was illustrated in a summary in *Ugeskrift for Læger* in 1936 of an article in *The Lancet*, written by the late chief medical officer in the English Ministry of Health, Sir George Newman. He argued that medicine's new role was to prevent diseases, raise the standard of physical life and enhance the human being's capacity. Disease, he argued, is the man himself, his heredity, temperament, habits and religion. Therefore, today's practitioner should focus on personal hygiene and lifestyle (Bie, 1929: 753; 1935: 161; Gotfredsen, 1936: 186).

Fridericia and Ørum's accounts pinpoint a type of health promotion that I explore more thoroughly below, namely a type through which the

human being was the object of transformation. This mode of intervention gave prominence to solving the problems of the quality of the race and bad hygiene through a general strengthening of the bodies and minds of children and young people (Ugeskrift for Læger, 1927: 1163) and a promotion of physical culture.

In the section dealing with negative eugenics, we saw how sexual administration was put into practice with the purpose of preventing procreation by the tainted part of the population. However, tainted individuals were not the only group targeted for their sexuality. Children and the youth were also merited attention and a correlation was established between a weak bodily constitution and immoral acts such as masturbation. This section outlines a kind of sexual administration determined to strengthen the physical and moral constitution of children and the youth.

Instead of reading bawdy novels, children should engage themselves with physical exercise and sports, and play about in nature, the acknowledged writer and doctor Hans Kaarsberg argued at the turn of the twentieth century (Kaarsberg, 1892b: 57). He emphasised the importance of bodily exercise. Encouraging and ensuring physical activity and discipline was an excellent way to prevent sexual disease and disease in general.

In 1908 the celebrated gymnastics theorist J. P. Müller published a popular book named 'Sexual Morality and Happiness ["livslykke"] – A Contribution in Popular Form to the Solution of the Sexual Question' (Müller, 1908). He stressed that sexual life was not immoral as such, as long as it was exercised according to natural laws and was not physically or mentally damaging to either individuals or present and future human kind. The means proposed by Müller for children to gain a "*natural, healthy sexual life*" (Ibid. 147) was gymnastics and maintaining their fitness. This, he argued, would lead to a decrease in the number of abnormal and defective individuals. Simultaneously, it would relieve the sexual urge when the child reached sexual maturity (Ibid.) while making sexual performance more forceful and enduring (Ibid. 148). The point,

according to Müller, was not to decrease the natural sexual urge, but to have the individual satisfying it without risking physical damage. Moreover, as physical culture would secure both bodily wellbeing and a degree of self-control, it would provide a guarantee that satisfaction was achieved within reasonable limits (Ibid. 149).

In 1899 the first international conference on venereal diseases was held in Brussels. All participating countries agreed that governments should put effort into raising awareness within the population, in particular young people, about the dangers of prostitution for both sexes, including venereal diseases. At the second conference in 1902, chastity was placed on the agenda as a crucial preventive means (Ibid. 25). The same year, the Danish Association for the Fight against Venereal Diseases was formed. In the following years, the association and others were occupied with solving 'the sexual question', which included venereal diseases (Dansk Forening til Kønssygdommenes Bekæmpelse, 1903; Den alm. danske lægeforenings hygiejnekomite & Dansk Forening til Kønssygdommenes Bekæmpelse, 1945; Bibliotek for Læger, 1903; Pontoppidan, 1903; Ingerslev, 1920; Brun-Pedersen, 1929; Philipsen, 1932). U. H. Wöldike, a member of the association asserted that sports, dentist Alfred Bramsen's chewing method, Müller's exercise system, Mikkel Hindhede's low-protein diet theories and, finally, regular baths would all in different ways increase the possibility of a healthy body and avoiding immoral acts such as masturbation (Wöldike, 1907: 21). In general, the association emphasised the necessity to provide the youth with information about the dangers of venereal diseases (Kistrup, 1928: 3). Additionally, offering free treatment for everyone suffering from a venereal disease was recommended as well as the obligation to sign a declaration about one's venereal health status before matrimony (Ibid. 14-15; Corning, 1929: 786). In this way, the individual was encouraged to actively take into account his/her health and to a certain extent intervention was made possible on the basis of the citizen's active and often voluntary involvement.

We see a very different way of coming to terms with the 'sexual question' than the negative eugenic take seeking to eliminate life. In this case, it is

concerned with attuning individuals to healthier and more responsible conduct, and thereby transforming them into agents of their own health. In the first part of the chapter I illustrated how the problematisations of children and the youth identified a relationship between their physical being and their moral one. When it came to the promotion of physical culture, a similar relationship was established along the lines of the idea that physical exercise could affect their morality positively. Below I show how physical exercise was seen more or less explicitly as a solution to the 'sexual question' (Ugeskrift for Læger, 1926b: 383; Freudenthal, 1936a: 19).

Alva Myrdal advocated what she termed spiritual nursing, which included overseeing the quiet children and their tendencies to masturbate, suck their fingers and bite their nails (Myrdal, A., 1936: 83), as well as furthering children's bodily and spiritual health (Ibid. 154).

> Equally, the homes and the children's room should aim at the following: the child's bodily and spiritual health and prosperity (Ibid.).

The hygienist Holger Rud advocated what he termed spiritual hygiene and emphasised the intimate connection between physical and spiritual health (Rud H., 1935a, 1935b, 1935c). Hygiene, he argued, was first and foremost a matter of preventing the causes of mental illness; causes he identified as a combination of external conditions, heredity and bodily phenomena, which together were the sum of the individual's constitution (Ibid. 1935b: 2). The most important aspect, he argued, was the administration of sexual life: a crucial area for preventing unfortunate character traits (Ibid. 1935c: 4).

The physician Poul la Cour also established a direct line between physique and morality; one should avoid idleness, he explained, and bodily exercises are the best means of prevention. When effort is put into useful matter, the youth would not as easily be drawn to morally corrupt behaviour (la Cour, 1924: 253). "*To begin with, courage is in the muscle*", he stated in 1924 in his published book about the human physique. He explained that the development of spiritual abilities depends on a healthy development of the muscles, as the muscles are the

primary form of the will and the place where the character, courage and self-esteem are steeled (Ibid.).

Hence, we find a very different approach than negative eugenics. It is less a question of avoiding particular elements in society, than of promoting health through an amelioration of human corporeality.

At the *Eighth Nordic Congress of Physical Education and Child and School Hygiene* held in 1935, the problem of the physical and moral state of children and the youth was also placed on the agenda. Taking its point of departure in the problem of tuberculosis, the debate focused on how to strengthen the character of children and the youth through physical exercises (8. Nordiske kongres for legemlig opdragelse, børne- og skolehygiejne, 1935: 43-68; Ugeskrift for Læger, 1935: 161).

H. Daniel (Daniel, 1931) emphasised that the doctor had to have a social angle on the matter of hygiene, that is, he had to have knowledge about the hygienic state of homes and schools as well as the lived life in the families (Ibid. 368). Moreover, he needed to relate to emotions, the patients' psyche and soul. As Daniel argued, it should not be diseases one should treat but ill people. In addition, the doctor's job was to lead the individual to the proper path, particularly regarding the 'sexual question'. A central means was gymnastics (Ibid. 369).

Body culture was high on the agenda from the beginning of the twentieth century. All over Denmark, mostly in the countryside, sports organisations and folk high schools were established. These were generally seen as crucial for the general education of the people (Lembcke, 1922: 55; Dansk Idræt, 1930a: 1-2; 1930b: 17-18; 1930c: 26-27; Anthonisen, 1933; Hallas, 1933: 621-22; Harløf, 1933: 658; Osier, 1933: 658; Munck, 1934: 1069; 1935d: 20; Freudenthal, 1938b: 197-99). Apart from the organised gymnastics and sports organisations, the preoccupation with body culture was specially aimed at schoolchildren and the youth.

The most influential gymnastics system in Denmark in the first half of the twentieth century was Ling gymnastics, developed by the Swedish gymnastic pedagogue Pehr Henrik Ling during the nineteenth century. Niels Bukh, founder of Ollerup Gymnastics Folk High School, promoter of organisational gymnastics and one of the leading gymnastic figures during the 1920s and 1930s, emphasised Ling's focus on gymnastics as a pedagogical tool. He argued for the necessity to build a better future for the human stock (Bukh, 1930: 6) by building a worthy posture for the human being: one that reflects a healthy spirit (Ibid. 5) and at the same time enhances health (Ibid. 2).

The Finnish Elli Björkstén's exercise system was also influential and the greater purpose of her method was the following:

> Gymnastics does not only aim at providing physical power and health, but is equally aimed at increasing and improving the character and the soul's aptitude (Björkstén, 1933: 8).

The Danish gymnastic pedagogue Agnete Bertram's so-called natural gymnastics for women was particularly influential in the first half of the twentieth century. In her book published in 1933, Bertram outlined the purpose of physical exercises by illustrating how activating specific parts of the body corresponded to particular character traits: bending furthers a good posture, lifting exercises further strength, breathing exercises further general health, jumps further courage, and arrangement exercises further discipline (Bertram, 1932: 20):

> We wish to bring the students to a state in which they in posture and movement find a worthy expression of their personality (Ibid. 21).

In a review of Bertram's natural gymnastics in *Ugeskrift for Læger*, the medical practitioner Arne Faber acknowledged Bertram's system but pointed to the difficulties in establishing a connection between anatomy and spiritual purposes (A. Faber, 1933a: 294). He therefore suggested that the students watch documentaries about African animals as a supplement. The animals' free movement, he argued, illustrates well the

overall goal of gymnastics: strength, good posture, courage, flexibility, economy, discipline, grace, beauty, decency and cheerfulness (Ibid. 296).

The relationship between physique and spirit was also put forth in the sports journal *Danish Sports* ("*Dansk Idræt*"). A central focus was on the question of how to strengthen the young generation and in this way secure the future stock (Dansk Idræt, 1931a: 122-23, 1931b: 130-31; Lidegaard, 1931: 230-32). Particularly arguments concerning the importance of gymnastics for developing proper spiritual characteristics and proper character traits were presented (Th., 1931: 218-19). In this connection, the prophylactic nature of gymnastics was stressed. Not only was physical exercise furthering health, the argument went, it also prevented youth criminality as well as furthering sexual abstinence, particularly during puberty as it reduced sexual desire (Secher, 1931: 198-99).

The celebrated gymnastics theorist referred to as Captain Jespersen (Jespersen, 1951a, 1935b, 1935c, 1935d) also participated in the debate. Jespersen's main claim was that the spirit pays the body's debt (Ibid. 1935b: 27). Gymnastics, he argued, was a weapon against indolence, dullness, softness and indulgence: character traits that could be detected directly on the body and the general appearance: obesity, paunchy stomachs, and a number of deformities as well as heavily made up women, who do not know about moderation and are deprived of aesthetic appreciation (Ibid.). First lieutenant Otto Olsen also raised the issue of how to strengthen the will of individuals through bodily exercises. There is no doubt, he argued, that those who are physically well-equipped can pass through life easily although their character might be weak. Nevertheless, if we should aim above average, spiritual strength is just as important as physical (Olsen, 1931: 56).

Both medical practitioners and gymnastic theorists regarded physical exercise and gymnastics central techniques for establishing the proper correlation between human corporeality and interiority. *Healthy Lifestyle* editor Poul Freudenthal emphasised the necessity of what he identified as 'constructive hygiene' (Freudenthal, 1936e), that is, hygiene

and diet aimed at creating healthy, slim and supple individuals (Ibid. 1935a, 1935b, 1935d, 1935e, 1935f, 1935g). The point with the journal, he argued, was to hatch a body culture, harden the will, cultivate the character and raise the feeling of life: "*We are all for the stock!*" (Ibid. 1935a: 6-7). His main focus was on measuring and transforming schoolchildren's bodily appearance (Ibid. 1935c) and thereby strengthening the general mental state of the population (Ibid. 1936d).

Medical practitioner and gymnastics theorist Viggo Munck also put forth the notion of constructive hygiene as a central means, emphasising the importance of physical exercise for the general upbringing of the population (Munck, 1935c: 1-4, 1940: 1098-1100). He referred to the accomplishments made by National Socialism in Germany and the organisation of medical practitioners for the furtherance of physical exercises (Ibid. 1935b: 609). In Germany, he argued, the social hygienic purpose of gymnastics had now been approved (Ibid. 1935a: 232; 1935b: 610). This, however, had yet to be recognised in Denmark. Only through prophylactic and constructive hygiene, he continued, are we able to have 100 percent humans rather than average humans, that is, 75 percent humans (Ibid. 1935b: 611; 1935d: 21).

We see how constructive hygiene as a mode of health promotion, despite being the opposite of preventive technologies informed by negative eugenics, nevertheless was informed by a similar problem, namely the problem of racial quality. While the negative eugenic approach aimed at solving this problem by arresting particular life forms and by controlling degenerate individuals and those considered bad for the whole, this health promoting approach was another way of solving the problem. Strengthening the bodies and minds of the youth through physical exercise is, I suggest, a form of positive eugenics; not the techniques in themselves – gymnastics and physical culture – but in being informed by the overall problem they seek to solve: the deterioration of the race. Constructive hygiene thereby was an intervention targeting bodies and beings with the aim of creating a strong population – both bodily and spiritually. Accordingly, a correlation may be established between what we see as a kind of phrenological approach to the relationship between

corporeality and interiority, soma and psyche, in the sense that a correlation was established between the human physique and the mind.

In sum, what by some was termed 'constructive hygiene' was a kind of health promotion that sought, through physical exercise, to solve the problem of racial quality and, related to this, come up with a solution to the 'sexual question'. It is worth noting that, unlike negative eugenics, this type of health promotion targeted the bodies and beings of the youth to strengthen them both physically and mentally. However, this practice was not governmentalised, that is, it was not part of public health campaigns. In this way, the medical and gymnastics' way of solving the 'racial problem' through physical exercise – also referred to as 'constructive hygiene' – was not a state interventional practice, apart from the fact that gymnastics for a time had been made obligatory in schools.

A number of legal changes and health policies were launched in the first half of the twentieth century, corresponding to the above-mentioned measurements of children and the youth.

In 1924 the *Great School Commission's Report* ("Den store Skolekommissions Betænkning") emphasised the necessity for systematic control of schoolchildren in order to detect physical weaknesses.

The social legislation of 1933 envisioned medical officers inspecting the hygiene conditions in public schools. In 1936 the Ministry of Education appointed a Hygiene Committee (Roholm, 1948: 817) to coordinate this. The committee's legislative proposals included appointing medical practitioners and dentists in all schools (Frandsen, 1963: 123) and conducting regular health checks at public schools of the environment, schoolchildren, teachers and other staff. Moreover, the committee proposed tuberculosis examinations as well as weighing and measuring children annually (Fenger, 1943: 22). The bill was promulgated and its measures launched in 1946 (Ministerial tidende for kongeriget Danmark for året 1932, 1933; Frandsen, 1963: 123, 125).

A gymnastics inspector was appointed to give a yearly account of the state of physical education in public schools, including facilities for playing ball, swimming, outside bathing, bathing in baths as well as gymnastics facilities (Sundhedsstyrelsens medicinalstatistiske kontor, 1925: 176). By the end of the 1920s most schools in the cities were equipped with gymnastics facilities and there were both municipal and private baths (Sundhedsstyrelsen, 1930: 112-13). Since 1917 two hours a week of gymnastics has been mandatory in Danish public schools. In the mid-1930s, more or less half the public schools had facilities for soaping, and about a quarter also had facilities for washing feet. In two thirds of the schools bathing was compulsory every fourteenth day. In some schools bathing was restricted to the winter season only and in others it was practised once or even several times a week, usually after the gymnastics lessons. In most schools, pupils were also encouraged to use the school's bath facility after school hours (Ibid. 1933: 107).

In relating to sub-question 2, we have seen three technologies at work: a socio-genetic technology pairing up eugenic means with welfare services, a socio-hygienic technology combining hygienic means with welfare services and finally, a corporeal-hygienic technology working through the promotion of a body culture.

6.4. CONCLUSION

To place the promotion of a body culture within the notion of eugenics, more specifically positive eugenics, as I have done above, calls for an elaboration. Firstly, just because such a body culture promotion is still to a certain extent within a preventive health domain does not automatically call for its placement within eugenics. However, it shares its problematisations regarding the general quality of the race with negative eugenics. While preventive health along lines of negative eugenics entailed means of arresting life before it appears (sterilisation), just as it appears (abortion) and after it appears (institutionalisation), health promotion aimed at transforming the lives that already existed into stronger and more vital ones. Nonetheless, in both cases a

strengthening of the race was advocated, albeit one was set on preventing particular elements while the other aimed at nurturing particular elements. This overall aim to improve the quality of the race runs through both preventive health and health promotion. In the first part of the chapter we saw how the problem of racial quality found various expressions within medicine. The relationship between the determining aspects of racial quality and the aspects believed to change it were of major concern, particularly within heredity science. For instance, this regards the question raised among heredity scientists related to which aspects of a human being were determined by ancestry and which by environment. Whilst not explicitly arguing in favour of gymnastics and sports as a means to transform the human constitution and conduct, heredity scientists did upheld a notion of amelioration of the exteriority and the individual.

Moreover, negative and positive eugenics seem to have supplemented each other and to a certain extent form a relationship. Where the bio-heredity standpoint was very clear on the matter of positive eugenics: its take was without recourse to the notion of breeding super humans and other means to actively nurture the fit part of the stock, for instance through means to increase their fertility. However, negative eugenics (preventing the tainted from procreating) was supplemented with the positivity of body culture: through physical exercise bodies and beings were transformed into strong and healthy individuals. Hence, gymnastics undertook the task of positive eugenics, which heredity science had shunned. Through a kind of health promotion aimed at strengthening the race, what was at stake in both cases was the creation of a physically and mentally strong race as a response to the general concern of the quality of the race. Nonetheless, positive eugenics in the form of the promotion of body culture was not governmentalised.

Below I elaborate on how the relationship between body and mind, soma and psyche, was identified and governed as a particular effect of the preventive health problematisations of racial quality.

Firstly, this relationship was established within physical anthropology. Along with identifying the problem of racial quality came a concern with particular racial characteristics and signs of uniqueness, as put forth by the Anthropological Committee under Søren Hansen. This gave way for a number of measurements of the physical constitution of the Danish race, including head and body size, shape and weight, hair and eye colour. It also cut a path for investigations of the feebleminded, including identifications of their characteristics and measurements of the degree of feeblemindedness and of feebleminded people's family circumstances and modes of conduct. The physical anthropological take on eugenics also opened the way for a number of measurements of the physical health of children and the youth. Particular numeric indicators were used to identify the degree of their wellbeing or unfitness.

Secondly, a relationship between body and mind was established within hereditary science. Drawing from both degeneration theories, theories on genetics and eugenics, arguments were put forth as to how much individuals' physical constitution – bodily shape, hair and eye colour and so forth – indicated their mental and moral outlook. This relationship was established to the extent that the two were fused together.

Thirdly, within welfare economics, allusions were made towards the relationship between bodily and spiritual hygiene and the necessity to oversee children and the youth in order to prevent bad conduct such as masturbation, and thereby secure the moral constitution of the next generation.

Fourthly, within gymnastics and sports, lack of physical strength was identified as a symptom of a youth's weak character. Consequently, physical exercise was put forth as a means to strengthen moral constitution as well as the body.

What links all these modes of establishing a relationship between the body and the mind was a causality that worked one way, namely physical fitness would create moral strength. Additionally, to the extent that individuals or groups were considered able to transform – which de

facto excluded tainted individuals like the feebleminded – this transformation was addressed at a physical level. The crux of it was that the body was a symptom of the mind (the morality) and consequently the body became the means through which a morality could be instilled.

Relating to the workings upon the population, a socio-genetic technology was put forth in the overall effort to secure the health of the population. It operated *vertically*: it revolved around an epistemology of heredity where past lives, sins and diseases manifest themselves on a human being and at the same time determine the physical and moral outlook of future generations. Equally, eugenic means was manoeuvred by decreasing the negative effect on the present generation of their ancestors (through institutionalisation and marriage control) and at the same time by decreasing the negative effect passed on from the present generation to the future generation (through abortions and sterilisation). Eugenics thereby merited attention to and constituted the population by informing both its history and its future.

Secondly, the socio-hygienic technologies were a kind of health promotion through social legislation that, unlike the socio-genetic technology, was detached from a heredity epistemology. It operated horizontally on the exterior space, activating homes and families and governing them through an amelioration of the immediate environment into a healthy environment through health promoting technologies. With the introduction of the health visitor, we see the promotion of an expert in turning the immediate environment into a healthy one, guiding the homes and in particular the mothers. We thereby see a type of working that, as I illustrate in the following chapter, resembles what may be termed the governmentalisation of a health-enabling environment.

Thirdly, a corporeal-hygienic technology targeted children and young people upon and by virtue of their bodies, promoting strength and cleanness, personal hygiene and exercise. Along these lines, sexual administration was a matter of enhancing bodies in such a way that morality was furthered. The gymnastics instructor and the school practitioner were the types of expertise linked to these workings,

encouraging children to engage in exercise and combat laziness in all its forms and overseeing the pupils' health in the schools. However, while the promotion of a body culture was mainly a medical and gymnastics concern, upheld by folk high schools and private initiatives, the school was governmentalised as part of the public health intervention to create a healthy environment through bodily measures and gymnastics. Thereby human corporeality was governmentalised only so far as it was subjected to health inspection. The *active* body that was so intensely promoted by gymnastics and medicine remained un-governmentalised as a health technology. The performer of gymnastics as an active individual in quest of his/her own health and strength was not placed under public health intervention. From this vantage point, human interiority was not a means for health promotion, but an end. The means was a body amenable to dressage; this was how mental strength was achieved. As we shall see in the millennial analysis in the next chapter, the active individual has indeed been governmentalised.

I suggest that 'constructive hygiene' and the promotion of a body culture, though hinged on the vocabulary and epistemology of eugenics, simultaneously broke with its hereditary notions; 'constructive hygiene' did not require genetic means, only an active individual at the centre of his/her own transformation. In other words, constructive hygiene sidestepped a socio-genetic administration of human vitality by appealing to the administration of individual transformation. However, this break with heredity – i.e. the initiation of a health promoting practice that placed human beings as both the means and the object of their own health – took place outside of public health. Along these lines, we see the anticipation of subjectivity to be governmentalised through health promotion rationalities and technologies.

As public health operated through a norm of health rather than sickness – both in the case of measuring children and in the installation of the health visitor – it simultaneously transformed the target of the intervention. The children and their families were no longer either doomed by a tainted past or members of a fit and proper breed. They were instead *potentially* healthy or sick. We thus see the introduction of

a health promoting practice that operated through risk and probability. As a consequence, the limit between the two was blurred and so was the target group: a point that is elaborated in the subsequent analysis.

7. MILLENNIAL ANALYSIS FACILITATING HEALTH TO THE NTH DEGREE

7.1. ENTRÉE

Throughout the 1920s and 1930s physician and nutritionist Mikkel Hindhede persistently drew attention to the connection between proper diet and health (Hindhede, 1922, 1925, 1926, 1927, 1928, 1933, 1934, 1940a, 1940b, 1940c). As the manager of the State's Laboratory for Nutritional Investigations ('Statens Laboratorium for Ernæringsundersøgelser') from 1910 to 1932, Hindhede was appointed nutritional advisor for the government during WW1. Unlike most of his fellow contributors in the debate about nutrition, he raised the problem of overweight (Ibid. 1925: 493, 495). What Hindhede claimed was that a direct link existed between health and wellbeing. Therefore food had to be light. Too much food – particularly too much meat – would cause dissatisfaction, premature aging and early death (Ibid. 1922: 433-35; 1940b: 955; Plum, 1945: 1031). Healthy food, he argued, was in fact monotonous food (Hindhede, 1940a: 1225), such as bran bread and porridge (Ibid. 1926: 358; 1934: 222), potatoes (Ibid. 1927: 1083) and milk (Ibid. 1928: 95). At the beginning of the 1930s a discussion took place in the medical journal *Ugeskrift for Læger* caused by Hindhede's attack on his fellow practitioners, accusing them of leading an unhealthy lifestyle and therefore setting a bad example for the population (Ibid. 1933). Criticism was put forth arguing for Hindhede's lack of scientific grounding (Meier, 1926; Nielsen, Th., 1933; Rørdam, 1933; Hasle, 1934; Poulsen, 1934; Sylvest, 1934). Additionally, the question was raised whether medical practitioners were obliged to live healthy lives, and Hindhede's accusation was rejected as bizarre (Nielsen, 1933; Rørdam, 1933).

My point in highlighting the above debate is not to argue that the notion of lifestyle was being introduced in the first half of the twentieth century. I have already illustrated the more or less common use of lifestyle, for instance in the journals *Healthy Lifestyle* and *Physical Culture*

(Borgbjærg, 1939: 4-5). However, the way health is presented by Hindhede furthers another type of government than promoting a strong body and consequently a strong mind. It engenders an individual who not only engages in gymnastics but more thoroughly engages in a healthy lifestyle, expressed in diet and other everyday habits as well as physical exercise. In other words, what is at stake is an individual who actively and systematically reflects upon himself/herself in terms of diet, exercise, posture, and who takes his/her own health into consideration. It is not a person whose invalid and weak constitution is problematised by expertise. It is an individual who through self-reflection considers whether he/her lives a properly healthy life. Further, Hindhede's attack on his fellow practitioners illustrates his belief that lifestyle was not merely an issue for those typically targeted through preventive health, such as children and the youth or the feebleminded, but also for those imposing health upon others (in this case, the doctors), who should themselves become examples of health, not in the way they perform their medical practice but in the way they lead their lives. In the following analysis, I illustrate how today this point is not only regarded as crucial but is placed at the centre of public health campaigns targeting both the individual and the population as a whole.

7.2. INTRODUCTION

The following analysis explores the ways human exteriority, i.e. the population, social space as a whole and the immediate environment, and human corporeality and interiority, i.e. the individual – both body and mind – are governmentalised in the period 1980 to 2012. Placed under scrutiny are state authorities, municipalities and the DGI's engagement in preventive health and health promotion campaigns. Taking the point of departure in the fight against obesity among children and young people, a concern is both to investigate how these are problematised and identified, i.e. how they are epistemologically grounded, and how they are made into a site for government through particular technologies.

The analysis is divided into two main parts.

The first part investigates the problematisation put forth of human exteriority, corporeality and interiority in public health campaigns targeting obesity, particularly among children and young people, by examining medical and government reports along with other types of health expertise.

The second part investigates the government technologies targeting human exteriority, corporeality and interiority that offer various solutions to the problem of obesity among children and young people. I do so by extracting data from government strategies, municipal strategies and ideas put forth by the DGI in their campaign *Seize the Chance – For an easier life* and the connected *Camp Fanø* for obese children. Likewise I investigate network collaboration (NC) between the DGI and public authorities as a particular way of governing administration and attuning it to preventive health.

7.3. PROBLEMATISATIONS OF HUMAN EXTERIORITY, CORPOREALITY AND INTERIORITY

7.3.1. KNOWING AND SEGREGATING

During the 1990s, the Danish Institute for Clinical Epidemiology (DIKE) launched an extensive investigation into obesity within the Danish population. It showed that 36 percent of all adult men and 21 percent of adult women were overweight and about eight percent of the Danish population suffered from obesity (Sundhedsstyrelsen, 1999: 1). Additionally, at the beginning of the millennium, on advice from the National Council for Public Health and in collaboration with the insurance company TrygFonden, the Ministry of Health and Prevention carried out what was considered the most thorough investigation of the Danish population's diet, smoking, alcohol and exercise habits, the so-called *KRAM* factors.[19] Between 2007 and 2008 13 municipalities carried out these KRAM investigations where thousands of citizens were

[19] KRAM is a contraction of the first letters in Danish of *diet* (Kost), *smoking* (Rygning), *alcohol* (Alkohol) and *exercise* (Motion).

asked to fill out questionnaires and undergo physical examinations (Ministeriet for Sundhed of Forebyggelse, 2009: 3). The physical examinations included measuring blood pressure, pulse, waistline, hipline, height, weight, lung function, bone mineral density, muscular strength, balance, level of physical fitness and blood tests (Ibid. 7).

In the light of these investigations, the Danish municipalities' interest organisation Local Government Denmark (KL), and the National Board of Health developed a databank on children's health, based on systematic collection of selected data from already existing child examinations performed by home visitors and GPs in the preventive health system (Sundhedsstyrelsen, 2011a: 4). Each municipality published surveys using an electronic case record system. The data included weight and height from birth till the end of school, data from the seven annual examinations at the GP, and, finally, the health visitor's registration of whether the child was exposed to passive smoking and details on the child's nutrition in the first four months of its life (KL, 2010: 1). Likewise, in 2009, Nyborg municipality in Funen collected extensive data for a health profile of both adults and children. The profile was to be compared with a similar one in Odense municipality, also in Funen. The data served as a point of departure for some general guidelines on where to focus the preventive health intervention.

To gather the data, health authorities from Nyborg municipality sent out an internet-based, anonymous questionnaire to 1226 pupils from seventh to tenth grade at both public and private schools in the municipal area (Nyborg Kommune, 2009b: 4). While the biometric data on children consisted partly of already existing data from GP examinatins and the like during the children's lives, another part came from self-estimated health indicators (Ibid. 2009a: 6). The youth were asked to judge their state of health. They were also asked to consider how – in their own opinion – health and disease affected their daily lives, which health habits they engaged in and their motivation for changing their habits. Accordingly 17 percent of the boys and 10 percent

of the girls stated that they had a Body Mass Index (BMI)[20] above 25. In addition, 44 percent of the girls were satisfied with their weight, and an equal number thought they weighed too much, while 65 percent of the boys were satisfied with their weight and 17 percent said they weighed too much (Ibid. 2009b: 9). The response rate was 87 percent, that is, 1044 pupils (Ibid. 5).

Hence, the survey entailed both objectifying and self-objectifying measurements: in the latter case, it was argued in a report published by the Ministry of Health and Prevention that a connection existed between how a person judged their own health on the one hand and their actual levels of vitality and sickness on the other (Ministeriet for sundhed og forebyggelse, 2009: 154). Or, as explained in an article in *Ugeskrift for Læger*: "*It is well known that a person's estimation of its own health is an extremely good predictor for sickness and mortality*" (Ekholm et al. 2006: 30).

