

Disaggregating Responsibility

Epistemic Communities and the Political Response to the Obesity Epidemic

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ABSTRACT

Policymakers will be challenged to address obesity at the local or global level because today's global obesity debate is characterised by rival communities of knowledge construction, in which there are overlapping semi-hierarchical networks where the private-public and local-global responsibility for health is disaggregated, decentralised, and blurred. Two epistemic communities—the medical network and 'Big Food'—construct rival information about obesity and health. Whether obesity is a public or private, or a local or global matter is contested, and responsibility for the issue becomes disaggregated or fractured. As responsibility for health and obesity become disaggregated, policymakers have less authority and legitimacy in responding to the issue. This paper concludes with recommendations for how states can reclaim, or re-aggregate knowledge and respond to the issue of obesity.

Introduction

Obesity is no longer an “American disease,” nor is it just a concern for the industrialised world.² Globally, there are over one billion people who are either obese or significantly overweight;³ 300 million of whom are clinically obese.⁴ In addition, significantly high rates of obesity (20% of the population or more) have emerged in the South Pacific, Western and Eastern Europe, North Africa, and the Middle East, leading the World Health Organization (WHO) to declare obesity to be a global epidemic.⁵

State leaders, their spouses and other popular figures, such as celebrity chefs, are compelled by obesity's endemic proportions to advocate for public responses. Jamie Oliver, Michelle Obama and others may popularize measures to help ‘solve’ obesity, by teaching people to eat well and exercise or implementing

poverty reduction strategies and/or tax incentives. Yet 'solving' obesity will prove to be much more challenging. Indeed, obesity is just as complex, political, and rife with power-politics as other global challenges, including climate change or small arms reduction.⁶

Due to the blurred spaces within the discourse on obesity, public actors seeking to respond to the 'obesity epidemic' will be constrained by competing information and knowledge about the issue. Communities of private non-state actors, including businesses, non-profit organizations and think tanks, have produced information on the obesity epidemic marked by consistent disagreement about whether obesity is a problem and who is responsible for its emergence. Political leaders and policymakers will be challenged to address obesity at the local (state) or global level because today's global obesity debate is characterised by rival communities of knowledge⁷ and discourse construction, in which there are overlapping semi-hierarchical networks where the private-public and local-global responsibility for health and image is fractured and disaggregated, contested, and blurred. Put simply, addressing global and local obesity will be difficult, because "*it's a jungle out there.*"⁸

This paper provides some insight into the complex jungle of health politics by first highlighting competing private discourses on the conceptualisation of overweight and obesity. It opens by demonstrating that the orthodoxy – fatness-as-a-problem – is a local construction spreading to all global spaces through flows of knowledge. There are many spaces where excessive fatness is desired, but hierarchical knowledge networks globally impose the belief that fatness and obesity are undesirable. It also shows how two particular epistemic communities respond to this issue in their own right: (1) the medical/health communities and (2) food-related industry. These epistemic communities construct particular concepts which blur public actors' ability to understand and respond to the issue of rising weights. The second section illustrates how the two above mentioned epistemic communities represent semi-hierarchical networks with the common objective to disaggregate and privatise responsibility. As a result of the struggle between the public-private to aggregate and disaggregate accountability, responsibility for health and image becomes blurred. This conceptualisation explains why public actors face particular challenges in responding to obesity. In the final section, the implications of this analysis are explored, and governance options are presented and assessed. It concludes by contending that the public needs to actively develop new knowledges which enable the state to determine if, and how, obesity should be addressed.

Blurry conceptualisations of fatness and obesity and rival communities of knowledge construction

Globally, people of all races, ages, and genders have gained weight in the past four decades.⁹ As access to food has increased in almost all parts of the world, global rates of weight gain is undeniable. Many competing conceptions are raised about this gain in mean weight and there exists considerable uncertainty on its the impact, which in turn gives rise to a demand for knowledge.¹⁰ The saturation of

new concepts on these issues has resulted in multiple discourses that emerge from rival epistemic communities.

Geographer John Agnew asked readers to rethink “where knowledge is produced and how it circulates and the ways in which this rethinking can be used to inform understanding about geographies of knowledge of world politics.”¹¹ This paper also investigates the spaces in which particular understandings of health and obesity emerge. Critical theorists have challenged the “hegemonic discourse” on obesity and have worked to promote “critical positions [that question] the uncertainties surrounding knowledge of obesity.”¹² Still, for mainstream policy developers, this approach illustrates some of the on-going critical concerns of obesity knowledge, and highlights the complex webs of knowledge that serve to complicate and blur conceptions of obesity.

