Off the couch and on the move: Global public health and the medicalisation of nature

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Abstract

In May 2004 the World Health Organization (WHO) officially launched the ‘Global Strategy on Diet, Physical Activity and Health’. Lying at its heart is the recognition that many of the risk factors associated with non-communicable diseases, particularly poor diet and physical inactivity, have begun to move beyond the confines of the West. It was this apparent shift in the epidemiological boundaries of such diseases, along with fears over the so-called ‘double burden’ that they presented to some nations, that finally prompted the WHO to develop such a far reaching strategy. This paper adds to the on-going debate surrounding this important issue by drawing on the concepts of medicalisation, governmentality and the spatiality of scientific knowledge to explore one particular element of it: namely, the identification of nature as a setting for the promotion of physical activity. We adopt this perspective because we are concerned to understand the ways in which the knowledge and practice of the ‘new’ public health travels. As our analysis reveals, in many Western nations the natural environment has emerged as an important ‘transactional zone’ where the governmental imperative for the production of fit and active bodies coalesces with the individual desire to be healthy. However, while it is apparent that this physical activity discourse increasingly operates throughout the globe, there is less evidence of an equivalent discourse that promotes the health-related benefits of nature. We argue that this is significant because it helps us to recognise that contemporary public health discourse has a distinct geography.

Keywords: Public health; Mobility; Nature; Governmentality; Medicalisation; Spatiality of knowledge

Introduction

The time is right for health promoters to take a close look at the evidence of the impacts nature has on the health of individuals and communities. Why? Because we may actually be able to achieve more appropriate and sustainable conditions that support health than if we only address interventions that focus on a particular health issue… (St Leger, p. 174).

The above quotation is taken from an editorial, published in the journal Health Promotion International. As implied, the editorial sought to encourage health promotion experts to re-examine the scientific evidence surrounding the links between the natural environment and health. In an earlier article, another advocate of nature’s health-related benefits presented a similar argument when he suggested that environmental, and by association public, health needs to move beyond its current
focus on toxicity: “If people have regular contact with flowers or trees, do they report greater wellbeing, better sleep, fewer headaches, reduced joint pain? Do inner city children who attend a rural summer camp have better health during the next semester at school than their friends who spent the summer in the city?” (Frumkin, 2001, p. 238).

For many geographers, the idea that nature should be thought about in this way will come as little surprise. In his highly influential paper on therapeutic landscapes, Gesler (1992, p. 736) identified some of the ways in which health and wellbeing have come to be associated with the natural environment: “whether this entails materials such as medicinal plants, the fresh air and pure water of the countryside, or magnificent scenery”. The response to Gesler’s initial account has been an examination of the relationship between landscape or place and health (see Williams, 1998).

A key feature of this literature is its recognition that the connection between therapeutic landscapes and human health is a relational one. As Conradson (2005) suggests, an interest in the relational dynamics of therapeutic landscapes has been present in geographical research on gardening (Milligan, Gatrell, & Bingley, 2004), walking (Palka, 1999), and exercise and play (Kearns & Collins, 2000).

While such studies vary both in the approaches they adopt and the scales at which they operate, they often take as their starting point the idea that contact with nature “affords a range of personal, social and health benefits” (Milligan et al., 2004, p. 1785). The purpose of this paper is to reflect a little more critically on this belief because we are interested to explore how this discourse relating to nature and health has been captured by the ‘new’ public health. In order to do so, we refer to literatures that sit outside of the therapeutic landscapes tradition; namely, those relating to medicalisation, governmentality and the spatiality of knowledge. We begin with the former because, as Nye (2003, p. 117) indicates, medicalisation is not only understood in terms of the “nefarious collaboration of experts and state authority” imposing their will from above. Rather, it is also thought of in less pejorative terms, as a “process whereby medical and health precepts have been embodied in individuals who assume this responsibility for themselves”.

Central to this interpretation is the notion of “governable space” (Rose, 1999, p. 31ff). Here, regulated freedom, as a form of neo-liberal rule, is seen to operate through the alignment of governmental objectives with personal life-projects. This process is argued to occur within certain spaces, or particular micro-locales, “where authorities of all types exercise their powers over the conduct of others” (Rose, 1999, p. 36). We suggest in this paper that the natural environment has emerged in contemporary public health discourse as such a micro-locale. As we go on to demonstrate, this is in part related to the intuitively held belief that health and nature are intricately linked; what Arnold (1996) terms the ‘environmentalist paradigm’. However, it is also closely associated with the production of active rather than sedentary bodies within related physical activity debates. Following this, we turn our attention to a discourse that promotes nature as a setting within which the governmental and personal desires for good health can be translated into embodied practice.