In summary, it is worth noting how self-estimation constituted a central means for collection of biometric data and individual health-wise factors in the millennial period. In relation to the findings in the interwar chapter, in which we saw a general mapping of the population and measurement of children in particular, three points can be made:

First, the mapping, weighing and measuring of today was not put forth only along the lines of human corporeality, as was the case during the interwar era. Other factors were measured, such as lifestyle: the degree to which lived life constituted a risk. In the interwar setting, a health norm was put forth through measurements of schoolchildren. In the millennial era, a health norm was also put forth. However, the health norm that emerged through the general mapping of the population took

[20] Body Mass Index (BMI) is measured accordingly: weight (kg) / height (metres) x 2. An individual BMI between 25 and 29,9 indicates overweight, between 30 and 34,9 indicates obesity category one (moderate), between 35 and 39,9 obesity category two (severe) and from 40 and above obesity category 3 (very severe or morbid) (Ernæringsrådet, 2003: 17; Statens Institut for Folkesundhed, 2007: 262).

into account not only human physique, but also ways of living and ways of reflecting upon one's health, and this brings me to my second point.

Unlike the interwar data gathering techniques, an ethical dimension is activated along with the millennial biometric measuring practices. The individual subjected to the measuring – in this case children and young people – are simultaneously encouraged to reflect upon the state of their health and thereby become an expert in their own health. Thus, an individualising element is encompassed within the totalising technology of mapping the population. The difference between mapping risk according to biometric standards and lifestyle indicators and asking participants themselves to measure and estimate their risk is the difference between an objectifying practice and an ethical practice; the latter relies on the active participation and self-regulation of the individual targeted. It seems the issue at stake is less to identify who is at risk, than a matter of instilling in each individual a self-reflective and self-regulating practice along an index of risk.

7.3.2. THE SPREAD OF OBESITY

The public health concern with obesity did not occur as an isolated case in Denmark, but as part of the WHO and other international organisations' increasing interest in the problem (WHO, 1986, 1999). An article from 1999 in the medical journal *Ugeskrift for Læger* drew attention to the WHO's focus on the worldwide rise of obesity, concluding that obesity was among the most significant health problems in the world. It was argued that it had reached such a proportion that just after smoking it was the most important cause of preventable death (Heitmann, 1999: 4380). Additionally, the leading article in *Ugeskrift for Læger* in 2004 warned about the rise of obesity with the following headline: 'The Obesity Epidemic has Hit Europe'. The article pointed to data indicating that every second citizen in Europe was overweight or obese. In Denmark, the article explained, 1,4 million adults were overweight and 400.000 obese (Svendsen, 2004: 25).

At the beginning of the millennium, a group of experts formed under the Board of Exercise and Nutrition argued that, in line with data in international public health publications, Danish adiposity had risen to the extent that it now posed a greater threat than underweight (Ernæringsrådet 2003: 17). A government report from 2002 also stressed the seriousness of the new threat, showing statistics that indicated that the percentage of severely obese adults (individuals over 16 years) had increased from 5,5 percent in 1987 to 9,5 percent in 2000 (Regeringen, 2002: 10).

Likewise, warnings were put forth regarding the rise of obesity among children. A medical research team and DIKE came up with the following conclusion: not only had the number of obese children increased, but already obese individuals had put on even more weight (Sundhedsstyrelsen, 1999: 5; Pearson et al. 2005: 161). The increase of the share of obese children started around 1998 and came into focus as a problem around the first years of the new millennium (Ernæringsrådet 2003: 5, 21). The Ministry of Health and the National Institute of Public Health also called attention to the dramatic increase in the number of overweight children and youths (Sundhedsstyrelsen, 2003b: 4; Ekholm et al., 2006: 12). Obesity among children had increased 30 times faster between 1993 and 2006 compared to the period from 1943 to 1960 (Statens Institut for Folkesundhed, 2007: 266).

In 2001 the Danish Society for Adiposity Research (DSAF) presented an account of the economic consequences of the rise in obesity numbers within the population. Whilst a thorough investigation had not been carried out in Denmark, estimations based on investigations carried out in comparable European countries indicated that additional expenses related to obesity were between four and eight percent of total health expenses, or DKK five billion per year (Dansk Selskab for Adipositasforskning, 2001: 7; Svendsen, 2004: 25). Based on these numbers, the association concluded that it was likely that the expenses would increase as a consequence of the growth in illnesses related to obesity (Dansk Selskab for Adipositasforskning, 2001: 7).

State and municipal authorities also called attention to the negative effect of obesity and overweight vis-à-vis the national economy. This included extra expenses on treatment of diabetes type 2, osteoarthritis and other weight-related complaints (Ernæringsrådet, 2003: 30; Nyborg Kommune, 2010: 5) along with an increase in cases of early retirement (Sundhedsstyrelsen, 1999: 3). As argued by the Board of Nutrition in their obesity report from 2003: "*The obesity epidemic is […] a ticking bomb under both the Danes' health and the economy*" (Ernæringsrådet, 2003: 29).

Thus, millennial problematisations of human exteriority address the welfare state not as a solution but as threatened by the heavy burden of obesity.

7.3.3. INDIVIDUAL SUSCEPTIBILITY

While obesity was identified as a public health problem, the population was segregated according to their susceptibility to obesity, along the lines of somatic risk, lifestyle risk and psychosocial risk.

As to somatic risk, according to the Board of Nutrition's published report from 2003 type 2 diabetes had reached epidemic proportions (Ernæringsrådet, 2003: 25-26). Arguably, 85 percent of all patients with diabetes type 2 were very or moderately obese (Sundhedsstyrelsen, 2007b: 9-10). DSAF listed the most important risk groups: individuals who are at risk of developing diseases related to obesity if they gain weight, including those who are genetically disposed for diabetes, high blood pressure and/or cholesterol levels, and heart disease. In addition, statistics indicated that the risk of type 2 diabetes increases concomitantly with an increase in a person's BMI (Statens Institut for Folkesundhed, 2007: 262). Among one thousand examined schoolchildren, approximately six percent showed indications of diabetes type 2 (Sundhedsstyrelsen, 2007b: 9-10). Cardiovascular disease was also emphasised as resulting from obesity (Ernæringsrådet, 2003: 26). Its link to the so-called metabolic syndrome – indicating the presence of a number of conditions that together constitute a risk of

cardiovascular disease – was considered a serious factor, particularly in the case of insulin resistance (diabetes) and abdominal obesity (Statens Institut for Folkesundhed, 2007: 263). Other somatic diseases, identified as directly or indirectly linked to obesity, were some types of cancer, osteoarthritis (Ibid. 264; Ernæringsrådet, 2003: 28), hormone and fertility disturbances in women (Ibid.; Statens Institut for Folkesundhed, 2007: 262), lung problems and sleep apnoea (Ernæringsrådet, 2003: 28-29; Statens Institut for Folkesundhed, 2007: 264) as well as high mortality or reduced life expectancy (Ernæringsrådet, 2003: 26; Statens Institut for Folkesundhed, 2007: 262; Nyborg Kommune, 2010: 5). As for the latter, reports warned that obesity increases the risk of arteriosclerosis, which again increases the risk of cardiovascular disease and death (Statens Institut for Folkesundhed, 2007: 263-64).

> Mortality rises almost exponentially with the degree of overweight and is especially caused by cardiovascular diseases (coronary thrombosis and cerebral thrombosis). Overweight individuals as a group suffer from twice as high mortality as those with standard weight. In the case of serious obesity [...] the mortality is presumably more than double in relation to those with standard weight (Sundhedsstyrelsen, 1999: 3).

Lifestyle risk constituted another factor when explaining the rise of obesity. The nature of modern jobs and family life requires less physical activity and physical transport, more sitting in front of the computer or the TV and sitting in the car. Moreover, individuals who give up smoking often put on weight and there are individuals whose drug use causes weight increase (Dansk Selskab for Adipositasforskning, 2001: 8; Ernæringsrådet, 2003: 23; Statens Institut for Folkesundhed, 2007: 267). This general lack of physical activity in everyday life, the argument went, combined with a huge supply of provisions, makes it difficult for individuals to keep up a steady weight and increase the level of energy consumption (Statens Institut for Folkesundhed, 2007: 269). A direct link existed between adiposity levels and the mortality rate, combined with lack of physical activity (Regeringen, 2002: 10). Taking its cue from the WHO (Sundhedsstyrelsen, 2003a: 9; 2003b: 6), the National Board of Health predicted that by 2020, 70 percent of all fatal diseases would

be lifestyle related, arguing: "*Everybody agrees that a connection exists between the way we lead our life and the diseases we get*" (Ibid.). It added that 20 to 30 percent of the Danish population was inactive to the extent that they were jeopardising their health (Ibid. 85; 2007b: 9-10).

Apart from somatic and lifestyle related factors, a notion of social susceptibility was presented. Hence, problematisations of human exteriority also included problematising the family and the environment in which obese children were brought up: a link was established between obese children and parents belonging to the lower rungs of the social ladder (Notes, 19.11.09). The term 'Chance inequality' ('chanceulighed') indicates that the parents' social heritage to a great extent determines the chances for a child to be healthy as an adult (Ernæringsrådet 2003: 22; Statens Institut for Folkesundhed, 2007: 267, 269; Sundhedsstyrelsen, 2011b: 43). The National Board of Health found a direct link between parents' social resources and children's health problems as adults. This was seen in terms of early death, physical disabilities, cardiovascular diseases, psychiatric disorders and lung function. An article in *Ugeskrift for Læger* from 2004 examined the link between social imbalance and obesity, arguing that children from lower social strata and rural children had an increased risk of developing obesity. Children from dysfunctional families and children with problems at school were all at a higher risk of developing obesity. This negative causality was regarded as going both ways in that obesity itself increased the risk of social mobility downwards (Niclasen, 2005: 1145). The National Board of Health identified a number of factors in the home environment that correlated with a child's development of obesity, including parents' responsiveness to their children's needs, levels of protection and support, and parenting style; all factors that were regarded as influencing the child's cognitive and social development and later educational level (Sundhedsstyrelsen, 2011b: 46). Parents' ability to take parenting seriously and stand up as role models for their children in terms of conveying healthy habits and norms was stressed (Ibid. 2003b: 25). Stimulation and care, especially during the first 18 months, were regarded as crucial in the sense that they affected the development of the brain and thereby the child's cognitive, social and behavioural skills later

in life (Ibid. 2011b: 43). The speech development was believed to determine schooling abilities and later job skills, and also to affect the risk of obesity (Ibid. 44). Moreover, a clear tendency, according to several studies, was that the lower the working status of a mother, the more likely it was that children would have health problems. The same was the case for children whose parents were both receiving social benefits (Ibid.). A medical study by the National Board of Health of the concept of social heritage showed a general tendency: 42 percent of parents of obese children and 81 percent of parents of overweight children were not concerned with their child's weight, although the condition had direct consequences for the child (Niclasen, 2005: 1147).

In relation to the findings in the interwar chapter, it is worth noting that a notion of inheritance is also at stake in the millennial data. However, unlike the elaboration of genetic inheritance and problematisation of human quality that is so intensively put forth during the 1920s and 1930s, it is social inheritance that is at stake at the turn of the millennium (Lissau, 1999). In the earlier era, genetic heritage was only a determining factor to a certain extent, and social environment and upbringing were also regarded as factors that increased or decreased the risk of being tainted. By the millennium it was social environment and upbringing that were regarded as the core factors in explaining obesity. Genetic inheritance played a part (Sundhedsstyrelsen, 2011b: 5), but only as part of social inheritance and was not further elaborated (Ibid. 26). Social inheritance however, was the determining factor. Whether or not this social factor was seen as open to transformation forms part of the analysis below.

We see how human exteriority was problematised through a mix of two types of problematisation: firstly, by addressing particular groups as susceptible to obesity along indices of somatic, lifestyle and social risk factors, and secondly, by addressing social welfare, albeit merely as a passive entity that is also jeopardised by obesity. Social welfare seems less a solution to obesity than its passive victim. The terms 'accumulation of risk factors' (Ibid. 2007a: 7) and 'disease burden' (Ibid. 2011b: 37) illustrate the heavy weight put upon welfare-economics by the

individuals through social conditions. Determinants to social inequality, according to the National Board of Health in 2011, were educational level, social inheritance, gender, age, ethnicity and health (Ibid. 26), along with housing conditions and social isolation (Ibid. 27). Social inequality was not exclusively a problem of the obese child, but also to society as such, placing a burden upon the welfare state. In this way, the *social* itself was regarded as at risk, due to the fact that welfare services were burdened by the increase in obesity. On the other hand, social risk referred to the tendency that individuals from a lower social background were more inclined towards obesity than the rest of the population. The segregation along the lines of social risk, then, was put forth according to the following causality: children belonging to socially vulnerable families were at risk of becoming obese and this extra pressure on the social welfare system put it at risk of going down.

7.3.4. TAXONOMY OF OBESITY

In labeling particular individuals obese, a number of biometric tests were put forth. Obesity was defined as a condition in which the amount of fat in the body is increased to such a degree that it has consequences for the individual's health. Exactly how much fat was too much fat, however, was less clear (Dansk Selskab for Adipositasforskning, 2001: 4), and neither did a clear definition of overweight exist (Magarey et al. 2003: 506). BMI was the most common biometric measuring technique for determining obesity and overweight, and had been recognised by the WHO as the primary means for establishing a biometric norm for health and illness respectively vis-à-vis body weight and height (Ibid.; Dansk Selskab for Adipositasforskning, 2001: 4). However, doctors had reservations about applying the BMI measurement to children and young people, taking into account that their different physical developmental stages did not follow the same measures as fully-grown individuals. For instance, a child could be brawny and muscular, or have a large bone structure without being obese. It was therefore generally recommended that BMI be supplemented with a clinical gaze, that is, the eyesight of a professional (Pearson et al., 2005: 159).

Although the biometric standard followed precise parameters (e.g. BMI above 30 indicates obesity), these indicators could still be expanded and remain flexible. For example, the Ministry of Health and Prevention introduced the concept 'thin fat' (Ministeriet for Sundhed of Forebyggelse, 2009: 153), which took into account individuals who were not overweight according to BMI measures or even according to eyesight, in other words they appeared slim to the untrained eye, but whose fat percentage was nevertheless too high or their waistline measurements were too high[21] (Ibid. 154). Thin fat was a condition often seen in children and young people. Fat percentage then constituted another way of establishing a health norm for the body, usually supplemented with BMI measures.

In comparison with the interwar era, when physical characteristics such as a weak posture and a pale face were indicators of a risk of degeneration, the problem in this setting was less obvious to the naked eye. The concept thin fat, for instance, allowed for a broadening of the category of bodies at risk; risky individuals could hide behind apparently slim bodies and consequently, only advanced measures could detect that an at first sight slim or standard looking body was in fact obese and therefore at risk.

[21] Fat percentage in relation to lean body mass is calculated in a procedure called bio-impedance analysis. Electrodes are attached to the body that send an electric current through it. Different parts of the body like bones, muscles and fat each have a particular composition and mass, each with its own level of resistance to the current, which is measured. Waistlines are typically measured with the use of the so-called WM02 body tape. The health worker doing the measure marks the lowest edge of the rib as well as the upper iliac crest and then makes a mark between these two points on each side of the measured body (Ministeriet for Sundhed og Forebyggelse, 2009: 231). A waistline measure that exceeds 94 centimetres for European men and 80 centimetres for European women is considered an indicator of obesity (Statens Institut for Folkesundhed, 2007: 263).

7.3.5. OBESE CHILDREN'S SOMATIC, LIFESTYLE RELATED AND PSYCHOSOCIAL RISKS

Just as the population was segregated along the lines of the risk of obesity, so were individuals, problematised according to links between obesity and somatic, lifestyle related and psychosocial problems. As to somatic problematisations, it was argued that those who remained slim all their lives had the lowest risk of cardiovascular disease, while the incidence of early mortality among very obese individuals was twice as high as standard weight individuals. Hence, the raised mortality rate was first and foremost linked to cardiovascular disease (Statens Institut for Folkesundhed, 2007: 264). Moreover, individual conduct was identified as a major factor in terms of developing obesity. This included the combination of diet – more specifically food with a high energy density and a high occurrence of sugar and fat, also referred to as "*passive overconsumption*" (Sundhedsstyrelsen, 1999: 31) – and lack of physical activity (Statens Institut for Folkesundhed, 2007: 269). The board also argued that lifestyle factors pose the biggest threat to health, especially smoking and physical inactivity (Sundhedsstyrelsen, 2003a: 9): the latter was considered a growing problem among some groups of children.

A connection between obesity and psychosocial problems was established as incidents such as bullying, exclusion from the community, low self-esteem, and isolation were identified as being linked to obesity (Ernæringsrådet, 2003: 29; Statens Institut for Folkesundhed, 2007: 264; Nyborg Kommune, 2010: 5; Odense Kommune, 2009: 14; Niclasen, 2005: 1146). However, the opposite argument was presented, namely that low self-esteem could incline people more towards obesity. "*Can insecurity make us obese*?" professor and consultant Thorkild I. A. Sørensen rhetorically asked in a medical article (Sørensen, T., 2011). He pointed to studies that indicated a correlation between obesity and insecurity, and that this factor could explain why some individuals develop obesity and others do not. Sørensen argued that the correlation pointed to our so-called primeval brain, which is programmed to secure our survival, that is, to ensure that we have enough food. The brain

therefore interprets every experience of insecurity as a signal of lack of food supply (Ibid. 6). Sørensen's investigations indicated that neglected children in particular developed obesity. To be neglected, Sørensen explained, is to be in an insecure state of mind, causing obesity among socially exposed groups (Ibid. 7).

> Overweight, for the individual, is not just a problem of health, but often also a psychosocial problem. Overweight is often connected to low self-esteem. Low self-esteem makes it difficult to leave the vicious circle of engaging in overconsumption/unhealthy food habits, as it is precisely these fattening and unhealthy foods that are used as comfort, entertainment and compensation for a life that is probably not lived fully and in agreement with one's own values and wishes (Fødevarestyrelsen, 2005: 8).

The National Board of Health advocated a broader understanding of health; one that went beyond the strictly medical (Sundhedsstyrelsen, 2003b: 4; 2003c: 7), as complications related to obesity usually included low quality of life, increased illness and early retirement (Ibid. 1999: 3) as well as social isolation, depression and anxiety (Ibid. 2003b: 4, 10). The term 'sports insecure children' (Kulturministeriet, 2008: 4, 31; 2009a: 54) encompassed a targeted group of children who were not only physically inactive and therefore at risk of obesity, but also socially and psychologically vulnerable. These children were considered left out in terms of sports and exercise, often living in low-income families and ethnic minorities that did not support engagement in sports and physical activity (Kulturministeriet, 2008: 27; 2009b: 37). While twelve percent of all children did not participate in exercise or related activities, one fifth of children in low-income classes engaged in no sports (Sundhedsstyrelsen, 2003a: 85; 2007b: 9-10). The target group also encompassed the so-called large city girls, who had a tendency to drop out of sports and lead an inactive lifestyle (Kulturministeriet, 2009b: 38).

> Often, psychosocial problems are greater for the overweight person than the apparent physical inconveniences. Obese persons are subjugated to various prejudices, which can lead to discrimination against adults in the labour market and bullying of children in schools. Also the health professionals have prejudices towards overweight persons, who are regarded as weak in character

> and incapable of carrying out a possible treatment. An increased occurrence of lack of self-esteem, social isolation, depression and anxiety exist among obese persons (Statens Institut for Folkesundhed, 2007: 264).

In a similar manner, obese children were more likely to drop out of school, get bad grades and suffer from low self-esteem (Niclasen, 2005: 1146). Hence, as for problematisations targeting the individual, we see how somatic, lifestyle and psychosocial risk factors were linked directly to obesity. A relationship then was established between corporeality, interiority and way of life (Sundhedsstyrelsen, 2007a: 6).

To summarise, in problematising obesity in terms of individuals, a link was established between corporeal and interior factors: an obese child and, in general, an individual who lived an unhealthy lifestyle, tended to be caught up in social and psychological disarray (stigmatisation and self-stigmatisation) which prevented him/her from leading a responsible life in terms of his/her own health. That said, this psychosocial obstacle was rather superficially mentioned and not elaborated further. The identification of the obese child as a child lacking self-esteem was merely a point of departure for psychosocial transformation: the obese body was regarded as a symptom of an inner lack, namely self-esteem. It followed that this inner obstacle to health could be removed through physical and psychosocial workings. Thus, corporal reality (obesity) was a symptom of an inner reality (low self-esteem) and vice versa – an inner reality caused a particular corporal reality. It is not clear from the extracted material what came first: low self-esteem or obesity. Instead they seem to form a mutually dependent relationship. In other words, the obese child was only stuck within a kind of psychosocial disarray to the extent that he/she were not *aware* of the fact that this obstacle was not an insurmountable obstacle. The main problem then was lack of awareness of one's own potential.

In relating to sub-question 3, obesity found numerous links to other problems that called for public health intervention. However, the notion of vulnerability illustrates well how the problem of obesity fed into human exteriority, corporeality and interiority. Obesity was medically and socio-economically constituted as a public health risk through a

number of causal relations; or, in the wording of an article published in *Ugeskrift for Læger* in 2004: obesity now constitutes the biggest threat to public health, the negative effects of obesity being equally somatic, social, psychological and economic (Svendsen, 2004: 25).

Firstly, obesity was problematised in terms of its effect on the social body due to the rise of obesity among the population in general. The main argument was that obesity threatened the general welfare of society due to extra health expenses and social risk. The idea presented was that obesity occurred mostly among those groups that were lower on the social ladder, in other words in inadequate housing conditions and with low education and working skills. Moreover, social risk here referred to the risk that social inequality posed to the welfare state: an argument that can be said to be a contradiction in terms. The social body – in this case the welfare state – was at risk of deterioration due to economic and social problems. Hence, while in the interwar era the welfare state became an answer to and a means for solving the problem of the deterioration of the race, at the turn of the millennium the welfare state – in the form of health and social expenses – was in fact what was jeopardised. Welfare was not a means here; it was generally referred to as a vulnerable entity threatened by obesity. Compared with the 1920s and1930s, the question at stake was not the threat of degeneration posed by certain individuals to the race as a whole, but the threat posed by individuals to the welfare state. Moreover, obesity was directly linked to a child's upbringing and social placement. The terms 'social inheritance' and 'chance inequality' highlighted how family and social upbringing were crucial factors for children's susceptibility to obesity. In comparison with the interwar era, genetic inheritance played only a minor role and instead social inheritance assumed the dominant role that genetic inheritance played earlier.

Secondly, obesity was problematised in terms of human corporeality by referring to somatic risk. It was constituted as a clinically established reality (through BMI, fat percentage measures and waistline measures) and linked to deadly somatic illnesses such as diabetes and cardiovascular diseases as well as having a negative effect on the general

public health. In the interwar period we saw how biometric measures allowed for the identification and segregation of the tainted part of the population from the rest while at the same time constituting a normalising effect in terms of children and young people as a health norm was established through physical measures. In the case of obesity in the millennial era, BMI analyses, waistline measurements, weighing and other ways of measuring bodies were also carried out to establish a health norm; a norm that was, however, somewhat flexible. The flexibility of the biometric standards, along with the introduction of other standards such as 'thin fat', allowed for a broadening of the targeted group, including the ones that did not appear obese to the naked eye. In the 1920s and 1930s, degeneration and bodily weakness were identifiable problems detected on the body. Physical-anthropological categorisations linked the physically identifiable characteristics of degeneration and weakness to other physical features, such as head shape, hair structure and the like. In the later period obesity – although for the most part identifiable with the naked eye – through its linkage with other somatic health conditions was posed as bringing a constant risk of disease and death.

In addition, obesity was put forth as a problem of lifestyle and mode of conduct, such as over-consumption and lack of exercise. Hence, linked to obesity as a somatic and a psychosocial reality was obesity as a way of doing. Particular ways of living, ways of leading one's everyday life, caused obesity. In the interwar era lifestyle was a minor factor when problematising the quality of the race and certainly not a factor that regarded the individual as an actor. By the turn of the millennium lifestyle had opened up for individual action, responsibility and transformation.

Thirdly, obesity was linked to psychosocial problems that had a negative effect on the obese individual's quality of life, causing stigma and low self-esteem. Thereby, obesity was problematised not as a lack of *worth*, but as a lack of *self-worth*, i.e. the self's estimations of the self were linked to the problem of obesity. Hence, conjoining obesity and psychosocial issues was first and foremost expressed as a lack within,

namely a lack of self-esteem. In the interwar analysis the relationship established between the body and mind was one in which the body to a certain extent was a symptom of an inner condition: low morals and lack of grit. At the turn of the millennium low self-esteem and lack of self-worth were not objectifying factors but self-objectifying conditions; although identified by the outsider's trained eye, for instance the health authorities, they related to self-estimation. The issue at stake was not the individual's *worth* per se, estimated by an outsider (as it was in the interwar era) but his/her self-estimated worth. We may recall the debate presented at the beginning of the dissertation. In the medical journals of the 1930s, the debate put forth two essentially different ways of addressing an individual: is inferiority a condition or a feeling? Today, inferiority – or worth – is not considered an objective condition, but rather a self-objectified one. As we shall see, this is also the case with health intervention.

7.4. TECHNOLOGIES FOR GOVERNING HUMAN EXTERIORITY, CORPOREALITY AND INTERIORITY

In 1998 DSAF initiated a national 'Task force on obesity' to come up with a solution to the growing problem of obesity (Dansk Selskab for Adipositasforskning, 2001: 3). They outlined a number of reasons that preventive health was more effective than treatment: obesity develops over time and once it has occurred, it is difficult to treat. In general, it was argued, treatment had not provided enough positive results. Also, the consequences in terms of physical and metabolic stress were less likely to be treated. Finally, the obese part of the population was now so huge that resources were not available to treat everyone (Dansk Selskab for Adipositasforskning, 2001: 7). The Board of Nutrition presented a similar argument, emphasising the necessity of an overall preventive technology to fight obesity. However, they acknowledged that it might have a limited effect. The point, according to the board's report, was that no means had yet proved effective, and it was therefore too early to come up with solutions as to how to prevent obesity. Nonetheless, the severe nature of obesity and its increase among the population demanded

action before it was too late, the argument went (Ernæringsrådet, 2003: 95).

In 2001 the National Board of Health was affiliated with a number of municipal 'Centres for Prevention', which had been established under the Ministry of Health to increase health preventive efforts. The idea was to initiate a national strategy for preventing and treating severe obesity, which came into force in 2003 (Sundhedsstyrelsen, 2003b: 4).

At the beginning of the millennium, on recommendation from the WHO (WHO, 1999) and in the light of an international task force on obesity, DSAF signed the so-called Milan Declaration, by which the association was obliged to work towards a Danish national strategy for the prevention and cure of obesity (Dansk Selskab for Adipositasforskning, 2001: 3). Denmark was then one of the first countries to launch a national strategy against severe obesity (Indenrigs- og Sundhedsministeriet, 2007: 12). According to the board's report, a national preventive health programme had to consist of two overall strategies: one focused on how to promote obesity reduction alternatives, so that healthier choices became easier for the individual, and the other how to increase individual responsibility for pursuing a healthy lifestyle (Ernæringsrådet, 2003: 95-96). Additionally, the primary attention was to be placed on children and young people (Ibid. 96), emphasising physical activity (Ibid. 99) and actively involving the actors in a child's environment, such as home, school and afterschool recreation (Ibid. 104).

The following pages are structured by this dual preventive strategy as it correlates with the overall attempt in this thesis to view preventive health and health promotion as related to the biopolitical technologies targeting social space and the population as a whole on the one hand, and technologies targeting individuals on the other. First, I investigate technologies targeting human exteriority. These include DGI campaigns to map the population as a particular attempt to add value to the population and social space. Under this heading I also discuss campaigns directed at obese children's families and instructions for

health professionals and sports instructors dealing with obese children. Second, I investigate individualising technologies targeting human corporeality and interiority. This includes selected campaigns targeting obese children connected to the DGI. I thus seek to address the research question guiding the analysis, namely how preventive health and health promotion informed workings on human exteriority, corporeality and interiority. That said, I illustrate how NC may be seen as a particular way of introducing an individualising aspect to the totalising concern of regulation, and thus may be found somewhere in between individualising and totalising biopolitical workings.

7.4.1. PROMOTION OF PARTNERSHIPS

Already in 1989 lifestyle was placed on the political agenda with 'The Government's Preventive Programme' (Sundhedsministeriet, 1989a; 1989b), considered the first initiative for an overall preventive strategy (Ibid. 1989b: 7). The purpose was to contribute to a transformation of the population's lifestyle (Ibid. 9, 13-14). In 2002, in line with the programme 'Healthy for Life' ('Sund hele livet') the need to combat lifestyle diseases was highlighted, the main focus areas being smoking, diet, physical activity, obesity, accidents, the work environment and environmental factors (Indenrigs- og Sundhedsministeriet, 2002: 10).

While promotion of lifestyle changes constituted one part of the technologies aimed at the population, another was concerned with the means for reducing social inequality. Fighting social inequality as a means for fighting obesity was an idea that found support in the WHO. In 2005 the organisation appointed a commission that published its report in 2009: "*Reducing health inequities through action on the social determinants of health*" (WHO, 2009: 3). Based on this report the Danish National Board of Health launched its own investigation into how to reduce social inequality as a preventive health means (Sundhedsstyrelsen, 2011b: 3). A reduction in social inequality, the argument went, could lead to a greater share of the population joining the workforce (and thus raising the tax base), while simultaneously reducing health expenses (Ibid. 5). Additionally, a concern regarded

minimising child poverty, while another focused on increasing children's self-esteem and improving social relations (Ibid. 8).

> Social inequality in health is an important theme for health authorities and health services to consider. With regard to the mortality rate, social inequality has a relatively large influence on the average lifetime, and politically an intention has been formulated to increase the Danes' average lifetime. Concurrently, greater social equality in health could bring a greater share of the citizens into the workforce, while expenses for the areas of health, work and the social services could be better maintained or even reduced (Ibid. 5).

The quotation illustrates how fighting social inequality was partly a strategy aimed at decreasing health expenses and the burden posed on social services, as an increase in the mortality rate would potentially increase the work force.

Various recommendations were published as to how to come to terms with social inequality: maternity services to prevent early birth and low birth weight, health visitors who should focus on the socially and psychologically less resourceful families and on addiction. Also it was emphasised that the already legislated regular GP examinations of children should be better enforced, as should recruitment of children to nursery classes (Forebyggelseskommissionen, 2009: 62-63; Sundhedsstyrelsen, 2011b: 50). Moreover, schools were to ensure a low class quotient, qualified teaching and special teaching for those in need and for those who were not literarily stimulated from home, as well as working against exclusion and stigmatisation (Sundhedsstyrelsen, 2011b: 57-59). Also urban planning was emphasised as a means of equally distributing the share of common housing and raising the quality of the houses (Forebyggelseskommissionen, 2009: 226; Sundhedsstyrelsen, 2011b: 65). In addition, economic means regarded regulation of taxes, securing the universal model of social politics and making it possible to sustain a quality of life on social benefits (Sundhedsstyrelsen, 2011b: 73). Finally, increasing taxes on tobacco, alcohol and sweets was also recommended (Forebyggelseskommissionen, 2009: 66; Sundhedsstyrelsen, 2011b: 106).

