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Health promotion as a politics of subjectivity: constitution, limits, and potentials of health promotion institutionalization at schools

La promoción de la salud como política de subjetividad: constitución, límites y potencialidades de su institucionalización en las escuelas

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ABSTRACT This article faces the tension, formation and main characteristics of the fieldof health promotion at schools to examine the limits, and potentials of its institutionalizationin Argentina. Firstly, we state the main phases of the process of constitution of such fieldat an international level, summarizing the factors that make its experimental phase difficult.Then, and using present bibliography, tools of social contemporary theory and our ownworks in the field, we analyze the main paradigms present when facing health andeducation,highlighting the conceptions of presupposed/reproduced subjectivity fromthem. Finally, we think over the potential of the institutionalization of the health promotiondemocratic paradigm at schools to generate subjectivity policies in the present contextof our societies.

KEY WORDS Health Promotion; Education; Social Medicine.

RESUMEN En el artículo se abordan las tensiones, conformación y principales características del campo de la promoción de la salud en las escuelas para indagar en torno a loslímites y potencialidades de su institucionalización en Argentina. En primer lugar, se rese-ñan los principales momentos del proceso de constitución de dicho campo a nivel inter-nacional, sintetizando los factores centrales que dificultan la superación de su actual faseexperimental-inicial. A continuación, articulando la bibliografía actual, herramientas de lateoría social contemporánea y nuestros trabajos de investigación/intervención en elcampo, se analizan los principales paradigmas actualmente presentes en los abordajes desalud y educación, haciendo especial hincapié en las concepciones de subjetividad pre-supuestas/reproducidas desde los mismos. Finalmente, se reflexiona en torno a las poten-cialidades de la institucionalización del paradigma democrático de promoción de la saluden las escuelas para la generación de políticas de subjetividad en el actual contexto denuestras sociedades.

PALABRAS CLAVES Promoción de la Salud; Educación; Medicina Social.

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> "There is a biopolitics of metaphorical meanings that has been surfacing before us. If one does not grasp the metaphorical dimension, the politics of health will remain a mystery." Ágnes Heller and Ferenc Fehér[1p.73]

INTRODUCTION

Although the proposals, experiences, and studies within the field of health promotion (HP) in educational institutions have increased during the last twenty-five years, the scarce theoretical reflection about them has complicated the construction of solid bridges between practices and policies.[2-4] Most research studies and actions of this field focus on the transmission of information to generate changes in people's attitudes and practices. In this sense, the weak connection of many of these actions of HP with the problems they are trying to address is principally due to the increasing distance between knowledge, hegemonic disciplinary, and moral practices within health and educational institutions, as well as the plurality of experiences, socialization, and identity construction modalities of young people. Therefore, the prevailing institutional responses in the HP field, rather than open encounter spaces, close them.

This failure becomes more serious in the current context of increasing inequality, uncivilization, and negative individualism within our society. According to Juan Carlos Tedesco,[5] currently, the school should be created in a public countercultural space, not only on the educational level, but essentially on the ethical-political level, fostering solidarity, responsibility, dialogue, autonomy, justice, and recognition of the other. By focusing on these *politics of subjectivity*, educational institutions could restore their legitimacy and their link with youth experiences, taking part in the transmission and display of generic dimensions (discursive, institutional, critical, aesthetic), which are essential to ensure the right to build and unfold subjectivity in current democratic societies.

However, before analyzing how the actions of HP in educational institutions can take a strategic position within the politics of subjectivity, it is necessary to define the limit and scope of this category. In order to do that, the concept of *biopolitics* should be mentioned, given that it understands the tensions in health policies from a social sciences perspective. Michel Foucault defines biopolitics as follows:

> The way in which, from the seventeenth century, government practice has attempted to rationalize those phenomena posed by a set of living beings which form a population: problems related to health, hygiene, birth, longevity, races and others. We are aware of the increasingly important role that these problems have played starting in the nineteenth century, as well as that since then; these problems have become truly crucial issues, both politically and economically.[6 p.367] [Own translation]

