WITH ALL DUE CAUTION:

GLOBAL ANTI-OBESITY CAMPAIGNS AND THE INDIVIDUALIZATION OF RESPONSIBILITY

ALISON REIHELD

Abstract

Obesity is one of several targets of public health efforts related to availability of and access to healthy foods. The tension between individual food decisions and social contexts of food production, preparation, and consumption makes targeting individuals deeply problematic and yet tempting. Such individualization of responsibility for obesity and nutrition is unethical and impractical. This article warns public health campaigns against giving into the temptation to individualize responsibility, and presents an argument for why they should proceed with all due caution, advising providers and public health organizations to keep in mind structural factors rather than aiming at individuals.

Keywords: Public health, obesity epidemic, individualized responsibility, food and women, health and body size

1. Introduction

Media and public health organizations have begun trumpeting the "obesity epidemic" occurring not only in the United States, long the butt of jokes about "fat Americans," but also in much of the rest of the world. In February 2008,

health experts from around the world gathered in Sydney, Australia, for the Oxford Health Alliance Summit. There, U.S. legal expert on global health law Lawrence Gostin stated that obesity was more dangerous than terrorism and claimed that "obesity may be responsible for the first reversal of longevity since 1900" (Mercer 2008). An April 2014 piece in the *Atlantic* framed it thus: "In many parts of the world, obesity has become a greater public-health crisis than hunger. Nearly every region has seen dramatic increases in obesity rates over the past few decades" (Khazan 2014).

As with the problems of hunger and undernutrition that have long occupied global public health, obesity is also related to food and nutrition. Responsibility for these facets of life is highly gendered. Food procurement is often the task of women, be it through subsistence farming or grocery and market shopping. Food preparation is also deeply connected to gender, and in some cases constructs gender, as when "women's work" is defined, in part, as the work of preparing meals and men who do so are feminized in ways that may carry stigma (Reiheld 2014). It is thus foreseeable that any attempt to address food related aspects of obesity will bear heavily on women. As we shall see, this has been the case for women with respect to hunger and malnutrition. I have deep ethical reservations about the way anti-obesity campaigns will also bear on women. The tension between individual food decisions and the social contexts of food production, preparation, and consumption makes targeting individuals deeply problematic. Yet doing so is also politically and economically palatable in contrast with a system wide change that may have to work against entrenched forces within agriculture and food businesses.

This is a recipe for misplaced blame and thus ineffective change. Individualizing responsibility means targeting food preparation and purchasing. Moreover, targeting food in this way risks targeting women and is very likely to do so given the social contexts of food and gender. I argue that public health campaigns that target food in the context of the obesity epidemic must proceed with all due caution for both pragmatic and ethical reasons, lest those most vulnerable to food issues and least able to rectify food problems are held most responsible for doing so. Such campaigns must avoid individualizing responsibility and take care not to target women in targeting food.

2. Who is obese, and how is obesity as a public health concern framed?

Before we can see how targeting nutrition targets women and why this is ethically suspect, we must understand the global character of obesity and the concept of obesity as a disease versus a risk condition. Who is considered obese, and where do they live? How is obesity as a public health concern framed?

On June 18, 2013, the American Medical Association (AMA) House of Delegates endorsed further medicalization of obesity. Once considered a risk condition for diseases and malfunctions such as diabetes and joint pain, obesity is now classified as a disease in its own right by the AMA. In doing so, the association joins several other professional medical and public health organizations, as it mentioned in the text of the resolution: "The World Health Organization, [U.S.] Food and Drug Administration (FDA), [U.S.] National Institutes of Health (NIH), [and] the American Association of Clinical Endocrinologists … recognize obesity as a disease." To pass this resolution, the AMA House of Delegates voted against the conclusions of the AMA's own Council on Science and Public Health, which urged that obesity not be considered a disease "mainly because the measure usually used to define obesity, the body mass index (BMI), is simplistic and flawed. Some people with a B.M.I. above the level that usually defines obesity are perfectly healthy while others below it can have dangerous levels of body fat and metabolic problems associated with obesity" (Pollack 2013). Since BMI is so integral to the definition of obesity—whether as a disease or a risk condition—let us see how this functions to define obesity.

BMI is essentially a measure of body size rather than function or body composition. It uses height and weight as follows: weight (kg) / [height (m)]^2. In the United States, a BMI below 18.5 earns a patient the label Underweight; 18.5 to 24.9, the label Normal; 25.0 to 29.9, the label Overweight; and 30.0 or above, the label Obese (Centers for Disease Control and Prevention 2014). By these adult standards, "[i]n 1995, there were an estimated 200 million obese adults worldwide…. As of 2000, the number [had] increased to over 300 million" (World Health Organization 2014b). As the World Health Organization (WHO) notes, a significant proportion of the global obese population—115 million—exists in developing countries rather than industrialized nations. In

2014, Marie Ng et al. published a survey of global obesity data from 1980 to 2013, using 1,769 surveys, reports, and published studies. They found that, at present, 62 percent of the world's obese individuals live in developing countries. The prevalence of obesity exceeded 50 percent in the general population in Tonga and particularly in women in Kuwait, Kiribati, the Federated States of Micronesia, Libya, Qatar, Tonga, and Samoa. In particular, they note, "[i]sland nations in the Pacific and the Caribbean and countries in the Middle East and Central American have already reached especially high rates of overweight and obesity" (777).