> We have to make it easier for the citizen to make the right choice in prevention and health promotion (Nyborg Kommune, 2008: 3).

The quotation pinpoints what the following pages illustrate as a crucial argument for the promotion of NC as a means for fighting obesity. I argue that rather than viewing NC as merely a means for health administration, it should be viewed as a governmental technology. The inquiry will centre on how various health authorities advocated NC through private-public partnerships as a solution to preventive health administration. Accordingly, two concrete cases of NC will be analysed, namely the forming of *Seize the Chance* with DGI Funen as a primary actor and the formation of an 'Overweight Association' with DGI Greater Copenhagen as a primary actor. Both projects, then, had DGI as the prime mover in collaboration with external partners such as private partners as well as regional and state bodies.

Just as establishing obesity as a public health concern was not merely a Danish phenomenon, the promotion of NC as an administrative means was also a worldwide trend. While the WHO's *Ottawa Charter*, launched in 1986 (WHO, 1986), was the epitome of an international preventive health campaign to transform lifestyle (cf. Larsen, L., 2010: 219; Vallgårda, 2003: 190, 195), it can also be seen as the epitome of a worldwide launching of NC (WHO, 2000). In promoting NC, Danish policies directed at obese children to a certain extent took their cue from the Ottawa Charter (Sundhedsministeriet, 1989a: 27, 120, 138, 227, 1989b: 32-33, Indenrigs- og Sundhedsministeriet, 2007; Sundhedsstyrelsen, 2003a, 2007a, 2007b; Forebyggelseskommissionen, 2009: 10; Nyborg Kommune, 2008: 2).

The *Ottawa charter* reads:

> [H]ealth promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organisations, by local authorities, by industry and by the media [...] Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health [...] Health promotion policy requires the

> identification of obstacles to the adoption of healthy public policies in non-health sectors and ways of removing them. The aim must be to make the healthy choice the easier choice for policy makers as well (WHO, 1986: 2).

I will not elaborate further on the *Ottawa Charter* and the WHO's international preventive health technology. However, the excerpt illustrates well how NC was identified as a necessary means for coping with the spread of obesity. Firstly, we have the argument that the more actors involved the better. Secondly, NC was put forth as a way to enable and increase the awareness of responsibility of each actor vis-à-vis the outcome of policies. Thirdly, the different actors – public, private, voluntary, etc. – together were regarded as able to remove obstacles so that healthier choices become easier to make.

In 1999 the National Board of Health emphasised the necessity to decrease obesity by focusing particularly on promoting activity and healthy diet (Sundhedsstyrelsen, 1999: 3). However, as it was argued in the excerpt below, these efforts would only prove effective if both public and private bodies took part in promoting health.

> Experiences with prevention of overweight are limited, but in the newly published WHO report (1998) it is stated that it is not likely that an individually oriented preventive strategy alone will succeed, but that society's general involvement via legislation, official institutions, provisions trade etc. has to be incorporated within a broader and more general preventive strategy (Ibid.).

At the beginning of the millennium a number of ministerial initiatives aimed at adjusting the administration of health, making it more attuned to NC. In 2004 the government published its plan of action for the promotion of NC (Regeringen, 2004), arguing that the use of private contractors increased efficiency, flexibility, innovation, quality and efficient utilisation of society's resources (Ibid. 9). In 2003 the Danish Veterinary and Food Administration held a nutrition conference with the purpose of increasing partnerships as a means for bettering the population's diet habits. Two hundred people joined the conference, representing business organisations, unions and various public authorities. The conference culminated in the establishment of a think

tank, which would facilitate the formation of partnerships directed at promoting healthy diet and physical activity in the population (Fødevarestyrelsen, 2005: 4). A number of actors, ranging from childcare institutions and schools to workplaces, were singled out as potential partners (Ibid. 7). Danish Veterinary and Food Administration supplemented with a publication on 50 public-private initiatives that would strengthen the fight against obesity and break the 'obesity curve' (Ibid. 3). Arguments presented were that partnerships could access areas that single actors could not access alone, and that each partner's knowledge, ideas and practical experiences would form a more resourceful basis for action when pooled (Ibid.).

Along with a general promotion of NC, special attention was placed on creating partnerships with sports associations, including the DGI. Already in the government's launching of a preventive health programme in 1989, the health benefits of engaging in sports (Sundhedsministeriet, 1989a: 221-22). Sports organisations' potential role in preventive health was equally emphasised in the government's launching of a national health strategy. The argument presented was that it was a matter of profiting from what was referred to as 'association Denmark', referring to the Danish population's strong tradition of volunteerism and engagement in associations of all kinds, including sports organisations.

> The voluntary world plays an important part in Denmark. Health-wise it is therefore important that "association Denmark", together with institutions, working places etc. take on a responsibility for health (Regeringen, 2002: 7).

From this perspective, the argument went, it was necessary that as many branches as possible take part, including schools, institutions, workplaces, sports organisations and the associations that combat diseases (Ibid. 20). Hence, partnerships were the new means for preventive work (Ibid. 7, 9).

The promotion of partnerships with sports organisations amounted to a committee established by the Ministry of Culture, whose task was to elucidate the possibilities of NC between sports organisations and public

authorities. The committee, which was established in 2002, consisted of a number of representatives from sports organisations, sports education and science institutions, sports folk high schools, institutions for the education of children and the youth, public schools and the ministries of Culture, Education, Interior and Health. An anthology published in continuation of the committee's findings put forth solutions for strengthening NC among sports organisations and public authorities (Kulturministeriet: 2003: 2).

In 2003 the Ministry of Culture established a pool to fund the development of a so-called 'movement politics' directed at children and young people (Ibid. 2008). The background for the funding was an increasing polarisation of children and young people's sports habits; a polarisation that supposedly called for partnerships in order to draw in the so-called 'sports insecure children' (Ibid. 1, 4). Collaboration between sports organisations and the public sector was viewed as having great potential (Ibid. 24). In the National Board of Health's 2007 guidelines for a 'movement politics' in schools and municipalities, collaboration between the school and local communities was equally promoted (Sundhedsstyrelsen, 2007b: 25).

In 2009 the Ministry of Culture appointed a committee for popular sports. In their report 'Sports for everyone', published in 2009 (Kulturministeriet, 2009b), the committee came up with 42 suggestions directed at municipalities for promoting sports, including how to enter partnerships with private actors (Ibid. 2009a: 1). As for the latter, voluntary sports associations were encouraged not only to focus on the connection between sports and health (Ibid. 2009b: 52), but also to focus on the social aspect of sports and thereby include vulnerable groups (Ibid. 54). Popular sports, the argument went, was a potential alternative for the social groups because such sports organisations were able to embrace the vulnerable children, due to the associations' democratic and social nature (Ibid. 38). Because popular sports centre on pleasure – unlike elite sports where competition is a central element – they should be able to draw in vulnerable groups (Ibid. 39). In addition, the argument presented was that sports associations were an

inclusive and stabilising factor due to their potential to orient their activities towards special target groups, such as physically inactive children:

> Apart from the preventive value, popular sports are valuable as means for social integration, democratic teaching and general education (Forebyggelseskommissionen, 2009: 284).

In summary, NC was identified as a preventive health means for fighting obesity among children. Inspired by the international health strategy initiated by the WHO, various public authorities launched a number of technologies for the promotion of NC. The overall purpose was to have as many actors as possible involved, to divide the responsibility for health and to make administration more flexible and innovative. From this vantage point, technologies were put forth to develop partnerships with sports associations and encourage them to bring health to the forefront of their activities. The strong voluntary aspect of sports associations and their ability to include 'sports insecure' children were central arguments for including sports associations as partners.

7.4.2. DGI AS HEALTH AND NETWORK FACILITATOR

In investigating more thoroughly the character of NC, the following pages have their point of departure in the DGI-NC initiative *Seize the Chance* ('Grib Chancen'). The idea is to analytically unfold the administrative practices at work, keeping the theoretical premise in mind that NC, apart from being a means toward a particular outcome – in this case, healthier children – is in itself an outcome. The point is that NC is a way to govern administration by empowering each administrative unit involved in the collaboration.

While public authorities encouraged sports associations to engage in NC, the DGI commenced with some administrative changes to attune itself for NC (DGI, 2010, 2011a+b). I will not go into the overall dilemmas for associations whose general activities are based on voluntary work (for this discussion, see Mondrup, 2005, Ibsen, 2006, Høyer-Kruse et al., 2008, Aagaard, 2007, cf. Vucina, 2011). Instead, I outline the

background for the DGI's participation in preventive health through NC to illustrate how – through the example of the DGI – NC was promoted as a means for providing health.

The president of the DGI, Søren Møller, pointed to the voluntary aspect of the associations' work, emphasising that it was up to each sports association whether they wanted to strengthen the health dimension of the DGI or whether they wanted to offer sports with the emphasis on its recreational dimension (Møller, 2003: 126). Moreover, Møller stressed the importance of non-profit undertakings as well as the formative role of sports (Kulturministeriet, 2003: 127).

In 2004, the process of transforming the DGI into a more suitable partner was carried out when health – along with fellow feeling and challenge – was added in the association's preamble (Teglgaard, 2004: 1). This change opened up for the DGI to assume a more active role in preventive health. When the structural reform came into force in 2007, the DGI began to design strategies for collaboration in order to ensure influence within the area of preventive health. Collaborations were to evolve around the following areas: seven hours exercise a week for children and young people, efforts targeting the so-called sports insecure individuals, development of sports friendly areas, recruitment of volunteers and flexible offers for adults (DGI, 2011b: 33). Moreover, the DGI pointed to the association's task to contribute to active citizenship, and thereby contributing to the welfare tasks (Ibid. 34).

The appeal to local sports associations to engage in public health activities was met with mixed responses. A number of critical voices were raised against the intensified collaboration strategy. The main objection was that increased professionalisation could lead to a change in the organisational structure of the DGI, particularly its voluntary element (Fisker, 2007: 2). Another was that the DGI now engaged in solving problems related to public health, which had traditionally been solved by public authorities (Larsen, K., 2005). A third was at the new conditionality attached to funding for voluntary organisations such as the DGI, forcing them to collaborate with municipalities or take a cut in

income (DGI, 2010: 9). Nevertheless, the DGI's political advisor, Søren Riiskjær, emphasised the necessity for it to engage in NC with public authorities and other external actors. He argued for an organisational adaptation in favour of the fight against lifestyle related diseases, emphasising the positive value sports had for the targeted groups (Riiskjær: 1-2).[22] What the DGI, as a voluntary organisation, needed to emphasise, the argument went, was its ability to strengthen community feeling (Ibid. 2), followed by an announcement that by 2010 it would be engaged in collaboration with at least 50 municipalities (Ibid. 3).

In 2008 DGI Funen took the initiative to form 'Sports Political Forum Funen' (SPFF) ('Idrætspolitisk Forum Fyn') (Idrætspolitisk Forum Fyn, 2009a, 200b) with the purpose of establishing a dialogue forum between municipal decision makers and sports associations in Funen (Ibid. 2008a: 1). The idea was to create a joint effort in the Region of Southern Denmark (RSD) so that sports facilities were in line with the population's changed sports habits and also to contribute to preventive health and integration (Ibid. 2009b: 1). In 2008 DGI Funen invited the heads of the municipal committees of sports and leisure time, heads of the municipal committees of health and prevention, municipal managers and various sports associations, as well as Danish Association for Company Sports ('Dansk Firmaidrætsforbund') (DFIF) in Funen, all from the RSD (Ibid.).

A month later representatives from DGI Funen and the municipalities of Assens, Ærø, Middelfart and Nyborg, together with Funen Sports Association ('Fynske Idrætsforbund') and DFIF Funen, agreed to make a joint effort to place sports and health on the agenda in the RSD (Ibid. 2009a: 1). Hence, SPFF was founded in 2008, and in 2009 the forum applied for state subsidies to finance *Seize the Chance* through the state football pools as well as the Ministry of Culture's pool for the benefit of children and young people; the latter being the major source of financing (Ibid. 2009c).

[22] Please note that the reference is an internal letter, which does not have a publishing year.

It goes without saying that the structural reform of 2007 (through which municipalities were given responsibility over most areas of preventive health services) was an influencing factor for local authorities to engage actively in establishing preventive health projects. That said, the initiation by SPFF of a joint effort towards preventive health illustrates well how self-regulation in terms of NC was less a question of following particular instructions set by state authorities than one of adapting to local needs and wishes and modes of doing preventive health. From this perspective, although the state subsidised *Seize the Chance* and state authorities had strategically supported NC, they did not have a direct influence in the establishment of SPFF and were not involved in any decision-making processes.

A steering committee was appointed comprising one representative from each municipality, organisation and association involved, a representative from the Ministry of Culture and a healthcare representative from the RSD, the National Prevention Council and the Ministry of Health (Idrætspolitisk Forum Fyn & DGI Fyn, 2009: 3). Among others, the committee consisted of the section leader in the Leisure Time Department in Odense municipality, managing nurse in Faaborg-Midtfyn municipality, manager of the local health service in Nyborg municipality, and association consultant in DGI Funen. Finally, a project manager was appointed by SPFF and given an office at DGI Funen, to coordinate the project (Idrætspolitisk Forum Fyn, 2009d: 1; Interview, Månsson 19.11.09).

At the meeting at SPFF in September 2009 the newest initiatives were outlined. The initiatives included the founding of a joint course portal for sports associations (Idrætspolitisk Forum Fyn, 2009c: 1) and an initiative to develop a joint Funen exercise route. Further, the members of SPFF decided to single out exemplary associations and thereby demonstrate best practice (Ibid. 2). Some months later the steering committee decided to arrange a yearly conference allowing the municipalities to elaborate on the preventive tasks each one had engaged in as well as their collaboration with private actors (Ibid. 2009d: 1). Two major challenges were identified when forming partnerships between

sports associations and municipalities: how to upgrade association leaders who were employed on a voluntary basis and how to take into consideration the independence of sports organisations and the public and private suppliers (Ibid. 2009a: 2). In 2010 the steering committee arranged a conference where both local politicians and officials were invited. The purpose was to shed light on the interaction between the public sector and the civil sector and at the same time to document the effects of NC (Notes, 29.4.10).

Hence, NC was activated at all levels of authority, ranging from state and local authorities to nurses and local sports associations. From this vantage point, the creation of NC as an enabling environment was not a question of moulding the physical environment into a healthier one. It was more a matter of moulding relations at various levels, activating each unit and actor engaged in the administration of preventive health and thereby attuning and directing the smallest administrative component towards a common goal: preventive health and health promotion. In addition, the good example was promoted as a means. However, the activation of each administrative component towards a common goal was not a top-down endeavour. On the contrary, as I illustrate below, NC was promoted as a self-regulating technology through which each unit and actor was to bring to the fore its unique capacities and abilities.

In 2009 the joint Funen project for overweight children and youngsters, *Seize the Chance – For an easier life* ('Grib Chancen – Til et lettere liv') was established. A number of activities were put forth, all aimed at on the one hand achieving *Seize the Chance's* goals and on the other hand, installing a number of small entities whose primary task was to offer independent activities on behalf of the whole. A so-called holistic view was emphasised: involving parents and family, seeking to gain insight into the child's particular situation and establishing a contact person for the child outside the home who would in a positive manner motivate the family to make the necessary lifestyle changes with regard to exercise and diet. The criterion for success was that a minimum of 30 initiatives aiming at the target group of obese children and young people was

established; they were to operate for a minimum of one year; and they had to be anchored by the end of the three-year funding period (Ibid.).

The initiating phase of *Seize the Chance* included generating knowledge, contacting all municipalities in the RSD, sports associations and other interested parties, working up a basic model, introducing and publicising the project, establishing forums for partnerships, creating a bank of instructors and considerations about evaluation design. The second phase was the practical phase. It included a dialogue meeting with all municipalities in Funen, implementing, coordinating and optimising the simple operations and those ready to be carried out in the municipalities that wished to participate, integrating new initiatives, and fixing the evaluation design. The third phase was the consolidation phase and included adjustment and development of the concrete operations, conference and developing an anchoring strategy. The fourth and final phase was about anchoring the efforts, collecting data for an evaluation, closing and communication at conferences (Idrætspolitisk Forum Fyn 2010; Idrætspolitisk Forum Fyn & DGI Fyn, 2009).

In summarising, SPFF was founded in 2008 in Funen on the initiative of DGI Funen. The purpose was to form partnerships between municipalities in the RSD together with DGI Funen, sports associations in the region and various private partners. The partnership was established as a joint effort for strengthening the focus on preventive health and sports in the RSD. SPFF appointed a steering committee consisting of representatives of both state authorities, local authorities and representatives of municipal departments dealing with preventive health and sports, sports associations, nurses connected to the municipalities and local health services. Moreover, a coordinator was appointed to put *Seize the Chance* into practice. The steering committee met to organise and discuss preventive health initiatives and held a conference with the purpose of strengthening NC. *Seize the Chance* was promoted in 2009 and divided into various phases, each with planned activities, meetings and conferences. The purpose was to establish anchoring preventive health projects aiming at obese school children

involving as many municipalities, private actors and others as possible within the RSD.

Eight out of ten municipalities in the RSD agreed to join *Seize the Chance* and support the project with staff-related resources. They also agreed to provide locations for meetings, personnel resources (hours taken from their preventive health budget) and in some cases also financial support (Notes, 3.3.10). Local authorities involved in the campaign included the departments of Culture and Recreation, and Health, authorities dealing with children and the youth and health services in each municipality, and local sports associations, schools, before- and after-school care, institutions, GPs and sports organisations. The administrators' tasks were to provide sports facilities, recruit children, do PR, and provide financial support; all in close connection with a key person from *Seize the Chance* (Ibid.). Moreover, already established efforts towards fighting obesity among children and young people were integrated within *Seize the Chance*, for example the health profiles that had already been carried out in all Danish municipalities, and *Camp Fanø*, connected to Odense municipality. Health visitors connected to the municipalities, typically in public schools, were asked to engage in *Seize the Chance* and to hand out flyers about the campaign along with singling out those children who were potential participants at *Camp Fanø* (Ibid.).

The municipalities involved in *Seize the Chance*, and the various sports associations connected to these municipalities, were presented and evaluated on a regular basis at dialogue meetings and conferences initiated by the *Seize the Chance* coordinator. The municipalities' contributions included setting up initiatives for direct involvement with families of obese children, appointing a project manager to liaise with *Seize the Chance*, instructing health visitors to spot obese fifth graders and give their names to local sports associations, establishing a steering committee to liaise with associations focusing on the most overweight children, teaming up with sports associations and offering special activities for overweight children (Ibid.).

Nyborg municipality was regarded as having gone furthest in carrying out the tasks set by *Seize the Chance*. Second came Kerteminde municipality with an already established private clinic for overweight children and youngsters, which was integrated into *Seize the Chance* so that their clients were passed on to *Seize the Chance* after completing treatment. Odense municipality already had various preventive health efforts in place targeting the primary target group, namely those from 10 to 14 years. The Health Service, for instance, had been part of a local strategy in which health visitors screened all children in the fifth grade, including weighing and measuring them. Those who were identified as overweight were offered a stay at *Camp Fanø* (Ibid.).

University of Southern Denmark was another partner in *Seize the Chance*. The university's published anthology on NC directed at children and physical activity (Høyer-Kruse et al. 2008) provided the theoretical framework (Idrætspolitisk Forum Fyn & DGI Fyn, 2009). Moreover, Professor Bjarne Ibsen from the University of Southern Denmark took part in seminars and gave professional advice regarding the implementation of *Seize the Chance*. Finally, Ibsen was in charge of the final evaluation of the project (Notes, 29.11.10).

In summarising, the coordinator of *Seize the Chance* and SPFF had succeeded in incorporating eight out of ten municipalities in the RSD within the *Seize the Chance* campaign. In various forums each municipality was to outline and evaluate the activities carried out connected to *Seize the Chance* and some were pointed out as the most successful. While this practice enabled municipalities to share experiences and learn from each other, it also opened up for constant self-reflection and self-regulation in each unit, thereby allowing the administering of preventive health to become a self-governing practice.

All sports associations in the RSD were asked to adjust the activity programmes they offered so that they integrated facilities for overweight and inactive children, including so-called 'sports insecure' individuals. Unlike the municipalities – who could only use means from their own budget – the associations were able to apply for state funding (Notes,

3.3.10). The municipalities had been given guidelines by the steering committee as to how to tackle and respect the sports associations' autonomy (Ibid.). The following points were listed: respect each other's differences and take part in a dialogue with the associations. Communication is important. Municipalities have to listen to the associations, their ideas and competences. They have to be nursed. Be clear about differences in goals and motives. Listen to the associations instead of forcing on readymade models (Ibid.).

Already in the initial phase of *Seize the Chance* representatives of the local sports associations were invited by Nyborg municipality to meet with the chief health officer in Nyborg municipality, head of Nyborg Health Service, project manager in a project for overweight citizens, project manager of *Seize the Chance* and coordinator and project facilitator in Nyborg municipality. The associations were asked to present their point of view as to what they saw as major challenges in terms of adapting sports facilities that include and take into consideration overweight, inactive and generally 'sports insecure' children. Some of the associations expressed their concern with adapting too much to a health strategy, their point being that it could remove the core purpose of the activities, which was to have fun and gain a sense of belonging. Another reservation regarded the voluntary work of the instructors and their lack of professional knowledge as to how to deal with children with special needs. A representative of an association put forth the argument that obese children were surrounded with many walls, which made it difficult to reach out to them. Another emphasised that 10-14-year-olds often drop out and become physically inactive. Overweight children often experience a number of difficulties. They suffer from low self-esteem; they do not engage with other children and they lack a social element in their lives (Notes, 19.11.09).

In the above outline we have seen how a number of external actors were invited to join *Seize the Chance*, including health professionals, nutrition students, schools and sports associations, which in particular were asked to integrate into their offered activities particular sports for overweight and 'sports insecure' children. Representatives of the sports associations

were far from accepting the terms set by *Seize the Chance* and some expressed this new dimension as too problematic. The resistance of the sports associations was anticipated by the steering committee, which came up with guidelines for the municipalities. Here it was emphasised that the municipalities had to respect the associations' standpoint and not force a transformation, but instead nurse them. The latter illustrates how NC was operationalised by allowing each unit to provide its unique – and sometime contradictory in relation to the overall purpose – self-reflections and ways of doing things – to come to the forefront. From this perspective, NC can be seen as promoting ethical workings of self-reflection and self-regulation as a central mode of governing administration. In addition, freedom was given to each administrative unit to adapt to the prescribed norms of preventive health administration.

The main argument in favour of NC was that it provided a flexible, innovative environment that enabled children and young people to make healthier choices. This particular moulding of the social is different from more traditional means such as reducing economic and social inequality or reducing unequal access to health and welfare services. While the latter is mainly carried for the purpose of economic and social transformation, NC, despite the fact that it takes its point of departure in an administrative transformation, is first and foremost an empowerment technology, that is, a way to strengthen the responsibility, free choice and empowerment of the targeted units.

Subsequently, economic means for addressing inequality in health was promoted, but nevertheless less emphasised than the socio-administrative means that NC was part of, enabling the less fortunate ones to make healthier choices. A central characteristic of this kind of governmentalisation of administration is that although in the above-mentioned case, the promotion of a health-enabling environment was targeting obese children, its flexible nature allowed for potentially everyone to be affected by it.

7.4.3. ENABLING THE IMMEDIATE ENVIRONMENT

While NC can be seen as a particular means to ameliorate social space by attuning each administrative actor towards the overall goal of providing health, NC also included technologies for activating the immediate environment.

DSAF recommended what they term 'environmental intervention' in fighting obesity, the idea being to decrease the population's exposure to fat boosting environments, increase physical activity, and improve the quality of diet and access to healthy food (Dansk Selskab for Adipositasforskning, 2001: 9). The National Board of Health also emphasised the need to promote technologies to activate the immediate social environment and thereby promote empowerment of citizens (Sundhedsstyrelsen, 2007a: 14), focus on their preferences and motivations, and engage them to come up with strategies through focus group interviews, citizen boards and key persons (Ibid. 15).

> It is important, that the children's close environment encourages the children to engage in physical activity, so that the desire for physical activity is promoted, even beyond the schools and institutions (Fødevarestyrelsen, 2005: 8).

In the interwar chapter we saw how the introduction of the health visitor allowed for the families of newborn children, and particularly mothers, to install within the home a kind of health unit, securing the health and development of the infant. The argument guiding the inquiry in the following pages is that this installation of a health unit goes beyond the family and the home to include the health professionals close to the obese children.

As to the family, indeed the health visitors were still a central source of health expertise, providing knowledge and tips for families to attune their home environment towards the prescribed norms of health. It was the health visitors' professional judgment of schoolchildren that formed the basis for inviting them to *Camp Fanø*. At the camp, they were also the primary actors with regard to the biometrical measures of the

children. These same health visitors were the primary contact with the families of the obese children and also the ones initiating an active involvement of the parents on behalf of their children's health transformation.

Immediately after a child had been identified as a *Camp Fanø* candidate, the health visitor contacted the child's parents. Those families who showed interest were invited to attend some information meetings. After three of these meetings, parents could fill out an application form for the child's enrolment in the camp. While the child was attending the camp, the parents took part in an education programme in which a dietician taught them how to prepare healthy food, how to lose weight, how to support their child's healthy lifestyle, how to prepare a healthy lunch box for school and how to include physical activity in their daily lives (Odense Kommune, 2010a: 4-11). Nyborg municipality had formulated an action plan as a supplement to the other workings, in which the parents were asked to sign a contract confirming that they had reflected upon the problems connected to obesity and that they were willing to help their child to lose weight (Notes, 19.11.09). Thus, self-reflection and self-engineering were crucial means when targeting the obese children's parents.

After the child's enrolment at *Camp Fanø*, children and their families were invited to take part in four follow-up meetings with two health visitors and two sports science students in charge of the activities. In one follow-up meeting emphasis was placed on BMI, waistline measures and physical activity in accordance with normal development and normal bodyweight. Another meeting concerned 'The appreciative conversation', which will be elaborated in the following section. In the third follow-up meeting, parents and children turned up with sports clothes to do some exercise and movements (Odense Kommune, 2010b). At the final meeting, the families were presented with a list of Odense's municipal facilities for transforming lifestyle into a healthier one (Ibid. 2010a: 11).

The intervention technologies put forth to target obese children's families were characterised as taking their point of departure in the idea

that transformation had to occur in a positive and all-embracing manner, targeting families with an open-minded attitude and appreciation. Health visitors were drawing from the so-called *Appreciative Inquiry* (AI) method (Interview, Krum 19.1.10).[23] With AI conversation, the health professional was to take into account the families' dreams, relations, and their success experiences, supporting them with positive and appreciating expressions (Odense, 2010a: 10). The health visitors in their dealings with obese children and their parents applied AI, while at the same time encouraging the parents to use AI towards their children. Regarding the latter, in conversations with parents, health visitors stressed the need to allow the child to develop in a proper manner, emphasising that the point was not to put pressure upon the children but to meet them positively and in an open-minded way (Ibid. 2010b).

The focus on developing psychosocial competences within the family was further accentuated in a guide offered to the health visitors in charge of the *Camp Fanø* programme. The guide reads that it is important that parents are involved. Because some parents have difficulties admitting the problem of their child's obesity, the initial talks were crucial. The guide emphasises that apart from communicating to the parents how they can change their lifestyle into a healthier one through for instance changing their diet and being more physically active, it is important to visualise good examples rather than focusing on negative aspects (Nyborg Kommune, 2010: 9). The positive approach included drawing attention to the results that the family will get: a better shape, more happiness, increased self-esteem, more friends, better concentration and also stressing the fact that it is fun to join the camp (Odense Kommune, 2009: 15).

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[23] Appreciative Inquiry (AI) is developed and promoted by David Cooperrider in collaboration with Suresh Srivastva and Diana Whitney among others (Cooperrider & Srivastva, 1987; Cooperrider & Whitney, 2005). Directed at transforming organisations and people in the organisations, AI breaks with what is regarded as a more traditional 'problem-solving' approach to organisation, and promotes positive change through creativity and innovation. Both health visitors connected to *Seize the Chance* and instructors facilitating an 'Overweight Association', which will be elaborated later in the chapter, drew from guidelines that referred to Cooperrider's method among others.

While AI was offered to the parents as a tool to encourage their obese child's health transformation, the approach was also offered to the health visitors themselves, guiding them as to how to meet the parents. In the guidelines it was emphasised not to act superior in relation to the family and its weight problems. Further, the health visitor was guided as to how to bring about self-esteem with the families and how to engage in a holistic approach toward transforming the physical and the psychological components of the overweight children and their families (Ibid.).

While obese children, parents and health visitors were guided according to a similar technique – AI – so were schoolteachers and pedagogues. Moreover, they were instructed in how to appoint a child to a health visitor and how to provide clinical didactics to the whole family, alone or in groups. For this purpose, Middelfart municipality had established a mentor agreement with burdened families, where a person would step in as the child's adult friend (Notes, 19.11.09).

The voluntary association the Diet Caravan ('Kostkaravanen') – which was run by students from Ankerhus health and diet school – had also been enrolled in *Seize the Chance*. This mobile diet school – apart from facilitating diets for obese children and providing food workshops for parents of obese children – was offering individual diet guidance as well as diet courses for all instructors and health professionals involved in *Seize the Chance*. This included five free diet courses for sports associations – where they could receive advice on how to incorporate healthy food in sports activities – as well as three free courses for nurses and other health personnel. Moreover, health visitors could contract out the Diet Caravan to work with 10 to 14-year-old children in schools (Interview, Månsson, 19.1.10).

The above pages illustrate how preventive health action entailed carving out a healthy environment by targeting the parents of obese children and the health professionals in their lives. One may regard this environment as an admin-social environment, by which obese children were enabled to make healthier choices through various levels of relations and

engagements. Accordingly, AI was a crucial technique to engender this enabling environment as a positive, empowering and all-embracing facilitator. And, as the following pages illustrate, the same technique was applied towards instructors in DGI Greater Copenhagen who were involved in forming an Overweight Association for obese children and their families.

> Process management is a kind of art where you yourself are the artist (Bjerre, Overby & Lindholm 2009: 11).

