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Healthy Choices and Heavy Burdens: Race, Citizenship and Gender in the 'Obesity Epidemic'

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Abstract

The 'obesity epidemic' is widely accepted as a major public health threat in the United States. This paper provides a critical examination of the White House Task Force on Childhood Obesity's action plan that is foundational to First Lady Michelle Obama's 'Let's Move!' campaign. The report reveals ideological anxieties about race, American citizenship, changing gender roles and women's bodies. The framing of obesity as a personal problem and individual failing reflects the merger of American individualism and neoliberalism. Self-regulation and responsibility (and the mother's responsibility for her children) are key in prescriptions to manage obesity, reflecting biopolitical techniques of governance and a new model of 'the healthy American citizen'.

Keywords: obesity, gender, citizenship

Introduction

Testifying before the United States House of Representatives in 2003, U.S. Surgeon General Richard Carmona warned that obesity was 'a health crisis affecting every state, every city, every community, and every school across our great nation' (Carmona, 2003). The 'obesity epidemic'[2] is widely accepted as a major public health threat in the United States, garnering attention from The Centers for Disease Control and the U.S. Department of Health and Human Services. However, Carmona's statement fails to acknowledge that obesity is not a homogenous or uniform phenomenon. The prevalence of obesity varies greatly depending on location, race, gender, age and class. Obesity is most common among African American and Hispanic[3] populations in the southern states of Alabama, Mississippi, Oklahoma, South Carolina, Tennessee, and West Virginia (Centers for Disease Control, 2010b). Black women have the highest rates of any group[4] (Centers for Disease Control, 2009). Compared to whites, the prevalence of obesity is 51% higher in African Americans and 21% higher in Hispanics (Ibid). The 'obesity epidemic' is therefore racialised and gendered, an 'epidemic' that affects certain people in certain places. Interrogating these trends and how they intersect and diverge with other

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[2] 'Obesity epidemic' appears in quotes throughout this paper to stress that the 'epidemic' is not taken as fact but is contested. The terms obesity and obese are also disputed and are used in the same spirit as 'obesity epidemic', but do not appear in quotes for stylistic reasons.

[3] The Centers for Disease Control defines Hispanic as a voluntary ethnic category denoting origin from Hispanic countries in Latin America or Spain (Centers for Disease Control, 2010a).

[4] Overall, 25.6% of the U.S. population is obese. Non-Hispanic blacks have the highest prevalence (35.7%), followed by Hispanics (28.7%) and non-Hispanic whites (23.7%). Non-Hispanic black women have the highest rates overall (39.2%), followed by non-Hispanic black men (31.6%), Hispanic women (29.4%), Hispanic men (27.8%), non-Hispanic white men (25.4%) and non-Hispanic white women (21.8%) These statistics are from the CDC's analysis of Behavioral Risk Factor Surveillance System surveys from 2006 – 2008 (Centers for Disease Control and Prevention, 2009).

inequalities is crucial to understand obesity. Examining how the rhetoric of the 'obesity epidemic' is mobilized within public health and popular media discourses reveals why the nation's current obsession with obesity is problematic.

The widespread concern about obesity is not solely (or arguably, primarily) health based. Rather, it reflects deep ideological anxieties about race, American citizenship, changing gender roles and women's bodies. Obesity is framed as a personal problem and individual failing. This reflects a long history of American individualism[5] as well as more recent articulations of neoliberalism. In the context of neoliberal economic policies that call for lessening the role of the state in healthcare and welfare provision, obesity discourse reveals tensions about who is responsible for public health. Public health interventions increasingly acknowledge the societal foundations of obesity: the growing interest in food deserts and access issues helps illuminate deep systemic issues of racism, poverty and inequality in the United States. But, the media still rarely frames obesity in terms of socio-economic injustice and inequality (Kim and Willis, 2007; Lawrence, 2004).

This essay examines obesity discourse primarily through an analysis of the White House Task Force on Childhood Obesity's action plan, which is foundational to First Lady Michelle Obama's 'Let's Move!' campaign. 'Let's Move: America's Move to Raise a Healthier Generation of Kids' was launched in February 2010 and is ongoing. Although the Task Force document is largely gender-blind in its language, I argue that it presents childcare and the work of 'feeding the family' as women's responsibility (DeVault, 1991; Grant et al, 2004; Inness, 2001). A woman's failure to ensure that her children are the 'correct' size is punished socially through 'mother blame' (Boero, 2009). Precisely because feeding work is considered women's work, the burden and responsibility of the obesity epidemic falls on women's shoulders. Women are deemed responsible for not only the size of their own children, but for the health of the nation. Building on previous scholarship that links citizenship to the requirement of inhabiting a healthy and normative body, obesity can be conceptualised as a failure of citizenship (Herndon, 2005; Peterson and Lupton, 1996).