Insofar as obesity is a problem, it is a global problem affecting both resource-rich and resource-poor societies, and this is the case not only for adults but also for children. There are different definitions of what constitutes obesity for children than for adults. For children, *overweight* means one standard deviation BMI for age and sex, and *obese* means two standard deviations BMI for age and sex. By such pediatric definitions, the number of overweight children under the age of five in 2013 was 42 million globally, with close to 31 million of these children living in developing countries (WHO 2014a). Again, we see that obesity is not just a developed world problem.

But how much of a problem is it, and how is it that it is a problem? Even though many medical and public health organizations describe obesity as a disease, and BMI is the primary means by which one is diagnosed as obese, the U.S. Centers for Disease Control and Prevention (CDC) describes BMI as a screening tool rather than a diagnostic one. In fact, the CDC explicitly continues to consider BMI "only one factor related to risk for disease" and argues that other predictors be taken into account such as waist circumference, high blood pressure, and physical inactivity (CDC 2014). By taking the more reductive approach to obesity as a disease, and taking BMI as the primary diagnostic tool, medical and public health organizations have "established body weight as a barometer of wellness, so that being thin is equated with being healthy" (Oliver 2006, 6).

Numerous studies have cast doubt on so simple an equation. These include meta-analyses indicating poor methodology in studies associating obesity with poor health because they do not take into account other confounding factors, such as smoking, access to medical care, family history, exercise, and diet, that might account for increased disease burden (Oliver 2006). There are also several studies that indicate it is possible to be healthy and obese so long as one eats well and is physically active. There may indeed be such a thing as

"fit fat" people or "healthy obese" people (Park 2011; European Society of Cardiology 2012; Saguy 2013b). A Canadian study found that there is "considerable variation in the health risk profile" within the population of obese adults (Kuk et al. 2011, 573). Contrary to the conventional wisdom on obesity and health, being slightly overweight seems to be more protective of health than does being normal weight; this has been called the "obesity-mortality paradox" (Ahima and Lazar 2013).

Ignoring the complexity of obesity in health outcomes—and attributing illness in obese people to their obesity—can have serious consequences for patients. As Abigail Saguy (2013a), a medical sociologist at the University of California, Los Angeles, has written, "Medical providers often blame patients for their weight and blame their weight for any health problems they have." Saguy also points out that studies that carefully compare metabolic health—based on triglycerides, cholesterol, blood glucose, insulin resistance, and inflammation—with BMI have found that, while more obese people have unhealthy clinical markers, many normal people do as well. In one study, "[a]lmost a quarter of normal-weight people had abnormal profiles, while more than half of overweight people and almost a third of obese people had normal profiles" (Saguy 2013a). To conflate health and body size is to make a grave error that risks misdiagnosis of patients who fall into either the underweight-and-normal or the overweight-and-obese category. And this is a problem that is compounded in the developing world, where resources—in both funding and laboratory availability—may not support pairing clinical markers like BMI with such laboratory markers as the bloodwork that can help to distinguish the healthy obese from those at higher risk for poor health outcomes. Ng and her coauthors (2014) share this concern, noting that robust measurements gained from physical examinations are expensive, and nations may rely on routine survey platforms to collect height and weight. Individuals in developing nations are thus very likely to have their health judged on BMI alone.

Despite these shortcomings of obesity as a measure of health, obesity diagnosed via BMI is as tempting a public health measure as ever there was. Just as economists use measurable, gatherable data to calculate the productivity of nations even though this leaves out harder to measure forms of productivity such as unpaid domestic labor and paid informal labor (Waring 2004), population-wide health data—and especially global health data that can be compared between nations and regions—are necessarily composed of measurable

and gatherable data. It should be no surprise that obesity has become such a powerful measure. After all, it is based on BMI, which is calculated from a set of objective numbers that can be gathered from both children and adults on a population-wide basis through mechanisms such as pediatricians, school-based health care providers, driver's license databases (which record both height and weight in the United States and many other nations), and adult health care providers. It meets the basic criteria for a "good" source of population-wide data.