According to this definition, from the 1970s to the present day, several authors of social sciences have been analyzing the accelerated process of *medicalization* of Western societies and their articulation of the economic and political transformations of the second modernity.[7] Among them, Ivan Illich holds one of the most radically critical positions, pointing out in the introduction of his classic book *Medical Nemesis* that:

> Institutionalized medicine has become a serious threat to health. The disabling impact of professional control over medicine has reached the proportions of an epidemic.[6 p.4]

The author uses the concept of *Iatrogenesis* (*iatros*, "doctor," *genesis*, "origin") to analyze this process from three main interconnected dimensions:

a. *clinical:* generating health damage caused by lack of safety, abuse of drugs, and one of the most advanced medical technologies;
b. *social:* causing increasing dependence of population on drugs, the behaviors and the measures prescribed by medicine in preventive, curative, industrial, and environmental branches;
c. *cultural:* the progressive destruction of the potential of both the cultural and political individuals and communities to deal with their own disease, pain, and death, due to the subordination of individuals to heteronomous *professional techniques*.

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In later texts, Illich[9,10] delves into this last dimension, claiming that, at the end of the 20th century, the main sign of *cultural iatrogenesis* is the "*pathogenic* search for health." This true devotion to one's own body and health was not generated by mere biomedical expropriation, but by the increasing commercialization of self-care, driven by the mass media, the "diet" industry, and the academies of physical culture.

In this sense, in recent work, Ágnes Heller and Ferenc Fehér[1] discuss Hannah Arendt[11] and Foucault's work,[6] analyzing the biopolitics of social movements regarding ethnic, gender, and health rights demands. According to these authors, how these issues are hegemonically addressed overcomes the *depoliticization* of *biopolitics'* process generated by *modern iatrogenesis* instead of fostering it. In this way, as Francisco Ortega synthesizes:

> Scientific thinking replaces opinion by truth. If politics is the arena for the confrontation of opinions, dialogue, initiative, novelty, spontaneity and free action, scientifically legitimated biopolitical thinking is the space of truth, certainty, necessity, determinism and causality, where dialogue is substituted by the politics of self-seclusion, of friends and enemies. The reduction of plurality of opinions to a single politically correct opinion is another fundamental antipolitical characteristic of biopolitically organized groups.[12 p.13]

However, instead of naturalizing this situation by refusing any possibility of politically tackling social issues, Heller suggests *repolitization*, based on the Arendtian concept of *politics* (concretization of freedom in the public space) according to which any issue becomes political if it is decided, discussed, and debated in the public sphere.[1,12] In this sense, as analyzed by Ruben Araujo de Mattos,[7] one of the main political-symbolic achievements of the *social medicine* movement in Brazil (as recalled in the World Health Organization documents) was to center claims, analysis, and actions in the "right of everyone to health." Within this framework, biopolitics, authoritarianism, and commercialization are losing legitimacy. Whereas solidarity between the disputes over the right to health and the many struggles about subjectivity rights (freedom, autonomy, recognition, justice, and so on) are gaining legitimacy.

As mentioned before, the existing tensions in health biopolitics also affect the field of HP in educational institutions. The hegemonic *moralistic paradigm* contributes to the reproduction of reified conceptions of institutions and identities, contributing to the depoliticization of norms and knowledge regarding health, and in general, to the naturalization of the current socioeconomic conditions of inequality and exclusion of many young people accessing the right to subjectivity. Nevertheless, in the field of health education there is also, although in a discontinuous, fragmentary, and subordinate way, a *democratic paradigm* centered on dialectical conceptions of institutions and subjectivities as well as in critical pedagogy proposals. In our view, visibilization, analysis, deployment, and institutionalization of this paradigm can occupy a strategic place for a counter-hegemonic repolitization of health biopolitics and, in general, for the generation or strengthening of politics of subjectivity in our democratic societies.