The instructors engaged in forming of an Overweight Association in DGI Greater Copenhagen drew from somewhat loosely formulated guidelines (Interview, Hansen, 19.11.09), some from a 'Process Guide', some from 'Fat Tips' ('Fede Tips') (Jakobsen, 2005); the latter particularly aimed at activities targeting inactive and/or overweight children. In the Process Guide, general guidelines are listed as to how to start up an association. In different ways, these points refer to how to create a proper setting for the creation of an association, i.e. how exteriority functions as a positive factor in the smooth formation of the association. It is emphasised that the environment has to consist of positive, playful and creative elements:

> Have fruits in a bowl – it surprises people and makes them smile. Play Mozart at a low volume. [...] Use unorthodox appliances to attract attention, e.g. a squeeze-bulb horn, plastic animal toys for individual presentation, disposable clothes to write on. Vary the lining up of chairs and tables, work without chairs and tables, use tall café tables, sack chairs, tables placed in "islands" like a cinema (Bjerre, Overby & Lindholm, 2009: 5).

A crucial element, the Process Guide reads, is to find the proper balance between play and seriousness (Ibid. 7). First of all, it is important as an instructor to radiate positivity, energy, security and joy in order to create a surplus (Ibid.). This also implies the use of a particular vocabulary: "*Beware of the language you use: there is a difference between calling something 'a problem' [and calling it] 'a small obstacle'*" (Ibid.)... "*Focus on the positive ideas*" (Ibid. 20)... "*Develop ideas with 'thinking hats' in order to see different sides of a situation. Each hat symbolises different points of view*" (Ibid. 26-27). An environmental setting was established for the creation of positive thinking and letting go of rigid

thoughts: "*Behind every problem lies a frustrated dream – and the dream came first*" (Ibid. 12)…"*Use associations and dream journeys*" (Ibid. 18)…"*Let go of habitual thinking*" (Ibid. 20).

In the project information about the Overweight Association it was emphasised that the instructors and the executive committee should have professional knowledge about diet, exercise, communication, psychology and pedagogy. Focus was equally placed on physical and psychological wellbeing (DGI Storkøbenhavn, 2010: 1):

> When one feels one is able to exercise control in one's life it often leads to an increased sense of responsibility and strength with regard to achieving one's goals in life. Empowerment is equally a means and a goal for obtaining an understanding of oneself and to gain self-insight (Ibid. 1-2).

Hence, apart from having technologies concerned with empowering the targeted obese children, instructors instructing the obese children themselves were to embrace empowerment as a mode of administering the Overweight Association. In other words, the expertise had become both the provider and an example of empowerment. The following outline of the first gathering of the instructors who were to be in charge of the Overweight Association at DGI Greater Copenhagen illustrates how the instructors in charge of the intervention towards obese children were subjected to similar technologies as the obese children.

The workshop for the instructors engaged in forming the Overweight Association started with encouraging the participants to form a line according to when they last did their laundry. Other games were introduced during the three-day workshop. One was a competition where participants would lie on the floor in two groups and compete in puffing a ball towards the goal without using their hands (Notes, 16.1.10). In the process of coming up with suggestions as to what the Overweight Association should look like, the organiser made the following point: it is important to work creatively with each other, so always say 'yes', never 'no', because an idea is always good. A circle was formed in which each participant was asked to relate to and be honest about the following questions:

What do I expect of the day?
What do I expect of myself?
What emotion do I have?
Do I like the person sitting next to me?

Some participants expressed a bit of anxiety as to the proceedings of the day, others expressed insecurity and others again felt happy and positive. All inputs were out in the open and the group was asked to be accepting and open (Ibid.).

Later, participants would do a so-called *walk-and-talk*, using the AI technique. In couples each would present what they thought would be the best scenario regarding the association. Again the organiser emphasised the importance of being open-minded towards the other's opinions, always answering with a yes. If one had doubts about a suggestion, one could answer "*Yes, good idea. However…*".

At the end of the day, participants were divided into smaller groups and asked to make a 'newspaper' using old magazines. They were to write an article where the Overweight Association was presented as the best initiative ever. The groups' 'newspaper' was presented and put on the wall (Ibid.).

Finally, the instructors sat down to present visions and overall goals for the Overweight Association, starting with the more airy visions, less likely to be implemented, and slowly narrowing down to the most feasible. The participants came up with the following visions and goals for the children participating in the Overweight Association: happy children, happy families, happy people, to develop self-confidence, to provide the tools to make a lifestyle transformation, experience success, and increase the obese children's self-esteem (Ibid.).

In summarising, the following point can be made: we see how instructors are put forth as examples of how to engage in activities, how to communicate and how to relate to challenges. Empowerment techniques, techniques for self-reflection and self-regulation were means

used by health professionals towards the obese children's families and towards themselves too. They, too, were to exemplify good practice, a proper attitude – namely a positive and open-minded one – and good relations, that is, relations that are appreciative, engaging and positive. Thus, an enabling human exteriority also included the promotion of enabling health professionals. Hence, the installation of an enabling environment within the child's immediate environment is twofold: firstly, the parents of obese children are governed to take responsibility by creating within the home a health-enabling environment, which involves them gaining a health expertise that can influence the child positively. Not only are the parents instructed in healthy food and exercise, but also in how to think and reflect upon themselves as parents and at the same time how to create a positive atmosphere within the homes. Secondly, the health expertise that guides the parents takes the role of a parent: enabling positive change by modelling the positive thinking, healthy diet and exercise.

7.5. TECHNOLOGIES FOR GOVERNING HUMAN CORPOREALITY AND INTERIORITY

> A child's bodily experiences constitute the basis of the child's intellect, just as a motor secure body is the entrance to collaboration and the founding of social competence. Children who are physically active often prosper better socially and have a higher confidence and stress threshold (Sundhedsstyrelsen, 2011c: 58).

An article in *Ugeskrift for Læger* called attention to what was considered a well-documented fact, namely that intensive lifestyle intervention that brought about consumption of fewer carbohydrates and more physical activity could lead to weight reduction. However, it was noted, weight reduction could only be preserved as long as the unhealthy lifestyle was maintained (Svendsen, 2004: 25). Exercise constituted a central means when promoting lifestyle transformation. Physical activity, it was argued, increases the level of energy consumption and at the same time has a regulative effect on appetite and insulin sensibility (Dansk Selskab for Adipositasforskning, 2001: 10; Statens Institut for Folkesundhed, 2007: 269). Moreover, the National

Board of Health established a direct link between exercise and wellbeing: joy of movement, desire for movement, drive, physical activity and identity are all indicators of one's personal and social identity, a signal of who one is, what one is worth and what sort of communities one belongs to (Sundhedsstyrelsen, 2007b: 3).

At *Camp Fanø* the physical aspect of health was also on the agenda. This was the case already in the selection phase, where those children in the fifth grade who were regarded as candidates to stay at the camp were singled out. The health nurse connected to a given public school in Odense was in charge of regular health examinations and health talks conducted with all children, including a major examination in the fifth grade. She would then conduct a number of biometric measurements in order to select the children for the camp. These included BMI (Odense Kommune, 2010a: 5), waistline size, weight, and hipline and height according to age (Ibid. 14), as well as physical activity level; the latter through a questionnaire where the children were asked to state how much exercise they engage in on a daily basis, whether they bicycle to and from school, how much they sit in front of the TV on a daily basis (Ibid. 18). These indicators, along with the health visitor's professional judgement, formed the basis for inviting a child to the camp. A health visitor explained that some of the children invited did not seem overweight and they may even appear slim to the untrained eye. But waistline measurements can reveal overweight or, at least, potential overweight. Moreover, new knowledge in the field, the health visitor asserted, shows that fat around the waist and the stomach area is the most problematic health-wise. Hence, some children were offered a stay at the camp not due to their own obesity but along the lines of the notion of 'thin fat' or because they had an obese sibling (Notes, 8.6.10).

At the camp, dance and movement was part of daily life during the six-weeks stay from May to end of June. Moreover, the children attended a daily 'health class', in which various themes related to health were brought up. Also questionnaires were handed out to the children; one with the following questions:

What is health for you?
What would you do to continue to be healthy, when you get home?
Who can help you?
How can your family help you?
How can your friends help you?

The children were asked to discuss the questions in class and come up with some answers in smaller groups. The instructor in charge of the session emphasised the necessity to be open-minded when discussing the issue and to positively come up with answers (ibid.). The questions addressed the children's self-reflective abilities and active participation in their transformation: a transformation that was also emphasised by health authorities. This kind of psychosocial working was explicitly put forth at the camp, not only as a means, but also as an aim. After the stay at the camp, the children were said to be "*physically and psychologically transformed…having success, weight loss, new friends, a new image and increased self-esteem*" (Odense Kommune, 2010a: 2). As one of the health visitor explained: the children who arrived at the camp had often been bullied; they isolated themselves and had low self-esteem. However, after the camp, they were completely transformed. They had more confidence in themselves, and their parents often felt they had a whole new child (Notes, 8.6.10.).

> Treatment of overweight does not concern only what most people understand by traditional medical treatment, but a more interdisciplinary pedagogical-psychological endeavour with the purpose of creating lifelong lifestyle changes (Sundhedsstyrelsen, 2003b: 12-13).

The quote indicates that transformation of lifestyle to a healthier one calls for psychosocial work. In other words, to secure a transformation, it had to take place from within the targeted subject. A focus was to be placed on the notion of wellbeing (Ibid. 2007b: 13), that is, a more "*positive notion of health*" (Ibid. 14). A healthy human being, it was argued, is someone who is able to handle life's many challenges, has a high quality of life and a feeling of wellbeing, and engages in healthy habits (Ibid. 39). As stated in the Ministry of Culture's report on popular sports:

> Effective efforts towards the inactive groups demands an understanding of the various practical, psychological, social and cultural barriers that may prevent the individual from engaging in sports (Kulturministeriet, 2009b: 38).

Furthermore, motivation was regarded as a question of consciously or unconsciously looking at the advantages, making them clearer and more appealing (Fødevarestyrelsen, 2005: 8). The National Board of Nutrition published a report in which motivation was emphasised as a crucial means for lifestyle transformation. The advantages of change of lifestyle, the report argued, were that children became healthier and happier, they were no longer bullied, they were able to wear nicer clothes, they would not become ill so easily and were less short of breath. The motivation for acting healthier rely, the argument went, on the individual motivation. Therefore, in order to gain success, it was crucial that children themselves were involved in initiating the transformation. Concurrently, when encouraging lifestyle transformation for children, it was important not to be indignant or judgmental towards obese children. They were already stigmatised; more stigma would only worsen the problem. Instead, intervention required positive encouragement (ibid.).

Likewise, empowerment was a central aim for preventive health efforts concerned empowerment (Sundhedsstyrelsen, 2007b: 15): taking part in the development of children's competency to aim for a central goal and furthering participation in the decision making process regarding the child's own health (Ibid. 17). As explained in the National Board of Health's strategy:

> Participation in decision-making is at one and the same time the goal and the means [...] It is an independent goal due to ethical reasons as it is only reasonable that children and the young ones are listened to and are involved in questions that concern them personally (Ibid. 18)

At the local level, Nyborg municipality in the RSD put forth the following vision: the individual experience of life as meaningful, comprehensible, and intelligible is connected to the ability to gain control over one's own life situation, and therefore it is important that each person is made co-

responsible for his/her own health (Nyborg Kommune, 2008: 3). The municipality offered to help citizens to change and avoid habits that put them at risk of serious diseases. Further, it introduced ideas of health in daily life, and offered to help lonely citizens to engage in social settings and enable them to take responsibility for their own health. The programme further reads: as many citizens as possible in the municipality should gain a high quality of life and a feeling of wellbeing (Ibid.).

The term coping was put forth as central, dealing with how to cope with situations in daily life and learning to make healthy choices (Sundhedsstyrelsen, 2007a: 17) for instance through cognitive therapy, positive role models and self-help (Ibid. 18). An aim was to allow obese individuals to experience victories in their daily lives, developing their self-confidence and action competences while motivating them to disengage from unhealthy behaviour (Ibid. 2011b: 8). Strategies for fighting obesity among schoolchildren also emphasised coping technologies as a way to increase their self-esteem and general wellbeing (Nyborg Kommune, 2009b: 10), combating bullying among school children (Ibid. 11), fighting depression, anxiety and dizziness (Ibid. 2009a: 11-12), strengthening the belief in the children's efforts to keep up good health (Ibid. 14), focusing on their action competence (Ibid. 16-18), social relations (Ibid. 37-40), and above all integrating the children's own suggestions as to how they may become more healthy (Ibid. 41-43).

In summarising, we have seen how various preventive health technologies were aimed at individuals by public authorities both state and municipal as well as in *Camp Fanø*. Biometric indicators, psychosocial wellbeing and activity measures respectively, allowed for obese children to be designated as a public health concern in different ways. Moreover, we have seen how a causality was established in such a way that physical indicators – such as weight, BMI and activity level – were paired up with psychosocial indicators. That is to say, apart from physical risks, obesity was also considered a psychosocial problem linked to stigmatisation and low self-esteem. Transformation of

individual conduct included addressing individual lifestyle changes, such as exercise and change of eating habits, as well as psychosocial transformation, promoting empowerment technologies and psychosocial competences. In addition, coping technologies constituted a central means for empowering the children at the camp, in order for them to be able to make the healthy choice themselves. It is worth noting that the technologies offering lifestyle transformation and psychosocial transformation correspond well with how obesity was problematised as partly a problem of individual conduct. Hence, while psychosocial barriers were identified as linked to the problem of obesity, the promotion of psychosocial competences and empowerment constituted a solution to these barriers. Put differently, individual transformation led to social transformation.

The targeted individual was placed at the centre of attention, allowing his/her ability to transform psychologically, and thus socially. In other words, a governmental space was carved out for health to become linked to the individual ability to turn himself/herself into an object of constant self-transformation and self-engineering. This was also the case with the selection of the children who were to engage in *Camp Fanø*, basing the judgement on a number of biometrical measures together with knowledge about the child's background, which was already known to the health visitor. This extra clinical gaze on the child and knowledge about him/her were able to reveal what the biometrical measures did not take into account, namely family circumstances, genetic disposition and the child's own account of his/her health state. Although health professionals singled out the children participating in the camp, already during the selection period the children themselves were engaged in estimating their health state and risks. Self-estimation can then be seen as a technique for empowerment and self-regulation. Also, as I pointed out earlier, self-estimation put forth a relationship of self-objectification, that is, of reflection of the self by the self. The empowerment effect implied opening up a space for self-reflection and self-regulation in order to actively choose a healthy lifestyle. Put differently, empowerment was a question of raising the awareness of one's own potential to take responsibility for one's life and health – regardless of

social and economic circumstances. In this way, despite the fact that, in the section dealing with *problematisations*, we saw that social inequality was regarded as a crucial factor for obesity in children and young people, and despite the fact that economic means, through tax regulation, was also put forth as a way to fight social inequality, in this individualising setting, self-reflection and self-engineering were crucial means. That is to say, social inequality served as an explanatory factor, not only for obesity but also for the lack of self-reflective and self-engineering capabilities; capabilities that through these technologies could be instilled within the children. From this perspective, one may say that these psychosocial workings were in fact psychological workings upon the social: empowerment technologies and the instillation of self-reflective and self-engineering capabilities were the means put forth to transform the individual and thereby transform his/her social entrapment within the lower end of the social ladder.

In relating to sub-question 4, I have illustrated how an ethical working was incorporated within both technologies for governing the population and for governing the individual body, including his/her psyche. While mapping the population and particularly children and young people, a self-reflective practice was simultaneously promoted with the notion of 'self-estimated health'. Hence, unlike the case of the interwar era, an ethical working was activated along with biometric measures. The individuals subjected to the measures – in this case children and young people – were at the same time encouraged to gain some health expertise, that is, to become experts in their own health. The investigation of technologies for governing social space was also an attempt to illustrate a theoretical point, namely that NC can be characterised as a qualitative shift from the *governmentalisation of the state* to *the governmentalisation of administration*. NC in health administration may be seen as an ethical practice by which each administrative unit was empowered to become a health-enabling unit in constant self-reflection and self-regulation. Self-reflection and self-regulation was also a central technology for the individualising workings upon human corporeality and interiority. In the same way, transformations of human physique, mind-set and lifestyle were

addressed and targeted through empowerment technologies nurturing the individual's health competences. Regardless of social stratum, empowerment and self-engineering practices opened the way for constant self-transformation and self-reflection. These individualising workings were put forth as a means to break free of the social entrapment bestowed on the individual through his/her (probable) placement at the lower end of the social ladder. The health professionals and others directly related to campaigns targeting obese children were governed in ways that resemble the way obese children were governed, namely through AI. From this perspective, both the parents of obese children and the health expertise involved were subjected to the same technologies for government as the children themselves: positive self-reflection and self-engineering capacities. Human exteriority in this way was rendered technical as a positive, all-embracing facilitating environment enabling the healthy choices to be made, not only for the obese child but also for the parents and the facilitators themselves. Thus, the facilitators offered techniques to the obese children for self-reflection and self-government – i.e. techniques for ethical workings – while at the same time incorporating these techniques for their own health-engendering practice. This dual ethical working may be seen as a particular outcome of the regulative aspect of biopower, by which regulation is given an ethical dimension.

7.6. SUMMARY

The first part of the analysis shed light on problematisations of the population as a whole, i.e. human exteriority, as well as problematisations of the individual with regard to their human corporeality and interiority.

Social space, i.e. welfare services, was seen as deteriorating under the economic and social weight of the problems caused by obesity. Unlike in the interwar era, where social services were seen as a means for preventing the deterioration of the race, here welfare services (i.e. the welfare state) were viewed as burdened by the increasing expenses on health. In other words, the social and the population as a whole were

seen as vulnerable entities threatened by the rise of obesity. From this vantage point, obesity was linked to psychosocial problems that affected the obese individuals vis-à-vis their quality of life and self-esteem.

The terms 'social inheritance' and 'chance inequality' illustrate how, like in the interwar era, inheritance was used to substantiate an argument of sickness being likely. However, in millennial terms, inheritance first and foremost encompassed the idea of 'social inequality', appointing social stagnation as a central factor for obesity.

In relating to the entrée presented in the beginning of the chapter, Hindhede's argument for lifestyle transformation among doctors – which at the time did not find scientific grounding – is today governmentalised to the n^{th} degree: the health professional enabled health and simultaneously practised it; engenders it and simultaneously engages in it. Thus, the promotion of health through the campaign against obesity among children and young people was a question of instilling in each individual, be it an obese child, a parent or a health professional – as well as in each administrative unit – self-reflecting, self-engineering and self-enabling capacities. Thus, health government has indeed become self-government at social, individual and administrative levels.

8. SUMMARY AND CONCLUSION

8.1. SUMMARY

The following research question provided a guideline to the dissertation:

How were human exteriority, corporeality and interiority governed through preventive health and health promotion in the period from 1920 to 1940 and from 1980 to 2012?

What then are the effects vis-à-vis human exteriority, corporeality and interiority?

First, human exteriority: In the interwar analysis, what was at stake when problematising human exteriority in the interwar period? First and foremost human vitality on the loose and a twisted biology in the form of tainted individuals. The population was envisaged and rendered technical as a biological organism, whose biological functions – fertility, sexual urge and sexuality – were jeopardising social equilibrium. Heredity science provided a vocabulary and practice for encompassing this dangerous biology. On the other hand, problematisations of human exteriority were concerned with the filth and diseases lurking in the immediate environment, the homes and schools. Here, hygiene provided a vocabulary and practice for encompassing the problem of bad hygiene. However, both by seeking to establish biological equilibrium in society and promoting health within the immediate environment, the *social* became a crucial answer: social legislation, a medico-social practice and generally social welfare. Even heredity science – which to a large extent argued in favour of a kind of genetic determination – had recourse to the idea of social transformation and thereby also social welfare. So, while the problem was both biological and hygienic, the solution became social, either socio-biological through a pairing of eugenics and social welfare or constructive hygienic by conjoining hygiene with social welfare. Consequently, a door was left open for the possibility of social

transformation regardless of genetic determination. While eugenics was governmentalised with a firm grip on the notion of the social body as first and foremost a biological whole, both constructive hygiene and the introduction of the health visitor, in effect offered a governmentalisation of public health detached from biology's hold. Hence, the social reform made possible within government a turn away from a vocabulary and practice preoccupied with securing a biological whole and instead opened a radical new way of approaching the population and the individual, namely in terms of problematising social risk and promoting social relations.

On this note, the point is not that for the first time we see a social practice. However, a new government relationship was formed with the introduction of the health visitor: the governmentalisation of a health-enabling environment. In fact, there is no significant qualitative change in the nature of the health visits from the interwar era to the millennial. But indeed a quantitative change has occurred, going from one health visitor meeting the family of a newborn child to a countless number of health professionals, public authorities, school teachers and other faces of government. In a similar way, there is not a big difference between interwar hygiene education and millennial diet courses and child rearing tips. However, the installation of a health unit within the family works at all levels, and has the potential to expand to the n^{th} degree.

The central point made in relation to the role of human exteriority in a millennial setting is the following: in the entrée of the previous chapter, we saw how the idea proposed by Hindhede during the 1920s and 1930s of the doctor's responsibility to set a good example of health was rejected as a bizarre proposal. Yet by the millennium *exemplifying* health has become a key element in the promotion of health and fight against obesity. One may even say that this exemplary practice has reached its second and third power: health visitors are to be positive role models for both the children and their parents with regard to how to live a healthy life; the parents are then to become good examples for the children, who in turn are to become good examples for themselves, while at the same time instructors and other actors involved are to engage in the same

positive transformation. The health normativity at stake here does not imply a particular stand or identity; rather, a particular attitude, which is that change per se is positive, or to put it differently: any change is positive change. This constant quest for non-fixation of a problem engenders an attitude of eternal, active construction of positive ideas and empowerment. Moreover, the rejection of negativity and dwelling on problems may be seen as a kind of refusal of the interventional aspect; there is no problem, only small obstacles and positive solutions.

Second, human corporeality and interiority: when sexual lewdness was a crucial concern in the interwar setting, was it just because the expertise at the time – lacking the liberal viewpoints of today – were caught up in and guided by a morality that was lacking a scientific basis? I argue that they did not lack a scientific basis, but that the basis was a hereditary one: if the population is considered a biological entity, uncontrollable and dangerous biological functions, i.e. sexuality, sexual urge and fertility, are a central concern. In the millennial era, public health government is indeed detached from biology. In effect, to put it crudely, the targeted individuals have gained worth, but seem to have lost their vitality/sexuality in the process of disentangling health government from biology's grip. Instead, the obese child is caught up in stigma and self-stigmatisation, with a body that is merely a frame for accessing the actual governmental object: transforming the mind. From this perspective, it is tempting to argue that the lack of human quality so persistently problematised in the interwar era has simply been internalised at present day: obese children do not lack worth and quality, but quality of life and self-worth. Regardless of whether such causality can be established, what can be concluded is that today, the obese child is asked to engage in the constant activity of self-reflection and self-engineering: health is not forced upon the child; rather, the child is presented with an active choice to be made after having reflected upon his/her health status. The health workers and volunteers' role in this setting is the role of a midwife, providing an environment that nurtures children and makes it easier to make healthy choices.

8.2. BIOPOWER TODAY

A central pursuit has been to investigate preventive health and health promotion as governmental strategies while at the same time contributing to a Foucauldian analytics through a genealogical method. In what follows relate to both the analytical and the methodological contribution. The outline of the analytical contribution centres on placing the findings of the dissertation in relation to a debate within Foucault studies concerning the question of biopower and the role of totalising and individualising technologies respectively. The outline of the methodological contribution centres on the overall question of the critical potential of the dissertation, taking its point of departure in Foucault's notion of parrhesia as a particular kind of truth-claim.

Within Foucault studies questions have been raised as to how to analytically encompass biopower today when the regulative concern with racial quality and a general cleansing of social space is not a key concern. While some argue that individualisation has surpassed totalising ways of governing, others argue that totalising intervention is still very much at work, albeit in more subtle ways.

Nikolas Rose and Poul Rabinow (Rabinow & Rose, 2006; Rose, 2007) point to what they regard as a biopolitical shift in the mid-nineteenth century. The 'macro side' of biopolitics, that is, the regulatory side, mainly took shape during the first half of the twentieth century's development of the welfare states and the subsequent regulation of standard of housing, health campaigns and the like (Rabinow & Rose, 2006: 204). Moreover, biopower is no longer framed in terms of the consequences of the population as an organic whole, as the population is not directed to maximise racial fitness along the lines of eugenics (Ibid. 210).

> There is all the difference in the world between using genetic techniques to diagnose and even select against embryos with Down syndrome or foetal tube syndrome, and seeking to use those techniques to diagnose intelligence and eliminate the 'feebleminded' (Ibid. 211).

Rabinow and Rose thereby argue that public health can be characterised as shifting from totalising technologies to individualising ones, or more precisely technologies aimed at somatic individuals.

Counterarguments have been put forth questioning whether in fact contemporary biopolitics has loosened its grip on the 'old' concern with populations, and thereby whether the totalising element of biopolitics since its heydays in the first half of the twentieth century is less important today. Sujatha Raman and Richard Tutton (2010) argue that the tendency by Rabinow and Rose to emphasise 'molecularisation,' i.e. individualising technologies, over population-centred biopolitics is problematic (Raman & Tutton, 2010: 10-11). What Raman and Tutton suggest is sticking to Michel Foucault's characteristics of the interrelationship between the dual nature of biopower, namely the population-centred and the individual-centred (Ibid. 19). Martin Frandsen and Peter Triantafillou (Frandsen & Triantafillou, 2011) put forth a similar argument. Drawing from a Danish context of public health, they show how population-centred technologies are in fact very much at work at present day. The central argument they pose is that although eugenics' concern with the stock's quality is no longer a central characteristic of contemporary health practice, the population as a whole still forms a central point for health intervention. However, the target today is to ensure people live a healthy and qualitative life (Ibid. 204-5).

In what follows is an attempt to contribute to the question of the role of biopower today. I do this firstly by summarising more thoroughly the findings of biopower as a totalising technology through the notion of human exteriority informed by problematisations of the social body. Secondly, I summarise the findings of biopower as an individualising technology working through notions of human corporeality and interiority and informed by certain problematisations of the human body and mind. I thereby relate to the four sub-questions that have guided the analytical endeavour.

8.3. PREVENTIVE HEALTH AND HEALTH PROMOTION AS A TOTALISING TECHNOLOGY: FROM CLEANSING THE SOCIAL BODY TO CREATING A HEALTH-ENABLING ENVIRONMENT

8.3.1. THE INTERWAR PERIOD

Two modes of problematisation in particular informed the totalising technologies aimed at the population and the social body as a whole. One mode was put forth along the lines of a notion of social space as a vital organism whose vitality depends on demographic equilibrium. The other was put forth along the lines of a concern with the hygiene standards of the immediate environment.

The former mode of problematisation was twofold: firstly, it concerned a physical anthropological preoccupation with the question 'who are the Danes?' This involved establishing the particular characteristics of the Danish race within a worldwide racial taxonomy and as part of the so-called Nordic race. What was interesting here was not so much the placement of the Danish population within a racial category but how this concern amounted to an extensive mapping and biometric measuring of height, weight, eye colour, hair colour and other physical features. In other words, the preoccupation with the Danish race gave way for physical features, bodily appearance and characteristics to become crucial points of reference when questioning the general health of the population; and also when establishing the problem of obesity today. Secondly, linked to this identity project along the lines of physical appearance was a concern with the tainted part of the population, particularly those regarded as feebleminded. The genetic-medico, heredity, psychiatric, physical anthropological, plant physiology and welfare expertise of the day all tapped into this concern. This preoccupation with the feebleminded subpopulation hinged on the idea of a degeneration of the race as tainted individuals were regarded as procreating too fast. One may characterise these problematisations as epistemologically bound to a notion of demographic unbalance that affected the health of the socio-biological whole. The 'sexual question'

additionally connoted a general worry about the spread of venereal diseases and the spread of tainted individuals through their prolificacy. The idea that the quality of the stock was deteriorating placed weight on a question of how to confront the problematic effects of sexual urge, sexual excess and the spread of venereal diseases; all concerns that established a correlation between the spread of tainted individuals and the deterioration of the human stock.

The other mode of problematisation aimed at the immediate environment. In particular hygiene expertise and nursing expertise, but medical and welfare expertise as well, expressed a concern with the increase in neonatal deaths, tuberculosis, poverty and lack of proper hygiene in families, including bad diet and inappropriate child rearing. This mode of problematising placed attention on the family environment, and thus its nature was distinct from the concern with the general quality of the race. It did not hinge on an idea of a racial totality that was in decline due to a demographic imbalance, but instead on economic and parental shortcomings. While these problematisations of the home environment constituted a completely different approach to human exteriority, they simultaneously addressed not procreation and reproduction as a focal point, but parenthood and family dynamics.

Informed by the above-mentioned problematisations, three central technologies targeted human exteriority: technologies of eugenics, technologies of welfare and technologies of constructive hygiene. The relationship formed between welfare and eugenics is a somewhat tricky one: eugenics provided the means for decreasing the number of tainted individuals while at the same time curbing their fertility and ability to procreate, mostly through abortion and sterilisation. Welfare technologies both provided the means to detect, regulate, confront and segregate the tainted individuals, for instance by installing school practitioners in public schools and by encouraging particular individuals in workplaces to identify the feebleminded and report them to public authorities. Likewise procedures for institutionalisation of the feebleminded were carried out, along with matrimonial restrictions for genetically exposed individuals. At the same time, however, welfare

technologies aimed at securing the welfare of these tainted individuals: they were not allowed to procreate and dwell among the rest of the population, but they did have the right to live a decent life.

The pairing of constructive hygiene and welfare was a distinctly different technology: health promoting rather than a preventive strategy; i.e. constructive hygiene was promoted to *construct* hygiene. Some nurses took up the new role of health visitors, gaining expertise in how to create a proper home environment and taking on the authority to ensure the family home was turned into a health-enabling environment. The mother in particular was given responsibility to secure the health of her children through proper diet and child rearing and by keeping the home clean and fresh. She was simultaneously given authority as a health provider. The type of health promotion that was at stake installed within the very heart of the family a health unit and the home was targeted as a potentially health-enabling environment. A health promoting strategy was at stake that ameliorated family and social relations as such, bringing relations between mother and child, other household relations, and relations between health expertise and family all into tune with health.

8.3.2. THE MILLENNIAL PERIOD

Problematisations of human exteriority, in terms of the spread of obesity, first and foremost tapped into a notion of vulnerability. Medical expertise, nutrition expertise, public health authorities and government authorities all addressed the rise of obesity as a burden on the national economy due to early retirement and extra health expenses for treatment of other weight-related conditions like diabetes type 2 and osteoarthritis. Terms such as 'obesity epidemics', 'accumulation of risk factors' and 'disease burden' stressed the seriousness of obesity in terms of the general population and the burden that it placed upon the population, along with international organisations' warnings of the rise of obesity worldwide. The WHO, for instance, concluded that obesity had reached such a proportion in the developed world that just after smoking it was the most important cause of preventable death. In

addition, the number of obese children was identified as increasing at high speed: an increase that had been taking place from the mid-1990s.