The research presented in this article is inspired by the need to understand obesity as reflective of systems of inequality rooted in systemic poverty and racism. Simultaneously, feminist engagement with the body forces exploration of normative constructions of 'healthy' and 'unhealthy' bodies. Indeed bodies, and especially women's bodies,[6] are the site of intense policing and regulation. The requirement of thinness for women has long been critiqued from feminist perspectives (Bordo, 1993; Manton, 1999; Cherin, 1981; Orbach, 1978). In the fields of gender studies and sociology, recent work on obesity surgeries considers the way 'moral failure' is invoked to censure those deemed obese (Throsby, 2009). Critical perspectives on the 'obesity epidemic' question the science and politics behind the phenomena (Campos, 2004; Gard and Wright, 2005;

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[5] 'American individualism' is used broadly to signify deeply rooted beliefs that all Americans, regardless of gender, class, race, etc. can overcome adversity through hard work.
[6] Bordo argues that in cultural constructions of masculinity and femininity men are thought to inhabit the mind side of the Cartesian dualism, while women reside in the body (Bordo, 1993). For Bordo, woman *is* the body: 'the cost of such projections to women is obvious. For if, whatever the specific historical content of the duality, *the body* is the negative term, and if woman *is* the body, then women *are* that negativity, whatever it may be' (Ibid: 5).

Oliver, 2006). Fat Studies scholars and activists challenge weight-bias and work to promote fat acceptance,[7] challenging the dominant 'obese bodies are unhealthy bodies' discourse (Rothblum and Solovay, 2009; Wann, 1998). The merger of public health with the sexist and consumerist agenda of normative bodies must be examined critically.

Current understandings of obesity and public health interventions, however well intentioned, may have severe consequences. As the majority of people deemed obese are women of colour, the health agenda specifically targets a demographic which has long been considered deviant and thus highly regulated and morally policed. This paper attempts to simultaneously understand the inequalities that create obesity in certain places and among certain people, while also questioning the use of 'obese' as a category or health threat.

Discussion of Findings

This paper is divided into two parts. The first section considers women and race in obesity rhetoric. The second section looks at three pillars from the White House Task Force on Childhood Obesity's report in depth.

Relational Constructions of Race, Gender and Obesity

Over 80% of black women over the age of forty are overweight or obese (Wang and Beydoun, 2007). 13.5% of African American women are 'extremely' or 'morbidly' obese which is more than twice the rate of white and Mexican-American women in the United States (Ibid). Considering these statistics, it is important to examine how racial ideology constructs women of colour not only as different from white women but also as more bodily than white women.[8] The bodies of white women are seen as more easily controlled and regulated. By contrast, the bodies of black women are uncontrollable and more deviant. My suggestion is that Ahmed's relational formulation[9] is applicable to obesity discourse about dieting and weight loss: white women are constructed as able to successfully regulate and discipline their bodies while black women are not. Racial ideology constructs white women as self-disciplined and capable of exercising greater self-control than black women. Media representations of obesity are often racially loaded. Images of 'successful' dieters are primarily middle and upper-middle class white women (Boero, 2007; Saguy and Gruys, 2010), and medical research also validates this formulation by arguing that African American women are less likely to diet. Subsequently, their perceived 'acceptance' of fatness or 'blindness' to their own obesity is constructed as problematic (Bennett et al, 2006; Davis et al, 2005; Horm and Anderson, 1993).

In a related example, Glenn shows how the racialised division of labour has helped white women distance themselves from 'doing the dirty work' by offsetting responsibility

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[7] Many fat-positive activists and academics use the term fat rather than overweight or obese. Fat is used politically in an attempt to reclaim the term from its pejorative usage. It is also considered more neutral as a descriptive adjective along the lines of tall/short.

[8] Black men are similarly constructed as more bodily than white men, of having bodies but lacking minds (Mercer, 1994).

[9] Discussing the Victorian era, Ahmed posits that the white woman, while still more bodily than men due to her sex, was less bodily than the black woman. The white woman was 'able to transcend the bestiality and sexuality of the body' due to her membership in 'the higher race' (Ahmed, 2002: p.53).

for physical labour or 'body work' to women of colour (Glenn, 1996). Rooted in a long history of domestic servitude, women of colour are now clustered in the service industries of the labour market. Even within the service industry, which is dominated by women generally, racial specialisation appears: white woman dominate in jobs that require interaction with the public (such as waitresses and nurses), while women of colour are found in 'dirty back-room' jobs (such as maids, janitors/cleaners, and nurse's aides) (Ibid: 20).