Issue Emergence: how fatness is detested and becomes “obesity”

Obesity has emerged as a new “issue” for advocates to lobby behind and for leaders to address. However, while rates of obesity are rising globally, excessive weight is not necessarily a global concern. To begin with, excess weight and obesity are not identical terms: “obesity” is a medical condition, whereas “overweight” is not. The broad discussion by population health specialists and public officials on obesity primarily refers to *both* overweight and obesity, not simply the medical condition of obesity. In other words, obesity has become a *buzzword* to capture the growing concern about the rapid rise in excess weight gain.

The ideas that fatness and obesity are undesirable and negative qualities in an individual often associated with being unproductive, gluttonous, or lazy are constructed conceptions emanating from Western spaces often authoritative in multiple knowledges.¹³ As James Ron et al. contend, “[t]ransnational activists resemble social problems ‘claims makers’ and the intensity of their work on a given issue or country may not reflect its real-world prevalence.”¹⁴ Essentially, ‘health’ advocates construct local problems that may not reflect global prevalence. In some cases, the local problems become global issues. While Western nations may be concerned with rising weights within their respective local jurisdictions, advocates and organisations such as the WHO are transferring their concern to the global realm. To explain why some issues become the subject of international advocacy one should recall that “advocates can link a new set of intersubjective understandings to preexisting [*sic*] applicable moral standards.”¹⁵ In the case of obesity, moral standards are directly associated with ideas of particular local spaces—though its emergence as an issue reflects the power of the spread of knowledges from the local to global.

Control over knowledge and information is important for exerting soft power and authority.¹⁶ While the negative perception of fat has only emerged in Western spaces over the past few centuries, this perception has gained a progressively dominant position to the extent that it has now emerged as global knowledge.

These views are not without their rivals. In some local spaces, being fat is still associated with power, wealth, prestige, and health. As one scholar notes, “most of the world continues to celebrate physical largess,”¹⁷ with some prominent examples being Cameroon, Niger, China, and India. Just as some languages do not have words for “over-rich” or “over-beautiful,” it has only been of late that local spaces began to understand the concept of “overweight,”¹⁸ and therefore, the knowledge of fatness and obesity. When transnational governmental and professional networks exchange ideas and information, they too share ideals. As a result, the Western construction—fatness-as-undesirable—is becoming increasingly dominant in spaces across the globe.

J. Eric Oliver argues that, “historically speaking, fatness has always had political connotations.”¹⁹ He goes on to show how fatness became undesirable in the West. When revolutionaries opposed wealthy elites, overthrew them, and sought to be their antithesis, they began to revile the lifestyle and traits of the detested elites. Consequently, Protestants “condemned fatness as embodying the indulgences (sensual and otherwise) of the Catholic Church,” while French revolutionaries detested that physique of the “bloated and inert aristocratic classes.” As a result, “American progressive reformers in the early twentieth century advocated rigorous diets in opposition to the overindulged wealth and power of monopolist capitalism.”²⁰ Negative attitudes towards fatness are one factor that is driving increasing concern about a ‘global obesity epidemic.’ Common attitudes against fatness have strengthened and solidified in the past century. The perception of fat-as-undesirable emerged with groups and actors seeking to distance themselves from detested rulers, norms, and ideals.

The current ideal of ‘thinness’ is one many are protesting. Deborah McPhail contends the obesity epidemic has been manufactured to regulate the image of the female body and reinforce “dominant ideals of beauty.”²¹ Indeed, fatness is not wholly accepted as undesirable, nor is thinness necessarily a positive attribute—for some, thinness is viewed as sickly; for others, such as some Cameroonians, it is a sign of impoverishment or failure.

Yet, authoritative transnational actors that dominate knowledges—such as the WHO, the International Obesity TaskForce, the International Union of Nutritional Sciences, and the International Association for the Study of Obesity—view excess fatness and the medical condition of obesity as a threat to one’s productivity, success, and health. Fatness is therefore a state which must be altered. As transnational advocacy networks (TANs) and leaders adopt the issue of ‘solving’ obesity, they recognise some of the local challenges that need to be faced in changing behaviour and environment. The tools public officials have to address obesity include public education, taxation, subsidisation, poverty reduction, and infrastructural changes. However, responding to obesity may not be so simple. Public actors are confronted with the challenges of navigating through the existing communities and networks that construct knowledges. Specifically, there are two identifiable epistemic communities—health/medical and the food industry—that construct rival knowledges on what obesity is and how it develops in an individual. These competing knowledges serve to blur the subject of obesity and, more broadly, whether it requires action by policy-makers.