Firstly, obesity was defined and identified through a biometric taxonomy used by health visitors, school nurses and other health professionals. The so-called BMI parameter – the sum of weight and height in the second – was a primary biometric tool, with a BMI above 30 indicated obesity, but other biometric standards were used for a classification of obesity. For instance, some government strategies for fighting obesity adopted the term 'thin fat', identifying those individuals who may have had a BMI under 30 but whose fat percentage was nevertheless too high. The idea of obesity as a phenomenon that was not necessarily obvious to the naked eye was emphasised by health visitors in their reporting on schoolchildren's health. Thus, although there were established biometric standards for obesity, at the same time it was a somewhat flexible category.

Apart from children and young people, individuals from the lower end of the social ladder, that is, those with the shortest education, lowest salaries and least skilled jobs were identified as more prone to obesity. One explanation of child obesity, then, was that fat children came from dysfunctional families, which predisposed them to both the risk of obesity and a stagnation – or even downward slide – in social status.

Informed by the concern with the spread of obesity, a central technology targeting the population as a whole and children in particular was mapping, weighing and measuring. The so-called *KRAM* factors (diet, smoking, alcohol and exercise) constituted the point of departure for physical examinations such as blood pressure, pulse, waistline, hipline, height, weight, lung function, bone mineral density, muscular strength, balance, level of physical fitness and tests on blood samples. Thousands of citizens were asked to fill out questionnaires regarding their health and various public actors were involved. A children's electronic case record system was formed, which included health visitor reports on whether the child had been exposed to passive smoking and details of its nutrition in the first four months of its life. Data from existing surveys

published by municipalities were also taken into account, covering data of the child's weight and height from birth to the end of school as well as data from the GP's general examinations, which all children were subjected to.

Notwithstanding the fact that the collection of data was an objectifying practice – measuring of bodies according to given standards – self-estimated health measures were also included. The children and young people participating were asked to judge their own health state, reflect upon which health habits they engaged in and how their lifestyle affected their health. Hence, subjectifying practices constituted a central means in the collection of biometric data.

Apart from mapping and measuring, health administration in the form of NC was another crucial technology for targeting human exteriority. While technologies aimed at reducing social inequality – such as securing proper housing or offering social benefits – were incorporated to a small extent as a means of fighting obesity in preventive health and health promoting strategies, it was mostly collaborative networking that offered itself as a solution to social inequality. The techniques were not socio-economic but rather empowerment techniques targeting primarily the self-governing capacities of both administrative units and selected individuals and families. The formation of NC can be seen as a particular way of governing the social body with the purpose of installing within health administration a health-enabling environment that made it easier for individuals to make healthier choices. It is a kind of administrative practice aimed at activating each unit and actor within health administration towards a common goal: health.

This was also the case in terms of technologies targeting human exteriority through the immediate environment. I argue that the concept of 'immediate environment' was extended from the home and family members to include all the health professionals in direct contact with the children targeted.

First, the family: in recalling *problematisations*, the household was on the one hand regarded as a risky environment as it was the source of the child's unhealthy state. On the other hand, the family was a potential health unit, able to secure the health of the child. It is in light of this ambiguity that the technologies targeting the family sought a transformation towards a healthy environment. However, this transformation was put forth in a positive light. With appreciation as a central notion, intervention towards the family fed into empowerment strategies, just as in the case of intervention towards the individual. The family was not exposed in a negative light, but was asked to positively make a change. A key for this transformation was self-reflection. The technologies then aimed at nurturing the family's self-engineering and self-reflective potential.

Second, the health professional setting: during the interwar era, when children and young people were targeted as *objects* of health promotion, their environment did not nurture self-reflection and self-engineering. In the millennial period, the health professionals themselves were *subjected* to the same technologies as the children and the young people targeted by the intervention; they were to become agents of appreciation, play and creativity. In addition, they were to nurture the playful and creative nature of the children and young people targeted by nurturing it within themselves and each other, creating a positive environment, embracing a positive mindset and engaging in an open-minded manner.

Hence, the child's immediate environment, both familial and health professional environment, was targeted for transformation into a conducive environment – one that facilitated positive change, self-reflection, happiness and health.

In light of the above-mentioned debate, rather than asking to what extent totalising technologies of the early twentieth century were still in play by the turn of millennium, the focus is on exactly how these two interacted and found new forms of relations, carving out a new governmental space. I argue that a *qualitative* dislocation took place vis-

à-vis the relationship between totalising and individualising technologies. In the interwar era, the development of the welfare state and social services were promoted as a kind of preventive health to secure the quality of the race and the social space in its totality. Likewise, an emphasis was placed on medicine in particular as a social practice, in terms of its role in providing better living conditions for the population and increasing the general welfare. This promotion of *social* medicine encompassed a variety of associations that had social practice at the heart of their work. Even the names of these associations or groups formed indicate the emphasis on the social: *Danish Association for Social Education*, *the Social Secretary*, *Social-Political Association* and *Society's Demand*. This wide-ranging activation of the *social* in the 1920s and 1930s had changed by the turn of the millennium, where the social was more an effect, a passive entity. The social body was problematised not as a dangerous environment but social stratum prevented the individual from making the proper choices in terms of health. The population was no longer on the verge of deterioration due to bad elements, but seemed to be jeopardising the social itself – i.e. economic and social welfare – through its burden on health expenses. Accordingly, preventive health was promoted as a way to secure those very welfare services rather than the population as such, according to the following logic: promoting health could decrease social and public health expenses and thereby lighten the burden placed on welfare services by unhealthy individuals. The social was no longer understood as a biological entity whose vitality had to be secured. Instead it referred to a social network activating social relations at as many levels of society as possible. From this perspective, what was aimed at was not a strong race but a healthy population that was constantly engaged in making healthy choices.

Can it then be concluded that health promotion has turned into an individualised undertaking at the expense of social measures? I think that would be an oversimplification. Despite the fact that obesity was directly linked to a 'bad' social environment, social means, such as better housing conditions and welfare services, seem less prioritised. Instead, NC secured a health-enabling environment at several levels of human

life – family, school and the health administration itself. However, I claim that NC in fact is a social technology: one that, instead of ameliorating the social through economic and social means, ameliorates the social through the transformation of human relations along the lines of administration. If constructive hygiene in the 1930s, with the introduction of the health visitor, was a social practice that targeted family members through a transformation of their familial relations, then NC's installation of a health-enabling environment at all levels, too, is a social practice; one that transforms the relations not only between family members (offering new vocabularies and modes of bringing up children) but also between schoolteachers and children, health professionals and children, health professionals in their interaction with each other, children in their interaction with each other and so forth.

In theoretical terms, to place collaborative networking within the sphere of government rather than envisaging it as merely an administrative (a-political) tool, I take into account Foucault's notion of the *governmentalisation of the state* along with Mitchell Dean's elaboration of *the governmentalisation of government* and *reflexive government*. Additionally, Guy Petersen's notion of *ethical administration* and Peter Triantafillou's notion of *self-regulating* administration all illustrate how this expansion of government also includes administration as such. I then suggest that the totalising aspect of biopower has gained a new characteristic. Through health administration a countless number of health units have been installed on social space – ranging from the health visitor in the home to the gymnastic instructor at a camp for obese children – and thus it can be seen as a totalising technology. However, on the other hand, that same NC is an individualising technology in the sense that it nurtures the self-reflecting and self-engineering capacities of both the obese child and the health expertise targeting the child. Following in the footsteps of these conceptualisations, the term *governmentalisation of administration* throws new light on NC as a totalising technology: one that operates through and by virtue of individualising technologies of the self, namely self-reflection and self-engineering. Put simply, NC is an operation on

the exteriority by means of an individualising technology that in effect promotes a totality.

Thus, by turning down or devaluing the totalising aspect of biopower and referring to its anachronistic nature (installation of sewerage, social housing and the like) one misses out on a crucial aspect of neoliberal government today: the promotion of a health-enabling environment.

8.4. PREVENTIVE HEALTH AND HEALTH PROMOTION AS AN INDIVIDUALISING TECHNOLOGY: FROM CREATING A STRONG BODILY AND MORAL CONSTITUTION TO NURTURING SELF-STEERING CAPACITIES

8.4.1. THE INTERWAR SETTING

Problematisations of human corporeality were aimed mostly at young people, who were seen as generally weak and lacking physical and mental strength. The notion of heredity with regard to the individual body was followed by the question of the relationship between heredity and environment: to what extent is human appearance and behaviour a result of hereditary elements and to what extent environment? Regardless of disagreement among heredity scientists as well as medical, gymnastics and anthropological expertise, what most of them did agree upon was that bodily appearance to a large extent was a symptom of the mental and moral makeup of the individual. In addition, young people's weak appearance, pale looks and defective posture were seen as indicators of their moral and mental characteristics. While the notion of the 'sexual question' was raised to problematise tainted individuals, it was also raised when problematising the corporeal and mental deterioration of young bodies. Masturbation was considered an evil in this matter as a direct correlation was claimed between masturbation practices and bodily defects, such as a weak, crooked body. With this followed an idea of a weak body pointing to a weak mind and vice versa, a strong body being symptomatic of a strong mind. Along these lines, the health of individual bodies would accordingly be symptomatic of the health of the nation and the race as such. A link then was established

between the individual body and mind on the one hand and the population on the other, in the sense that this general bodily and moral weakness of the future generation could cause a general weakness of the race as such.

Constructive hygiene was a kind of health promotion that – apart from targeting the families – had its point of departure in the nurturing of young people's physical and mental strength. A central means was gymnastics and physical exercise along with keeping clean and maintaining bodily hygiene. By placing the corporeality of particularly the youth at the centre of attention, these health promoting technologies made the individual the object of health and it was the young person's way of living, eating, sleeping and doing exercise that was given prominence. Although a health *promotion*, and thus, distinct from the heredity kind of preventive health, it nevertheless still tapped into eugenics, providing an alternative answer to the problem of the decreasing quality of the race. Hence, these health promoting technologies – albeit qualitatively different from the preventive technologies of negative eugenics – were a kind of positive eugenics. While abortion and sterilisation, along with institutionalisation of the tainted individuals, offered itself as a eugenic solution to a eugenic problem, namely the deterioration of the race, so did gymnastics and physical exercise among the young generation. But while heredity science only gave way for negative eugenic technologies, gymnastics allowed for a positive eugenics, not on the basis of a heredity rationality but by ameliorating human corporeality. And, at the same time, gymnastics offered itself as an alternative solution to the 'sexual question': one that, instead of arresting the fertility and the sexual drive of the tainted individuals, in fact nurtured the vitality of the youth, both through strengthening their physique and through bringing about mental tranquillity by offering an outlet for uncontrolled and amoral desires. While this latter type of constructive hygiene was not governmentalised, it nevertheless can be seen as having informed today's focus on fitness and movement in the fight against obesity, albeit disentangled from a eugenic epistemology.

8.4.2. THE MILLENIAL SETTING

Problematisations of the individual were put forth along the lines of the notion of vulnerability: a vulnerability that can be divided into somatic, lifestyle-related and psychosocial vulnerability.

The linking of vulnerability and obesity along the lines of a somatic problem was made through a linking of obesity and a number of illnesses. One was diabetes type 2, the argument being that the risk of the disease increases alongside an increase in a person's BMI. In addition, the so-called metabolic syndrome – which indicated the presence of a number of components that together increase the risk of cardiovascular disease – was also directly linked to obesity. Finally, it included some types of cancer, osteoarthritis, hormone and fertility disturbances in women, lung problems and in general a risk of reduced life expectancy.

As to the linking of obesity and lifestyle, a central argument put forth was that modern life as such constituted a risk factor, in terms of a general lack of physical activity in everyday life, too much sitting in front of the TV or the computer combined with a diet with a high energy density and a high occurrence of sugar and fat.

Finally, a link was established between obesity and psychosocial problems. Particularly among children an argument presented was that stigmatisation and self-stigmatisation are effects of obesity and vice versa. Obese individuals were generally perceived as psychologically and socially vulnerable, insecure, lacking self-esteem, isolated, depressed and anxious. Trapped in a vicious circle, obese children were bullied and excluded from the community. This vulnerability in turn made them prone to so-called lifestyle temptations, such as fattening food. Consequently, obese children were more likely to drop out of school and get bad grades. The risk group also included children who were not necessarily obese but in a category termed 'sports insecure', in other words physically inactive as well as socially and psychologically vulnerable.

While in the interwar era a question was raised as to what extent the individual was a product of his/her heredity, at the turn of the millennium a notion of social heredity was emphasised. This included the parents' lack of responsiveness to their children's needs, lack of protection, support and parenting style. All these factors were seen as crucial for the child's development of cognitive skills and educational level. Hence, social heritage and family environment were seen as posing a risk to the child in three aspects: somatic – making the child prone to obesity; social – decreasing the child's chances for upward social mobility; and psychological in terms of self-stigmatisation and low self-esteem.

With regard to the government technologies put forth, although obesity at first presented itself as a bodily condition, the main targets of the health promoting technologies were the obese child's mindset, and mode of thinking and reflecting. The child was not in need of a disciplining of the body in order to come to confront lewd and immoral ideas and practices as in the interwar era. Instead, health promoting technologies aimed at installing within the child capacities for self-reflection and self-engineering. Although the targeted children were encouraged to lose weight, engage in physical exercise and change their eating habits, what was really at stake was a gentle enticement to engage in a constant self-reflective practice along the line of how to become a healthier being. In this way, the obese child was equally the target and the means of health transformation, not by following a particular regime of exercise or by being subjected to particular authorities, but by constantly engaging in a self-reflecting and self-governing practice. Measurements were put forth only in so far as the child was actively participating in self-estimation of risks and possible solutions. Hence, government of health was primarily rendered technical along lines of empowerment techniques, creating not only a particular relation to the obese child and the health professionals but also a particular gaze and mode of acting upon himself/herself. The bodies of the 1920s and 1930s that were objectivised into strong bodies no longer played a prominent part in government. In the millennial setting, the mind was at the centre of attention. Techniques of self-

estimation and empowerment – even when identifying somatic conditions such as obesity – seemed to be a primary means as well as end in millennial preventive health. From this perspective, the body merely became a point of entry, so to speak, for the actual governmental workings: the steering and nurturing of the individual's capacities. And it is also in this light that NC can be seen as providing the proper social setting for effectively rendering human interiority amenable to government. Put differently, the passive, obese body was the point of departure for engendering an active, self-reflective and self-engineering being.

Further, the interwar era's sexual administration of lewd behaviour (masturbation) as a key component in the promotion of a physical culture was completely absent in the later era. The targeted individual was no longer sexually problematic or potentially lacking the ability to administer his/her sexual urge. One may say that the object of intervention went from an individual being too vital, acting out its rampant vitality uncontrollably, to an individual who had lost a vital spark and had become dull and passive. Accordingly, the individual body subjected to preventive health technologies was no longer identified as weak or degenerate but as unhealthy and risky. Similarly, the body was not a symptom of bad (sexual) morality but a symptom of passivity and lack of self-reflection. Subjectifying technologies were the key measures at work, promoted as both a means and an end: self-reflection and self-government were techniques used in health promotion and also the effect: a self-reflective and self-governing individual. Put simply, the body could only be activated through the mind, through a will to health.

8.5. HOW TO CRITICISE? – THE DISSERTATION'S TRUTH-CLAIM

A central methodological bearing of the genealogical take on government is that government implies identifying its objects through a number of problematisations. These modes of rendered human beings and their surroundings into a problem inform the governmental technologies. Accordingly, investigating preventive health and health promotion in the

interwar era along the lines of problematisation was a fairly straightforward task as the very vocabulary was explicitly negative. Notions such as 'low quality', 'lack of worth', 'minus people', 'lewd' and the like emphasised the problematic nature of the targeted groups and individuals. The opposite, however, was the case in the millennial era. While obese children were indeed targeted, they were not explicitly problematised. Instead, positive notions, such as 'appreciation', 'open-minded', 'value-setting conversation' and 'positive attitude', infused the health promoting setting. In other words, a governmental site was formed in which government refused to problematise the targeted individuals. This rejection of a vocabulary of problematisation, while also rejecting government itself, is in fact a central point in the method of *Appreciative Inquiry* which was used by health professionals, both when approaching obese children and their families and when training parents in how to engage with their obese child. As stated by the key inventor of Appreciative Inquiry, David Cooperrider:

> In problem solving it is assumed that something is broken, fragmented, not whole, and that it needs to be fixed. Thus the function of problem solving is to integrate, stabilise, and help raise to its full potential the workings of the status. By definition, a problem implies that one already has knowledge of what "should be" [...] In this sense, problem solving tends to be inherently conservative; as a form of research it tends to produce and reproduce a universe of knowledge that remains sealed (Cooperrider & Srivastva, 1987: 19).

If a crucial methodological premise guiding a genealogical analysis assumes that intervention involves problematisations of the ones targeted, what to do when intervention *refuses* to problematise? A possibility is to turn this methodological challenge into an analytical keynote: when a problem is not clearly defined, neither is the object of intervention. Accordingly, intervention is difficult to detect and confront. In other words, contemporary health promotion is a setting that enables solutions in the form of human transformation without dwelling on problems – only the constant possibility of change. It is as if health promoting government – maybe as an outcome of self-reflection itself – has become ashamed of governing the objects of government; as if government justifies itself only in so far as it is linked to *self*-government. In a constant evaluating practice, health promoting

government has become a looping of self-government: "*I govern you only in so far as you govern yourself*"; "*I govern you only in so far as I govern myself too*"; "*I govern you only in so far as government governs itself too*".

Along with the notion of problematisation, a central argument throughout the dissertation has been that health government informs modes of being human with regard to exteriority, corporeality and interiority. Whether or not these formations are successfully installed has not been a central concern. Instead, a point has been to elaborate on the *effects* of the ways preventive health has been epistemologically grounded and technologically carried out through and by virtue of human beings and the social setting in which they are placed.

The focus on technology implies a methodological distancing from those social scientific and sociological analyses that fall prey to power as linked to ideology while indirectly suggesting that the less ideology the more truth. The methodological distancing thus entails a claim that it is not the productivity of power as such that is the object of scepticism (is power only productive? When does power reveal itself to be domination?), but instead how power produces subjects, desires and feelings by means of scientific alliances. On the other hand, by emphasising technology, I do not proclaim power-knowledge relations to be a (social) *construction* (Butler, 1990; Grosz, 1994). A constructionist take draws its methodological take-off from a *reaction* against naturalisations of human characteristics, societal elements, and the like. Consequently, construction, instead of nature, is accorded *a priori* status. By replacing nature with construction, one kind of normativity is replaced by another (cf. Vucina & Triantafillou, 2009). Moreover, constructionism seems to obtain a somewhat frivolous attitude towards reality, implying that reality is *just* a construction: "*now that I have showed what power-knowledge relations you are shaped by, you are free to detach yourself from them*".

From this vantage point, taking into account technology as a methodological prerequisite implies a tricky balance between a notion of power-knowledge relations as in fact producing *real* effects, and thereby constituting reality, without either bowing to the laws of nature or reducing it to a mere error, illusion, construction, alienated consciousness, or ideology (Foucault, 2000g: 133). It is through this balance that genealogy offers a materialism both to historical and contemporary analyses: "*Truth isn't outside power or lacking in power […] truth is a thing of this world*" (Ibid. 131). Accordingly, it is through this exercise that this dissertation's genealogical analysis presents its truth-claim.

> Under no circumstances should one pay attention to those who tell one: "Don't criticise, since you're not capable of carrying out a reform." That's ministerial cabinet talk. Critique doesn't have to be the premise of a deduction that concludes, "this, then, is what needs to be done." It should be an instrument for those who fight, those who resist and refuse what is. Its use should be in processes of conflict and confrontation, essays in refusal. It doesn't have to lay down the law for the law. It isn't a stage in a programming. It is a challenge directed to what is (Ibid. 2000d: 236).

If *problematisation of problematisation* points to the researcher's role when engaging in genealogical undertakings, a question can be raised as to the researcher's role in the production of truth. Put differently, if a central concern in genealogy is to illuminate and thereby critically question science's role in the production of truth, what about the researcher's engagement in the same production of truth?

While the investigation of modes of knowing offers a way of understanding how knowledge is connected to forms of truth through expertise, truth-claims also have a critical bearing by offering an ethical stand for the researcher.

In his historical account of *parrhesia*, Foucault investigates the formation of the ancient practice of truth-telling, i.e. forms of 'veridiction' (Ibid. 2010: 41-42, 350). Throughout history, truth-telling appears in various formations, from being primarily an ethical practice concerned with the freedom to tell the truth and the courage to bind

oneself to the truth to the extent of risking one's life (Ibid. 66), to a moral guidance of governments according to the state's nature (Ibid. 206, 213). According to Foucault, parrhesia enters a relationship with government through political intervention, when the parrhesia speaker attempts to exercise ascendancy over others (Ibid. 318). Truth-telling thereby forms a relationship with politics as it becomes technical, more precisely by being transformed into a rhetoric enterprise (Ibid. 301, 309). From this perspective, the genealogical interest in power's intimate link to knowledge, particularly scientific knowledge, is in fact an interest in the dubious pairing of power as a secular and positive enterprise and the governmentalisation of truth-telling. While providing an account of various modes of truth-telling, one may see Foucault's elaboration of parrhesia as an attempt to provide an archaeology of critique as a normative evaluation of political programmes; a mode of criticism that is often found within social studies (cf. the Introduction). Concurrently, the very mode of engaging in criticism by normatively evaluating politics and political programmes can then be seen as a looping of this governmentalisation of truth-telling.

The genealogical undertaking in this dissertation has offered a diagnosis of a relatively small area of public health as a governmental practice and has thereby put forth a truth-claim: government through health at the turn of the millennium was epistemologically and technically shaped through an incitement to self-reflect and self-govern; an incitement informed by the first half of the twentieth century's creation of a welfare state through the dual concern with how to cleanse the social body of tainted individuals and how to promote hygiene in the home along with a general promotion of a body culture. It is a truth-claim that insists on bringing to light the kinds of power-knowledge-ethics relations informing beings as prone to government. However, it is a form of critique that cannot and does not strive to become entangled within political strategies, either by offering particular solutions to particular problems or by devaluing politics as such. Instead, by illuminating existing power-knowledge-ethics relations, the critique offered attempts to unshackle the firm grip between power and ethics, i.e. the linking of government and self-government. The ethical dimension of this

endeavour is to insist that ethics as a particular relationship with oneself can have many other forms and can be exercised along many other avenues than the ones power offers.

ENCLOSURE

Afrapportering af survey-resultater

I alt: 50 respondenter ud af 98 adspurgte
Svarprocent: 51%

1 Hvor mange har indgået partnerskaber som led i den borgerrettede sundhedsfremme?

- Har igangværende aftale eller har før indgået partnerskaber som led i den borgerrettede sundhedsfremme: **37** [**74%**]
- Har aldrig indgået aftale og har ingen planer om at indgå én i 2010: **13** [**26%**]

- Har igangværende aftale: **33** [**66%**]
- Har hverken igangværende aftaler eller planer om at indgå aftaler i 2010: **17** [**34%**]
    - Har hverken igangværende eller planer om at indgå aftaler i 2010 men har før indgået aftale: **4** [**8%**]

2 Hvor mange har indgået aftale i 2010?

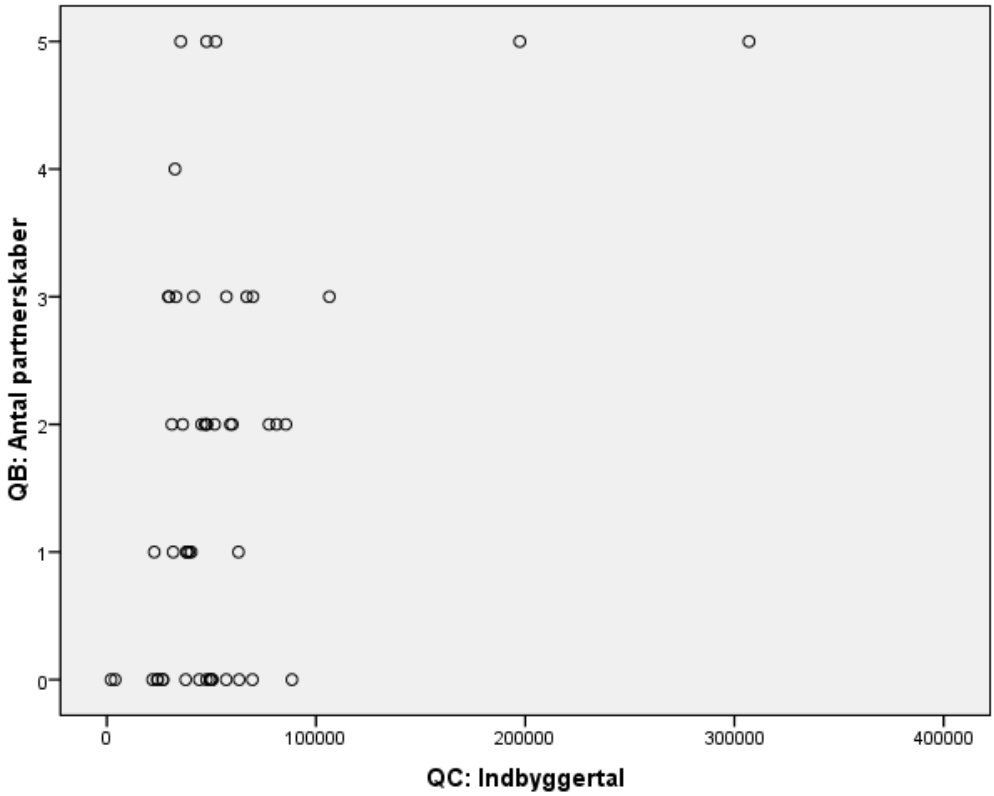
- Har indgået aftale i 2010 eller har planer om at indgå aftale i 2010: **12** [**24%** af alle kommuner, **36%** af alle kommuner med igangværende aftaler]
    - Har indgået aftale i 2010: **8**
      [**16%** af alle kommuner, **24%** af alle kommuner med aftaler]
      NB: Alle, der har indgået aftale i 2010, har igangværende aftaler fra tidligere.
    - Har planer om at indgå aftale i 2010: **4**
      [**8%** af alle kommuner, **12%** af alle kommuner med aftaler]

NB: Alle, der har planer om at indgå aftale i 2010, har allerede igangværende aftaler.

- Har igangværende aftale men har ikke indgået aftale i 2010: **21** [**42%** af alle kommuner, **64%** af alle kommuner med igangværende aftaler]

3 Er der sammenhæng mellem kommunestørrelse og antal partnerskaber?

Der kan ikke identificeres nogen klar sammenhæng mellem kommunestørrelse og antal partnerskaber.



4 Er der dele af landet, hvor kommunerne er mere aktive med at indgå partnerskaber?

Ja, kommunerne i Region Sjælland, Nordjylland og Syddanmark ligger over gennemsnittet, mens kommunerne i Region Midtjylland og Hovedstaden ligger under. Der synes dog ikke at være betydelige udsving (se skema).

Region	Gennemsnitligt antal partnerskaber	N	Std. Deviation
Sjælland	2,08	13	1,553
Nordjylland	1,83	6	1,941
Syddanmark	1,78	9	1,716
Midtjylland	1,50	8	1,773
Hovedstaden	1,29	14	1,490
Total	1,68	50	1,609

5 Er der sammenhæng mellem borgmesterparti og antal partnerskaber?

Kommuner med en socialdemokratisk borgmester har gennemsnitligt godt to partnerskaber, kommuner med en borgmester fra Venstre har gennemsnitligt cirka halvandet partnerskaber, mens kommuner med en borgmester fra Konservative, SF eller lokalliste gennemsnitligt har under 1 partnerskab etableret.

Borgmesterparti	Mean	N	Std. Deviation
S	2,07	29	1,710
V	1,46	13	1,391
K	,80	5	1,304
Lokalliste	,50	2	,707
SF	,00	1	.
Total	1,68	50	1,609

6 Hvordan er fordelingen på landsplan mht. typer af sundhedsfremmende foranstaltninger?

Der er for få respondenter til at kunne udtale sig om dette.

7 Med hvilke typer organisationer er der typisk indgået partnerskab?

7.1 Hvor mange kommuner har indgået partnerskab med:

*A. Sports- eller idrætsorganisationer: **18** kommuner [**36%** af alle kommuner, **55%** af alle kommuner med igangværende partnerskaber]*

*B. Patientforeninger: **18** kommuner [**36%** af alle kommuner, **55%** af alle kommuner med igangværende partnerskaber]*

*C. Sundhedsfremmende organisationer: **7** kommuner [**14%** af alle kommuner, **21%** af alle kommuner med igangværende partnerskaber]*

*D. Andre organisationer end de ovenfor nævnte: **25** kommuner [**50%** af alle kommuner, **76%** af alle kommuner med igangværende partnerskaber]*
NB: Se Q5_X, Q12_X, Q19_X, Q26_X og Q33_X i datasættet for kvalitative beskrivelser heraf.

7.2 Hvor mange partnerskaber ud af de 96 partnerskaber, som er blevet opgivet i surveyen, er indgået med:

*a. Sports- eller idrætsorganisationer: **21** partnerskaber [**23%**]*

*b. Patientforeninger: **21** partnerskaber [**22%**]*

*c. Sundhedsfremmende organisationer: **9** partnerskaber [**9%**]*

*d. Andre organisationer end de ovenfor nævnte: **45** partnerskaber [**47%**]*
NB: Se Q5_X, Q12_X, Q19_X, Q26_X og Q33_X i datasættet for kvalitative beskrivelser heraf.

8 Hvem er de typiske målgrupper?

8.1 Hvor mange kommuner har et eller flere partnerskaber rettet mod:

A. *Overvægtige/inaktive voksne: **20** kommuner [**40%** af alle kommuner, **60%** af alle kommuner med igangværende partnerskaber]*

B. *Overvægtige/inaktive børn: **15** kommuner [**30%** af alle kommuner, **45%** af alle kommuner med igangværende partnerskaber]*

C. *Rygere: **17** kommuner [**34%** af alle kommuner, **55%** af alle kommuner med igangværende partnerskaber]*

D. *Alkoholikere/misbrugere: **4** kommuner [**8%** af alle kommuner, **12%** af alle kommuner med igangværende partnerskaber]*

E. *Etniske grupper: **5** kommuner [**10%** af alle kommuner, 15**%** af alle kommuner med igangværende partnerskaber]*

F. *Socialt udsat(te) gruppe(r): **11** kommuner [**22%** af alle kommuner, 33**%** af alle kommuner med igangværende partnerskaber]*

G. *Andre grupper end de ovenfor nævnte: **16** kommuner [**32%** af alle kommuner, **48%** af alle kommuner med igangværende partnerskaber]*
NB: Se Q7_X, Q14_X, Q21_X, Q28_X og Q35_X i datasættet for kvalitative beskrivelser heraf.