Concern about African American 'acceptance' of large bodies reveals sexist and normative tendencies in obesity discourse. The desire for thinness is often unquestioningly invoked to encourage or praise weight loss. Commenting on research that young black women have higher satisfaction rates with their bodies than young white women, popular author Greg Critser states that: 'Such sidestepping denies poor minority girls a principal — if sometimes unpleasant — psychological incentive to lose weight: that of social stigma' (Herndon, 2005, discussing Critser, 2004: 121). In medical research these sexist norms are less blatant, but still prevalent. A study arguing for increased participation rates in weight loss programs suggests that women are twice as likely to attempt to lose weight than men because 'women have a greater concern for thinness and a higher level of body dissatisfaction than men' (Kruger et al, 2004: 404). Invoking body dissatisfaction as a powerful motivator for weight loss trivialises eating disorders, the impossible task of conforming to beauty norms, and the lived experiences of weight stigma.

The White House Task Force on Childhood Obesity's Report to the President, 'Solving the Problem of Childhood Obesity In a Generation'

Following a Memorandum issued by President Obama, the White House Task Force on Childhood Obesity released a federal action plan in May 2010 with the aim of 'solving childhood obesity in a generation'.[10] The report outlines five pillars or action areas: 1) Early Childhood; 2) Empowering Parents and Caregivers; 3) Healthy Food in Schools; 4) Access to Healthy, Affordable Food; and 5) Increasing Physical Activity. Pillars 2-5 are also the main elements of First Lady Michelle Obama's 'Let's Move!' campaign.

This paper does not specifically discuss Pillar 3: Healthy Food in Schools and Pillar 5: Increasing Physical Activity. Both sections focus on the school environment, a topic that lies outside the scope of this research, although, in brief, the inclusion of schools appears to be a positive move away from individualistic explanations of obesity, and focusing on schools at an institutional level signals a serious sense of importance to structural explanations.

Pillar 1: Early Childhood

> "Recommendations of the report: Encourage a healthy pre-natal weight in
> mothers; increase breastfeeding; reduce chemical exposure; reduce screen
> time (such as sitting in front of a television or computer); and encourage

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[10] From now on The White House Task Force on Childhood Obesity's report 'Solving the Problem of Childhood Obesity in a Generation' will be referred to as the 'White House report' or 'the report'.

physical activity and healthy eating in early care and education (outside the home)."

Efforts to 'protect the health of the foetus' have been critiqued by women's rights advocates (especially in the context of abortion debates) as well as Foucauldian theorists who are interested in the pregnant body as a site of disciplinary power and regulation. Pregnancy has increasingly been the site of medical interest and intervention, and the pregnant body is largely the domain of the 'expert' medical gaze (Lee and Jackson, 2002: 115; Sawicki, 1991).

Many common elements of foetal protectionism appear in this section of the report. Tobacco use during pregnancy, which has been a major site of foetal protectionism efforts, is invoked as closely associated with childhood obesity. Alcohol consumption and drug use, also key in foetal protectionism rhetoric, are discouraged on the basis of 'children's health', but no direct connection is made between alcohol consumption or drug use and obesity in the report.

Male parentage is largely absent from this section, the single mention being 'paternal BMI' (Body Mass Index)[11] in a list of associated factors between maternal weight and long-term child health (White House, 2010: 11). Thus, men are relieved of responsibility for foetal health. This stems from the different social constructions of male and female bodies (Peterson and Lupton, 1996; Sheldon, 2002): the female reproductive body is a body that is 'permeable and penetrable – open to the invasion of foreign substances' (Sheldon, 2002: 24), while, in contrast, the male reproductive body is seen as stable, bounded and strong, 'not liable to succumb to penetration by foreign bodies such as toxins' (Ibid). Medical knowledge has often produced and reproduced such constructions. However, new research suggests that male reproductive capacities are far more fragile than previously considered, and that male parentage might have a much larger role in foetal and child health than currently acknowledged (Ibid: 27).

The report recommends that 'health care providers, as well as Federal, state and local agencies, medical societies and organizations … should provide information concerning the importance of conceiving at a normal BMI and having a healthy weight gain during pregnancy…. In many cases, conceiving at a normal BMI will require some weight loss' (White House, 2010: 12). This relates to what Boero terms 'maternal blindness' (Boero, 2009: 117). Although this usually takes the form of mothers who are 'unaware' of their child's obesity, it also appears in foetal protectionism where pregnant women are 'blind' to the damage that their actions can cause. Thus, pregnancies require expert intervention in the form of increased medical screenings and education about 'healthy behaviours' for the mother. Women must be informed that their obesity could harm their future child, and they are hence responsible for making 'healthy choices' to reduce their weight.