There is, however, one further issue that we seek to address. In the preface to the World Health Report, 2002, the then director-general of the World Health Organization (WHO), Dr. Gro-Harlem Brundtland, stated that “the world is living dangerously, either because it has little choice or it is making the wrong choices” (WHO, 2002a, p. 4). Made in light of epidemiological evidence suggesting that a global “risk transition” is currently underway, this statement identifies unhealthy patterns of food consumption and physical inactivity as two of the major risk factors for premature death. Such a threat is not new to many countries in the West. Indeed, until recently chronic or non-comunicable diseases were referred to as ‘diseases of affluence’ and were seen to reflect problems associated with the ‘Western lifestyle’ (McKeown, 1988; Trowell & Burkitt, 1981). The response of the WHO to this ‘crisis’ was to establish a Global Strategy on Diet, Physical Activity and Health (see WHO, 2004).

Officially launched in May 2004, the Global Strategy was described by Brundtland’s replacement, Dr. Lee Jong-Wook, as a “landmark achievement in global public health policy” (WHO, 2004). In many regards, the Director-General’s triumphant remarks do not appear too far off the mark. While only in its infancy, the strategy is already extremely wide-ranging and has been endorsed by most national governments, especially those in the West. There is, however, one aspect of the discourse surrounding the strategy that is of particular interest; that is, the belief that risk behaviours...
“travel across countries and are transferable from one population to another like an infectious disease...” (WHO/FAO, 2003, p. 5. Emphasis added). What is significant here is the parallel movement of ideas and practices associated with the management of these risk behaviours. Put differently, we seek to explore whether public health knowledge and practice travels (see Shapin, 1998).

We finish, then, by reflecting on the ways in which ideas about the natural environment and physical activity have been engaged with in different national contexts. We do so because we recognise that surprisingly there has been neither a sustained attempt to explore the spatiality of such knowledge nor the difference that place makes to it. Given the current prominence attached to the Global Strategy there is an urgent need to explore how this differs according to the “domains that constitute its geography and transform its meaning” (Davies, Day, & Williamson, 2004, p. 293). By examining some of these differing domains, we are able to highlight the spatiality of this particular form of knowledge and, at the same time, locate and problematise contemporary debates regarding the interrelationship between nature and health.

The medicalisation of nature

According to the medical sociologist, David Armstrong, “[a] body analysed for humours contains humours; a body analysed for organs and tissues is constituted by organs and tissues; a body analysed for psychosocial functioning is a psychosocial object” (Armstrong, 1994, p. 25). In this statement, Armstrong suggests that knowledge of the body has altered as the medical gaze has shifted both in terms of the perspective that it adopts and the objects upon which it is focused. A similar argument might be made in relation to the medicalisation of nature, for, like the body, neither the idea of nature nor its relationship to health is constant. Given this, we begin our analysis by briefly mapping out some of the differing ways in which this relationship has been expressed.

As Arnold (1996) suggests, the ‘environmentalist paradigm’ provides a distinctive model for understanding the importance of the natural environment to the history of human development. Located within a philosophical tradition that dates back to the Hippocratic treatise On Airs, Waters and Places, the environmentalist paradigm covers a wide range of interpretative possibilities included among them the recognition that nature and human health are dynamically interlinked. While its origins lie in antiquity, the Hippocratic tradition began to flourish from the early modern period and informed studies conducted throughout Continental Europe and North America, but also to a lesser extent in Britain (Valencius, 2000). In many of these accounts, the interrelationship between nature and health was presented in a less than positive light, with disease the focus of attention and the natural environment pathologised, particularly in a deeply ingrained imaginative geography of ‘the Tropics’. Moreover, for many scholars, it was not simply disease that was conditioned by “topography and climate” but “everything from human physiology to religion and mortality” (Arnold, 1996, p. 21).