Therefore, I consider that renouncing to all kinds of HP policy today, referring to its inherent heteronomous or medicalizing nature, can contribute, as an *unexpected consequence of the action*, to the process of naturalization of the moralistic paradigm, and even more serious, to the current sociopolitical conditions of the access to the right to health. However, in order to give a real critique of HP in schools from the point of view of social sciences, it is necessary to analyze them from their concrete historical-social expressions, identifying the tensions and disputes present in the discourses and practices of the individuals in each particular institutional context.

On these analytical-political lines, along with the research team of the Gino Germani Research Institute, University of Buenos Aires, we have been developing for many years several research studies and intervention works to contribute to the analysis of the limits and potentialities of HP in state-run secondary schools.[13,14] Based on these inquiries and previous works,[15] we have found that health is a signifier that, when opened, interpellates individuals (especially the youth) in schools, to reflectively and participate, assigning

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them new meanings and horizons to the right to integral health, changing the social and institutional conditions that impede their access.

PROMOTION OF HEALTH AND SCHOOL: CHRONICLE OF A LONG EXPERIMENTAL-INITIAL STAGE

According to the state of the art prepared by Ian Young,[16] in 1985 the WHO organized a European symposium that had 150 delegates from 28 states, called *Health Promoting Schools* (HPS, this name came up during the organization of the event). The healthy school document arose from this event (using this new name as the Europe WHO Regional Office was interested in connecting it to its new *Healthy Cities project*), which defines the HP in educational institutions as a "combination between health education and of all other actions that a school carries out to protect and improve the health of those who host."[16]

Since the 1990s, various research studies and intervention projects carried out, financed by national or international specialized organizations, which theoretically and politically strengthen the belief that the school is a key institution to carry out HP programs. Social psychology and other social and educational sciences prove that the behaviors learned during childhood and adolescence are very likely to remain in adulthood, and that youth involvement in HP activities can significantly reduce the risk of preventable diseases, and consequently, increase the population's health status.[17-20]

In the Americas, the Pan American Health Organization (PAHO) is one of the main intellectual and technical organizations which promotes these lines of intervention, these organizations are called Health Promotion Schools.[21,22] In order to build new meanings and sign agreements which allow its institutionalization at different levels of national governments, in 1995 the PAHO launched the *Regional Initiative Health-Promoting Schools*. Similarly, PAHO organized regional and subregional meetings that support the creation of the *Latin American and Caribbean Network of Health Promoting Schools*.[23](a)

Shortly afterwards, as per the First Conference of the European Network of Health Promoting Schools provisions, organized by the WHO in Greece in May 1997, the ten central concepts that would lead the way for the HPS policies were established (Table 1).

According to the state of the art prepared by Ian Young,[16] in the last years studies and experiences that return to the documents and proposals of WHO and PAHO have spread worldwide, resignifying and adapting them to several regional and national realities. Although, most of the HPS initiatives are still in what the author calls *the initial experimental phase* of the institutionalization process, sharing the following characteristics:

- First innovators (international organizations, NGOs, academic institutions) present HP related issues to the educational sector agents.
- The educational sector initially tends to understand health in biomedical terms rather than as a social model, which is an obstacle in the articulation between the educational and health sectors.
- School health services primarily meet the requirements of a traditional prevention model.
- NGOs work on specific health issues with particular schools and specific educational authorities.
- From time to time, there may be rapid changes, driven (and fueled) by political concerns related to specific issues such as HIV/AIDS, adolescent pregnancy, or drug addiction.
- The educational community does not perceive initiatives related to HPS proposals, such as *Community Schools* or *Eco Schools,* as related to HPS, due to the hegemony of the biomedical health model.
- The HPS terminology adoption does not generate real changes in institutional and individual practice.

FOCUSING ON DIALECTICS BETWEEN INDIVIDALS AND INSTITUTIONS

Based on the principles formulated at the First Conference of the *European Network of Health Promoting Schools* (see Table 1), Bjarne Bruun Jensen[25] carries out a comparative analysis of a

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Table 1. Ten central concepts to carry out health promoting schools.