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[11] Body Mass Index (BMI) is calculated by dividing a person's weight in kilograms by a person's height in meters squared. The resulting number is an estimate of a 'healthy' weight for a person of that height: <18.5 'underweight'; 18.5-25 'normal'; 25-30 'overweight'; >30 'obese' (World Health Organisation, 2010). A BMI measurement over 40 is considered 'morbidly obese'. BMI does not directly measure the accumulation of body fat in an individual, and thus provides a 'surrogate' or estimated measurement of possible body fat.

One of the crucial ways in which foetal protectionism relates to the main thesis of this paper is that requirements of self-regulation regarding weight during pregnancy hold women individually responsible for any future deviations of the 'normal' weight of their child. As Lee and Jackson observe, 'By alerting the pregnant population to ways in which they can prevent disease and abnormality, illness is subtly transformed from an unavoidable misfortune into a failure of personal responsibility' (Lee and Jackson, 2002: 124, discussing Crawford, 1994).

Importantly, the report's discussion of chemical exposures and 'obesogens' (the term given for chemicals that may promote weight gain and obesity) deviates from standard 'personal responsibility' rhetoric (White House, 2010: 17). Although listed after two 'behavioural' elements (the first pre-conception weight/pre-natal care; the second breastfeeding), the report's mention of chemical exposures suggests that foetal health is not exclusively tied to a pregnant woman's health choices and self-control. Most preventative health programmes have focused on how women's actions affect a foetus' health, rather than exploring factors outside mothers' immediate control or responsibility, such as toxic environments or poor social health care (Lee and Jackson, 2002: 126). But the section's departure from 'personal responsibility' rhetoric is only partial. The section is brief and provides a single example of chemical exposure: that of chemicals released when microwaving plastic baby bottles or plastic containers that are not explicitly microwave safe. The report cites previous recommendations that parents should avoid microwaving such plastics. Thus, rather than considering toxic exposure in air, land or water, the report limits the discussion to individual actions that must be taken by parents to ensure the future health of their child.

Pillar 2: Empowering Parents and Caregivers

> "Recommendations of the report: Make nutrition information such as the U.S. dietary guidelines widely available; ensure that food labels are easy to understand; encourage responsible food marketing (primarily through industry self-regulation); and increase preventive health care by increasing BMI screenings, increasing the role of dentists and oral health care providers in obesity prevention, and increasing medical counselling for all parents and caregivers about nutrition and physical activity."

The first paragraph of Pillar 2 reads: "Fundamentally, parents and caregivers are responsible for their children's health and development. They instil and promote certain values, reward or reinforce specific behaviors, and shape choices that form life-long healthy habits .... Children learn from the choices adults make" (White House, 2010: 23). Several issues worthy of exploration arise in this opening statement. First, parents and caregivers are assigned fundamental responsibility for child health and development, turning away from understandings of health that are reflective of larger social, cultural, and economic structures.

Second, this statement is indicative of a trend throughout the report to refer to parents and caregivers in gender-neutral terms. There are 0 mentions of 'father' in the

report, and the term 'men' is used only once.[12] There are 35 mentions of 'mother' but the term is used exclusively in the first pillar in reference to pre-natal care and breastfeeding. The term 'women' appears 32 times, the majority of which refer to conception or pregnancy. The exact phrase 'pregnant women' appears 20 times. There is no mention of 'woman' in the report.

This use of gender-neutral language seems positive at first, suggesting less rigid and traditional parenting roles. Yet genderless language is problematic because it suggests an equality that is, in fact, fictional. Care work, including feeding and childcare, is predominately women's responsibility (Grant et al, 2004). In the gender division of labour, feeding work is quite specifically constructed as women's work and is loaded with social meaning about being a 'good woman' and also a 'good mother' (DeVault, 1991; Harnack et al 1998; Inness, 2001). DeVault stresses the social importance of feeding the family by arguing that 'the character and organization of the work give to women virtually limitless responsibility for the family's well-being' (DeVault, 1991: 95). By referring to 'parents and caregivers' in a gender-neutral way throughout the report, the White House Task Force fails to acknowledge the ways in which gender roles shape care systems and children's feeding practices.