Yet, closely intertwined with this pathologising discourse were contrasting ideas about the therapeutic qualities of nature. As Porter (1997) explains, during this period the size and number of spa towns increased throughout Europe, the therapeutic properties of the seaside were widely acknowledged and the idea of “good air” was invoked in remedies to improve the constitution and “strengthen the nerves” (for further examples see Conradson, 2005; Smyth, 2005). In addition, these were ideas that were translated into the colonial context (Jennings, 2002). According to Kenny (1995), the British hill stations in India were perceived to be healthy environments because of their cooler climate and the apparent lack of diseases, particularly malaria. Similar observations were made in other colonial settings; for example, early representations of the East African highlands have been shown to promote the climate as “healthy and invigorating” (Kennedy, 1981) and 19th century tourism and settler patterns are believed to have been influenced by the “healthiness of the temperate” climate in the Cape Colony (Deacon, 2000).

These theories regarding the symbiotic relationship between the environment and health were pursued by a wide range of individuals, including historians, geographers, medical physicians and colonial administrators (Arnold, 1996). Furthermore, they often drew upon the knowledge and understanding of other disciplines in an attempt to enhance their own scientific standing (see Harrison, 2000; Rupke, 1996). Despite this, the challenge from new epistemological frameworks appeared too difficult to withstand. Alternative theories, most notably germ theory, supported as it was by modern laboratory research, began to challenge the central
tenets upon which the environmentalist paradigm was based: “climate and vegetation had been reduced, disarmed, and exonerated; “nature” appeared ever less determinate and implacable” (Anderson, 2000, p. 147). However, while environmental determinism was on the wane at the beginning of the 20th century, the idea that nature and health are intricately linked has remained.

There are many examples where this is the case. For instance, in the 1950s and 1960s medical biometeorology sought to establish itself as “the science studying the influence of weather and climate on the living organism” (Tromp, 1963). Where this particular body of inter-disciplinary research continues on the margins of contemporary scientific explanation, another area of scholarship has become central to the ways in which the environmental paradigm is currently imagined; namely environmental psychology. Closely associated with Wilson’s (1984) ‘biophilia hypothesis’, the idea that people feel an innate connectedness with the natural environment, such research has sought to explain how contact with, and appreciation of nature, contributes to a person’s health and wellbeing. According to Frumkin (2001), the evidence for this interrelationship is extremely widespread. For example, where some scholars suggest that simple contact with nature has a restorative effect (Kaplan & Kaplan, 1989; Ulrich, 1979, 1984), others point to the social and psychological benefits of horticulture (Sempik, Aldridge, & Becker, 2002), pet ownership (Wood, Giles-Corti, & Bulsara, 2005), or the ‘wilderness experience’ (Cumes, 1998).

The importance of the environmental psychology literature, to this paper at least, is that it has played a prominent role in (re)positioning the natural environment at the centre of contemporary public health debates, particularly in the West. For individuals such as St Leger (2003), this body of scholarship provides the necessary scientific evidence base to justify a much broader engagement with nature by health promotion specialists and other related health professionals. While debates regarding the importance of differing forms of evidence are important (on which see Raphael, 2000), our concern lies with the capturing of this interrelationship between nature and health within a broader set of debates. More specifically, we focus our attention on a discourse which presents nature as a ‘setting for health’, not simply because of the physical qualities of a particular landscape, although this remains important, but because of the range of physical activities that can take place within it.

‘Capturing’ nature, moving for health

Thus far, we have sought to highlight some of the shifts in the environmental paradigm as a way of demonstrating the enduring belief that nature and human society are dynamically linked. In this section, we move beyond these debates to consider how elements of this understanding have been mobilised in contemporary public health debates. More specifically, we argue that Rose’s (2001) notion of the ‘transactional zone’ is a useful concept for understanding the ways in which the natural environment has been appropriated by a broader discourse related to the promotion of physical activity. That a link has been made between physical activity and the natural environment should come as little surprise. As Hughes (2004) notes, 19th century public health concerns regarding urban sanitation were, in Britain as elsewhere, mirrored by an emergent ‘open air’ movement that resulted in the expansion of parks and other green spaces throughout the industrial landscape (see also Bryder, 1992; Bunce, 1994; Conway & Lambert, 1993). The significance of this is illustrated especially well in Matless’s (1998) examination of landscape and identity in inter-war England. As he reveals, exposure to nature through such spatial practices as walking, hiking, orienteering or climbing were seen to be closely allied to the development of a healthy, “open-air body”.