Democracy. HPS are based on democratic principles aimed at promoting learning, personal and social development, and health.
Equity. HPS place equity at the center of the school experience. This principle guarantees that the school is free from oppression, fear, and ridicule. It provides equal access for everyone to the maximum level of educational opportunities. They are aimed at the promotion of the social-emotional development of each individual, enabling them to reach their maximum potential, free of discrimination.
Empowerment and action competence. HPS give young people the ability to develop actions and generate change. They provide a climate in which students, working along with their teachers and others, can be encouraged towards achieving their goals. Young people's empowerment, in relation to their visions and ideas, allows them to affect their lives and living conditions. This is achieved through high-quality educational policies and practices, which provide opportunities to participate in critical decision-making.
School climate. HPS emphasize the school climate, both physical and social, as a crucial factor in promoting and maintaining health. The school climate is an invaluable resource for the effectiveness of health promotion, between the policies aimed at promoting well-being. It formulates and controls health and safety standards and the inclusion of an adequate institutional management.
Curriculum. HPS curriculum provides young people opportunities to increase their knowledge and perceptions and acquire essential life skills. It should be relevant to young peoples' needs, both present and future, encouraging their creativity and motivating them to learn and gain the necessary knowledge. It is also a source of inspiration for teachers and other workers at school and is aimed at encouraging their professional and personal development.
Teacher training. Teacher training is an investment in health as well as in education. In addition to the appropriate incentives, Law should guide the teacher's training structure, both initial and active, using the HPS framework.
Measuring achievements. HPS value the effectiveness of their actions at school and in the community. Measuring achievements is a way of providing support and empowerment, and it is a process through which HPS principles can be applied at maximum potential.
Collaboration. Sharing responsibilities and close collaboration between ministries, especially education and health, are essential requirements for strategic planning of HPS. The National collaboration generates good effects at a regional and local level. All parties should establish and clarify their roles, responsibilities, and control mechanisms.
Communities. Parents and the educational community play a fundamental role leading, supporting, and reinforcing the HPS concept. Working together, schools, parents, NGOs, and the local community are a powerful force for positive change. Similarly, young people are more likely to become active citizens in their local communities. The school and the community as a group will have a positive impact on creating a physical and social environment aimed at improving their health conditions.
Sustainability. All levels of government must provide resources for the HPS. This investment will contribute in the long term to the sustainable development of the community as a whole. In return, communities will generate increasing resources for their schools.

Source: Own elaboration based on data from the World Health Organization.[24]

large number of HPS experiences. According to this analysis, Jensen identifies the coexistence of two great paradigms, present in the approach that articulates school and health. We consider that this analysis is along the same lines as the general aforementioned HP sociological critiques, and in particular, identifies the main source of weakness that prevents the majority of HPS proposals and experiences from overcoming the initial experimental phase of their institutionalization.

Next I summarize the main characteristics of the two paradigms identified by Jensen[25] (the *moralistic* and the *democratic)*, regarding the following theoretical and practical dimensions: a) *conception of health*, b) *pedagogical framework*, c) *operational framework*, d) *evaluation,* as synthesized below. Also, going back to contributions from social theory, pedagogy, and recent reflections of the HP field, I have incorporated a fifth analytical dimension: e) *conception of subjectivity*,

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from which the latter dimensions can be articulated, contributing to the analysis of the limits and potentialities of the current HP biopolitics.