Once obesity is accepted as a risk condition or a disease in its own right, it becomes quickly associated with food and nutrition. The text of the AMA's resolution labeling obesity a disease was very clear on attributing obesity to personal choice, saying that obesity is "a consequence of a chosen lifestyle exemplified by overeating and/or activity," yet this makes it no less a disease than lung cancer acquired by the "choice to smoke cigarettes" (AMA House of Delegates 2013, 2). WHO attributes increases in childhood overweight and obesity to both overeating and inactivity. WHO's description of the food cause, which reinforces the global nature of changes in eating, is as follows: "a global shift in diet towards increased intake of energy-dense foods that are high in fat and sugars but low in vitamins, minerals and other healthy micro-nutrients" (2014c). So strong is this association that, even though the WHO's tenth revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) (2015) distinguishes between obesity (coded E66) of different types, it is largely considered a form of "hyperalimentation" (overeating) grouped in the larger category "Obesity and *other* hyperalimentation" (emphasis added). The primary classification for obesity is "E66.0 Obesity due to excess calories." Exceptions to the framing of obesity as hyperalimentation include drug induced obesity (E66.1), Pickwickian syndrome (E66.2), and the catch-all categories of "Other obesity" (E66.8) and "Obesity, unspecified" (E66.9). Thus, with rare exceptions, to discuss obesity as it has been framed is to discuss a disease that is related to food. Here, as with many things, the old saying applies: it is the exceptions that prove the rule.

The framing of obesity is complete and as follows: it is a disease (possibly a risk condition) that is itself a sign of ill health, is characterized by body size as measured by the ratio of height to weight known as BMI, and is due to a combination of overeating and physical inactivity. As I have indicated, this framing is suspect. But, within this framing, obesity is a legitimate public

health concern, one that affects individuals in both the developing and indus-trialized worlds. Although I would argue against such an intense focus on obesity in its own right or even as a very critical risk condition, nonetheless it is plausible to argue that poor diet and physical inactivity combine to lead to ill health in people who are obese as well as those who are not. Whether we focus on obesity or on nutrition, food—the stuff of life—becomes the stuff of public health.

3. Food as the target: The individualization of responsibility

When food becomes the stuff of public health, it becomes the target of public health interventions. With undernutrition and hunger, this is clearly appropriate. It may even be appropriate with obesity, or with poor dietary conditions marked out in some people by obesity and in others not at all by BMI. But whenever we target food, whether for undernutrition and hunger or for obesity, two ethically problematic features can occur. Each is ethically suspect in its own right.

First, we can see the individualization of responsibility. Where situational factors are, in fact, major or even primary determinants of access to food, public health campaigns and clinical encounters between patients and pro-viders can reinforce and instantiate the notion that it is the responsibility of individuals to change how they eat. This is already apparent in the AMA's attribution of obesity to personal choice ("a consequence of a chosen lifestyle exemplified by overeating and/or activity"; AMA House of Delegates 2013, 2).

Second, this individualized responsibility can be placed on women. Wherever food is socially and culturally "women's work," women will be the targets of individualized solutions since either women will be doing most of the cooking, or it will be assumed that they are.

Let us begin with this second point—the targeting of women—and, along the way, make the first—the individualization of responsibility—even clearer. To do so, we must start with the gendered nature of food. While it is not always possible to make cross-cultural generalizations when discussing global public health, food preparation is surprisingly consistently feminized. This is, of course, with respect to whatever constitutes the feminine in each society. A few forms of food preparation may be seen as masculine, but in

general, food preparation continues to be seen as women's work, and the men who do it are considered to be acting in either a supererogatory or feminine manner.

The gendered nature of food is well documented the world over. It is certainly the case in Anglo-heritage nations such as the United States. Health studies scholar Will Courtenay (2000) provides the example of a gay man raised on a farm in the largely rural state of Indiana who "said he would have been ridiculed as a 'sissy' had he done the tasks of cooking, baking, and sewing that he preferred" (1389). In the United States, the term *sissy* is used to refer to a man who is unmasculine by virtue of being too feminine. The gendering of cooking as women's work begins early in American culture: even the division of children's chores has girls more likely to be assigned cooking and cleaning tasks, while boys are more likely to be assigned maintenance ones; both children and adults generally do not question such stereotypical divisions (Schuette and Killen 2009), and no less so with cooking. Nearly two-thirds of household labor in America is spent cooking and cleaning, work that continues to be, and to be seen as, much more often the realm of women than of men (Bianchi et al. 2000). The world over, highly educated and married women in masculine cultures do less paid work and more house-work such as cooking than do their counterparts in more feminine cultures (van der Lippe et al. 2011). Indeed, this goes beyond Europe and Anglo-heritage countries. In many other societies, men do not do the cooking and have not learned to cook because doing women's work is considered shameful. In one society, cooking was so explicitly women's work that men who used cooking pots were no longer considered men (Fürst 1997).