The contemporary refocusing on physical activity and nature is, in part, related to this valorisation of the natural environment as a place of “physical and spiritual regeneration” (Williams, 1973, p. 252). However, the relationship between the two was given greater scientific authority with the publication of the US Surgeon General’s report, Physical Activity and Health, in 1996. Widely regarded as a benchmark in the field, the report suggests that a “regular, preferably daily regimen of at least 30–45 min of brisk walking, bicycling, or even working around the house or the yard” will drastically reduce the risk of developing chronic diseases such as coronary heart disease, hypertension, certain cancers, and diabetes (US Department of Health and Human Sciences, 1996, p. 1). The report’s importance here lies with its helping to reterritorialise everyday spaces, including spaces of nature, as sites for the maintenance of good health.
Indeed, even a cursory glance at current literature reveals a considerable interest in the role that nature plays in the promotion of physical activity (for example, see Giles-Corti & Donovan, 2002; Owen, Humpel, Leslie, Bauman, & Sallis, 2004).

As Raphael (2000) suggests, the significance of this overlapping evidence base might be that it acts to reduce the uncertainty surrounding the validity of claims regarding the health-related benefits of nature. This was certainly the case for St Leger (2003, p. 174) who argued that the strength of this evidence was such that health promotion specialists should become more proactive “as a professional group in interacting with those who are responsible for the forests, plains and urbanised areas of our country or region”. Whether or not this is the case, and we are not in a position to argue either way, it is apparent that these various forms of evidence, relating both to the therapeutic value of nature and its suitability as a setting for health, have been taken up by a range of governmental and non-governmental agencies responsible for the management of the natural environment. Therefore, in the remainder of this section, we wish to identify the ways in which nature is currently being mobilised as a space in which the individual and governmental desire for good health can be met.

As a recent report suggests, countries such as Australia, Canada, New Zealand, and the United States all state “that being active—especially in natural surroundings or the ‘great outdoors’” is an important part of their culture and plays a significant role in campaigns to promote physical activity (Cavill Associates, 2004). This is a point which is reflected in the discourse surrounding such initiatives; for examples, see the ‘Together for Healthy Communities’ initiative established by the Canadian Parks and Recreation Association (CPRA, 2006), the ‘New AGE Project’ established by the University of Illinois at Urbana-Champaign, USA (New AGE Project, 2006), and elements of the ‘Getting Australia Active’ campaign (Bauman, Bellew, Vita, Brown, & Owen, 2002). In order to explore the contours of this international discourse in more detail, we illustrate our point by referring to examples taken from Britain where governmental and non-governmental agencies increasingly make reference to the health-related benefits of the natural spaces that they manage or promote (see English Nature, 2002, 2003, 2004; National Urban Forestry Unit, 2002a, b).

One such example of this reterritorialising process comes from the Forestry Commission, which recently replaced its ‘Forest Fitness’ campaign with the notion of ‘Active Woodlands’. Perhaps responding to the fact that many people do not identify positively with the idea of fitness (Henwood, 2001), the latter campaign uses an array of slogans and symbols to promote physical activity and mental health: as it states, “Woods are great places for exercise and, as well as being good for the body, they are good for the soul” (Forestry Commission, 2005). Moreover, people are encouraged to view woodlands and forests almost as outdoor fitness centres or ‘green gyms’: “A brisk 30-min walk will burn more calories than 30 min of badminton”, “Aerobic exercise is most commonly thought of as an instructor-led class in a gym or hall, but walking (briskly), cycling and running are all forms of aerobic exercise”, “Once you’ve reached a good level of fitness why not pick up the pace” (Forestry Commission, 2005). It is in this sense that we refer to the natural environment as a ‘transactional zone’. As we note earlier, Rose (1999) employs this term to refer to those spaces in which the rationalities of government overlap with personal techniques of self-care. We would argue, that it is clear from these statements, that the discourse of the ‘new’ public health, and the forms of self-governance that it encourages, are increasingly being employed by agencies such as the Forestry Commission.

As previously noted, such a territorialising process is not limited to the Forestry Commission. Indeed, the Countryside Agency stands out in its desire to promote ‘spaces of nature’ as ‘spaces for health’: “our intention [is] to increase the health and well-being of sedentary people by promoting walking through a national initiative” (Walking the way to Health, 1999). The initiative referred to is ‘Walking the way to health’, which was established in 1998, with the British Heart Foundation, following the success of a pioneering walking scheme in the village of Sonning Common, Oxfordshire (see Bartlett, Ashley, & Howells, 1996). As the quote suggests, since these relatively modest beginnings, the initiative has grown into a nationwide programme and forms a significant part of the broader public health campaign to get the nation on the move (see DoH, 2004a, b). It is clear from the documentation surrounding the initiative, that governmental concerns regarding transport, public health and the environment played a crucial role in the Countryside Agency’s decision-making process.
(Walking the way to Health, 1999). Moreover, there was a recognition that the Agency felt it was in an almost unique position to “spread good practice” and “encourage more action on the ground” (Walking the way to Health, 1999).