Third, the statement exemplifies the prevalence of the word 'choice' in the report as a whole. 'Choice' is mentioned 59 times, including references to 'food choices', 'nutritional choices' and 'consumer choices'. The phrase 'healthy choices' appears 12 times. The use of the term is significant because it reflects battles within obesity discourse regarding the assignment of blame for the 'epidemic'. If diet and exercise are understood as decisions of free will, then being obese (or thin) is the result of such freedom. In this formulation, unhealthy choices lead to obesity, while healthy choices lead to a 'normal' body weight. The assumption of voluntary choices made outside of all social, economic and cultural constraints ignores the factors beyond an individual's control that shape consumption. As DeVault notes, 'concepts like consumer "choice" and "power" apply to only some consumers' (DeVault, 1991: 201).

The food and beverage industry has led the campaign for 'choice' language in food consumption patterns. In a famous example, major food manufacturers (including Kellogg's, General Mills, Kraft Foods, PepsiCo and ConAgra Foods) formed a coalition in 2009 and created the Smart Choices food labelling program. The program featured a green checkmark label on a wide variety of foods determined to be 'better for you' because they meet Smart Choices nutritional criteria. Products receiving the label included the cereals Froot Loops, Cocoa Krispies, Lucky Charms and Frosted Flakes, as well as Skippy peanut butter, Kraft Macaroni and Cheese, Hellmann's mayonnaise, and Fudgsicle bars. Dr. Eileen Kennedy, President of the Smart Choices Board, told the *New York Times* that consumers 'want to have a choice. They don't want to be told "You must do this"' (Neuman, 2009). Following extensive negative press and an inquiry from the U.S. Food and Drug Administration, the program was discontinued several months after its launch.

In the Food Marketing section, the White House report also uses 'choice' language in reference to both consumer choice and food industry choice. The main recommendation regarding the food and beverage industry is to encourage voluntary self-

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[12] Figure excludes bibliographic references.

regulation. The report cites findings regarding the ineffectiveness of the Children's Food and Beverage Advertising Initiative (CFBAI) in which 'each company developed its own nutritional standards for what constitutes a "better for you" food or a "healthy dietary choice"' (White House, 2010: 29). But, the report still advocates for industry self-regulation. The report cites freedom of speech issues, but also notes that the federal regulations targeted at children's television advertising do not apply to other media and to advertising not explicitly marketed to children (but that children are exposed to nevertheless).

Interrogating Choice: Neoliberalism, Biopolitics and Citizenship

The prevalence of the word 'choice' reveals many core ideologies at work in the 'obesity epidemic'. The 'obesity epidemic' is representative of the merger between American individualism and neoliberalism. The increase in average BMI has been concurrent with the rise of neoliberalism and 'the degree to which this increase has been both widely publicised and evoked rhetorics such as choice, personal responsibility, and citizenship says something about the proliferation of neoliberal governmentalities' (Guthman, 2009: 190). Expert medical knowledge continually informs the public of its own blindness to bodily threats. Simultaneously, self-regulation and responsibility (and the mother's responsibility for her children) is key in prescriptions to manage obesity. In assigning responsibility to the individual, the state absolves itself from financial or institutional liability. The state may therefore appear to be 'hands off', but it actually continues to produce ideological and normative constructions through the 'obesity epidemic'[13].

The ideological projects of the 'obesity epidemic' outlined in this paper include: anxiety over changing gender roles; a fear of the loss of 'traditional' family structures; the policing of 'deviant' bodies, primarily those of women and women of colour; and the acceptability of vast inequalities due to dogma of individual responsibility and deeply rooted beliefs in American individualism. Although these value-laden components are tenets of the 'obesity epidemic', obesity is presented in the innocuous attire of public health. Public health, believed to be firmly based in the objective realm of science, is therefore seen as free from politics and ideology. The 'obesity epidemic', then, is evidence of 'a new relationship between government and knowledge through which governing activities are recast as nonpolitical and nonideological problems that need technical solutions' (Ong, 2006: 3).

Citizenship[14] provides a framework in which neoliberalism, biopolitics[15] and the 'obesity epidemic' can be brought together. Public health has been conceptualised as a

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[13] Indeed, the state has been actively involved: twelve federal agencies (including the Departments of Agriculture, Defense, Justice and Interior) helped create the White House's report studied here.

[14] Citizenship is understood as 'more than simply the formal relationship between an individual and the state presented by an earlier liberal and political science literature' (Werbner and Yuval-Davis, 1999: 4). Citizenship is 'more a total relationship, inflected by identity, social positioning, cultural assumptions, institutional practices and a sense of belonging' (Ibid).