A public health focus on food is often similarly gendered. Consider the case of Wawa Mum, a food product designed by the World Food Program, which has an array of specialized food products for disaster relief. It is a fifty-gram serving of nutrient-added chickpea paste produced at factories within Pakistan and designed for aid in Pakistan. Chickpeas are common to cooking in India, Pakistan, and Bangladesh. How is this related to the gendering of food? The very name, Wawa Mum, is gendered: "In Pashto *Wawa* means 'good food', and wawa mum is what the children would say to their mothers when they wanted some more" (Smith 2011). By mentioning this, I make no normative judgment on Wawa Mum. Rather, I intend it solely as a descriptive example of the gendered nature of food the world over.

Women also tend to be perceived as the home health manager, with food and nutrition as an explicit part of this role. This is especially true of mothers, who are a crucial layer in health care systems, especially within the United States:

> We take mothers to be primarily responsible for nutrition, basic care, fostering appropriate self-care practices, protecting children from the risks and harms of daily life, and organizing and sustaining appropriate contact with more formal medical institutions, through keeping children vaccinated, arranging for timely checkups, and judging when a visit to the doctor or emergency room is necessary. (Kukla 2006, 157)

This is not limited to the United States, however. In the 1990s, Nepalese children suffered widespread vitamin A deficiency. Health experts recruited grandmothers to distribute nutritional supplements; these women had the social authority to be sure pills were taken and the time to get and administer them. As of 2005, 48,000 Nepalese grandmothers were involved in distributing these nutritional supplements to 3.5 million children. Given the social roles of women for health the world over, development agencies often give resources or money for children's health to women in the family (Kluger 2010). As Aya Kirata Kimura (2013) notes in discussing campaigns to combat under/malnutrition:

> *Commendation* of women's role in improving food has often been coupled with *condemnation* of women for not fulfilling their familial, nationalistic, and humanistic duties.... Often women are considered the solution because their inadequacy is the problem to be rectified. From governments' and experts' perspectives, women's food knowledge, cooking ability, feeding practices, and breast-feeding patterns are the means to solve the food problem, precisely because they are the origin of that problem. (7; original emphasis)

Kimura is writing in the global context, and her work looks at nutritional campaigns in Indonesia, at the development and use of golden rice, and at the development and use of commercial baby food to replace—even in the developing world—what public health advocates called "traditional homemade foods" that "could not meet infant and young children's micronutrient requirements" (Soekirman, quoted in Kimura 2013, 111). Such examples indicate that, in both developing nations and industrialized ones, "with their long-standing association with food, cooking, and feeding, women are implicitly

and explicitly targeted by the state and development organizations and scientific experts" (8). This creates a troubling individualization of responsibility for public health, and one that falls primarily on women. Consider this constructed feminine role of women *being* responsible, and *being held* responsible, for health, in contrast with men and masculinity.

Writing on how constructions of masculinity affect men's well-being, Courtenay (2000) argues that masculine gender norms such as being independent, self-reliant, strong, robust, and tough (in a word, macho) lead men to seek out medical care less often and to take more risks. Indeed, health behavior "may be invoked as a practice through which masculinities (and men and women) are differentiated from one another" (Messerschmidt, in Courtenay 2000, 1388). In this context, Courtenay argues, "Health care utilization and positive health beliefs or behaviors are … socially constructed as forms of idealized femininity[,] … potentially feminizing influences that men must oppose with varying degrees of force" to retain and perform their masculinity (1389). Combine this with gender norms for women in many cultures that construct femininity as "caring for," providing care, and "taking care of," and we have a strong gender norm underdetermination of women being the home health manager and men not only eschewing responsibility for the health of themselves and others but, in some cases, working against attempts to change their behaviors to become healthier. This is, it should be noted, true only for societies with such gender norms. But many societies have such broad gender norms of masculine toughness and independence, of not being coddled, and of feminine caring and responsibility for the well-being of others.

Thus, food preparation and home health management are strongly seen to be the realm of women. Since such "women's work" is viewed as properly their role, efforts to alter such work perhaps understandably target women, as in the Nepalese vitamin A campaign. The family becomes the site of intervention, with women responsible for that intervention. This is ethically problematic where women do perform such labor because it puts the burden of population health primarily onto women. However, it is ethically problematic and also impractical even where women do not perform such labor because then campaigns miss their targets: the actual food preparer and home health manager. In both cases, regardless of who does the cooking, we have individualization of responsibility.

In theory, such individualization of responsibility should not even be an issue because it should not be happening. Public health efforts do, in principle,

consider the social context of health behaviors. Indeed, the American Public Health Association (APHA) (2014) describes a central aim of public health as ensuring the conditions in which people can be healthy. However, the examples the APHA gives of this are revealing:

> That can mean vaccinating children and adults to prevent the spread of disease. Or educating people about the risks of alcohol and tobacco. Public health sets safety standards to protect workers and develops school nutrition programs to ensure kids have access to healthy food.... The many facets of public health include speaking out for laws that promote smoke-free indoor air and seatbelts, spreading the word about ways to stay healthy.