MORALISTIC PARADIGM

As shown in Table 2, from the point of view of *the moralistic paradigm* (currently dominant in the approaches that articulate education and health), *health* is defined and regulated from the biomedical discourses. This concept focuses on the disease as an individual problem, refusing the connection with the problematization and transformation of the socio-political conditions that generate health risks. This synthesis between morals and health explains in part the resistance to the more complex, sociopolitical, and holistic definitions of individual and collective well-being, which emerged from the various critiques and experiences based on social medicine and which were partially embodied in the WHO documents.[3,4,7,32] Thus, this paradigm contributes to the processes of naturalization and reproduction of the current conditions of inequality and inequity to access human rights, in general, and health, in particular.[25,26]

In addition, the pedagogical framework, the hidden curriculum, and the type of teacher-student relationship resumed in this paradigm are based on the banking model: the imposition of rules and scientifically approved knowledge on the *docile* students' minds, *objectively* evaluable from diverse institutional mechanisms.[13,28] According to this paradigm, HP biopolitics in educational institutions seek to impose rational conceptions of *well-being* and *healthy behaviors* without taking into account the definitions, experiences, and reflexivity of the subjects involved.

According to the medical-hegemonic paradigm, the dimensions that would define a *healthy school* would be measurable only from *objective data*: observable changes in the behaviors of individuals, improvement in the physical conditions of the school environment, and so on (Table 2). This paradigm also uses concepts such as "factor," "group," and "risk behavior," used especially in research and intervention strategies in HIV/AIDS and sexually transmitted infections. However, as it has been shown in several studies, these categories generate greater negative consequences than benefits in technical, social, and political terms. Prejudice against the so-called "risk groups," the lack of concern about those groups which do not fit the parameters to be included in one of these groups, and the blaming of individuals who get infected by supposedly "adopting risky behaviors," are many examples of the negative effects generated by the use of these concepts. Similarly, the regular use of these concepts to describe young people contributes to *the negativization of the youth*.[4,13,14]

Finally, based on the classic modern conception of the individual, the behaviors are conceived as individually chosen, maintained, and changeable, making individuals responsible for the negative consequences these behaviors may have regarding scientifically established "healthy behavior" parameters.[4,7-9,25] In this sense, the researcher and Doctor of Public Health, José Ricardo Ayres,[4] considers that one of the main obstacles in the transformation of the HP at present is the persistence of conceptions of the individual anchored to the classic definition of modernity: a rational, self-centered, and self-sufficient individual, whose morality would be autonomous by subjecting one's will to the imperatives of reason (embodied in scientifically approved knowledge and institutional rules). Therefore, we can analyze the definition of *empowerment* proposed by the WHO:

> Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs.[32 p.16]

In our view, this definition accounts for an incomplete conception of empowerment, oriented to the change of individual practices, considered as already constituted (from an essentialist definition), and which only have to be oriented so that they gain control over themselves. Furthermore, "needs" are considered as given, rather than understood as historical, social, and cultural results. Therefore, the proposals to increase "political action" are presented as disconnected and subsequent to the inter-subjective construction of identities and needs.[13](b)

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Table 2. Two paradigms in health promoting schools.

Dimensions	Moralistic paradigm	Democratic paradigm
Health definition	• Closed category: hegemonic medical model • Oriented towards sickness as an individual problem	• Widened category: critical of the hegemonic medical model • Personal experiences and social conditions • Common good – the right to be
Pedagogical framework	• Objective: change behaviors • Moralistic/totalitarian/banking • Healthy schools	• Objective: action-competence • Democratic/participatory/ dialogical • Health promoting schools
Operational framework	• Teacher as role model (smoking, alcohol, nutrition) • School environment: school lunch, smoke-free areas, etc. • School-community: health professionals participate in the school and classroom activities	• Teacher who is open, democratic, listening and cooperative • School environment: stimulating, participatory project • School-community: school agents and students as subjects who are critical/ transformative or their personal and sociopolitical living conditions
Evaluation	• Measuring changes in students' behaviors (that have been scientifically validated)	• Analysis of the students' competencies (reflexivity, critiques, projects, commitment)
Conception of subjetivity	• *Idem-identity*: substantialist; self-centered individual, rational. • Mind-body divide • Moral based on duty: subordination of one's will to the rationality expressed in institutional norms	• *Ipse-identity*: dialectic, intersubjective, constitutive other • Dialectic theoretical-practical totality • Ethics as a political process: autonomy based in reflexivity and the instituting power