We draw attention to it here because it provides further evidence of the ways in which the natural environment has been encompassed within the healthy settings agenda. Although ‘natural’ spaces are not necessary for a healthy walk scheme to be established, it is apparent that many operate to a greater or lesser extent within such environments. Moreover, much of the literature used either to attract walkers or to guide them once they have joined draws heavily on the natural scenery that people will encounter. In this sense, the therapeutic values associated with nature in the environmental psychology literature are implicitly, if not always explicitly, signalled as being an important feature of the walks. While little reference is made to nature in the text of these leaflets, it is clear that the natural environment, whether local nature reserves, canals, allotments or golf courses, plays a significant role in the attempt to encourage people to get off the couch and take part in a healthy walks. Perhaps this should come as no surprise given that the organisers of walking schemes are advised to “focus on the benefits of walking which are most likely to appeal to people… [for example] the pleasure of being out in the countryside…” (Walking the way to health, 1999).

As this last quote suggests, the relative success of the initiative is, in part, based on the fact that it promotes ‘healthy walking’ within environments that many people already identify as being aesthetically pleasing. Perhaps more importantly, however, the aesthetic value people attach to nature is used to encourage individuals to move their bodies in particular ways. Put differently, the ‘Walking the way to health’ initiative, seeks to persuade people to adopt a walking regime that “is of sufficient intensity, is carried out with sufficient regularity and is performed for a sufficient length of time” (Walking the way to health, 1999, p. 9). Such a regime, with its emphasis on intensity, regularity, and duration, appears far removed from other walking practices that are more closely aligned with the pursuit of pleasure than the quest for health (Edensor, 2000; Kay & Moxham, 1996; Macnaghten & Urry, 1998). However, as we go on to suggest, in the process of inscribing this ‘new’ public health discourse onto the ‘natural’ landscape, the aesthetic value of nature, while retained, is altered as its gentle rhythms are given a more upbeat tempo.

**Governing the walking body**

In the previous section, we have sought to identify some of the ways in which the healthy living agenda has been mobilised by agencies responsible for the management of Britain’s ‘natural’ spaces. Moreover, we have alluded to the idea that within these spaces, which we refer to as ‘transactional zones’, individuals are encouraged to translate the discursive codes of the ‘new’ public health into “embodied performances” (Sharp, Routledge, Philo, & Paddison, 2000, p. 18). In this section, we wish to extend our understanding of this by exploring in a little more detail the discourse surrounding the ‘Walking the way to health’ initiative. As we mention above, a key issue for health promotion experts is the need to persuade people to walk in a way that benefits their health: “in the case of walking for health the crucial message to get across is the need for walking to be brisk” (Walking the way to health, 1999, p. 44). Some of the problems associated with achieving this goal were illustrated in a report published in the first issue of the ‘Walking the way to health’ newsletter. As the report states, “[t]he brisk walking message should be used carefully to avoid discouraging sedentary people from taking part…” (Walking the way to health, 1998).

This clearly is a dilemma and it is one that physical activity programmes have sought to overcome by adopting an encouraging and developmental tone: “[a]ny walking is better than none”, “[b]risk walking is the best but … gentle strolling is a good start”, “start slowly then build up to walking faster…” As is apparent, each of these statements highlights the belief that the simple act of walking, whatever its speed or intensity, is better than nothing. It is in this way that ‘risky’ groups, particularly those identified as being sedentary, are brought under the purview of this physical activity discourse. However, the key point here is that people are encouraged to view walking in developmental terms; as the initiative’s website suggests, “[w]here you start from isn’t important—it’s where you’re going that counts!” (Walking the way to health, 2006. Emphasis added). This developmental ethos is in evidence elsewhere in the literature surrounding the ‘Walking the way to health’ initiative. For example, potential walkers are provided with details of a 10-week strategy, the
aim of which is to enable them to adopt walking as a part of their everyday lives; to make it habitual. What is interesting about the strategy is that it draws heavily on well-established motivational techniques and, as such, splits the strategy into three stages—‘Starting off’, ‘Getting going’, and ‘Staying with it’—each of which moves the walker closer towards the desired goal of regular, brisk walking.