8.2 Hvor mange partnerskaber ud af de 96 partnerskaber, som er blevet opgivet i surveyen, er rettet mod:

*a. Overvægtige/inaktive voksne: **23** partnerskaber [**24%**]*

*b. Overvægtige/inaktive børn: **16** partnerskaber [**17%**]*

*c. Rygere: **17** partnerskaber [**18%**]*

*d. Alkoholikere/misbrugere: **4** partnerskaber [**4%**]*

*e. Etniske grupper: **8** partnerskaber [**8%**]*

*f. Socialt udsat(te) gruppe(r): **16** partnerskaber [**17%**]*

*g. Andre grupper end de ovenfor nævnte: **18** partnerskaber [**19%**]*

NB: Se Q7_X, Q14_X, Q21_X, Q28_X og Q35_X i datasættet for kvalitative beskrivelser heraf.

9 Hvilke former for sundhedsfremmende foranstaltninger er de typiske?

9.1 Hvor mange kommuner har partnerskaber, der beskæftiger sig med:

A. *Alkohol/misbrug: **5** kommuner [**10%** af alle kommuner, **15%** af alle kommuner med igangværende partnerskaber]*

B. *Rygning: **17** kommuner [**34%** af alle kommuner, **52%** af alle kommuner med igangværende partnerskaber]*

C. *Fysisk aktivitet: **26** kommuner [**52%** af alle kommuner, **60%** af alle kommuner med igangværende partnerskaber]*

*D. Mad/ernæring: **8** kommuner [**16%** af alle kommuner, **24%** af alle kommuner med igangværende partnerskaber]*

*E. Andre indsatstyper end de ovenfor nævnte: **19** kommuner [**38%** af alle kommuner, **58%** af alle kommuner med igangværende partnerskaber]*
NB: Se Q6_X, Q13_X, Q20_X, Q27_X og Q34_X i datasættet for kvalitative beskrivelser heraf.

9.2 Hvor mange partnerskaber ud af de 96 partnerskaber, som er blevet opgivet i surveyen, beskæftiger sig med:

a. *Alkohol/misbrug:* ***5*** *partnerskaber* ***[5%]***

b. *Rygning:* ***17*** *partnerskaber* ***[18%]***

c. *Fysisk aktivitet:* ***38*** *partnerskaber* ***[40%]***

d. *Mad/ernæring:* ***10*** *partnerskaber* ***[10%]***

e. *Andre indsatstyper end de ovenfor nævnte:* ***31*** *partnerskaber* ***[32%]***
NB: Se Q6_X, Q13_X, Q20_X, Q27_X og Q34_X i datasættet for kvalitative beskrivelser heraf.

LITERATURE

Aggebo (1940), Review of Henning Højrup "Fangen, vort medmenneske", *Ugeskrift for Læger*, February 8, 102 (6): 172.

Den alm. danske lægeforenings hygiejnekomite (1940) 'Profylaktisk lægegerning', *Ugeskrift for Læger*, August 22, 102 (34): 876-86.

Den alm. danske lægeforenings hygiejnekomite (1942a) 'Betænkning angående en skolelægeordning', *Ugeskrift for Læger*, July 16, 104 (29): 758-60.

Den alm. danske lægeforenings hygiejnekomite (1942b) *Lidt om behandlingen af sindssygdomme i Danmark*, in collaboration with psychiatrists and Landsforeningen til sindssygdommenes bekæmpelse, Den alm. danske lægeforenings hygiejnekomite.

Den alm. danske lægeforenings hygiejnekomite (1943) 'Hygiejnekomiteens betænkning angående tuberkulosebekæmpelse' *Ugeskrift for Læger*, July 15, 105 (28): 717.

Den alm. danske lægeforenings hygiejnekomite & Dansk Forening til Kønssygdommenes Bekæmpelse (1945) *'Gonorre og syfilis'*, Copenhagen: J. H. Schultz Universitets-Bogtrykkeri.

Den alm. danske lægeforenings hygiejnekomites udvalg for svangerskabs- og børnehygiejne (1937), 'Kosten i barnealderen, med særligt henblik på spædbørnskosten', Standard lecture, Kuhn, Johan (ed.) *Ugeskrift for Læger*, April 29, 17: 464-70.

Alstrup, Kaj & Th. Bøgelund (1931) 'Skolebørns sundhedstilstand og dens indflydelse på skolens resultater', *Ugeskrift for Læger*, April 16, 93 (16): 428-32.

Andersen, A., Schaumburg-Müller & Kuhn (1936) 'Skolelægesagen', *Ugeskrift for Læger*, April 23, 98 (17): 382-84.

Andersen, Niels Åkerstrøm (2009) *Power at Play – The Relationships between Play, Work and Governance,* London: Palgrave Macmillan.

Anthonisen, Harald (1933) 'Sporten – rekorden', *Ugeskrift for Læger*, July 27, 93 (30): 831.

Den Antropologiske Komite (1911) *Meddelelser om Danmarks Antropologi 1907-1911*, Vol. 1, Copenhagen: G. E. C. Gad's Forlag.

Den Antropologiske Komite (1928) *Meddelelser om Danmarks Antropologi 1920-1928*, Vol. 2, Copenhagen: G. E. C. Gad's Forlag.

Den Antropologiske Komite (1932) *Meddelelser om Danmarks Antropologi 1920-1928*, Vol. 3, Copenhagen: G. E. C. Gad's Forlag.

Arffman, Andre (1928) 'Tuberkulosearbejdet i marken', *Samfundets krav*, July 19, 19 (7): 140-45.

Armstrong, David (2009) 'Origins of the Problem of Health-related Behaviours: A genealogical Study', *Social Studies of Science*, December, pp. 909-926.

Baldwin, Peter (1999) *Contagion and the State in Europe, 1830-1930*, Cambridge: University Press.

Baldwin, Peter (2006) *Disease and Democracy. The Industrialized World Faces AIDS,* Berkeley, Los Angeles, London: University of California Press.

Bardenfleth, K. S. (1932) 'Samsøs anthropologi', *Den Antropologiske Komite 1929-1932*, pp. 1-58.

Bergmann, H. (1926) 'Samfundshygiejne og den praktiserende læge', *Ugeskrift for Læger*, July 22, 88 (29): 683-84.

Bergtrup-Hansen, T. H. (1939) Litteraturanmeldese af Knud Faber: "Tuberkulose og ernæring", *Ugeskrift for Læger*, March 24, 100 (12): 313-16.

Bertram, Agnete (1932) *Naturlig gymnastik for kvinder - Midler og metode*, Copenhagen: Fr. Bagges Kgl. Hofbygtrykkeri.

Bevir, Mark (2010) *Democratic Governance,* Princeton and Oxford: Princeton University Press.

Bibliotek for læger (1890) Review: Sigfred Levy: "Skjævheden hos pigebørn og dens forebyggelse gjennem opdragelsens reform". 1, 7. series: 316-17.

Bibliotek for læger (1903) 'Forebyggelse af kønssygdomme. Spørgsmål om elever i skolen skal oplyses om kønssygdomme', series 8, 95(4).

Bie, V. (1929) Review: Arne Faber and A. Willum: "Afmagringsdiæt i det daglige liv", *Ugeskrift for Læger*, September 5, 91(36): 753.

Bie, V. (1935) Review "Sund levevis. Populært tidsskrift for ernæring og hygiejne", *Ugeskrift for Læger*, January 31, 97 (5): 161.

Bjerre, Marlene, Carsten Friis Overby & Jette Velling Lindholm (2009) *Procesguide til foreningsudvikling*, DGI: DGI Uddannelsesforum.

Björkstén, Elli (1933) *Kvindegymnastik*, Copenhagen: P. Haase & Søns Forlag.

Blanchot, Maurice (1990) 'Michel Foucault as I Imagine Him', *Foucault/Blanchot*, New York: Zone Books.

Boje, Andreas (1935) 'Hindsgavlmødet' *Samfundets krav*, Copenhagen: Dansk forening for social oplysning, Det sociale sekretariat, July 3, quarter 35 (3): 102-5.

Bonnevie, Poul (1958) *Hygiejne og Socialmedicin – For medicinsk studium*, Copenhagen: Nyt Nordisk Forlag Arnold Busck.

Borgbjærg, Axel (1939) 'Sport og idræt', *Fysisk Kultur – Tidsskrift for skønhed, styrke,* June 1, pp. 4-5.

Bredsdorff, Jørgen, Agnete Lundsteen, Villars Lund (1943) 'Ernæringsvilkår i danske arbejderhjem', *Bibliotek for læger*, Vol. 135: 1-42.

Brun-Pedersen, M. (1929) 'Profylakse og kønssygdomme', Correspondence, *Ugeskrift for læger*, September 26, 91 (39): 832.

Brüel, Oluf (1930a) 'Mindreværdighed', Correspondence, *Ugeskrift for Læger*, November 6, No. 45: 1055.

Brüel, Oluf (1930b) 'Mindreværdighed', Correspondence, *Ugeskrift for Læger*, December 6, No. 49: 1165.

Brüel, Oluf (1930c) 'Mindreværdighed – En sproglig-terminologisk bemærkning', Correspondende, *Ugeskrift for Læger*, October 16, No. 42: 996.

Brüel, Oluf (1930d) 'Socialinsufficiens – socialinsufficeint', Correspondence, *Ugeskrift for Læger*, November 13, No. 46: 1075.

Brüel, Oluf (1939) 'Lidt om konstitutionstyper', Lecture in Danish Military Association, *Ugeskrift for Læger*, April 14, 100 (15): 383-93.

Bukh, Niels (1930) 'Primitiv Gymnastik' *Dansk Idræt* (P. Friis, red.) October 1, De Danske Skytte-, Gymnastik og Idrætsforeninger, Slagelse: Centraltrykkeriet, No. 1: 2-6.

Butler, Judith (1990) *Gender Trouble – Feminism and the subversion of identity*, London: Routledge.

Christensen, Ole (1949) 'Konstitutionstypernes biologi', *Bibliotek for læger*, Vol. 141: 105-47, Copenhagen: Ejnar Munksgaard.

Christiansen, Johanne (1934) 'Landboungdommen – svar til Dr. V. Meier', *Ugeskrift for Læger*, August 9, 96 (32): 879.

Christiansen, Johanne (1935) 'Skolebørns mad', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, December 1, No. 13: 1-4.

Christiansen, Johanne (1936) 'Folkeforbundets hygiejne-organisations beretning om den fysiologiske basis for ernæringen '*Ugeskrift for Læger'*, May 7, 98 (19): 423-27.

Christiansen, Johanne (1937a) 'Den danske og den norske børnedødelighed', Correspondence, *Ugeskrift for Læger*, January 24, 99 (2): 50-52.

Christiansen, Johanne (1937b) 'Ernæring og sundhedstilstanden i Danmark, især i rationeringstiden', *Ugeskrift for Læger*, January 28, No. 4: 114-18.

Christiansen, Johanne (1937c) Review by Axel Larsen: "Undersøgelser af skolebørn. Beretning om skolelægevirksomhed i Nakskov 1935-1936", *Ugeskrift for Læger*, June 24, 99 (25): 687-88.

Christiansen, Johanne (1939a) 'Dyrisk kost og folkesundhed', *Ugeskrift for Læger*, March 10, No. 10: 270-71.

Christiansen, Johanne (1939b) Summary by Knud Sand: "Den legale sterilisation og kastration i Danmark, *Ugeskrift for Læger*, September 29, 100 (39): 1121.

Christiansen, Johanne (1940a) 'Ernæringsvejledning', *Ugeskrift for Læger*, November 7, 102 (45): 1170-71.

Christiansen, Johanne (1940b) 'Populære sundheds-tidsskrifter', Korrespondance, *Ugeskrift for Læger*, February 1, 102 (5): 141.

Christiansen, Johanne (1940c) Review of Karl Evang: "Vår folkeernæring under krise" i "Liv og helse", February 2, 1940, *Ugeskrift for Læger*, June 13, 102 (24): 628-29.

Chrom, I. P. (1927)'Parlamentarisme og hygiejne', FAGLIGT OG SOCIALT, *Ugeskrift for Læger*, December 29, No. 52: 1217-18.

Clemmensen, Carl (1942) Review of Ib Ostenfeld: "Den thyreofile type", *Ugeskrift for Læger*, July 16, 104, (29): 757-58.

Cooperrider, David L. and Suresh Srivastava (1987) 'Appreciative Inquiry in Organizational Life', *Research in Organizational Change and Development*, Vol. 1, pp. 129-169.

Cooperrider, David and Diana Whitney (2005) *A Positive Revolution in Change*: Appreciative Inquiry (Draft), California: Berret-Koehler Publishers, Inc.

Corning, A. K. H. (1929) 'Om den individuelle forebyggelse af kønssygdomme hos mænd og dens resultater', *Ugeskrift for Læger*, September 12, 91 (37): 782-86.

la Cour, Poul (1924) *Menneskelegemet*, Copenhagen, Kristiania: Gyldendalske boghandel.

Coveney, John (1998) 'The government and ethics of health promotion: the importance of Michel Foucault', *Health Education Research*, 13 (3): 459-468.

Cruikshank, Barbara (1999) *The Will to Empower – Democratic citizens and other subjects*, Ithaca: Cornell University Press.

Dahl, Robert A. (1991) *Modern Political Analysis*, New Jersey: Prentice-Hall, Inc.

Dalmark, P. C. J. (1923) 'En undersøgelse af legemshøjde hos alumnerne på Sorø Akademis Skole. Tiaaret 1912-1921' *Ugeskrift for Læger*, November 1, 85 (44): 771-73.

Daniel, H. (1931) 'Undervisning i socialmedicin', *Ugeskrift for Læger*, April 2, 93 (14): 367-70.

Dansk forening til kønssygdommenes bekæmpelse (1903) 'Bør der allerede i skolerne gives oplysning om kønssygdommenes betydning og farer, og i så fald på hvilken måde?' Review of discussion meeting, February 18. 1903, Småskrifter No. 2, Copenhagen: Det Nordiske Forlag, Ernst Bojesen.

Dansk Idræt (1930a) 'Dansk Idræt', *Dansk Idræt*, Friis, P. (red.), October 1, *De Danske Skytte-, Gymnastik og Idrætsforeninger*, Slagelse: Centraltrykkeriet, No. 1, pp. 1-2.

Dansk Idræt (1930b) 'Dansk Idræt', *Dansk Idræt*, Friis, P. (red.) October 15, *De Danske Skytte-, Gymnastik og Idrætsforeninger*, Slagelse: Centraltrykkeriet, No. 2, pp. 17-18.

Dansk Idræt (1930c) 'Idrætsorganisationer i Danmark', *Dansk Idræt* (P. Friis, red.) Oktober 15, *De Danske Skytte-, Gymnastik og Idrætsforeninger, Slagelse*: Centraltrykkeriet, No. 2, pp. 26-27.

Dansk Idræt (1931a) 'Slægters arv' *Dansk Idræt*, Friis, P. (ed.), January 15, *De Danske Skytte-, Gymnastik og Idrætsforeninger*, Slagelse: Centraltrykkeriet, No. 8, pp. 122-23.

Dansk Idræt (1931b) 'Til gymnastiksalens unge pige' (af en kvindelig dansk delingsfører) *Dansk Idræt*, Friis, P. (ed.), February 1, *De Danske Skytte-, Gymnastik og Idrætsforeninger*, Slagelse: Centraltrykkeriet, No. 9, pp. 130-31.

Dansk Selskab for Adipositasforskning (2001) 'Fedme i Danmark – En rapport fra Dansk *"Task Force on Obesity"*', Klaringsrapport No. 8.

Dansk Sygeplejeråd (1941) *Lærebog og håndbog i sygepleje*, Funding, Inge and Frode Rydgaard (ed.), Copenhagen: Nyt Nordisk Forlag – Arnold Busck.

Dean, Mitchell (1994) *Critical and Effective Histories – Foucault's Methods and Historical Sociology*, London, New York: Routledge.

Dean, Mitchell (1999) *Governmentality – Power and rule in modern society*, London: SAGE Publications.

Dean, Mitchell & Kaspar Villadsen (2012) *Statsfobi og civilsamfund – Foucault og hans arvingers blik på staten*, Frederiksberg: Nyt fra Samfundsvidenskaberne.

Deleuze, Gilles (2006) *Foucault*, London, New York: Continuum.

DGI (2010) 'Årsberetning 2010 – Danske Gymnastik- & Idrætsforeninger,' DGI.

DGI (2011a) 'Strategi 2015 – En situationsanalyse', DGI.

DGI (2011b) 'Strategi 2015 – Flere aktive, flere medlemmer, flere frivillige', DGI.

DGI Storkøbenhavn (2010) 'Projektbeskrivelse af foreningen for overvægtige børn og deres familier', Copenhagen: DGI Storkøbenhavn.

Donzelot, Jacques (1979) *The Policing of Families*, New York: Pantheon Books.

Dreyfus, Hubert L. and Paul Rabinow (1983) Michel Foucault: *Beyond Structuralism and Hermeneutics*, Chicago: The University of Chicago Press.

Driver, Felix (1999) 'Bodies in Space. Foucault's account of disciplinary power', *Reassessing Foucault. Power, medicine and the body* Jones, Colin & Roy Porter (red.), London, New York: Routledge, pp. 113-31.

Dybroe, Betina & Nanna Kappel (2012) '*Ulighed I sundhed – et sundhedsfremmeperspektiv på socialt udsattes adgang til sundhed*', *Sundhedsfremme – et kritisk perspektiv*, Dybbroe, Betina, Birgit Land & Steen Baagøe Nielsen (red.), Frederiksberg: Samfundslitteratur.

Døssing, Johs. (1947) 'Konstitutionstypologiske undersøgelser hos værnepligtige – Med specifikt henblik på anvendelsen af indices og spørgsmålet om typernes specificitet', Københavns Universitetets arvebiologiske institut, *Bibliotek for læger*, Vol. 139: 123-50.

Ekholm, Ola, Mette Kjøller, Michael Davidsen, Ulrik Hesse,
Louise Eriksen, Anne Illemann Christensen, Morten Grønbæk (2006) *Sundhed og sygelighed i Danmark 2005 & udviklingen siden 1987*, Statens Institut for Folkesundhed.

Ernæringsrådet (2003) 'Den danske fedmeepidemi – Oplæg til en forebyggelsesindsats', Publication No. 30, Ernæringsrådet.

Faber, Arne (1933a) 'Apropos "Naturlig gymnastik"' Review of Agnete Bertram: "Naturlig Gymnastik", *Ugeskrift for Læger*, March 9, 95, (10): 294-96.

Faber, Arne (1933b) 'Sygegymnastik', *Ugeskrift for Læger*, March 9, 95, (10): 289-91.

Faber, Knud; J. Ostenfeld (1924) 'Undersøgelser over tuberkulosen i Vejle amts nordligste del', The National Association's annual report 1922-23, *Sygeplejen*, August 8, No. 8: 103-6.

Faber, Knud (1928) 'Tuberkulosen i Danmark i 1926', Lecture at the National Association's annual meeting, May 1928, *Ugeskrift for Læger*, September 6, 90, (36): 888-92.

Faber, Knud (1939) *Fra Sundhedskollegium til Sundhedsstyrelse*, Copenhagen: Gyldendalske Boghandel – Nordisk Forlag.

Faber, Knud (1945) 'Tuberkulosen i Danmark', *Ugeskrift for Læger*, November 29, 107 (48): 1022-27.

Fenger, V. A. (1943) Boganmeldelse af Børre Johansson: "Samfund og hygiejne", *Ugeskrift for Læger*, January 7, 105 (1): 22.

Fenger, V. A. (1943) 'Forslag til lov om skolelæger', *Ugeskrift for Læger*, June 10, 105 (23): 580-83.

Fisker, Bo (2007) 'Offentlige – frivillige partnerskaber, Til idrætscheferne', DGI.

Fog, J. (1930) 'En erstatning for ordet mindreværdighed', Correspondence, *Ugeskrift for Læger*, October 30, No. 44: 1033-34.

Forebyggelseskommissionen (2009) *Vi kan leve længere og sundere - Forebyggelseskommissionens anbefalinger til en styrket forebyggende indsats*, April 2009, Forebyggelseskommissionen.

Foucault, Michel (1970) *The Order of Things*, London: Routledge.

Foucault, Michel (1980a) 'Body/Power', *Power/Knowledge – Selected Interviews and Other Writings 1972-1977*, Gordon, Colin (ed.), UK: The Harvester Press Limited, pp. 55-62.

Foucault, Michel (1980b) 'The Politics of Health in the Eighteenth Century', *Power/Knowledge – Selected Interview and Other Writings 1972-1977,* Gordon, Colin (ed.), UK: The Harvester Press Limited, pp. 166-82.

Foucault, Michel (1980c) 'Prison Talk', *Power/Knowledge – Selected Interview and Other Writings 1972-1977,* Gordon, Colin (ed.), UK: The Harvester Press Limited, pp. 37-54.

Foucault, Michel (1980d) 'Truth and Power', *Power/Knowledge – Selected Interview and Other Writings 1972-1977*, Gordon, Colin (ed.), UK: The Harvester Press Limited, pp. 109-33.

Foucault, Michel (1980e) 'Two Lectures', *Power/Knowledge – Selected Interview and Other Writings 1972-1977*, Gordon, Colin (ed.), UK: The Harvester Press Limited, pp. 78-108.

Foucault, Michel (1981) 'Foreword', Barbin, Herculine *Af en hermafrodit erindringer*, Copenhagen: RHODOS.

Foucault, Michel (1983) 'Dreyfus, Hubert L. and Paul Rabinow (1983) *Michel Foucault: Beyond Structuralism and Hermeneutics*, Chicago: The University of Chicago Press.

Foucault, Michel (1984a) 'Polemics, Politics, and Problematizations', Rabinow, Paul (ed.) *The Foucault Reader*, New York: Pantheon Books, pp. 381-90.

Foucault, Michel (1984b) 'Politics and Ethics: An Interview', Rabinow, Paul (ed.) *The Foucault Reader*, New York: Pantheon Books, pp. 373-80.

Foucault, Michel (1988) 'The Political Technology of Individuals', *Technologies of the Self – A seminar with Michel Foucault*, Luther, H. Martin, Huck Gutman, Patrick H. Hutton (ed.), Amherst: The University of Massachusetts Press, pp. 145-62.

Foucault, Michel (1990) *History of Sexuality*, Vol. 1, New York: Vintage Books.

Foucault, Michel (1991) 'Question of Method', Burchell, Graham, Colin Gordon & Peter Miller (ed.) *The Foucault Effect – Studies in Governmentality*, Chicago: The University of Chicago Press.

Foucault, Michel (1997) *Ethics: Subjectivity and Truth*, London: Penguin Books.

Foucault, Michel (1998a) 'Nietzsche, Genealogy, History', Faubion, James D. (ed.) *Aesthetics, Method, and Epistemology – Essential works of Foucault 1954-1984*, Vol. 2, New York: The New Press, pp. 369-91.

Foucault, Michel (1998b) 'Structuralism and Post-structuralism', Faubion, James D. (ed.) *Aesthetics, Method, and Epistemology – Essential works of Foucault 1954-1984*, Vol. 2, New York: The New Press, pp. 433-58.

Foucault, Michel (2000a) 'The Birth of Social Medicine', Faubion, James D. (ed.) *Power – Essential Works of Foucault 1954-1984*, Vol. 3, London: Penguin Books, pp. 134-56.

Foucault, Michel (2000b) 'Governmentality', Faubion, James D. (ed.) *Power – Essential Works of Foucault 1954-1984*, Vol. 3, London: Penguin Books, pp. 201-22.

Foucualt, Michel (2000c) '*"Omnes et Singulatim*": Toward a Critique of Political Reason', Faubion, James D. (ed.) *Power – Essential Works of Foucault 1954-*1984, Vol. 3, London: Penguin Books, pp. 298-325.

Foucault, Michel (2000d) 'Question of Method', Faubion, James D. (ed.) *Power – Essential Works of Foucault 1954-1984*, Vol. 3, London: Penguin Books, pp. 223-38.

Foucault, Michel (2000e) 'The Subject and Power', Faubion, James D. (ed.) *Power – Essential Works of Foucault 1954-1984*, Vol. 3, London: Penguin Books, pp. 326-48.

Foucault, Michel (2000f) 'Truth and Juridical Forms', Faubion, James D. (ed.) *Power – Essential Works of Foucault 1954-1984*, Vol. 3, London: Penguin Books, pp. 1-89.

Foucault, Michel (2000g) 'Truth and Power', Faubion, James D. (ed.) *Power – Essential Works of Foucault 1954-1984*, Vol. 3, London: Penguin Books, pp. 111-33.

Foucault, Michel (2002) *Archaeology of Knowledge*, London and New York: Routledge Classics.

Foucault, Michel (2003a) *Abnormal – Lectures at the Collège de France, 1974-75*, Marchetti, Valerio & Antonella Salomoni (ed.), London, New York: Verso.

Foucault, Michel (2003b) *Society Must Be Defended: Lectures at the Collège de France, 1975-76*, Bertani, Mauro (ed.), London: Penguin Books.

Foucault, Michel (2004) 'The Crisis of Medicine or the Cricis of Antimedicine?', *Foucault Studies*, December, No. 1: 5-19.

Foucault, Michel (2007a) 'The Incorporation of the Hospital into Modern Technology', Crampton, Jeremy W. and Stuart Elden (ed.) *Space, Knowledge and Power*, UK, USA: Ashgate, pp. 141-62.

Foucault, Michel (2007b) 'The Meshes of Power', Crampton , Jeremy W. & Stuart Elden (ed.) *Space, Knowledge and Power*, UK, USA: Ashgate, pp. 153-62.

Foucault, Michel (2007c). *The Politics of Truth*, Los Angeles: Semiotext(e)

Foucault, Michel (2009) *Biopolitikkens fødsel – Forelæsninger på Collège de France 1978-1979*, Copenhagen: Hans Reitzels Forlag.

Foucault, Michel (2010) *The Government of Self and Others – Lectures at the Collège de France 1982-1983*, Hampshire, New York: Palgrave Macmillan.

Fox, Nick J. (1998) 'Is there life after Foucault?', *Foucault, Health and Medicine*, Petersen, Alan & Robin Bunton (ed.), London, New York: Routledge, pp. 31-50.

Frandsen, Johs. (1932a) 'Om den offentlige sundhedsplejes udvikling og fremtidige opgaver med særligt henblik på socialhygiejnen', Lecture in Medical Society in Copenhagen, March 8, 1932, *Ugeskrift for Læger*, April 14, 93 (15): 387-91.

Frandsen, Johs. (1932b) 'Om den offentlige sundhedsplejes udvikling og fremtidige opgaver med særligt henblik på socialhygiejnen', Lecture in Medical Society in Copenhagen, March 8, 1932, *Ugeskrift for Læger*, April 21, 93, (16): 415-21.

Frandsen, Johannes (1963) *Sundhedsvæsenet 1927-1961. Oplevelser og erfaringer*, Copenhagen: Nyt Nordisk Forlag Arnold Busck.

Frandsen, Martin & Peter Triantiafillou (2011) 'Biopower at the molar level: Liberal government and the invigoration of Danish society', *Social Theory & Health*, 9 (3): 203-23.

Freudenthal, Poul (1933) 'Den værnepligtige ungdoms fysiske habitus og ernæringsproblemer', *Ugeskrift for Læger*, July 13, 95 (28): 798-99.

Freudenthal, Poul (ed.) (1935a) *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, January 1, No. 1.

Freudenthal, Poul (ed.) (1935b) 'Folkeernæringen – den fysiske habitus' *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, January 15, 1 (2): 52-54.

Freudenthal, Poul (ed.) (1935c) 'Lægeundersøgelsen af skolebørn', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, April 1, Vol. 1, No. 5.

Freudenthal, Poul (ed.) (1935d) 'Samfundet og slægten', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, June 1, 1 (7): 9-12.

Freudenthal, Poul (ed.) (1935e) 'Fosterdrab, samfund og sjæl', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, July 1, 1 (8): 1-3.

Freudenthal, Poul (ed.) (1935f) Review of Th. Bøgelund: "Forældre og opdragelse", *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, July 1, 1 (8): 26.

Freudenthal, Poul (1935g) 'Slankhed og spændstighed', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, September 1, 1 (10): 16.

Freudenthal, Poul (1936a) 'Dagliglivets personlige hygiejne', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, May 1, 2 (5): 19-20.

Freudenthal, Poul (1936b) 'Hygiejnens og profylaksens krav', Correspondence, *Ugeskrift for Læger*, February 6, 98 (6): 121-22.

Freudenthal, Poul (1936c) 'Hygiejne-propagandaen', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, April 1, 2 (4): 1-2.

Freudenthal, Poul (1936d) 'Kampen for mental-hygiejnen', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, May 1, 2 (5): 1-2.

Freudenthal, Poul (1936e) 'Den konstruktive hygiejne', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, May 1, 2 (5): 17-18.

Freudenthal, Poul (1937a) 'Om svangerskabsloven', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, January 1, 3 (1): 10.

Freudenthal, Poul (1937b) 'Om tuberkulose og dens bekæmpelse', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, February 1, 3 (2): 33-37.

Freudenthal, Poul (1938a) 'Folkesundhed og samfundsstyre', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, August 1, 4 (8): 173-79.

Freudenthal, Poul (1938b) 'Idræt og folkehygiejne', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, September 1, 4 (9): 197-200.

Freudenthal, Poul (1940a) 'Ernæringsvejledning', *Ugeskrift for Læger*, December 5, 102 (49): 1308.

Freudenthal, Poul (1940b) 'Om sundhedsplejerske-institutionen', *Ugeskrift for Læger*, December 19, 102 (51): 1369.

Fridericia, L. S. (1927) 'Social medicin – social hygiejne', *Ugeskrift for Læger*, Correspondence, January 13, 89 (2): 35.

Fridericia, L. S. (1942a) 'Udkast til rammerne for et uddannelseskursus for læger, der ønsker ansættelse som skolelæger', *Ugeskrift for Læger*, July 16, 104 (29): 760-65.

Fridericia, L. S. (1942b) 'Højde- og vægtmåling af skolebørn', *Ugeskrift for Læger*, July 16, 104 (29): 764-66.

From, Ditte-Marie (2012) *De sunde overvægtige børn – sundhedspædagogiske potentialer i arbejdet med overvægtige børn*, PhD, Roskilde: Roskilde Universitet.