Source: Own elaboration based on Ayres,[3,4] Jensen,[25,26] Menéndez,[27] Freire,[28] Ricoeur,[29] Castoriadis,[30] and Mogensen.[31]

Based on this paradigm, HP and disease prevention biopolitics created in health and educational institutions tend to be subject to technical regulations ratified by hegemonic biomedical knowledge and power, contributing to the reproduction of an impoverished and reified conception of subjectivities, to which Ayres,[3] referring to Paul Ricoeur[29] calls *idem-identity*, *oneself*. This essentialist definition of the individual tends to consider the practices of individuals as repetitions of rules and knowledge established and legitimized by institutions and transmitted as normative information. Then, these rules are likely to be accepted as usual (hiding its historical and political nature), being reified in the true institutional imaginary and imposed on the individuals (*heteronomy*).[13,30] The hegemony of the moralistic paradigm tends to increase both the epistemological, and principally, the symbolic and political barriers that currently obstruct changes of the representations, practices, and relationships between agents in health and education fields.

DEMOCRATIC PARADIGM

However, according to both Jensen's analysis and proposals[25,26] and our recent research/intervention work,[13,14] in several HP experiences at schools there is currently a second paradigm to which Jensen, based on the first central concept of the aforementioned WHO document (Table 1), refers to as *democratic*. Although this paradigm is discontinuous, fragmentary, and subordinate in relation to the moralistic-normative paradigm, it leads the way towards which the various policies desiring to institutionalize and overcome the current initial experimental phase of the HPS should be directed.

As shown in Table 2, the democratic paradigm resumes the holistic and widened conception of health, created by the social medicine movement and postulated internationally by the WHO (dialectic between socio-structural conditions and personal experiences), allowing subjects (both individual and collective) to actively participate in its redefinition. From the denaturalization

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and reflexive recognition of socio-structural factors and their influences on individual practices and representations process, subjects begin to develop their potentialities to modify both conditions towards desired horizons of well-being, projected and created from their own experiences.[3,4,13,14,25,26]

In this sense, the democratic paradigm resumes the Critical Pedagogy philosophy carried out by Paulo Freire[28] (Table 2). In order to change the banking educational model, the construction of democratic, dialogic, and participatory spaces in schools requires profound changes in the teacher-student relationship, and in general, in the hegemonic social school *environments*.[15] Then, based on a dialectic traversed by socio-cognitive conflicts, institutional rules and knowledge are being denaturalized, redefining the bonds between school agents, young people and all the educative community.[3,4,13,25,26,31]

Within the framework of this paradigm, Jensen[25,26] proposes that HP activities in educational institutions, instead of starting from the subordination of agents' practices and perspectives to institutionalized knowledge and rules, must start from the priority of their actions (*action-oriented approach*) and their institutional potentialities (see Table 2). According to these definitions, actions start from the identification and denaturalization of the problems present in the objective and subjective conditions of the individual and collective subjects, changing in four moments that reciprocally feed into each other permanently:

a. *Knowledge/insight*: the participatory construction of coherent knowledge about nature and the complexity of the problem addressed by the subjects is fostered: emergence, development, consequences, and possibilities for improvement. Unlike the mere passive acquisition of information, this definition retakes the constructive and open meaning of education, for which it is fundamental to start from the subject's previous experiences and knowledge.
b. *Commitment*: it is connected to the previous moment and is a fundamental bridge between knowledge and practice. Therefore, the level of involvement and *true participation* of the agents in the HPS activities is one of the main objectives to be evaluated, rather than the changes in attitudes or levels of information.
c. *Visions/images of the future*: it is fundamental to incorporate from the beginning of the activities the different visions that the subjects have about how they would like their lives to be and the socio-structural conditions in which they would be developed. The development and added complexity of these images of the future are essential to succeed in the agents' involvement.
d. *Action experiences*: in order to study in depth and articulate the problematizations and knowledge created by the visions of the future, while increasing the subjects' commitment, it is necessary to develop concrete actions aimed at changing the socio-structural and personal conditions identified as limits to well-being throughout the learning process. Although these experiences will come up against different types of limits (conditions that exceed the agents' possibilities), they will be useful to reformulate, in a dialectical process, the other moments of the action, materializing them and improving their possibilities of generating real changes.[25,26]