[15] Biopower is a technology of power in which the individual bodies of populations are disciplined and regulated according to the needs of the state. In Foucault's formulation, power functions in 'the very grain of individuals' and it 'touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives' (Foucault, 1980: 39). In the context of Foucault's panopticon, the body becomes a site of the internalised gaze and self-regulation (Foucault, 1977). Drawing on Foucault's

citizenship project in which the needs and goals of the state are realised through the bodies of its citizens. A 'healthy' (and therefore 'good') citizen acts on expert health advice and 'engages in work, participates in social relationships and reproduces… Good health is deemed to be vital to achieving these activities' (Pearson and Lupton, 1998: 61). Biopower functions to produce ideal or virtuous citizens. The healthy, and therefore economically productive, citizen is especially important in the context of neoliberalism and the expansion imperative for Western economies:

> "'good health' is that condition which is least disruptive of production: the 'healthy citizen' is the citizen who can work continuously over her or his lifetime. Good health, therefore, is related to virtuous citizenship because of the benefits that extend from the individual to the social body. A healthy person is able to take part, to the best of his or her physical ability, in contributing to the nation's prosperity."
>
> (Pearson and Lupton, 1998: 68)

In this formulation, the 'healthy citizen' is one who is able to work and contribute to the economy.

As a public health concern, the 'obesity epidemic' is fundamentally concerned with producing healthy citizens. The second paragraph of the White House report addresses the financial costs of the obesity epidemic due to increased medical spending, reflecting the concern that non-healthy citizens are a drain or a burden on the nation (White House, 2010: 3). The third paragraph addresses military readiness and expresses concern that 25% of young Americans are currently unfit for military service due to their weight (Ibid).

Additionally, women's relationship with citizenship is already tenuous because women have traditionally been excluded from the concept (Hobson and Lister, 2002). It has been 'male', white, heterosexual and able-bodied both conceptually and in practice (Ibid). Citizenship as something that can be 'read' on the body is also relevant to anxieties about the changing racial/ethnic composition of the United States. The United States Census Bureau predicts that white citizens (66% of the population in 2008) will be a slight minority by 2050, with the Hispanic population tripling during that time period (U.S. Census Bureau, 2008). The fear of a loss of a white majority is reflected in both Arizona's anti-immigration bill SB 1070 (which uses racial profiling methods to identify and deport Latino/a immigrants who lack official paperwork) and the growth of the 'English Only' movement (Citrin et al 1990). Hispanics, possessing the second-highest obesity levels, are targeted by the 'obesity epidemic' as problematic bodies that threaten the ideals of American citizenship.

Family Meals and Women in the Workforce

In the 'Menu Labelling' section, the report cites a study which states that family meals in the home are associated with healthier eating habits (Anderson and Whitaker,

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notions of discourse and biopower, feminist poststructuralist perspectives on the body have focused on how bodies are discursively produced (Butler, 1993). Bartky examines disciplinary practices that produce the 'docile' female body, such as the enforcement of a standard female body size, (Bartky, 1990).

2010; White House, 2010: 26). This reflects common anxieties prevalent in obesity discourse over changing gender roles. Women's involvement in the paid labour workforce outside the home is often linked with increases in obesity in subtle ways. Convenience foods and fast foods are both assigned blame in the 'obesity epidemic', and both trends are linked to ideologies about 'good' and 'bad' mothering (DeVault, 1991; Julier 2005).

The rise of convenience foods in the 1950s introduced 'time-saving' products such as frozen TV dinners and Betty Crocker instant cake mixes, marketed to the busy, 'modern' woman (Inness, 2006). McDonald's Speedee Service System premiered in the late 1940s, marking the beginning of the fast food industry as it is known today. Food consumption outside the home has increased from 25% of total food expenditure in 1955 to 49% in 2010 (National Restaurant Association, 2010). This corresponds to the loss of the traditional family dinner eaten inside the home (Larson et al, 2007). Additionally, children's lack of physical activity, long hours of 'screen time' in front of a television or computer, and increased unhealthy snacking is often attributed to a lack of parental supervision.

The failure of mothers to 'be home' for their children is particularly relevant to charges of 'bad mothering' levelled at African American women. Hill Collins argues that the traditional public/private split of work life and family life (and all the gender ideology that accompanies the binary) has never explained the experience of African American women: 'Black women become less "feminine" because they work outside the home, work for pay and thus compete with men, and their work takes them away from their children' (Hill Collins, 2000: 47). The racialised division of labour and care chains are also relevant in this context. Wealthier women, especially white women, are able to hire out domestic responsibilities. This relieves them of some of the pressures of the 'triple burden' (see below) and can create more time for them to spend with their children. Conversely, the poor women of colour who make up the vast majority of the domestic service and home maintenance workforce may work long hours for little pay, while caring for other women's children rather than their own (Ehrenreich, 2002; Glenn, 1996).