Fødevarestyrelsen (2005) *50 forslag til initiativer og partnerskaber, der vil forebygge overvægt i Danmark – Tanker fra Familie- og Forbrugerministerens Tænketank for partnerskaber om sund mad og motion,* Copenhagen: Fødevarestyrelsen.

Gammeltoft, S. A. (1936) Review of Tage Kemp: "Prostitution, an investigation of its causes, especially with regard to hereditary factors", *Ugeskrift for Læger*, July 16, 98 (29): 670-71.

Garboe, Axel (1934) Review of Oluf Thomsen: "Menneskets arvelighedsforhold", *Ugeskrift for Læger*, May 31, 96 (22): 580.

Garde, Erik (1934) 'Nye veje for tuberkulosebekæmpelsen i København', *Ugeskrift for Læger*, September 13, 96 (37): 1016-23.

Gastaldo, Denise (1998) 'The body, the self', *Foucault, Health and Medicine*, Petersen, Alan & Robin Bunton (red.), Routledge: London and New York, pp. 113-33.

Geert-Jørgensen, Einar (1942) *Anlægspræget og de ydre forholds betydning for det sunde og syge sjæleliv*, Grundrids ved den folkelige universitetsundervisning, No. 445, Folkeuniversitetsudvalget, Copenhagen: Ejnar Munksgaards Forlag.

Gordon, Colin (1980) 'Afterword' *Power/Knowledge – Selected Interview and Other Writings 1972-1977*, Gordon, Colin (ed.), UK: The Harvester Press Limited, pp. 229-59.

Gotfredsen, Edv. (1936) Summary of Sir George Newman: "The new purpose of medicine", The Lancet, No. 19, Vol. I, 1935, *Ugeskrift for Læger*, February 27, 98 (9): 186.

Gotfredsen, Edv. (1937) Review of "Børn – alle forældres blad", *Ugeskrift for Læger*, March 25, 99 (12): 352.

Grosz, Elizabeth (1994) 'Experimental Desire – Rethinking Queer Subjectivity', *Supposing the Subject*, New York: Verso.

Gudjonsson, V., E. Harrsen, K. Trier (1935) 'Københavnske skolebørns daglige kost – Undersøgelse af kosten hos 270 skolebørn i kommuneskoler i København', *Ugeskrift for Læger*, November 14, 97 (46): 1158-62.

Gullestrup, A. (1948) 'Hygiejneudvalgenes opgaver', *Ugeskrift for Læger*, January 29, 110 (5): 125-26.

H. (1932) 'Hvor er vejen til sundhed?', *Dansk Idræt*, Friis, P. (red.) October 1, De Danske Skytte-, Gymnastik og Idrætsforeninger, Slagelse: Centraltrykkeriet, No. 1, pp. 262-63.

Hacking, Ian (1995) 'The looping effects of human kinds', Sperber, Dan, David Premack & Ann J. Premack (ed.) *Causal Cognition: A multi-disciplinary debate*. Oxford: Clarendon, pp. 351-83.

Hacking, Ian (2001) *The Social Construction of What?*, Cambridge, Massachusetts: Harvard University Press.

Hacking, Ian (2002) *Historical Ontology*, Cambridge, Massachusetts: Harvard University Press.

Hallas, E. A. (1933) 'Recorden og døden', *Ugeskrift for Læger*, May 25, 95 (21): 620-22.

Hansen, H. J. (1920-1928) 'Undersøgelser over nyfødte børns vægt', *Den Antropologiske Komite 1920-28*, pp. 2-109.

Hansen, Søren (1892) 'Til spørgsmålet om menneskeslægtens fysiske degeneration' *Bibliotek for læger*, Series 7, 84 (3): 387-91.

Hansen, Søren (1911a) 'Om hårets og øjnenes farve', *Den Antropologiske Komite*, pp. 285-307.

Hansen, Søren (1911b) 'The size of head in men and women', *Den Antropologiske Komite*, pp. 159-60.

Hansen, Søren (1912) 'Om raceforbedring', Lecture at Economic Association November 28, 1912, *Nationaløkonomisk Tidsskrift*, Særtrykssamlingen, No. 8, pp. 11-30.

Hansen, Søren (1917) 'Den biologiske genealogi og degenerationsproblemet', Særtryk, *Personalhistorisk Tidsskrift*, vii: 1-16. R.2.B.1.H. Copenhagen: J. H. Schultz.

Hansen, Søren (1920-1928a) 'Om de først fødte børns ringere kvalitet', *Den Antropologiske Komite 1920-1928*, pp. 111-198.

Hansen, Søren (1920-1928b) 'Skolebørns vækstforhold i København og nogle danske provinsbyer', *Den Antropologiske Komite 1920-1928*, pp. 199-279.

Hansen, Søren (1929-1932a) 'Københavnske skolebørns højde og vægt i andet skoleår' *Den Antropologiske Komite 1929-1932*, pp. 71-82.

Hansen, Søren (1929-1932b) 'Københavnske skolebørns højde og vægt ved skoletidens begyndelse', *Den Antropologiske Komite 1929-1932*, pp. 59-69.

Hansen, Søren (1929-1932c) 'Om legemsvægt og proportionering hos skolebørn' *Den Antropologiske Komite 1929-1932*, pp. 371-84.

Harløf, Vald. J. (1933) 'Sporten og rekorden', *Ugeskrift for Læger*, June 1, 93 (22): 657-58.

Hasle, Sv. (1934) 'Landbokosten', *Ugeskrift for Læger*, August 16, 96 (33): 905.

Havin, H. (1938a) 'Om kvindetyper'. From the journal "Liv og sundhet", *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, August 1, 4 (8): 180-83.

Havin, H. (1938b) 'Om kvindetyper'. From the journal "Liv og sundhet" *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, September 1, 4 (9): 206-8.

Heiberg, Povl (1925) 'Er den danske befolkning overernæret eller underernæret?', Correspondence, *Ugeskrift for Læger*, June 11, 87 (24): 547-48.

Heiberg, Povl (1934) Review of Gerh. Hertzberg: "Ernæring, helse, miljø", *Ugeskrift for Læger*, August 2, 96 (31): 861-62.

Heiberg, Povl (1936) Review of Burnet, E. & Aykroyd, W. R.: "Ernæringen og den offentlige sundhedspleje", *Ugeskrift for Læger*, May 7, 98 (19): 428-29.

Heitmann, Berit Lilienthal (1999) 'Forekomst og udvikling af overvægt og fedme blandt voksne danskere i alderen 30-60 år', *Ugeskrift for Læger*, August 2, No. 13, pp. 4380.

Hertz, Poul (1911) 'Københavnske kommuneskolebørns vækstforhold', *Den Antropologiske Komite*, pp. 319-50.

Heuch (1936) 'Kan de praktiserende læger undværes i den offentlige kamp for sundhed?', *Ugeskrift for Læger*, September 3, 98 (3): 835.

Heuch (1939) 'Apropos sundhedsplejersker', *Ugeskrift for Læger*, February 24, 100 (8): 208-10.

Hindhede, Mikkel (1922) 'Studier over tuberkulosekost', Lecture at Medical Society, Copenhagen, December 20, 1921, *Ugeskrift for Læger*, May 4 84 (18): 433-53.

Hindhede, Mikkel (1925) 'Er den danske befolkning overernæret eller underernæret?', Correspondence, *Ugeskrift for Læger*, May 21, 87 (21): 493-99.

Hindhede, Mikkel (1926) 'Levevis eller dødelighed', *Ugeskrift for Læger*, April 8, 88 (14): 356-59.

Hindhede, Mikkel (1927) 'Irsk levevis og dens virkninger på sundhedstilstanden', *Ugeskrift for Læger*, November 24, 89 (47): 1079-84.

Hindhede, Mikkel (1928) 'Diæt for drenge i skolealderen – engelske ernæringsforsøg', *Ugeskrift for Læger*, January 26, 90 (4): 92-95.

Hindhede, Mikkel (1933) 'Ungdommens fysiske habitus og ernæringsproblemet – et par spørgsmål til stabslæge Dr. Rørdam', Correspondence, *Ugeskrift for Læger*, July 27, 93 (30): 831.

Hindhede, Mikkel (1934) 'Groft brød', *Ugeskrift for Læger*, February 22, 96 (8): 221-23.

Hindhede, Mikkel (1940a) 'Ernæringsvejledning', *Ugeskrift for Læger*, September 19, 102 (51): 1359-60.

Hindhede, Mikkel (1940b) 'Ernæringsvejledning', *Ugeskrift for Læger*, November 21, 102 (47): 1225.

Hindhede, Mikkel (1940c) 'Sundhedskontrollen', *Ugeskrift for Læger*, September 12, 102 (37): 955.

Horkheimer, Max & Theodor W. Adorno (1944/1993) *Oplysningens dialektik – Filosofiske fragmenter*, Haslev: Samlerens bogklub.

Høyer-Kruse, Jens, Thøgersen, Marlene, Støckel, Jan Toftegaard, Ibsen, Bjarne (2008) 'Offentlige-frivillige partnerskaber omkring børn og fysisk aktivitet', Movements 2008: 8, *Center for forskning i Idræt, Sundhed og Civilsamfund*, Institut for Idræt og Biomekanik, Odense: Syddansk Universitet.

Ibsen, Bjarne (2006) 'Foreningsidrætten i Danmark – Udvikling og udfordringer', *Sundhed og Civilsamfund*, Center for forskning i Idræt, Idrættens Analyseinstitut, Syddansk Universitet.

Ibsen, Bjarne & Henning Eichberg (2006) *Dansk idrætspolitik – Mellem frivillighed og statslig styring*, Center for forskning i Idræt, Sundhed og Civilsamfund, Idrættens Analyseinstitut, Syddansk Universitet.

Ibsen, Bjarne, Thomas P. Boje & Torben Fridberg (2008) *Det frivillige Danmark*, Odense: Syddansk Universitetsforlag.

Idrætspolitisk Forum Fyn (2009a) 'Raport fra 3. møde i Idrætspolitisk Forum Fyn', March 19, Odense: Idrætspolitisk Forum Fyn.

Idrætspolitisk Forum Fyn (2009b) 'Raport fra møde i Idrætspolitisk Forum Fyn', June 4, Odense: Idrætspolitisk Forum Fyn.

Idrætspolitisk Forum Fyn (2009c) 'Raport fra møde i Idrætspolitisk Forum Fyn', September 21, Odense: Idrætspolitisk Forum Fyn.

Idrætspolitisk Forum Fyn (2009d) 'Raport fra møde i Idrætspolitisk Forum Fyn', December 3, Odense: Idrætspolitisk Forum Fyn.

Idrætspolitisk Forum Fyn (2010) 'Raport fra møde i Idrætspolitisk Forum Fyn', March 18, Odense: Idrætspolitisk Forum Fyn.

Idrætpolitisk Forum Fyn & DGI Fyn (2009) 'Grib Chancen – til et lettere liv. Projektinformation samt uddybning af grundmodel', Odense: Idrætspolitisk Forum Fyn.

Illich, Ivan (1976) *Limits to Medicine – Medical Nemesis: The expropriation of health*, London: Marion Byars.

Indenrigs- og Sundhedsministeriet (2002) 'Sund hele livet – de nationale mål og strategier for folkesundheden 2002-10', September. Electronic version, downloaded 1/9/10.

Indenrigs- og Sundhedsministeriet (2007) 'De samfundsøkonomiske konsekvenser af svær overvægt', May, Indenrigs- og Sundhedsministeriet.

Ingbøl, Kaj (1936) 'Den rettidige forsorg for lettere åndssvage', *Ugeskrift for Læger*, December 24, 98 (52): 1301-4.

Ingerslev, F. (1920) Review of Lerrede: "Syfilisbekæmpelsens organisation" (Le Musée Social 1920, pp. 131), *Ugeskrift for Læger*, December 23, 82 (1920): 1611-12.

Ingerslev, F. (1924a) 'Skolelæge eller skoleklinik', Correspondence, *Ugeskrift for Læger*, February 21, 86 (8): 171-72.

Ingerslev, F. (1924b) 'Sygepleje og sundhedspleje', *Sygeplejen*, July, 15 (7): 91-93.

J. K. (1927) 'International, kombineret social- og hygiejnekommission', *Ugeskrift for Læger*, April 21, 89 (16): 335-36.

Jakobsen, Jens Sune (2005) 'Fede Tips. En vejledning til idrætsprojekter for overvægtige børn', Copenhagen: DGI Storkøbenhavn.

Jacobsen, Lis (1930) 'Underlødig-underlødighed', Correspondence, *Ugeskrift for Læger*, December 11, No. 50: 1183-84.

Jensen, Adolph (1920-1928) 'Nogle træk af Danmarks befolkning i belysning af fødsels- og dødstallene', *Den Antropologiske Komite*, pp. 307-349.

Jensen, Aage (1936) 'Arbejdsløshed og underernæring', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, Freudenthal, Paul (ed.), February 1, 2 (2): 1-3.

Jensen, Torben K. & Tommy J. Johnsen (2000) *Sundhedsfremme i teori og praksis. En lære-, debat- og brugsbog på grundlag af teori og praksisbeskrivelser*, Århus: Forlaget Philosophia, Aarhus.

Jespersen, Kaptajn J. P. (1935a) 'Idrættens sande mål' *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, Freudenthal, Poul (ed.), June 1, 2 (6): 23-25.

Jespersen, Kaptajn J. P. (1935b) 'Legemskultur' *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, Freudenthal, Poul (ed.), January 1, No. 1.

Jespersen, Kaptajn J. P. (1935c) 'Legemskultur' *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, Freudenthal, Poul (ed.), January 15, 1 (2).

Jespersen, Kaptajn J. P. (1935d) 'Legemskultur' *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, Freudenthal, Poul (ed.), March 1, 2 (3).

Johannesen, Arne (1939) 'Børnelæger og sundhedsplejersker', *Ugeskrift for Læger*, May 12, 100 (19): 548-52.

Johannsen, Wilhelm (1923) *Arvelighed i historisk og eksperimentel belysning – en oversigt over arvelighedsforskningens vigtigste resultater*, København, Kristiania, Berlin, London: Gyldendalske Boghandel.

Johannsen, Wilhelm M.fl. (1924) *Arvelighed og alkohol*, J. H. Schultz, Copenhagen.

Johannsen, Wilhelm (1927) *Arvelighedsspørgsmål*, V. Pios Boghandel, Copenhagen.

Jonasen, Viggo (2003) *Dansk socialpolitik 1708-2002*, Den Sociale Højskole i Århus, Aarhus.

Jürgensen (1926) 'Ernæringssagens fremme – et opråb', *Ugeskrift for Læger*, July 15, No. 28: 667-68.

Jørgensen, Per (1993) 'Eugen Stahl Schmidt og DIF – Dansk Idræts-Forbunds baggrund, dannelse og etablering 1892-1925' in *Idrætshistorie og livshistorie, Idrætshistorisk årbog 1993*, Jørn Hansen, Henning Eichberg (red.), Odense Universitetsforlag, pp. 25-41, Odense.

Kamper-Jørgensen, Finn & Gert Almind (red.) (2005) *Forebyggende sundhedsarbejde – Baggrund, Analyse og Teori, Arbejdsmetoder*, Munksgaard Danmark, Copenhagen.

Kemp, Tage (1935) Review of Otto Louis Mohr: "Arvelighet og sykdom", *Ugeskrift for Læger*, August 15, 97 (33): 861.

Kemp, Tage (1936) *Prostitution – An investigation of its causes, especially with regard to Hereditary Factors*, Copenhagen: Levin & Munksgaard – Ejnar Munksgaard.

Kemp, Tage (1937) 'De asociale og forsorgen for dem'. Lecture at the 15th Social Summer Meeting, August 12, 1937, *Ugeskrift for Læger*, September 23, 99 (38): 1009-14.

Kemp, Tage (1940a) 'Om svangerskabsafbrydelse på eugenisk indikation', *Ugeskrift for Læger*, April 11, 102 (35): 373-79.

Kemp, Tage (1940b) 'Profylaktisk lægegerning', Correspondence, *Ugeskrift for Læger*, August 29, 102 (35): 912-13.

Kemp, Tage (1943) Review of Johan Henrik Wanscher: "Arvelighedsordbog", *Ugeskrift for Læger*, Oktober 28, 105 (43): 1111.

Kemp, Tage (1945) Review of Øjvind Winge: "Arvelighedslære på eksperimentelt og cytologisk grundlag", *Ugeskrift for Læger*, July 19, 107 (29): 584.

Kirkebæk, Birgit (1993) *Da de åndssvage blev farlige*, Holte: SOCPOL.

Kistrup, Poul (1928) *Kønssygdomme – Deres sociale farer og midler til deres bekæmpelse*, Dansk forening til kønssygdommenes bekæmpelse, Copenhagen: Engelsen & Schrøder.

KL (2008) 'Godt i gang – En kvantitativ undersøgelse af den kommunale forebyggelsesindsats i 2008', KL.

KL (2010) "Til den kommunale sundhedstjeneste: Udbredelse af børnedatabasen", Administrativ information, April 7, KL.

KL (2012a) "NOTAT: Kommunale sundhedspolitikker – en oversigt over indsatsområder, målgrupper og mål i 25 kommuner", January 19, KL.

KL (2012b) "UDSPIL: Kommunal forebyggelse der rykker!", Electronic version, downloaded January 24, 2012.

Knudsen, K. A. (1930) 'Elli Bjørksten' *Dansk Idræt* Friis, P (red.), November 1, De Danske Skytte-, Gymnastik og Idrætsforeninger, Slagelse: Centraltrykkeriet, No.3, pp. 40-41.

Koch, Lene (1996) *Racehygiejne i Danmark 1920-56*, Copenhagen: Nordisk Forlag.

Koch, Lene (2000) *Tvangssterilisation i Danmark 1929-67*, Copenhagen: Nordisk Forlag.

Korsgaard, Ove (1982) *Kampen om kroppen – Dansk idræts historie gennem 200 år*, Copenhagen: Gyldendal.

Koselleck, Reinhart (2002) *The Practice of Conceptual History*, Stanford: Stanford University Press.

Krarup, Frode (1927) 'Betænkning afgivet af "Den under 23. december 1924 nedsatte kommission angående sociale foranstaltninger overfor degenerativt bestemte personer"', *Ugeskrift for Læger*, March 31, 89 (13): 261-63.

Kretschmer, Ernst (1955/1931a) *Körperbau und Charakter – Untersuchungen zum Konstitutions-Problem und zur Lehre von den Temperamenten*, Berlin, Göttingen, Heidelberg: Springer-Verlag.

Kretschmer, Ernst (1931b) *The Psychology of Men of Genius*, London: Kegan Paul, Trench, Trubner & Co. Ltd., New York: Harcourt Brace and Company.

Kulturministeriet (2003) *Børn og unge i bevægelse – Perspektiver og ideer*, June 2003, Copenhagen: Kulturministeriet.

Kulturministeriet (2008) 'En opsamling af Kulturministeriets udviklingspulje Børn og unge i bevægelse', Skoleidrættens udviklingscenter for Kulturministeriet, June 2008, Electronic version, downloaded January 24, 2012.

Kulturministeriet (2009a) 'DGI og Breddeidrætskommunerne', Udsnit af brev til kommunerne fra Kulturministeriet, July 8, 2009, BF/2010.

Kulturministeriet (2009b) 'Idræt for alle. Breddeidrætsudvalgets rapport – konklusioner og forslag', March 2009, Kulturministeriet, www.kum.dk. Downloaded 25/8/10.

Københavns Amtslægekreds (1929) *Medicinalberetning for 1928*, v. Max Christiansen, Amtslæge, Copenhagen: Spuhr & Siebuhr, Bogtrykkeri.

Københavns Amtslægekreds (1930) *Medicinalberetning for 1929*, v. Max Christiansen, Amtslæge, Copenhagen: Spuhr & Siebuhr, Bogtrykkeri.

Københavns Amtslægekreds (1931) *Medicinalberetning for 1930*, v. Max Christiansen, Amtslæge, Copenhagen: Spuhr & Siebuhr, Bogtrykkeri.

Københavns Amtslægekreds (1934) *Medicinalberetning for 1933*, v. Max Christiansen, Amtslæge, Copenhagen: Spuhr & Siebuhr, Bogtrykkeri.

Kaarsberg, Hans (1892a) 'En replik i anledning af Dr. Th. Sørensens artikel "Menneskeslægtens fysiske degeneration"' *Bibliotek for læger*, 84 (3): 391-93.

Kaarsberg, Hans (1892b) *Vore børn, deres opdragelse, sundhed og almindeligste sygdomme*, 12 public lectures, Copenhagen: I. H. Schurothes Boghandel.

Larsen, Axel (1928) 'Bedømmelse af skolebørns ernæringsforhold', *Ugeskrift for Læger*, January 12, 90 (2): 40-42.

Larsen, Kirsten Harkjær (2005) *Førerposition i folkesundhed*, Review of DGI's National Congress in 2004, DGI.

Larsen, Lars Thorup (2010) 'The Birth of Lifestyle Politics: The Biopolitical Management of Lifestyle Diseases in the United States and Denmark', Bröckling, Ulrich, Susanne Krasmann & Tomas Lemke (ed.) *Governmentality: Current Issues and Future Challenges*, London: Routledge, pp. 201-24.

League of Nations, Health Organisation (1928) 'Reports on Public Health Progress of Twenty-Nine Countries (Thirty-Five Public Health Administrations)', *International Health Year Book*, Year 4, Geneva: Series of League of Nations Publications.

Lehmann, Henrik (1906) 'Tuberkuloseloven og skolerne', Særtryk af *Ugeskrift for Læger*, No. 47, Copenhagen: Fr. Bagges Kgl. Hof-Bogtrykkeri.

Lembcke, C. (1922) 'Danmark i de næste 20 år', *Samfundets krav – socialt tidsskrift*, Boje, Andreas (ed.), Copenhagen: Oplysningsselskabet, Det Sociale Sekretariats forlag: 22 (¾): 49-64.

Lendorff-Kugler, Erica (1929-1932) 'Studier over københavnske skolebørns vækstforhold', *Den Antropologiske Komite 1929-1932*, pp. 393-404.

Leunbach, J. H. (1925a) 'Om racehygiejne', Correspondence, *Ugeskrift for Læger*, January 8, 87 (2): 42-43.

Leunbach, J. H. (1925b) 'Om racehygiejne', Correspondence, *Ugeskrift for Læger*, January 29, 87 (5): 114.

Leunbach, J. H. (1926) 'Læger, racehygiejne og overbefolkning', Correspondence *Ugeskrift for Læger*, November 4, 88 (44): 1014-16.

Leunbach, J. H. (1933) 'Den tyske sterilisationslov', *Ugeskrift for Læger*, August 31, 93 (35): 925.

Lidegaard, Kresten (1931) 'Nytidens ungdom', *Dansk Idræt*, Friis, P. (ed.), De Danske Skytte-, Gymnastik og Idrætsforeninger, Slagelse: Centraltrykkeriet, May 1, No. 15, pp. 230-32.

Lissau, Inge (1999) '*Den sociale arv og udvikling af fedme'*, Work paper 26 on social heritage, August 1999, Socialforskningsinstituttet.

Lomholt (1926) Review of F. Ingerslev: "Kønssygdommene og deres bekæmpelse", *Sygeplejen*, Voltelen, J. (ed.), Centralforeningen af sygeplejevirksomheder udenfor København, Slagelse: Sorø Amtstidendes Bogtrykkeri, April 4, 17 (4): 47-48.

Lukes, Steven (1976) *Power: A radical view*, London, Basingstoke: The MacMillan Press Ltd.

Lunddahl, Joh. (1926) 'Læger, racehygiejne og overbefolkning', Correspondence *Ugeskrift for Læger*, November 11, 88 (45): 1036-37.

Lunddahl, Joh. (1934) 'Landboungdommens sundhed', *Ugeskrift for Læger*, August 16, 96 (33): 905.

Macherprang, Edv. Ph. (1911) 'De værnepligtiges legemshøjde i Danmark', *Den Antropologiske Komite*, pp. 11-68.

Magarey, AM; Daniels, LA; Boulton, TJ & Cockington, RA (2003) 'Predicting obesity in early adulthood from childhood and parental obesity', *International Journal of Obesity*, No. 27: 505-513.

Meier, V. (1926) 'Ernæringens fremme', *Ugeskrift for Læger*, July 22, 88 (29): 684-85.

Metz, A. (1932) 'Hygiejne i landdistrikter', *Ugeskrift for Læger*, February 11, 94 (6): 161-63.

Ministerial tidende for kongeriget Danmark for året 1931 (1932) 'Vejledning for patienter med hareskår og ganespalte', November 25, Copenhagen: J. H. Schultz A/S.

Ministerial tidende for kongeriget Danmark for året 1932 (1933) 'Cirkulære til samtlige skoledirektioner for København angående gymnastikundervisning om vinteren ved landsbyskoler, hvor der ikke findes nogen gymnastiksal', February 17, 1921, Copenhagen: J. H. Schultz A/S, pp. 7-8.

Ministerial tidende for kongeriget Danmark for året 1937 (1938) 'Cirkulære til samtlige kommunalbestyrelser', July 3 , Copenhagen: J. H. Schultz A/S, pp. 190.

Ministerial tidende for kongeriget Danmark for året 1940 (1941) 'Regler om efterundersøgelse af sterilisation og kastration', June 19, Copenhagen: J. H. Schultz A/S.

Ministerial tidende for kongeriget Danmark for året 1940 (1941) 'Skrift. Om medico-legalt ligsyn', June 19, Copenhagen: J. H. Schultz A/S.

Ministeriet for sundhed og forebyggelse (2009)' KRAM-undersøgelsen i tal og billeder', Statens Institut for Folkesundhed & Syddansk Universitet.

Mondrup, Tina Kryger (2005) *DGI efter kommunalreformen – hvordan kan den organiserede idræt bidrage ved løsning af velfærdsopgaver?*, Institut for Idræt, Copenhagen: Københavns Universitet.

Munck, Viggo (1934) Review of "Liv og sundhet", *Ugeskrift for Læger*, September 27, 96 (39): 1069-70.

Munck, Viggo (1935a) Review of "Liv og sundhed", *Ugeskrift for Læger*, February 14, 97 (7): 232-33.

Munck, Viggo (1935b) 'Læger og idrætshygiejne', *Ugeskrift for Læger*, May 30, 97 (22): 609-11.

Munck, Viggo (1935c) 'Socialhygiejnen og idrætsbevægelsen', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, November, Vol. 1, No. 12: 1-4.

Munck, Viggo (1935d) 'Socialhygiejnen og idrætsbevægelsen', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, December 1, 1 (13): 20-22.

Munck, Viggo (1940) 'Idrætslægearbejdets tilrettelæggelse', *Ugeskrift for Læger*, October 17, 102 (42): 1098-1100.

Müller, J. P. (1908) *Kønsmoral og livslykke – Et bidrag i populær fremstilling til det seksuelle spørgsmåls løsning*, Copenhagen: Tillge's Boghandel.

Myrdal, Alva og Gunnar (1935) *Krise i befolkningsspørgsmålet*, Copenhagen: Martins Forlag.

Myrdal, Alva (1936) *Bybørn – En bog om deres opdragelse i børnehaver, daghjem og lignende institutioner*, Copenhagen: Martins Forlag.

Myrdal, Gunnar og Herbert Tingsten (1935) *Samhällskrisen och socialvetenskaperne – Två installationsföreläsningar*, Stockholm: Kooperativa förbundets bokförlag.

Myrdal, Gunnar (1958) *Value in Social Theory – A selection of essays on methodology by Gunnar Myrdal*, London: Routledge & Kegan Paul.

Møller, J. S. (1935a) 'Hygiejnens vilkår i folkeskolen på landet', *Ugeskrift for Læger*, November 28, 97 (48): 1220-25.

Møller, J. S. (1935b) 'Hygiejnens vilkår i folkeskolen på landet', *Ugeskrift for Læger*, December 5, 97 (49): 1236-42.

Møller, Niels (1937) 'Skolelægespørgsmålet', Lecture at Foreningen til skolehygiejnens fremme afholdte skolelægemøde, January 3, 1937, *Ugeskrift for Læger*, February 11, No. 6: 176-79.

Møller, Søren (2003) 'Forskellige idrætskulturer. Én idrætspolitik?' *Kulturministeriet: Børn og unge i bevægelse – Perspektiver og ideer*, June 2003, Electronic version, pp. 125-34.

Nexø, Sniff Andersen (2005) *Det rette valg. Dansk abortpolitik i 1930'erne og 1970'erne*, Ph.d.-afhandling, Institut for Folkesundhedsvidenskab, Københavns Universitet, Copenhagen.

Niclasen, Birgit Vollmer-Larsen (2005) 'Overvægt og fedme. Sociale følger, holdninger, selvværd og livskvalitet med fokus på børn og unge', *Ugeskrift for Læger*, 167 (10): 1145-48).

Nielsen, Niels Kayser (1993) *Krop og oplysning. Om kropskultur i Danmark 1780-1900*, Odense: Odense Universitetsforlag.

Nielsen, Th. (1933) 'Kan det kræves, at lægernes personlige livsførelse er sundhedsmæssig? – Nogle bemærkninger til striden omkring Dr. Hindhede', *Ugeskrift for Læger*, April 20, 93 (16): 479-80.

Nietzsche, Friedrich (1998/1887) *On the Genealogy of Morality,* Indiana: Hackett Publishing Company, Inc.

Nietzsche, Friedrich (2007/1887) *Menneskeligt, alt for menneskeligt,* Denmark: Samlerens Bogklub.

8. Nordiske kongres for legemlig opdragelse, børne- og skolehygiejne på Hindsgavl, July 1-6, 1935 (1935), Copenhagen: Thor Møller, Bogtrykkeri.

Nyborg Kommune (2008) 'Nyborg – En kommune med en vision om velvære og trivsel', *Sundhedspolitik 2008-2010*, January, Nyborg: Nyborg Kommune.

Nyborg Kommune (2009a) 'Sundhedsprofiler. Borgere i Nyborg Kommune', Nyborg: Nyborg Kommune.

Nyborg Kommune (2009b) 'Sundhedsprofiler, 7.-10. Klasse på folkeskoler og privatskoler i Nyborg Kommune', Nyborg: Nyborg Kommune.

Nyborg Kommune (2010) 'Handlingsvejledning – Når du møder et barn med overvægt', Nyborg: Nyborg Kommune.

Nyrop, Ejnar (1935) 'Indtægt – ernæring – helbred', *Samfundets krav*, Copenhagen: Dansk forening for social oplysning, Det sociale sekretariat, July 3, quarter, 36 (3): 101-27

Nyrop, Ejnar (1937a) 'Indtægt-ernæring-helbred', *Ugeskrift for Læger*, February 25, 99 (8): 227-34.