A Medical Frame and Conceptualisation of Obesity as a Disease

One epistemic community with a particular conceptualisation of obesity is the medical/health community. Medical knowledges disseminate through networks of epistemic and professional organisations. The medical and health communities are epistemic in nature, consisting of networks of knowledge-based experts sharing causal beliefs, as well as knowledge and interests.²² They communicate formally and informally through flows and networks of professional knowledges and ideas. The most explicit, formal, and identifiable places where knowledge is articulated and explained for this community are academic institutions, journals, conferences, and issue-specific events. Akin to other professions, medical officials “offer technical assistance and professional socialization [to community members] from less developed nations.”²³ Indeed, as Agnew writes “[t]he marketplace of ideas is not a level playing field.”²⁴ Therefore, the medical/health network is semi-hierarchical, because the ideas that emanate in Western spaces hold more rational legitimacy and power than those emerging in other spaces.

Still, these dominant communities, like other epistemic communities, exert influence over knowledge and shape norms and common practices. As a result, they influence the direction and priorities of decision-makers.²⁵ The values these communities share rest in the principles of medicine, whereby they strive to ‘do no harm.’ They possess shared tools in which conditions can be characterised as diseases, disorders, viruses, etc. This elevates problems to the point where response is necessary, such as treatments and medical interventions. In using the frame of obesity to address a concern about overweight *and* obesity, it can be argued the social issues of weight-gain become medicalized. In the obesity debate, health and medical communities have developed knowledge to support the categorisation of obesity as a “disease.”²⁶ For some in the medical community, a genetic factor causes obesity. The presence of this gene—the Ob-gene, which controls an appetite chemical called leptin—is suggested as *a* cause of obesity as a disease.²⁷

Medicalizing the issue of obesity and overweight shifts the frame of the issue from a social context to a medical context; and by categorising obesity as a disease, responsibility the condition from the comprehensive state level to the individual level. The medicalization of overweight and obesity provides opportunities for medical and health professionals—not, perhaps, social scientists—to be the prime authorities in knowledge construction on this issue.²⁸ These professionals currently conceptualise obesity to be an undesired state with increased risks of co-morbidities, such as diabetes and hypertension. Yet current health knowledge on obesity remains contested. Some medical personnel argue that there is a clear link between obesity and increased risk of co-morbidities, even though others contend that particular dangers of weight gain are over blown. Alternatively, one may contest the very notion of obesity as a disease, framing it as a social and environmental condition, rather than a medical condition. Such a frame would provide space for a social discussion on the issue of rising weights. But the influence of the health/medical communities is so strong that it results in the global diffusion of its views to institutions such as the WHO and the Global

Health Council. As Oliver suggests, “once an idea emerges that a certain condition is a ‘disease,’ it is often difficult to express scepticism or alternative points of view because of the professional norms within the medical field.”²⁹ For this community, the disease concept of obesity is essential to its credibility, which according to Oliver, “hinges on their claim to base their medical decisions on the objective standards of science.”³⁰

The Food-Industry's Obesity Knowledge: Eat, Just Exercise

For epistemic communities, knowledge control offers a significant form of power – namely, it enables these networks to frame issues and “export their policy projects globally.”³¹ Medical and health networks might construct authoritative knowledge, but they do so alongside the food-related community, colloquially known as “Big Food.” An epistemic community composed of corporate and industry organisations that share free-market and capitalist values and principles of profit maximisation, Big Food constructs knowledges and frames that directly deal with the interplay of their products and obesity. It works to develop new knowledges of its products and of the science of obesity. This construction of scientific knowledges assists in (dis)‘proving’ the relationship between its respective food products and obesity.