Mothers as the Cause of Childhood Obesity; Mothers as the Agents of Prevention
Mothers are assigned responsibility for the size of their children from conception through adulthood. This responsibility turns to 'mother blame' when children are not the 'correct' size (Boero, 2009). Mother blame functions as a way to frame widespread social problems as the result of women's failure to be 'good' mothers (Ladd-Taylor and Umansky, 1998). Again, individual responsibility is framed as the origin of collective social problems. Mother blame has been used to explain many different social 'problems' including homosexuality, crime, autism, poverty and birth defects[16] (Boero, 2009: 114). Mother blame functions within the binary construction of 'good' mothers and 'bad' mothers. Many feminists have argued that these constructions are loaded with normative values that assume 'good' mothers are 'heterosexual, white, middle class, and do no work outside the home' (Ibid).

Mothers are targeted as agents to reduce childhood obesity trends without consideration of the women who are responsible for facilitating such change. Women's

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[16] The last element, 'birth defects', relates to the discussion of foetal protectionism in Pillar 1.

workloads increase under the 'triple burden' of juggling productive, reproductive, and community management work (Moser, 1989). 'Community work' increasingly takes the form of women being mobilised as the agents of social change, rather than the beneficiaries of such programs (Chant, 2007). Childhood obesity prevention programs often assume that women's ability to participate in unpaid reproductive activities is limitless. There is an assumption that women have the time, energy and financial means to take children to doctor appointments, cook fresh meals from scratch, monitor children's eating habits and facilitate children's physical activity.

Additionally, the focus on preventing childhood obesity leaves very little agency for those adults currently deemed obese. The report states that 'often it is an entire family that experiences being overweight or obese (White House, 2010; 23). Mothers are useful in ensuring that their children are not obese, but the mother's obesity is permanent and 'un-fixable'. A mother's weight is only important when it poses a risk to her child's health profile.

PILLAR 4: Access to Healthy, Affordable Food

> "Recommendations of the report: increase physical access to healthy food by eliminating food deserts (primarily through the Healthy Food Financing Initiative); increase the production of fruits, vegetables and whole grains; evaluate the effect of subsidies and sales taxes; encourage the food and restaurant industry to develop healthy foods for young people; and address links of hunger and obesity by increasing participation rates in USDA nutrition assistance programs (such as school lunches and SNAP – commonly known as food stamps)."

The report states that 'attention on the relationship between retail food access and obesity has increased as researchers obtain a better understanding of the factors besides individual behaviors that may lead to differences in diet and health outcomes' (White House, 2010: 50). The consideration of access issues is important because it deviates from standard obesity rhetoric of personal responsibility and individual solutions. Although not directly expressed in the report, many anti-hunger and anti-racist organisations have taken access issues as an in-road to expose long histories of discrimination.

Food Deserts: Exposing Inequalities

Food deserts illuminate deep systemic issues of racism, poverty and inequality in the United States. In a food desert, residents lack access to fresh, 'healthy'[17] and affordable food. Access to supermarkets or large grocery stores is limited in areas that are low-income, predominately black or Latino, and rural (Karpyn, A. and S. Treuhaft, 2009: 13). Native Americans living on reservations have some of the biggest access problems

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[17] It is difficult to pin down what constitutes 'healthy' food. The term is used in quotes to acknowledge that nutrition guidelines are often politically motivated and change frequently (Nestle, 2007; Pollan, 2008). The category is also value-laden. Used broadly, 'healthy food' refers to nutrient-dense foods that contain few preservatives, salts and saturated fats.

(Ploeg et al, 2009). In 2009, the U.S. Department of Agriculture found that 23.5 million people living in low-income areas are farther than 1 mile from a supermarket, and many of them lack transportation to travel there (Ibid). In rural areas, low-income residents can be farther than 10 miles from a large grocery store (Ibid). Without access to a supermarket, residents are more likely to buy items at small convenience stores that are often geared primarily toward liquor sales[18]. Basic food items such as milk and bread tend to be significantly more expensive at such shops, and 'the poor pay more' has become a mantra of community food advocacy groups (Winne, 2008: xv).

There is some debate about the effect that food deserts have on obesity trends. The USDA report suggests that BMI levels are affected not only by a lack of 'healthy' food, but also by an abundance of 'unhealthy' food, such as cheap fast food chains (Ploeg et al, 2009: 3). Their report finds that increased consumption of healthy food does not necessarily result in a decrease of 'unhealthy food consumption (Ibid). The Food Trust and PolicyLink argue against the USDA's conclusion. They find that when residents have access to supermarkets, not only do they consume more fresh produce, but their risk for obesity and diet-related diseases also decreases substantially (Karpyn and Treuhaft, 2009). Regardless, examining food deserts helps expose specific examples of how obesity intersects with race, poverty and inequality.