Nyrop, Ejnar (1937b) 'Indtægt-ernæring-helbred', *Ugeskrift for Læger*, March 4, 99 (9): 242-48.

Nyrop, Ejnar (1937c) 'Indtægt-ernæring-helbred', *Ugeskrift for Læger*, October 7, 99 (40): 1063-69.

Odense Kommune (2009) 'Camp Fanø - Procedurebeskrivelse til sundhedsplejersker', Odense: Odense Kommune.

Odense Kommune (2010a) 'Camp Fanø - Indsats mod overvægt og fysisk aktivitet hos børn i 5. Klasse i Odense Kommune', Odense: Odense Kommune.

Odense Kommune (2010b) 'Camp Fanø – Plan over opfølgningsmøder', Odense: Odense Kommune.

Okkels, Harald (1940) 'Om legal kastration', *Ugeskrift for Læger*, March 28, 102 (13): 287-94.

Olsen, Aksel (1936) 'Åndssvageforsorg', *Ugeskrift for Læger*, September 17, 98 (38): 904-6.

Olsen, Otto (1931) 'Idræt og karakterdannelse', *Dansk Idræt*, Friis, P. (ed.), November 15, De Danske Skytte-, Gymnastik og Idrætsforeninger, Slagelse: Centraltrykkeriet, No. 4: 56-57.

Osborne, Thomas (1997) 'Of health and statecraft' *Foucault, Health and Medicine* Petersen, Alan & Robin Bunton (ed.), London and New York: Routledge, pp. 173-88.

Osier, Ivan (1933) 'Sporten – rekorden og døden – svar til E. A. Hallas', *Ugeskrift for Læger*, June 1, 93 (22): 658-59.

Ostenfeld, Ib (1942) 'Den thyrofile type', *Bibliotek for læger*, årgang 134: 1-41, Copenhagen: Ejnar Munksgaard.

Owen, David (1995) 'Genealogy as exemplary critique: reflections on Foucault and the imagination of the political', *Economy and Society*, London: Routledge, November 4, 24: 489-506.

Pearson, Seija, Lina W. Olsen, Bente Hansen & Thorkild I. A. Sørensen (2005) 'Stigning i overvægt og fedme blandt københavnske skolebørn i perioden 1947-2003', *Ugeskrift for Læger*, 167 (2): 158-62).

Petersen, Alan (1997) 'Risk, governance and the new public health' in *Foucault, Health and Medicine*, Petersen, Alan & Robin Bunton (ed.), London and New York: Routledge, pp. 189-206.

Philipsen, Kaj (1932) 'Om forebyggelse af Gonorre', *Ugeskrift for Læger*, April 28, 94 (17): 443-44.

Plum, Preben (1945) Review of Mikkel Hindhede: "Af mit livs historie", *Ugeskrift for Læger*, November 29, 107 (48): 1031.

Pontoppidan, Erik (1903) 'Kønssygdommenes betydning og forebyggelse', *Bibliotek for læger*, series 8, 95 (4): 566-68.

Poulsen, Vald. (1934) 'Landboungdommen – gensvar til Dr. Joh. Christiansen', *Ugeskrift for Læger*, August 30, 96 (35): 960.

Rabinow, Paul & Nikolas Rose (2006) 'Biopower Today' *Biosocieties*, Cambridge: Cambridge University Press, 1 (2): 195-217.

Raffnsøe, Sverre, Marius Gudmand-Høyer & Morten S. Thaning (2008) *Foucault*, Copenhagen: Samfundslitteratur.

Raman, Sujatha & Richard Tutton (2010) 'Life, Science, and Biopower' *Science, Technology, & Human Values*, September, 35 (5): 711-34.

Rambusch, S. H. A. (1911) 'Skolebørnenens fysikalske forhold I nogle midjydske sogne' *Den Antropologiske Komite*, pp. 173-89.

Regeringen (2002) *Sund hele livet – de nationale mål og strategier for folkesundheden 2002-10*, Indenrigs- og Sundhedsministeriet, Schultz Grafisk.

Regeringen (2004) 'Handlingsplan for Offentlig-Private Partnerskaber (OPP)', Finansministeriet, Indenrigs- og Sundhedsministeriet, Trafikministeriet og Økonomi- og Erhvervsministeriet, Datagraf Auning A/S.

Rehfeld, Åge (1939) 'Skoletanker', *Ugeskrift for Læger*, March 24, 100 (12): 324-25.

Riiskjær, Søren (?) 'DGIs samarbejde med de nye kommuner – grundlag og strategi', DGI.

Ringsted, Hans Chr. (1934) 'Landboungdommen før og nu', *Ugeskrift for Læger*, August 2, 96 (31): 861.

Rohleder, Sv. (1931) 'Skolebørns sundhedstilstand', *Ugeskrift for Læger*, Correspondence, May 21, 93 (21): 575-76.

Roholm, Kaj (1948) 'Om hygiejnens stilling som fag', inaugural lecture, *Ugeskrift for Læger*, February 26, 110 (28): 817.

Rose, Nikolas (1998) *Inventing Our Selves – Psychology, power, and personhood*, London, Cambridge University Press.

Rose, Nikolas (1999a) *Governing the Soul – The Shaping of the Private Self*, London, New York: Free Association Books.

Rose, Nikolas (1999b) 'Medicine, History and the Present', Jones, Colin & Porter, Roy (ed.) *Reassessing Foucault. Power, medicine and the body*, London and New York, Routledge, pp. 48-72.

Rose, Nikolas (2007) *The Politics of Life Itself: Biopower, Power, and Subjectivity in the Twenty-First Century*, Princeton: Princeton University Press.

Rubow, Dr. Phil. (1930) 'Minderwertigkeit', *Ugeskrift for Læger*, November 27, No. 48: 1109-10.

Rud, Einar (1942) Review of Inge Funding, Frode Rydgaard: "Lærebog og håndbog i sygepleje", *Ugeskrift for Læger*, July 30, 104 (31): 804-5.

Rud, Holger (1935a) 'Åndelig hygiejne', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, September 1, 1 (3): 9-11.

Rud, Holger (1935b) 'Åndelig hygiejne', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, September 1, 1 (10): 1-4.

Rud, Holger (1935c) 'Åndelig hygiejne', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, October 1, 1 (11): 3-6.

Rørdam, Holger (1933) 'Ungdommens fysiske habitus og ernæringsproblemet', Correspondence, *Ugeskrift for Læger*, August 3, 93 (31): 851-52.

Rørdam, Holger (1934) 'Landboungdommens sundhed', *Ugeskrift for Læger*, August 9, 96 (32): 878.

Schlanbush, I. (1931) 'Skolens sundhedstilstand og dens indflydelse på skolens resultater', Correspondence, *Ugeskrift for Læger*, May 7, 93 (19): 516-17.

Schmidt, Lars-Henrik og Kristensen, Lens Erik (1986) *Lys, luft og renlighed – den moderne socialhygiejnes fødsel*, Copenhagen: Akademisk forlag.

Schmidt, Vivien (2008) '*Bringing Ideas and Discourse Back into the Explanation of Change in Varieties of Capitalism and Welfare State*', May 2008, Working Paper No. 2, UK: The University of Sussex.

Schmidt, Vivien (2010) 'Taking ideas and discourse seriously: explaining change through discursive institutionalism as the fourth 'new institutionalism'', *European Political Science Review*, 2 (1): 1–25.

Secher, Knud (1931) i *Dansk Idræt* (P. Friis, red.) April 1, No. 13, *De Danske Skytte-, Gymnastik og Idrætsforeninger*, Slagelse: Centraltrykkeriet, pp. 195-200.

Sheldon, William (1940) *The Varieties of Human Physique*, New York: Harper & Brothers.

Simonsen, K. (1936) 'Intelligensundersøgelser hos børn i de første leveår ad mod. Bühler og Hetzer', *Ugeskrift for Læger*, April 16, 98 (16): 354-55.

Skinner, Quentin (1988) 'A Reply to My Critics', Tully, J. (ed.) *Meaning & Context: Quentin Skinner and his Critics*. Princeton, NJ: Princeton University Press, pp. 231–88.

Skinner, Quentin (2002) *Visions of Politics*, *Vol. 1,* 'Regarding Method', Cambridge: Cambridge University Press.

Smith, Jens Chr. (1928) 'Racehygiejne', *Ugeskrift for Læger*, December 17, 90 (52): 1205-6.

Smith, Jens Chr. (1929) Review by August Wimmer: "Sindssygdommenes arvegang og raceforbedrende bestræbelser", Lectures at Uppsala Universitet, *Ugeskrift for Læger*, July 4, 91 (27): 571-72.

Smith, Jens Chr. (1932) 'Åndssvaghedens årsagsforhold belyst ved undersøgelser af tvillinger', *Den Antropologiske Komite 1929-1932*, pp. 83-234.

Social Denmark – A survey of the Danish Social Legislation (1947) Copenhagen: Socialt Tidsskrift.

Statens Institut for Folkesundhed (2007) 'Folkesundhedsrapporten Danmark' Kjøller, M. Juel and Kamper-Jørgensen (ed.), Copenhagen: Statens Institut for Folkesundhed.

Steensby, H. P. (1911) 'Foreløbige betragtninger over Danmarks raceantropologi', *Den Antropologise Komite*, pp. 82-172.

Steincke, K. K. (1928) 'Sociallovgivning og racehygiejne', Lecture in Medical Society, *Ugeskrift for Læger*, December 6, 90 (49): 1138-45.

Steincke, K. K: (1930) *Sociallovgivningens revision*, Socialminister Steinckes tale ved lovforslagets forelæggelse i folketinget d. 12. december 1929, Socialdemokratisk forbund i Danmark, Copenhagen: Forlaget "Fremad".

Stockard, Charles, R. (1931) *The Physical Basis of Personality*, New York: W. W. Norton & Company, Inc.

Stockard, Charles R. (1941) *The Genetic and Endocrinic Basis for Differences in Form and Behavior – As elucidated by studies of contrasted pure-line dog breeds and their hybrids*, Philadelphia: The Wistar Institute of Anatomy and Biology.

Strömgren, Erik (1942) Review of Paul J. Reiter: "Martin Luthers Umwelt, Character und Psykose", *Ugeskrift for Læger*, January 15, No. 3: 69-70.

Støckel, Jan Tofteggard (ed.) (2008) *Parallel leg eller integreret leg? Partnerskaber om børn, leg og bevægelse*, Evaulations report for Danske Gymnastik- og Idrætsforeninger and Region Syddanmark, Center for forskning i Idræt, Sundhed og Civilsamfund, Institut for Idræt og Biomekanik, Odense: Syddansk Universitet, Movements 2008: 2.

Sund levevis - Populært tidsskrift for ernæring og hygiejne (1936) 'De skal veje så mange kg, som de måler cm over 1 m.', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, April 1, 2 (4): 14.

Sund levevis - Populært tidsskrift for ernæring og hygiejne (1938a) 'Den unge lovovertræder. Fysiske forhold spiller ofte ind', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, June 1, 4 (6): 139.

Sund levevis - Populært tidsskrift for ernæring og hygiejne, (1938b) 'Ungdom – kriminalitet – alkohol – det voksende antal ungdomsforbrydelser og nogle årsager dertil', *Sund levevis - Populært tidsskrift for ernæring og hygiejne*, September 1, 4 (9): 227-28.

Sundhedsministeriet (1989a) 'Regeringens forebyggelsesprogram – Dokumentationsdel', Copenhagen: Sundhedsministeriet.

Sundhedsministeriet (1989b) 'Regeringens forebyggelsesprogram – Programdel', Copenhagen: Sundhedsministeriet.

Sundhedsstyrelsen (1924) *Sundhedsstyrelsens årsberetning for 1923*, Johansen, Anders (ed.), Copenhagen: H. Hagerups Forlag.

Sundhedsstyrelsen (1926) *Sundhedsstyrelsens årsberetning for 1925*, Johansen, Anders (ed.) Copenhagen: H. Hagerups Forlag.

Sundhedsstyrelsen (1927) *Sundhedsstyrelsens årsberetning for 1926*, Johansen, Anders (ed.), Copenhagen: H. Hagerups Forlag.

Sundhedsstyrelsen (1930) *Medicinalberetning for den danske stat for året 1928*, Copenhagen: H. Hagerups Forlag.

Sundhedsstyrelsen (1933a) *Medicinalberetning for den danske stat for året 1931*, Copenhagen: Fr. Bagges Kgl. Hofbogtrykkeri.

Sundhedsstyrelsen (1933b) *Sundhedsstyrelsens årsberetning for 1932*, Nielsen, A.V. (ed.), Copenhagen: H. Hagerups Forlag.

Sundhedsstyrelsen (1936) *Medicinalberetning for den danske stat for året 1934*, Copenhagen: H. Hagerup.

Sundhedsstyrelsen (1937) *Medicinalberetning for den danske stat for året 1935*, Copenhagen: H. Hagerup.

Sundhedsstyrelsen (1999) 'Overvægt og fedme – Befolkningens sundhed set i relation til den øgede forekomst af fedme i Danmark', Sundhedsstyrelsen.

Sundhedsstyrelsen (2003a) 'Fysisk aktivitet – Håndbog om forebyggelse og behandling', Klarlund Pedersen, Bente & Bengt Saltin (ed.), J. H. Schultz Grafisk.

Sundhedsstyrelsen (2003b) 'Oplæg til national handlingsplan mod svær overvægt – Forslag til løsninger og perspektiver', Sundhedsstyrelsen, Center for Forebyggelse: J. H. Schultz Grafisk A/S.

Sundhedsstyrelsen (2003c) 'Oplæg til national handlingsplan mod svær overvægt – Forslag til løsninger og perspektiver', Sundhedsstyrelsen, Center for Forebyggelse: J. H. Schultz Grafisk A/S. SHORT VERSION.

Sundhedsstyrelsen (2005) 'Terminologi. Forebyggelse, sundhedsfremme og folkesundhed', Sundhedsstyrelsen, No. 27.

Sundhedsstyrelsen (2007a) 'Borgerrettet forebyggelse og lighed i sundhed – Planlægning af forebyggende indsatser til socialt udsatte grupper', Sundhedsstyrelsen.

Sundhedsstyrelsen (2007b) 'Politik for bevægelse i kommuner og skoler – et inspirationsmateriale til teori og praksis', Sundhedsstyrelsen & Videncenter for Sundhedsfremme, Schultz Grafisk A/S.

Sundhedsstyrelsen (2011a) 'Fællesindhold til indberetning til Sundhedsstyrelsens børnedatabase', Sundhedsstyrelsen.

Sundhedsstyrelsen (2011b) 'Ulighed i sundhed – Årsager og indsatser', May 17, Sundhedsstyrelsen.

Sundhedsstyrelsen (2011c) 'Vejledning om forebyggende sundhedsindsatser til børn og unge', Sundhedsstyrelsen.

Sundhedsstyrelsens medicinalstatistiske kontor (1925) *Medicinalberetning for den danske stat for året 1923*, Hansen, H. J. (ed.), Copenhagen: H. Hagerups Forlag.

Sundhedsstyrelsens medicinalstatistiske kontor (1926) *Medicinalberetning for den danske stat for året 1924*, Hansen, H. J. & Robert Nielsen, Copenhagen: H. Hagerups Forlag.

Svendsen, Ole Lander (2004) 'Fedmeepidemien har ramt Europa', *Ugeskrift for Læger*, 166/1-2: 25.

Sygeplejen (1926), Tale ved Nationalforeningen til tuberkulosens bekæmpelse ved 25 års jubilæet 16. Januar 1926, Udgivet af Centralforeningen af sygeplejevirksomheder udenfor København, February, Voltelen, J. (ed.) Slagelse: Sorø Amtstidendes Bogtrykkeri, 17 (2): 13-23.

Sylvest, Ejnar (1934) Litteraturanmeldelse af M. Hindhede: "Fuldkommen sundhed og vejen dertil", *Ugeskrift for Læger*, August 9, 96 (32): 881-83.

Sørensen, Eva & Jacob Torfing (2005) 'The Democratic Anchorge of Governance Networks', *Scandinavian Political Studies*, Vol. 28, No. 3: 195-218.

Sørensen, P. (1934) 'Landboungdommen', *Ugeskrift for Læger*, August 9, 96 (32): 878.

Sørensen, Thorkild I. A. (2011) *'Kan usikkerhed gøre os fede?*', Tema: Fedmeforskning, Bispebjerg Hospital, March 2011, pp. 6-7.

Teglgaard, Karen (2004) *Sundhed – en del af DGI's formålsparagraf*, Debatindlæg af Karen Teglgaard, medlem af DGI's hovedbestyrelse, DGI.

Th. (1931) 'Idrættens mål og værdier' i *Dansk Idræt*, Friis, P. (ed.) April 15, De Danske Skytte-, Gymnastik og Idrætsforeninger, No. 14, Slagelse: Centraltrykkeriet, pp. 218-20.

Thomsen, Oluf (1934) *Menneskets arvelighedsforhold*, Copenhagen: Povl Branner.

Triantafillou, Peter (2004) 'Addressing Network Governance Through the Concept of Governmentality and Normalization', *Administrative Theory & Praxis*, 26 (4): 489-508.

Triantafillou, Peter (2005) *Metodologiske problemstillinger i Michel Foucaults genealogiske magt- og frihedsanalytik: Ti bud*, Research Papers from the Department of Social Sciences, Roskilde: Roskilde University.

Troelsen, Jens (ed.) (2010) *Bevægende rammer – Omgivelsernes betydning for fysisk aktivitet og sundhed*, Odense: Syddansk Universitetsforlag.

Tvedegård, H. (1934) 'Landboungdommens dårlige holdning', *Ugeskrift for Læger*, August 9, 96 (32): 878-79.

Ugeskrift for Læger (1923), Review of R. Kjer Petersen: "Begyndende brystsyge", 85 (11): 196.

Ugeskrift for Læger (1923), Review of W. Allen Daley: "Hygiejnisk folkeoplysning", 85 (21): 384.

Ugeskrift for Læger (1924a), Review of E. V. McCollum: "The Newer Knowledge of Nutritian. The Use of Food for the Preservation of Vitality and Health", 86 (6): 125.

Ugeskrift for Læger (1924b), Review of Poul Hertz: "Lægen i skolen", May 1, 86 (18): 379-80.

Ugeskrift for læger (1924c), Review of C. E. A. Winslow: "Modern Public Health Campaign", May 29, 86 (22): 446.

Ugeskrift for Læger (1924d) 'Den store skolekommissions betænkning', Kuhn, Johan (ed.) February 7, 86 (6): 127-30.

Ugeskrift for Læger (1925), Review of H. Dragehjelm: "Vægt i forhold til højde, alder og legemstype", November 12, 87 (46): 1019-20.

Ugeskrift for Læger (1926a) Review of Gottstein et al.: "Håndbog i social hygiejne og sundhedsmæssig forsorg", March 4, No. 9: 229.

Ugeskrift for Læger (1926b) Anmeldelse af W. H. Hamer og C. W. Hutt: "A Manual of Hygiene", April 15, Vol. 88, No. 15: 383.

Ugeskrift for Læger (1927) Review of Carl Schiøtz: "Skolealderen – Utviklingsforhold, sygdomslære og hygiejne. En utredning for læger og medicinske studerende", December 8, 8 (49): 1161-63.

Ugeskrift for Læger (1935), Nordisk kongres for legemlig opdragelse, børne- og skolehygiejne, January 31, No. 5: 161.

Ugeskrift for Læger (1939) Review of A. Scheunert: "Nutidens folke-ernærings-spørgsmål og deres eksperimentelle besvarelse", August 4, 100 (31): 892.

Vallgårda, Signild (2003) *Folkesundhed som politik. Danmark og Sverige fra 1930 til i dag*, Århus: Århus Universitetsforlag.

Vallgårda, Signild (2009) 'Forebyggelse og sundhedsfremme – definitioner, historie og magtudøvelse', in Glasdam, Stinne (red.) *Folkesundhed – i et kritisk perspektiv*, Dansk Sygeplejeråd, Copenhagen: Nyt Nordisk Forlag Arnold Busck.

Vucina, Naja & Peter Triantafillou (2009) 'HIV, Constructionism and Biopower', *Distinktion: Scandinavian Journal of Social Theory*, No. 18: 29-46.

Vucina Pedersen, Naja (2011) *'Frivillige organisationers rolle i samarbejdsdrevne innovationsprocesser inden for den forebyggende sundhedsindsats*', in Eva Sørensen & Jacob Torfing (red.) Samarbejdsdrevet innovation i den offentlige sektor, Denmark: Jurist- og Økonomforbundets Forlag.

Vucina, Naja, Claus Drejer & Peter Triantafillou (2011) 'Histories and Freedom of the Present: Foucault and Skinner' *History of the Human Sciences*, 24 (5): 124-41.

West, Knud (1940) 'Ernæringsvejledning', *Ugeskrift for Læger*, November 28, 102: 48: 1276.

WHO (1986) 'The Ottawa Charter for Health Promotion – First International Conference on Health Promotion, Ottawa, 17-21 November 1986', WHO: Milestones Health Promotion: Statements from Global Conferences.

WHO (1999) 'The WHO Global Initiative on Active Living', Department of Health Promotion, Social Change and Mental Health Cluster, WHO: Geneva. Internet version, Downloaded 23/8/10.

WHO (2000) 'Meeting of the Active Living National Policy Network – Report of a WHO Meeting', Ottawa, Canada, September 14-16 1998, WHO/NMH/HPS/00.5. Internet version, Downloaded 23/8/10.

WHO (2009) 'Reducing health inequities through action on the social determinants of health', Sixty-second World Health Assembly, May 22, WHO.

Wildenskov, H. O. (1933) 'Den danske sterilisationslov og åndssvageforsorgen', *Ugeskrift for Læger*, November 9, 93 (45): 1222-30.

Wimmer, August (1909) *De sjæleligt abnorme børn blandt værgerådsbørnene, deres antal, erkendelse og behandling*, Copenhagen: Dansk Kriminalistforening.

Wimmer, August (1911) *Alkohol, dens virkning på individet og i samfundet*, Grundrids ved folkelig universitetsundervisning, No. 195, Universitetsforlaget, Jacob Erslev.

Wimmer, August (1929) *Sindssygdommenes arvegang og raceforbedrende bestræbelser – Forelæsninger holdt ved Uppsala Universitet 1928*, Copenhagen: Levin & Munksgaards Forlag.

Wimmer, August (1930) 'Alkoholismen', Retspsykiatriske forelæsninger *Ugeskrift for Læger*, March 27, No. 13: 308-15.

Winge, Øjvind, (1919) 'Om den ikke Mendlende arvelighed hos brogetbladede planter', *Meddelelser fra Carlsberg Laboratoriet*, 14 (3): 1-20.

Winge, Øjvind (1921) 'Om delvis kønsbunden nedarvning af øjenfarven hos mennesket', *Meddelelser fra Carlsberg Laboratoriet*, 14 (12): 1-22.

Winge, Øjvind, R. Spärk, Gudmund Hatt, Oluf Thomsen, Aug. Goll, K. K. Steincke, Aug. Wimmer, Axel Garboe, Albert Olsen (1934) *Arv og race*, Udgivet af Dansk forening for social oplysning, Nyt Socialt Bibliotek, Copenhagen: Martins Forlagstrykkeri.

Winge, Øjvind (1937) *Arvelighedslære – på eksperimentel og cytologisk grundlag*, Copenhagen: H. Hagerups Forlag.

Winge, Øjvind (1941) *Alkohol og arvelighed*, Landsforeningen Den Personlige Friheds Værn, Copenhagen: Gyldendalske Boghandel.

Wöldike, U. H. (1907) *'Skolen og det seksuelle spørgsmål'*, foredrag v. de højere almueskolers lærermøde i oktober 1906, Dansk Forening til Kønssygdommenes Bekæmpelse, Copenhagen: Martius Truelsens Bogtrykkeri.

Wøllekær, Johnny (1993) 'Gymnaster iblandt skytter – en analyse af gymnastikkens vilkår i Odense Amts skytteforening 1866-1929', *Livsrum, myter og praktikker – idrætshistorie, kulturanalyse og kulturteori* (1993), Idrætshistorisk årbog 1992, Hansen, Jørn & Else Trangbæk (ed.), Odense: Odense Universitetsforlag, pp. 9-19.

Ørum, H. P. T. (1924a) Review of 'Nordisk kongres for fysisk opdragelse og skolehygiejne 28. September til 1. Oktober 1924 i Kristiania', *Ugeskrift for Læger* November 20, 86 (47): 908-10.

Ørum, H. P. T. (1924b) 'Skolebørns vækstforhold', *Ugeskrift for Læger*, October 16, 86 (42): 797-99.

Ørum, H. P. T. (1925) 'Undervægtige skolebørn – en skolehygiejnisk oversigt', *Ugeskrift for Læger*, March 19, 87 (12): 300-302.

Ørum, H. P. T. (1926) Review of iv nordiske kongres for legemlig opdragelse og skolehygiejne, *Ugeskrift for Læger*, September 16, 88 (37): 851-52.

Ørum, H. P. T. (1927) *'Sundhedslæren som undervisningsfag eller –princip'*, July 7, 89 (27): 601-4.

Aagaard, Peter (2007) *Det unikkes dynamikker – De institutionelle mulighedsbetingelser bag den individuelle udforskning i professionelt og frivilligt arbejde*, Copenhagen: Samfundslitteratur.

Interviews

19.11.09: Annegrete Månsson, appointed coordinator of Grib Chancen.

19.11.09: Anita Hyldal Hansen, works for DGI Greater Copenhagen and is part of 'Kostpatruljen' under 'Børneidrætsudvalget' as well as the chair leader of the Overweight Association founded by DGI Greater Copenhagen and is a member of 'Børneidrætsudvalget'.

19.1.10: Stine Krum, dietician and member of the steering committee for Grib Chancen.

Notes

19.11.09 Dialogue meeting, Nyborg municipality

16.1.10 Visionary Seminar for Overweight Association, DGI Greater Copenhagen, Comwell, Helsingør.

3.3.10 Network Meeting, DGI Fyn.

29.4.10 Information meeting for *Seize the Chance*, DGI Fyn.

8.6.10 Trip with health professionals to *Camp Fanø*

29.11.10 Evaluation of *Seize the Chance* by Bjarne Ibsen & Louise Kamuk Storm from University of Southern Denmark, DGI Fyn.

DANISH ABSTRACT

Denne Ph.d. har sit afsæt i en undersøgelse af bekæmpelsen of overvægt i Danmark blandt børn og unge. Med udgangspunkt i Michel Foucaults magtanalytik udvikler jeg en konceptuel og metodisk ramme til at analysere styring gennem sundhed med Foucaults begreb om biomagt for øje. Det indebærer en hensynstagen til både et totaliserende niveau, med fokus på de magt-viden relationer der retter sig mod befolkningen og samfundet som en helhed, og et individualiserende niveau, med fokus på de magt-viden relationer retter sig mod individer i kraft af deres individualitet. Således begrebsliggør jeg tre niveauer, hvor magt-viden relationer udfolder sig: Med *Exteriority* begrebsliggør jeg hvordan det menneskeskabte miljø, samfundet m.m. problematiseres og teknikaliseres gennem forebyggende sundhedsforanstaltninger og sundhedsfremmende foranstaltninger. Med *Corporeality* begrebsliggør jeg hvordan kroppen og den menneskelige fysik problematiseres og teknikaliseres gennem forebyggende og sundhedsfremmende foranstaltninger. Endelig, med *Interiority* begrebsliggør jeg hvordan menneskets indre – sindet, selvværd, morale osv. – problematiseres og teknikaliseres gennem forebyggende og sundhedsfremmende foranstaltninger.

Analysen er delt i to: En historisk og en nutidig del. I den historiske del tager analysen udgangspunkt i perioden 1920 til 1940 med fokus på lægevidenskabelige, biologiske, antropologiske og velfærdsøkonomiske problemstillinger og tiltag mod på den ene side racens dalende kvalitet og på den anden side dårlig hygiejne i hjemmene. Jeg viser hvordan velfærdstiltag kobles til racehygiejniske tiltag i et forsøg på at sikre racens kvalitet. Samtidig iværksættes en omfattende kropskultur, med fokus på gymnastik og bevægelse, samt målrettede forsøg på at sikre hjemmene mod dårlig hygiejne og spædbørnsdødelighed. I nutidskapitlet tager analysen udgangspunk i to DGI- kampagner mod overvægtige børn. Jeg undersøger dels hvordan samarbejdsdrevet netværk fordrer en bestemt administrativ praksis og dels hvordan de konkrete projekter der retter sig mod at gøre overvægtige børn sundere

fordrer en særlig evne til at reflektere over egen sundhed og træffe de rigtige valg med hensyn til at leve et sundt liv. En central pointe er, at i dag udgør *subjektivitet* et væsentligt element i måden hvorpå forebyggende og sundhedsfremmende tiltag retter sig både mod overvægtige børn og unge og mod administrationen af selvsamme.

ENGLISH ABSTRACT

This PhD centres on investigating the fight against obesity among children and young people in Denmark. Taking the point of departure in Michel Foucault's power analytics, I develop a conceptual and methodological framework for analysing health government along the lines of Foucault's notion of biopower. This entails taking into consideration both a totalising level, focusing on the power-knowledge relations that target the population and society as a whole, and an individualising level, focusing on power-knowledge relations that target individuals by virtue of their individuality. On this score, I conceptualise three levels through which power-knowledge relations unfold: with *Exteriority* I conceptualise how the human environment, society and general surroundings are problematised and technicalised through preventive and health promoting arrangements. With *Corporeality* I conceptualise how the body and the human physique are problematised and technicalised through preventive and health promoting arrangements. Finally, with *Interiority* I conceptualise how a realm within the human being – the mind, self-esteem, morale and the like – is problematised and technicalised through preventive and health promoting arrangements.

The analysis is divided into two parts: the interwar era and the millennial era. The first takes its point of departure in the period 1920 to 1940 with a focus on medical, biological, anthropological and welfare-economic problematisations and measures aimed at, on the one hand, the decreasing quality of the race and on the other hand, bad hygiene in the homes. I illustrate how welfare is linked to eugenic measures in an attempt to secure the quality of the race. At the same time, an extensive body culture is promoted, with a focus on gymnastics and movement, and concurrent attempts to secure homes against bad hygiene and infant deaths. In the millennium chapter, the analysis takes its point of departure in Danish Sports Organisation campaigns aimed at obese children. I investigate how collaborative networking engenders a particular administrative practice and at the same time how initiatives

aimed at obese children engender a specific way to reflect upon one's own health and make decisions towards living a healthy life. A central point is that today *subjectivity* makes up a crucial element in the ways preventive health and health promoting arrangements target both obese children and young people, and the health professionals involved with them.