Big Food is politically active as a lobby organisation and funder of research. The vast majority of food-related companies and industry associations have scientific advisory boards. These entities fund academics and scientists as consultants to conduct research on the health impacts of interested products. While many other industry organisations also fund research related to their own products, the impact of such research is that Big Food-sponsored science may engender bias.³² Furthermore, it may also mean that headline research is articulated to directly favour industry, so that researchers can secure funding for future research projects. In both cases, industry may use the findings of their sponsored science to expose new “truths” about their products. Akin to “research” conducted by the tobacco industry in the mid-20th century, this work points to “truths” suggesting the consumption of the product(s) under review does not pose health risks. Of notable reference is the case of the American Beverage Association (ABA).³³ When ABA-member products were found to be directly linked to the growing obesity epidemic, the association funded a separate study to examine the link between soda and body weight. The findings of ABA’s sponsored research were contrary to the original literature. It held that “the consumption of soft drinks is not related to negative [health] outcomes.”³⁴

The food community has also used the construction of new science-based knowledge to respond to other challenges. In 2003, the WHO released a draft report on obesity.³⁵ This report included dietary guidelines that called for the reduced consumption of free sugars.³⁶ The Sugar Association (SA) responded to this report by criticising the science behind the report.³⁷ When SA’s critique failed, it sought to block the WHO’s report by enlisting American senators as lobby against it. The message of the lobby was that sugar does not negatively impact health.³⁸

Similar to other actors in the food community, SA also tried to influence ideas about the cause of obesity. As a means of protecting its interests, Big Food has used its 'science' to develop information on the relationship between physical activity and obesity. Big Food suggests obesity is not the result of the consumption; rather, it develops because of physical inactivity. This view, too, has developed in studies subsidised by the American National Soft Drink Association. Companies such as PepsiCo, Mars Candy, and Cargill further reinforce this knowledge by emphasizing physical activity in their respective Corporate Social Responsibility (CSR) initiatives. Indeed, as Oliver notes, "[f]acing charges that they are making Americans obese, many companies have worked very hard to shift the public concerns."³⁹

In sum, two rival and private epistemic communities compete to conceptualise the issue of obesity. The medical and health communities have developed knowledge of obesity as a disease. Such a conceptualisation of obesity leads to medical responses. In some spaces, the response to obesity then becomes a private affair best left to medical-related actors. Alternatively, the food and other associated communities have been actively working to construct the view that obesity is caused by physical inactivity, not the consumption of 'junk foods.' This conceptualisation abdicates the food industry's responsibility in the obesity epidemic, and places responsibility on the individual and their pursuit of physical activity. In either case, as will be explored in the next section, responsibility becomes disaggregated.

Public vs. Private: Disaggregated responsibility

With rival knowledges and conceptualisations on obesity, public actors and citizens are increasingly unsure who has a role in responding to the issue of obesity. Indeed, whether obesity is a public or a private responsibility, or a local or global matter is contested, particularly in some domestic spaces, such as the United States. To be sure, the rival knowledges and conceptualisations identified earlier showed how contested an understanding of responsibility can be. Regina G. Laurence argues that, within the obesity debate, individualised or personal framing removes the opportunity for public response, whereas "systemic frames invite governmental action."⁴⁰ On the other hand, by disaggregating responsibility so that it is privatised, the role of public actors in addressing an issue becomes limited, while aggregating responsibility means that multiple actors—including the public sphere—have opportunities to intervene and respond. For sure, the communities identified here are actively seeking to disaggregate responsibility related to obesity by privatising it and shifting the spatial frame of the issue.

A Privatised Medical Responsibility

The medical/health community and the food and food-related products community may have differing views on who has the responsibility to respond to obesity, but they both locate obesity as a private affair. Yet, the responses that they recommend are slightly different, albeit they are both pushing to disaggregate

responsibility. Instead of leaving the responsibility for addressing obesity in the hands of public actors, who are arguably best positioned to enact a comprehensive strategy, these communities seek to break down responsibility, push it away from the state, and essentially privatise the responsibility function. The result is that responsibility is blurred and the public sector is left unable to meaningfully respond to the issue.

The strategies of private actors, such as Big Food, in disaggregating and privatising responsibility have been successful. For the medical and health communities, the medical frame that is placed on obesity makes it susceptible to medical responses resting in the professionalised expertises of their own communities. This frame provides health-care personnel with the responsibility to respond, and the authority to provide medical solutions. Instead of implementing social policies and programs which alter the obesogenic environment, medicalizing the issue of overweight and obesity means interventions are predisposed to emanate from pharmaceutical companies, insurance firms, bariatric clinics, or other medical actors.