Bringing Jensen back to our discussion, the Danish specialist Finn Mogensen[31] goes deeper in the latter dimension, central to the institutionalization of the HP democratic paradigm in schools. According to this author, health education must have as fundamental responsibility the development of students' abilities, commitments, and motivations to face future problems related to their personal and socio-political living conditions. To achieve this objective, it is necessary to promote *critical and reflective thinking* among young people, defined by four interrelated dimensions:

a. *Epistemological*: the individual's understanding of reality is only possible if based on the process of examination and questioning of the various dimensions that form it. This dimension requires identifying, among others, the factual and normative aspects of a problem, analyzing and understanding them in a historical and structural context and developing possible strategies of action to confront them.
b. *Transformative*: changes involve in an interrelated way both the subject individual dimensions (values and practices) as well as the collective and structural dimensions. While the former can influence the process

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of denaturalization and partial changes of the latter, its true transformation requires profound political and socio-economic changes. Focusing on the community (educative, local) is a productive mediation to link levels, avoiding resignation and helplessness feelings.

c. *Dialectic*: it unfolds in two interrelated meanings. On the one hand, it requires the observation of a situation from multiple points of view, listening, understanding, and respecting other subjects. On the other hand, it is linked to a dynamic vision of reality, according to which progress and development are possible by the questioning, criticism, and permanent modification of the current agents' practices seeking the reconstruction of new practices without the identified failures and errors. Due to the interaction between both meanings, individuals perceive their own limits and increase their desire to keep changing, in spite of the obstacles and frustrations.

d. *Holistic*: it encompasses both feelings and reason. It differs from the conceptions that define the thought only from its cognitive and intellectual dimensions, displacing the subjects' emotions, feelings, and intuitions. This perspective is fundamental to transform the intention to act in a real action, based on a commitment made to this action.[c]

Thus, the democratic paradigm resumes the critiques made to the classical dualist definition of the modern subject (Table 2). In the same line of current contributions of social medicine, based on a work of epistemological-practical rupture with the hegemonic moralistic paradigm, it is proposed the recovery of a redefinition of subjectivity centered on a holistic, dialectical, and intersubjective conception that integrates the co-constitutive character of the others in the definition of individual and collective identities. A process that is necessarily both theoretical and practical, philosophical as well as political, proposes to displace the currently hegemonic meanings of the *idem-identity* towards a (re) conceptualization of subjectivity as a process of never-closed identification, in which the daily relations of oneself with the others holds a central place: *ipse-identity*.[3,4,13,29]

As Ayres[3,4] analyzes, and as the subjectivation processes centered on *ipse-identity* are fostered from the health and educational *institutions*, new possibilities open up regarding the construction of a *dialogue* between the various agents involved daily in these institutions. This dialogue is necessarily part of a clear and positive specification *of the normative horizon* that guides the subjects through the contextual and appraising aspects, objective and subjective, that they put on the scene (*knowledge/insight*). Regarding this aspect of a dialogical and desiring encounter between oneself and the other, it opens a possibility of profound changes in the relationship between the adults (teachers, health professionals) and young people. This relationship is no longer focused on scientific-technical rationality, but towards the various horizons of *happiness*, which also includes the ethical and aesthetic dimensions of existence (*visions/images of the future*).[3,4,25,26][d]

Therefore, it is possible to redefine the category of empowerment in HP field, using the definition of *autonomy* suggested by Cornelius[30]: individuals' ability to reflect on their co-constitutive relationships with social rules that, although emerging from institutions which tend to reproduce them as *effective imaginary*. Agents can denaturalize and recreate these institutions, disputing their meanings from their *radical imaginary*. In a never-closed dialectic and political process, individual and collective subjects are reflectively appropriating the knowledge they need and using them to resignify and transform their objective and subjective living conditions. Thus, this process of autonomy construction (a never fully reachable horizon) is only possible by the simultaneous change of the institutions that co-constitute individuals in every moment of their lives.[30]