The report suggests that hunger and obesity may be 'two sides of the same coin' (White House, 2010: 49). Food insecurity is rising in the U.S. in the context of the global financial crisis and the domestic recession. 14.6% (17 million households) were food insecure at some point during 2008, a 3.5% increase from 2007 when 11.1% (13 million) of all households were food insecure (Nord et al, 2009). Food insecurity is commonly theorised as scarcity of food or as inconsistent or undependable access (through lack of availability or purchasing power) to the food necessary to sustain human life. In reference to obesity, food insecurity stems from access problems and cycles of hunger. Links between food insecurity and obesity contradict common assumptions that obesity stems from excess or immoderation (such as obesity's association with the sin of gluttony)[19] (Ruiz, 2007).

Anti-hunger advocacy groups have highlighted some of the ways in which a lack of adequate resources for food could result in weight gain: 1) maximising caloric intake by consuming inexpensive yet high calorie foods; 2) choosing quantity of food over quality to ward off hunger pains; 3) over-eating when food is available; and 4) physiological adaptations in which the body may store fats to compensate for time periods when food intake is less (Center on Hunger and Poverty, n.d.). Research has shown a consistent association between food insecurity and obesity in women, but findings about men and children are less conclusive (Dinour et al, 2007; Martin and Ferris, 2007; Townsend et al, 2001). Some hypothesise that this is due to 'maternal deprivation' in which women eat last, less, or not at all when food is divided among the family. Others suggest that this is an error of the research itself, that women have been the focus of most studies, with men and children largely overlooked and under-studied.

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[18] Low-income zip codes across the United States have 30% more convenience stores than middle-income zip codes (Karpyn and Treuhaft, 2009: 8).
[19] Gluttony is one of the 'seven deadly sins' or 'capital sins' in the teachings of the Catholic Church.

Conclusion

> "Before coming to the White House, the President and I lived lives like most working families, two working parents, busy trying to maintain some balance, picking kids up from school, trying to get things done at work— just too busy, not enough time. And what I found myself doing was probably making up for it, being unable to cook a good meal for my kids and going to fast food a little more than I'd like, ordering pizza. And I started to see the effects on my family, particularly my kids. It got to the point where our pediatrician basically said, 'You may want to make some changes'. So, I started making those changes – short, easy changes – but they led to some really good results."

> (Let's Move, 2010)

The launch video for First Lady Michelle Obama's 'Let's Move!' campaign begins with the above narrative. Although it references both parents in the beginning ('the President and I'), the story focuses on Obama's role as a mother and her 'motherly' responsibilities. Obama expresses the difficulty of successfully balancing paid and domestic work. Due to her workload, she is unable to properly perform her role as a mother. She feeds her children fast food and pizza, 'making up' for her lack of home-cooked meals. An intervention from a medical expert, her children's pediatrician, alerts her to the fact that she is failing to take care of her children's health.

Obama states that she heeded the doctor's warning, that she started 'making changes'. But she does not elaborate on those changes. Can it be inferred that she was suddenly able to be a 'better' mother? Here the triple burden appears: now Obama must balance paid work and domestic responsibilities with the larger public health goal of improving her children's health. But questions remain about how Obama was able to 'make those changes'. Did the time demands of her paid employment change? Did her other motherly responsibilities suddenly lessen? Did she become less busy overall? Has the *source* of the problem changed? Although her initial framing of the narrative is much more complex, the 'take away' message from the story is a simple one. Mothers have the ability — and the responsibility — to end the childhood obesity crisis in the United States.

The 'obesity epidemic' reflects the emphasis on health in American citizenship — of the requirement to inhabit a disciplined, self-regulated body. As American individualism and neoliberalism have merged to create a unique post-industrial capitalism, the 'obesity epidemic' is an outlet for anxieties about race, American citizenship, changing gender roles and women's bodies. Public health approaches, such as the one explored in this paper, rely on stereotypical gender roles and the seemingly limitless reproductive labour of women to solve the 'obesity epidemic'. It is an undue and unnecessary burden.

Ending food deserts and improving access to affordable food does not mean having to engage in anti-fat rhetoric. Making the 'call to arms' the threat of obesity misses the mark and too easily reinforces racist, sexist and fat-phobic ideologies. Food system change in the United States and elsewhere may be necessary for a myriad of compelling reasons. Fighting obesity does not have to be one of them.

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