There are other calculative techniques that walkers are encouraged to adopt in order to manage the movement of their bodies through space. One such technique involves the adoption of a ‘How it Feels’ scale, which enables people to assess whether their levels of exertion are ‘appropriate’. This scale measures the affects of physical activity on the body using terms such as ‘no problem’, ‘beginning to feel puffed’, or ‘exhausted’. A similar example relates to the translation of the metabolic equivalent level or MET, the unit used to estimate the amount of oxygen used by the body during physical activity, into the following message: ‘Walk at an intensity which makes you: breathe a little faster, feel warmer, have a slightly faster heart beat’ (Walking the way to health, 1999, p. 10). These examples involve the conversion of often complex medical notions regarding the physiology of the body into a language that lay individuals can more readily understand and therefore adopt in their everyday walking practices. Another, and perhaps more well-known technique, is the adoption of the ‘step counter’, which as the name suggests enables people to count the number of steps that they take in a day.

These devices were adopted by the ‘Walking the way to health’ initiative for its ‘Step-O-Meter’ campaign, which was launched in 2002. This campaign was initially “[d]esigned to raise people’s awareness of the amount (or lack of) physical activity they do in the course of their normal day” and to provide “motivational guidance” to walkers (Walking the way to health, 2006). In a more recent development, the campaign has been extended into a nationwide programme, in partnership with Department of Health, and includes the provision of a log book in which walkers can monitor their progress towards achieving the recommended goal of 10,000 steps per day. What is particularly interesting about the ‘Step-O-Meter’ campaign is that it has been acknowledged by the Department of Health as an important element of a broader strategy of self-care because it encourages people to become more active (see DH, 2005). Its purpose, like the other practices and techniques, is to enable ‘responsible’ citizens to more effectively monitor their behaviours; to calculate and judge their activities and those of others (Rose, 1999).

In much of the above the connection to nature lies in its valorisation as a healthy setting, as a micro-locale, in which a largely sedentary population might be motivated to perform techniques of self-care (see Giles-Corti & Donovan, 2002; Pikora et al., 2002). It is because of this that we argue that the natural environment should be considered as a form of ‘governable space’, as it is inscribed with a language that seeks to “to shape, guide, direct the conduct of others” (Rose, 1999, p. 3). This is not to suggest that individuals operating within these spaces are the subjects of some form or other of repressive power; far from it. However, if we set this discourse within the context of broader debates regarding risk and health (on which see Lupton, 1998), it is apparent that people increasingly operate within a political and social landscape in which the ‘prudent’ individual is expected to take pre-emptive action in order to minimise their risk of future illness. In this sense, then, while individuals are clearly free to choose, the natural environment has emerged as one of those spaces in which the discourse of the ‘new’ public health operates (Brown & Duncan, 2002).

Moving beyond the West

As noted in the introduction, a key feature of the ‘Global Strategy on Diet, Physical Activity and Health’, and of the science that underpins it, is the idea that the risk behaviours associated with non-communicable diseases have begun to travel. This re-spatialisation of the global burden of disease has been recognised for some time (see Murray & Lopez, 1997); however it was not until the publication of documents like the World Health Report, 2002 that the implications of this shift were broadcast more widely. As the then General Secretary of the WHO announced in the report: “The real drama now being played out is that they [non-communicable diseases] are becoming more prevalent in the developing world, where they create a double burden on top of the infectious diseases that still inflict poorer countries” (WHO, 2002a, p. 4). It is at this juncture that we re-connect with one of the key concerns of this paper because we are interested to explore whether this risk transition has resulted in
the more widespread mobilisation of nature as a setting for health.

One example where this has occurred is Singapore, as the following quote implies: “Very often, all we need is to get back in touch with our natural selves. Get back in touch with nature. Get in touch with other people in a natural setting...” (National Parks Board, 2006). Here, health and wellbeing appear as important elements of a much broader strategy, one which is aimed at “greening the city”. What is interesting about this strategy is that it recognises that the natural environment has a broader social relevance: “Green spaces are valuable as venues for recreational activities and for community bonding.” (2003, p. 32). Though, perhaps more importantly here, it also replicates many of the dominant features of the nature/health discourse being articulated in the West: “Wake up to the morning sounds of birds chirping and come down to the parks for your morning exercises, or wind down your day with a slow leisurely jog around the parks. You can jog on the tracks, exercise your muscles on the fitness stations or practise group tai-jis on the open areas” (National Parks Board, 2006).