Note that these include not only policy issues but also the education of individuals, which then requires them to take on the responsibility for changing their lifestyles. If people are educated by public health officials or organizations but then fail to make the desired changes in health behavior, the responsibility falls on them.

This pattern occurs time and again. The U.S. Institute of Medicine's Committee on the Prevention of Obesity in Children and Youth (2004) notes that obesity requires a population-based prevention approach and says that obesity is "extraordinarily complex when considering the multitude of genetic, biological, psychological, sociocultural, and environmental factors ... and interrelationships between these factors." The same report then indicates that "preventing obesity involves healthful eating behaviors and regular physical activity—with the goal of achieving and maintaining energy balance at a healthy weight." Karen Throsby (2007) describes a similar pattern for clinical care in a *BMJ* article by David Ogilvie and Neil Hamlet, which she notes is characteristic of the dominant representations of obesity, which reduce it to "the simple physics of energy input and output," generating the "'rational prescription' of reducing consumption and increasing levels of activity" (1562). The Ogilvie and Hamlet article includes a perhaps humorous mocked-up prescription for one "Mr. E. Normous" to "eat less" and "exercise more" (1562). As Throsby herself puts it, this "presumed amenability of obesity to a 'common sense cure' of 'lifestyle' interventions contrasts with the recognition of its complex multi-factorial etiology" (1562). When social context is erased in this manner and responsibility reduced to what the individual eats (and how physically active she is), we have individualization of responsibility. This

changes the public health view from the big picture of food availability to the little one of food preparation and consumption. There is now a narrow focus on the individual and the family rather than on the social context.

There is, in practice, a further and related narrowing: population-wide public health efforts narrow to the level of the clinical encounter between health care provider and patient. This is due partly to the implication that individual patients are responsible for making lifestyle changes to eating behaviors and physical activity, which makes the clinical encounter and the doctor-patient relationship an ideal site for persuading patients to control their weight. However, there is another reason that public health efforts often narrow to the level of the clinical encounter, and it has to do with the strategies that can be used to address public health agendas.

Rosemarie Tong (2005) compares two public health strategies: the "high risk" approach and the "population" approach. In the population approach, the goal is to eliminate the underlying causes of a health problem (48). This would require modifying the complex sociocultural and environmental factors that have altered lifestyles and would require either creating a new infrastructure to effect these changes or working within the existing infrastructure with all that implies about countering institutional momentum. Abigail Saguy and Kevin Riley (2005, 887) recount Sylvia Tesh's argument that this would require major changes in industrial practices, in the economy, or in the government. This claim is reiterated in Kim McPherson's (2014) commentary on Ng et al. (2014). McPherson argues that an appropriate response to the global fact of obesity "would entail curtailing many aspects of production and marketing for food industries" (728). The solution, McPherson argues, "has to be mainly political and the questions remain, as with climate change, where is the international will to act decisively in a way that might restrict economic growth in a competitive world, for the public's sake?" (729). These approaches embody the population approach.

By contrast, the high risk approach is so called not because it is high risk but because it emphasizes high risk. It is also, importantly, clinician oriented and thus plays into the existing health care infrastructure: it works wherever there are health care providers and not just where there is a good national public health infrastructure or strong government capable of taking on vested interests. In the case of obesity, "the clinician identifies a patient as 'overweight' [via BMI] and counsels the patient that unless he gets his weight under

control, he is likely to become obese and suffer dire health consequences" (Tong 2005, 44). This high risk approach to public health is "content to alleviate or remove the signs and symptoms of a health problem" (48) at the level of the individual, person by person. Note that it too puts heavy responsibility for health on the patient ("unless he gets his weight under control"; if poor health outcomes occur in the absence of weight loss, it will be the patient's fault), as well as circumnavigating the complex causes to try to treat public health problems in populations at the level of individuals rather than at the population level. What this does is to "emphasize personal control over illness rather than requiring major changes in industrial practices, in the economy, or in government" (Saguy and Riley 2005, 887). Saguy and Riley point out that the "risky behavior frame of obesity exemplifies" "a personal behavior theory of illness" that holds individuals responsible for their own ill health (887). Tong's analysis of the appeal of the high risk approach is similar: it is, among other things, cost effective and individualizable.

Causally complex explanations of obesity and its rise begin in the population model, which best captures the APHA's aim of ensuring the conditions under which people can be healthy. In practice, however, this often narrows to the high risk approach as the rhetoric of the APHA, AMA, and others demonstrates. The high risk approach, in turn, supports and even drives the narrowing of the locus of responsibility to the individuals who prepare and consume food. Given women's disproportionate responsibility in many cultures—including in both industrialized and developing nations—for the health of children and men and their own persons, there is a clear risk that women will be targeted by governments and by transnational and local health organizations as the agents of change.