CLOSING AND OPENING: REPOLITIZING HEALTH AND EDUCATION BIOPOLITICS

Based on the conceptions of subjectivity and autonomy present in the democratic paradigm, it is possible recreate a theoretical-practical redefinition of the HP field, as an integral ethical-political approach focuced on health as a *right to be*. According to this last category, the researcher Roseni Pinheiro,[34] referring to the Arendtian political philosophy, places at the center of health policies the right to be different and respect these

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differences. Therefore, if all life is valuable, then health is a common good, so it is fundamental for its care and promotion to recognize the *Ethos*: the world inhabited by human beings, that is, how subjects organize and value their own life, both in the private sphere and in the singularities produced collectively.

As a result, along the same lines considered by Heller and Fehér,[1,12] from the democratic paradigm perspective the possibility of a *repolitization of biopolitics* in the fields of health and education is opened, redefining these fields as *practices of freedom* that, according to Arendt,[11] can only emerge in a *public space*:

> A space between men that can be created anywhere, without a privileged *locus*. This is the space in which subjects relate among each other through discourses and actions: to act is to begin, to create something new.[35 p.23] [Own translation]

In this sense, according to this emergent paradigm, it is possible to contribute to the HP articulation, critical recovery, and institutionalization in general and to educational institutions in particular, from the following central dimensions:

- Considering health as a problematic field, opening its meanings to the permanent historical-political process of critique, dispute, and dialogue among various discourses coming from multiple institutions, knowledge, powers, experiences, and individual and collective situations.
- Returning to a conception of subjectivity from which it is possible to overcome the essentialist and dualist definitions of the individual, exposing this conception to the complexity and dynamics between the socio-structural and personal conditions and allowing a conception of autonomy that incorporates the constitutive character of the others.
- Recovering the dialectical movement of the subject's social experience (overcoming the reifications and dualisms of the classic self-centered individual), in his/her permanent becoming another with him/herself, in his/her opening from the *possible* in action towards an *impossible* novelty.

Finally, articulating the previous dimensions, based on this paradigm, it is possible to recover the strategic place of the public school for the reformulation of politics of subjectivity in the current context of our democratic societies. The aforementioned conceptions of health and subjectivity establish a rupture with the individualistic conceptions that think that the success of educational or HP actions only come from gaining information and changing attitudes. This paradigm makes evident the fundamental importance that the institutions in general have, and especially educational institutions, in the constitutive dialectic of individual and collective identities, and therefore, in the promotion of democratic, reflexive, and critical subjectivities, both in relation between them and in their links with others as well as with their socio-political conditions of life.

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ENDNOTES

a. The Latin American Network of Health Promoting Schools meeting took place: I) 1996, in Costa Rica, with an initial affiliation of 10 countries; II) 1998, in the city of Mexico; III) 2002, in Quito; IV) 2004, in San Juan, Puerto Rico, attended by 115 participants from 26 countries; V) 2007, in Palmas, Brazil. The Caribbean Network of Health Promoting Schools meeting was held in 2001 and the II in 2006.

b. For a critical review of the multiple senses of the empowerment category in the health promotion field, see Carvalho.[33]

c. For a review and application of Jensen and Mogensen's proposals for sex education and HIV/AIDS prevention strategies developed by our team at public middle schools in the Autonomous City of Buenos Aires and the city of Junín (province of Buenos Aires), see Ley 17132[13], Sivori[14], Lavigne[15].

d. "We, in fact, have not asked ourselves, when we talk about health, what is it that us people dream of for life, for good living, for health. After all, what is our "deep desire" when we are dealing with each of the different obstacles we find on our path to health? Therefore, without devoting ourselves to this reflection, we are condemned to the negativity of the disease to define health and to know its regularities to understand how to control them."[3 p.10]

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