Although it is possible to identify some reference to the natural environment as a therapeutic space or as a setting for health, the scale and scope of this discourse beyond Singapore is rather limited. Indeed, it might even be argued that the natural environment is presented in many non-Western national contexts as a barrier to health and wellbeing because of a range of anthropogenic risk factors: “In the rapidly growing cities of the developing world, crowding, poverty, crime, traffic, poor air quality, a lack of parks, sidewalks, sports and recreation facilities and other safe areas make physical activity a difficult choice” (WHO, 2002b); “Urban living offers the fulfilment of a dream for a better life and better health...” (and yet it) is estimated that a third of China’s urban population is exposed to severely polluted air” (WHO, 2006). There is, however, a further example that we wish to draw on here; an example, which highlights both the mobility of this (Western) discourse and the importance of place in helping to (re)shape it.

The example we refer to is an initiative entitled ‘Agita São Paulo’ (Move São Paulo). Developed in response to growing evidence that the rates of non-communicable diseases were increasing rapidly in this region of Brazil (see Monteiro et al., 2003), the initiative forms a significant part of a much broader strategy to improve health and wellbeing throughout the Americas (see PAHO, 1996). What is interesting about ‘Agita São Paulo’, and indeed about the development of similar programmes across the region, is that it helps us to consider the spatiality of public health knowledge and practice. As Livingstone argues, the idea that “scientific knowledge has a geography goes against the conventional image of science as a transcendental undertaking...” (Livingstone, 2000, p. 285). While Livingstone was referring to debates about the location of scientific endeavour, this statement serves to remind us that knowledge is both socially constructed and the product of discursive communities operating within and through a variety of social and spatial settings.

In the case of ‘Agita São Paulo’ it is evident that international public health expertise played a crucial role in the development of the initiative: “[a]ll the activities and messages are supported by epidemiological and scientific information available in the international literature of the last decades” (Matsudo et al., 2004, p. 83). This knowledge and understanding, which was based largely on the experience of the industrialised West, was not only communicated by means of international literature. Rather, a wide array of (inter)national experts, from organisations such as the WHO, the US Centers for Disease Control and the UK Health Education Authority, were included on the programme’s scientific and executive boards (Matsudo et al., 2002). Clearly, the input of these various actors cannot be easily assessed without more detailed research. It is apparent, however, that prevailing ideas regarding the link between physical inactivity and health were mobilised in the discourse surrounding the initiative.

Yet, the universality that such an observation implies does not necessarily reflect the ways in which public health knowledge and practice travel for, like other forms of scientific understanding, it has the potential to be transformed as it moves from place to place. For example, at issue for those involved in designing ‘Agita São Paulo’ was the possibility, or otherwise, of translating traditional interpretations of the physical activity message into locally acceptable practice. As Matsudo & Matsudo, 2005, p. 148) explain, there were many barriers to the adoption of the 30–45 min recommended in
the US Surgeon General’s report: “the modern, fast urban pace that characterizes life in the metropolitan area has led many residents to report that a lack of time is a major barrier to developing an active lifestyle...”. Of more interest here is the idea that the natural environment was a further obstacle: “[a]nother factor influencing this tendency is the warm and tropical climate”.

Thus, while the knowledge and experience of other countries was important to the development of the initiative, so too was the region’s cultural, socio-economic and climatic diversity. As Matsudo and Matsudo (2005, p. 148) go on to explain, “the idea of engaging in moderate physical activity in brief [ten minute] sessions is probably a more appealing alternative than single 30-min periods of intense physical activity”. The point we are making is a relatively simple one, however the difference that place makes to the mobilisation of health promotion strategies is rarely reflected upon in academic discussion. In the case of ‘Agita São Paulo’ the activities and settings that were promoted tended to reinforce this difference. For example, in addition to targeting the everyday spaces of the home and the workplace, spaces of leisure were also identified as targets for the promotion of physical activity: “Dance became the most important inclusion message among leisure activities because children, adolescents, adults and the elderly can dance, Brazilians love to dance” (Matsudo et al., 2002, p. 255. Emphasis added).