By framing obesity as a problem of what people eat (calorie dense, nutritionally poor foods) and how much (hyperalimentation), it is framed as a food choice issue. In the context of a world in which women can generally grow only what can be grown or buy what is in the markets, much of the availability of food—what people eat—is beyond their control. And yet, as those responsible for food and home health management, the onus of changing falls on them, especially when public health campaigns are educational in nature. Targeting food risks individualizing responsibility, which in turn risks targeting women.

4. The ethics of individualizing responsibility and targeting women in public health campaigns

We have seen that the burden for dealing with obesity could easily be left to fall on those who globally have few resources and little power to change the factors that actually shape their food environment. In the developing world, this is an especial concern: that transnational health organizations will blame women in the developing world for obesity and place responsibility for change on them when, in fact, the global food market plays a heavy role, perhaps even more of a role than mere home food preparation. However, individualization of responsibility for obesity is also a risk in the developed world, where it may also fall on those who have few resources and little power: in America, women become thinner as they get richer (the reverse is true for men) (Khazan 2014). There may be many reasons for this. One is that causality goes from thinness to richness: female CEOs are far more likely to be thin than are similarly aged women; perhaps this is because one cannot become a CEO unless one is thin (Khazan 2014). However, causality may go from richness to thinness, and this is highly contextual and not subject to individual agency: poorer women may live in so called food deserts, urban or rural areas in which people without the resources to do so would have to travel a great distance to reach stores that carry an array of foods at reasonable prices, including fresh fruits and vegetables (U.S. Department of Agriculture n.d.). It is my abiding ethical concern that those most vulnerable to obesity, as it is framed in health and public health, are those least able to rectify it. Individualization of responsibility is thus an ethically bad idea: it burdens the already burdened.

We can see how this happens in analogous cases by looking at public health campaigns that target women for improving newborn nutrition by encouraging breast-feeding. Rebecca Kukla (2006) argues that campaigns regarding the effect of maternal behavior on babies assume personal agency. We need, she says, "to think carefully about how maternal duties and responsibilities for health care intersect with social and environmental determinants of child health, such as race, income, and social support networks" (158). Failing to do so leads us to treat women's choices as the primary determinants of children's health. And yet many cultures, and the public health campaigns that arise from them, assume that this is the case all the time:

> Although each is a complex, multiply determined phenomenon, in our social rhetoric we hold mothers responsible for childhood obesity and malnutrition, various birth defects (most prominently spina bifida and fetal alcohol syndrome), and various behavioral and social disorders (such as attention deficit disorder and anorexia nervosa).... The use of the active voice [in campaigns by the U.S. Department of Health and Human Services] implies that mothers control their children's health through exercises of their individual agency.

> Accordingly, many of our public health initiatives specifically target mothers' choices, as though these were morally and causally self-contained units of influence. (158)

Indeed, it has been argued elsewhere that diseases such as autism had, in their early years, embedded the failures of women to love their children adequately—a failure of femininity—in the very etiology of the disease that used to be attributed to "refrigerator mothers" (Reiheld 2010). Medicalizing a condition such that a single person's failure is its cause is surely simultaneously both the peak and the nadir in individualization of responsibility for health.

But how does this work in breast-feeding campaigns exactly, and how does it overburden the already burdened? It is worth seeing, because some of the same rhetoric occurs with obesity, uses the individualization of responsibility to mask complex causation, and burdens the burdened there as well. Kukla (2006) acknowledges that there are unequivocal data about the benefits of breastfeeding that make higher levels of it an important public health goal in both the American and the global health context, as acknowledged by WHO. In the United States, breast-feeding campaigns have been vigorous and informational, using slogans such as "breast is best." However, when that slogan did not work to increase breastfeeding rates, the U.S. Department of Health and Human Services claimed that "not enough US moms are getting the message" and that "it is time for a new slogan" (in Kukla 2006, 161). Kukla's interpretation of this is that the "fact that mothers are not behaving as they are being called upon to behave is here smoothly interpreted as empirical proof that they are not actually hearing the call. Such an interpretation *closes down any interrogation of why women might not behave as they are asked to*, even if they hear and understand the request" (161; emphasis added). This is, Kukla suggests, quite an odd assumption, even a remarkable one: one could also have assumed that the reason women are not complying is not

because they don't hear and understand but, rather, because social and cultural factors such as poor maternity leave policies, workplaces that do not support pumping or breast-feeding, lack of support for public breast-feeding, and so on make compliance prohibitive. This would have been the correct interpretation. As Kukla puts it, "There are many American women, especially women from the socially vulnerable groups least likely to breastfeed [poor women and women of color], for whom breastfeeding is *not* in fact a livable choice" (162; emphasis in the original). She goes on to urge that "an educational campaign designed to change women's *choices* will either be ineffectual or seriously damaging to women.... Unless we read mothers' infant-feeding behaviors as essentially placed within the cultural context we will be able to neither understand nor effectively and ethically alter them" (162–63; emphasis in the original).

Here, Kukla is getting at the root of my concern with campaigns against obesity. Public health campaigns and clinical encounters that individualize responsibility for causally complex medical conditions mean that we will not be able to understand and effectively alter either behaviors or conditions that encourage or discourage behaviors. For obesity, these are food behaviors. An anti-obesity campaign that falls prey to these features will, as Kukla contends that educational breast-feeding campaigns do, "be ineffectual or seriously damaging to women." How much worse if it is both ineffectual and seriously damaging to women? Much worse. Utilitarian reasoning is often used in formation of public policy and in public health arguments (Petrini 2010; Roberts and Reich 2002). Public health advocates might sensibly deploy such reasoning to argue that we are justified in imposing disproportionate burdens on some to achieve greater public health for all. However, such arguments are defeated in public health campaigns that are potentially *both ineffectual and seriously damaging* to women or any subset of persons. Campaigns that individualize responsibility for causally complex conditions are in just such a position, whether or not it is women, in particular, who are targeted.

On grounds of justice, we can also critique high risk public health campaigns that individualize responsibility. There are many theories of justice that deal with the vulnerable, but one that works nicely here is John Rawls's theory of justice. In *A Theory of Justice*, Rawls (1973) famously developed three principles of justice that he thought were generated by putting oneself in the original position, behind the veil of ignorance, in which case one has no idea whether one is rich, poor, female, disabled, white, black, English speaking, and so on. Those three principles are the liberty principle (that

each person should have liberty compatible with a similar amount of liberty for all), the principle of equality of opportunity (that each person should have equal opportunities to succeed, and positions should be open to similarly qualified people), and the difference principle. While the principle of equality of opportunity arguably seeks to reduce inequality and thus vulnerability, it is the difference principle that most suits our concern with the individualization of responsibility for obesity. It says that inequality is justified if and only if it benefits the "least well-off." While there is debate over what least well-off might mean, it seems fairly clear that poor women in industrialized nations and women in the developing world who are held individually responsible for systematic issues of access to food are among the least well-off. Individualizing such responsibility violates the difference principle: women in these circumstances lack access to the resources they are being asked to use, and the very inequalities that lead them to be poorly off are those that are being used to ask very difficult and perhaps impossible tasks of their individual agency.

It may be possible in some situations with some diseases to argue that women ought to be disproportionately burdened in their roles as home health managers. But the claim that women ought to be so burdened to rectify obesity simply does not hold up to scrutiny. When it comes to public health campaigns against obesity, targeting food risks targeting women, and this is simply not ethically acceptable.

5. An ethical warning and consideration of WHO's anti-obesity strategies

Targeting food through educational public health campaigns risks targeting women by individualizing responsibility for obesity, and targeting women in such ways is ethically problematic. I strongly urge, even warn, anti-obesity public health campaigns to avoid approaches that fall prey to this. This will mean taking into account social and cultural contexts in which food choices are made. To modify Kukla's claim about breast-feeding campaigns, it will mean not only urging women to make better choices in food procurement and preparation but also making such choices livable ones. In the language of the APHA, it will mean creating the conditions for health. Does WHO at least attempt to do this?

The answer seems to be yes. WHO's slogan for their anti-obesity response is "making healthy choices easy choices."

> WHO began sounding the alarm in the 1990s, spearheading a series of expert and technical consultations. Public awareness campaigns were also initiated to sensitize policy-makers, private sector partners, medical professionals and the public at large. Aware that obesity is predominantly a "social and environmental disease," WHO is helping to develop strategies that will make healthy choices easier to make. . . . It is working . . . to analyse the impact that globalization and rapid socioeconomic transition have on nutrition and to identify the main political, socioeconomic, cultural and physical factors which promote obesogenic environments. (WHO 2014b)

This is very promising. It acknowledges that choices don't happen in a vacuum and that moral agents cannot wish themselves into situations where they can both make and effect good choices.

How does this show up in practice? By way of example, consider the WHO publication "Obesity in the Pacific: Too Big to Ignore" (2004). This region is targeted because, as mentioned earlier in the discussion of Ng et al. (2014), Pacific Island nations—American Samoa, Fiji, New Caledonia, and the Cook Islands—have some of the highest rates of obesity in the world. While many nations' food consumption has shifted away from traditional foods produced locally to more processed foods produced abroad, the Pacific Island nations' food environments are particularly conducive to ill health. In 2004, the WHO wrote: "The foods that are most commonly consumed in Pacific communities have changed significantly. In particular, people have shifted away from traditional foodstuffs toward westernized, high-fat foods. . . . Corresponding with a fall in local food production, imported foods comprise between 30 and 90 percent of all foods eaten in the Pacific."