It is this emphasis on practices that were both appropriate to the local environment and culturally significant to the region that interests us here. While the epidemiological facts underpinning ‘Agita São Paulo’ were presented as universal truths, the programmes that were developed to counter these problems highlight a greater attention to the power of place in shaping their content and significance. There was some evidence that the natural environment was used to promote health, for example urban green spaces were mobilised as contexts within which physical activity could occur used (Matsudo & Matsudo, 2005). However, much less attention was paid to the idea that nature has a broader therapeutic appeal. In contrast, if we return to contemporary physical activity discourses emanating from the West, it is evident that the natural environment has emerged as an important setting for health because it is a space that has been long associated with the pursuit of wellbeing. In this sense, the medicalisation of nature through programmes such as ‘Active woodlands’ or ‘Walking the way to health’ in Britain, and in similar programmes established elsewhere, appears to build on already established cultural beliefs and patterns of behaviour rather than seeking to impose new ones.

Conclusion

Our findings raise many questions which provoke further investigation. In order to prompt this discussion we make three observations. The first of these concerns our understanding of the relationship between nature and health. Following Arnold (1996), we have located contemporary debates about the therapeutic properties of nature within a much broader set of ideas relating to the ‘environmentalist paradigm’. We did so because we wanted to highlight our belief that the association between nature and health is, like our understanding of nature itself, something that is made or constructed (Castree & Braun, 1998). Put differently, it is both historically and spatially contingent (Macnaghten & Urry, 1998). Clearly, this is not an original or novel observation. Yet, when set in the context of the ‘new’ public health, it helps us to make sense of a discourse that appears universally to valorise nature as an antidote to the stresses and strains of modern life.

In so doing, our purpose is not to undermine research that highlights the importance of the natural environment in the space of people’s everyday lives (Burgess, Harrison, & Limb, 1988). Rather, we would argue that by adopting a constructionist position we can begin to raise questions about the re-emergence of this discourse and the kinds of health-related practices associated with it. This leads us on to our second observation. The medicalisation thesis has been employed in an array of differing ways (Lupton, 1997). In this paper, we have drawn on a reading of it that builds upon the Foucauldian interpretation of the positive and productive ways in which disciplinary power operates on the human body (see Foucault, 1977, 1984). More specifically, we have suggested that the natural environment is currently being promoted as a ‘space for health’ both because of its supposedly aesthetic and therapeutic properties and because it provides an everyday space within which individuals can perform techniques of self-care.

Thus, the connection to Foucauldian notions of power lies in the ways in which individuals are
encouraged to use such spaces in the regulation and maintenance of their un/healthy bodies. As we have identified in this paper, physical activity discourse promotes nature as a setting within which the governmental desire for a fit and active population can best be achieved. The importance of the natural environment in this regard is that it acts to mask the health-related messages being promoted because it is recognised that individuals have other desires and motivations for being in nature. As Henwood (2001) suggests, “even if physical activity is not the main reason for people’s interest, it can be encouraged as an additional benefit of other leisure pursuits and interests”. It is in this sense that we might regard the natural environment as a ‘transactional zone’ where governmental and individual desires coalesce (Rose, 2001).

Our third observation emphasises the need to question the ability of this discourse to travel. In order to think through this question we turned to the WHO’s ‘Global Strategy on Diet, Physical Activity and Health’. We did so because the strategy is premised on the belief that the risk factors associated with non-communicable diseases are becoming increasingly prevalent in the countries of the South. Given this shift, and the subsequent announcement of the Global Strategy, we anticipated that there would be a similar movement in public health knowledge and practice. To this end, we set out to discover whether ideas about the natural environment were as important to physical activity discourses outside the West. As we revealed in our brief analysis of the Agita São Paulo initiative in Brazil, while the issue of physical inactivity is increasingly important, there is little emphasis placed on nature as a setting for the promotion of health and wellbeing.

It is apparent that a ‘new’ public health discourse relating to the individual responsibility for maintaining a healthy and active body increasingly operates throughout the globe. This is significant because few, if any, studies have sought to explore the spatiality of such discourses. However, the settings within which this sedentary body is encouraged into action appear to differ as this discourse travels. This was particularly apparent in the case of Agita São Paulo where both the practices and the settings being promoted were inspired by the locality within which they developed, rather than by programmes that were formulated elsewhere. Indeed, it was made clear that this was a distinctive feature of the programme. Such an observation helps us to recognise that the understanding of nature being promoted in public health discourses resonate with Western cultural values and social practices and that knowledge and practice are transformed in the different domains in which they are “produced, practised, contested, consumed, embodied, and stored” (Davies et al., 2004, p. 293).

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References