With respect to the question of what can be done to tackle the problem of obesity in these nations, the 2004 WHO document outlines a three pronged approach:

1. Creating supportive environments—Environmental determinants of obesity must be addressed through public health policies that promote the availability and accessibility of a variety of low-fat, high-fiber foods and that provide safe places and opportunities for physical activity.
2. Promoting healthy behaviors—Behavioral determinants of obesity must be addressed through the promotion of personal awareness,

attitudes, beliefs, and skills that motivate and enable people to modify recently introduced unhealthy eating patterns. Programs should aim to restore, as much as possible, traditional methods of food preparation, processing, and preservation by using locally grown products, and to increase physical activity, which has declined with modernization.

3. Mounting a clinical response—The existing burden of obesity and associated conditions needs to be controlled through clinical programs and staff training to ensure effective support for those already affected to lose weight or avoid further weight gain.

Note the emphasis on systematic, social, and cultural contexts present not only in point 1, "Creating supporting environments," which relates to countering, reducing, or eliminating obesogenic factors in society, but also in the description of point 2, "Promoting healthy behaviors," which emphasizes a return to locally grown products used in more traditional and less processed ways. This is very promising.

Even though the WHO's ethos is on the right track and seems to avoid the problems I have noted, a more practical question remains: Will the local instantiations of this program also do so? There is reason to be concerned about this, as indicated by Kimura's and Kukla's work on previous food-related public health campaigns and by the rapid shifts from the population model to high risk models in rhetoric from the APHA, the Institute of Medicine, the AMA, and others. Those implementing WHO protocols must be careful of two factors: first, not to lose track of the systemic and cultural aspects of anti-obesity efforts and thereby individualize responsibility disproportionately onto women; and, second, not to overemphasize the health risks incurred by obesity.

Yet I suspect it will remain tempting to violate both of these warnings in implementing anti-obesity campaigns. Recall McPherson's query: "Where is the international will to act decisively in a way that might restrict economic growth in a competitive world?" (2014, 729). Systemic change is difficult. Since it is commercially available foods—both those that are heavily marketed and available and those that are not—that are a major culprit in obesogenic environments, systemic change will require going to battle with major transnational corporations that sell food products in the industrialized and developing nations. These include companies such as Nestlé, which has proven to be difficult for public health agents to deal with in the past (Krasny 2012). In

addition, systemic change will require altering the distribution of food and access to food by the very poor: Is food produced in developing nations destined for local or international markets? These are simply two examples of how systemic change may need to be.

By contrast, educational campaigns are cheaper and easier by far. An additional temptation may be that they allow public health campaigners to push off the responsibility for failure onto the targets of the campaigns rather than accepting the responsibility for failing to address the bigger issue of obesogenic environments and social factors that make it difficult for those being educated to act on their education. Even if government and public health organizations do not deliberately drop efforts to reform obesogenic environments, they may find such widespread forces too powerful to combat effectively, or find them to be a long-term problem. In such cases, the loudest voice will be the one promoting individual "positive behaviors," which will again emphasize individual responsibility and burden women disproportionately.

Suppose, however, that anti-obesity campaigners are able to keep their eyes on the prize of changing obesogenic environments ("making healthy choices easy choices"). In implementing the companion measure of promoting positive behaviors ("making healthy choices"), there is an additional temptation to resist, namely, that of overemphasizing the health risks incurred by obesity. This feeds into the high risk model and encourages narrowing the public health measures to the clinical encounter between provider and patient. As I described earlier, conflating body size with health risks allows underweight and normal weight people to ignore the negative effects that diet and physical activity have on them at the same time that it leads practitioners and the public to presume wrongly that all fat people are unfit, that all obese people are unhealthy. Concern about the contributions to ill health made by poor diet may well justify a focus on food but not making food preparation the focus. And overemphasizing the relative health importance of obesity per se is a reduction that ill serves patients and public health.

6. Conclusion

I remain deeply concerned that anti-obesity initiatives will burden women in the ways that previous food related initiatives have, in part because of the relative ease of health promotion campaigns that emphasize individual behavior. Regardless of whether women are targeted, the individualization of

responsibility is deeply and ethically problematic and, as I have argued, a very real concern with anti-obesity campaigns. However, I am hopeful that it is possible to have public health campaigns that do not perpetrate injustice. These would be ones that can get at the very real problems of availability of and access to healthy foods without demonizing those who prepare them, that avoid the ethically problematic narrowing from population health to high risk models, and that avoid leaving the work of public health to the clinical encounter and then to advice to individuals. If these campaigns do not avoid these fates, they will unfairly burden those who prepare the food that is available to them and who must work with what they are given; most often, these will be women.

Public health campaigns must heed the warnings I offer and maintain their ethos in practice. They must target structural factors rather than focusing on individuals. And they must proceed with all due caution.

Acknowledgment

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Contributor Information

Alison Reiheld is an assistant professor of philosophy at Southern Illinois University in Edwardsville (near St. Louis) and Director of SIUE's Women's Studies Program. She works on medicalization and definitions of disease, civility, obesity, the ethics of memory, reproductive ethics, and ethical issues in the clinical treatment of transgender patients.