The medical framing of obesity is forceful. In previous decades, global pharmaceutical companies spent millions of dollars to develop new drugs that respond to and treat the obesity disease.⁴¹ This conceptualisation of obesity will have profound implications on treatment, responses, and responsibility. The framing of it as a disease will make obesity comparable to other disease—HIV/AIDS, cancer, heart disease, etc.—and will therefore require government programs and insurance firms to cover the costs of pharmaceuticals or other treatments.⁴² With more medical treatments covered, individuals will seek more treatment, and the actors within the professional medical and health communities may profit. As David B. Allison et al. note, “[i]f obesity were considered a disease and entitled to the same considerations given to other diseases, treatment paradigms would change fundamentally.”⁴³ With considerably more than 120,000 Americans seeking bariatric surgery annually, private medical profits may swell. As Oliver suggests, “[b]ariatric surgery is one of the leading growth areas within American medicine and represents an increasingly lucrative market for surgeons trying to expand their practices.”⁴⁴ The medicalization of obesity therefore leaves increasingly wide spaces of response open to the private community of medical actors.

The medical frame of obesity could place responsibility for funding of research in the hands of public actors, but it privatises, individualises, and disaggregates responses to private communities and individual people, rather than changing the nature of public space and how it results in obesity. As disaggregated responses and responsibilities multiply, private epistemic communities become increasingly empowered and authoritative.

Individual Fitness Responsibility

The food community also seeks to frame obesity as a private individual problem of limited physical activity, not a public or collective problem arising from a market of unhealthy and addictive food choices. These ideas have become widely

accepted within other professional and political communities. As one doctor noted, “the evidence suggests that declines in physical activity are more likely than increases in food intake to be the explanation for the recent increase in obesity.”⁴⁵ This point may be compelling, however, the logic of the food community—eat junk, just exercise—may reduce fatness, but may not increase health.

The knowledge construction by this community is political. As the food community faces increased lawsuits, taxes, and regulations, it is motivated to change the public's knowledge towards privatised frames of responsibility.⁴⁶ As some scholars posit, food companies “support sports, gaining a 'virtuous' association of a high sugar drink brand or a high energy density food with sporting heroes.”⁴⁷ Determining whether increased consumption of unhealthy foods or inactivity is the cause of obesity, therefore, is blurred.

This framing is at once powerful and successful. In the United States, there is a clear divide amongst citizens as to who should respond to the obesity epidemic. A 2003 poll conducted for the Harvard School of Public Health showed an equal split between respondents who believe obesity is a private health concern, and those who believe it is a public matter.⁴⁸

The food community's strategy has been to “emphasize physical activity over diet,” and argue that there are no “bad” foods that merit changes or added regulation.⁴⁹ As Brownell and Warner contend, “a problem framed as a matter of personal irresponsibility will be addressed differently from one for which other factors, such as corporate misbehavior, [*sic*] environmental toxins, or infectious agents, are responsible.”⁵⁰ While locating responsibility in the individual, the community has also been working to keep itself—not public actors—in a position to set standards and make changes.⁵¹ This privatised responsibility hinders the opportunities available for public responses.

Global and Local Implications: Grey Policy Spaces

As responsibility for health, fatness, and obesity become disaggregated, public actors have less authority and legitimacy in responding to the issue. In some circumstances, public actors may prefer private solutions.⁵² Yet, as responsibility becomes increasingly disaggregated, public officials lose the ability to determine public or a private solutions. In the case of obesity, privatised responsibility means that public officials ‘have no business in the kitchens of the nation’; yet, in many local spaces, obesity and other health concerns emerge as symptoms of social and economic inequality.

Disaggregated responsibility is not necessarily a tragedy. The increased role of private actors in resolving policy problems can result in more efficient and effective solutions, as “networked threats require networked responses.”⁵³ Indeed, given the transnational food-product network which has played a significant role in the onset of overweight and obesity, the issue may require a public-private networked response. The concern, though, is who will have more authority and power in such networks: public or private actors? Will policies and governance mechanisms—local or global—emerging from public-private partnerships be effective in addressing the causes of obesity? Or, will such networks rely on the

views of private actors, without a public assessment of the problem? Witness the global Codex Alimentarius Commission, a body charged to “help governments protect the health of consumers and ensure fair trade practices in the food trade”.⁵⁴ It has been met with policy development challenges as private representatives “hugely outnumber” public actors.⁵⁵ The result of imbalanced networks is that interests and programs can become one-sided.

As knowledge authority moves from the domestic to the global sphere, so too do the mechanisms of control, enforcement, and governance. Certainly, following other global policies and programs there may be room for public, private, and public-private governance. For example, voluntary CSR initiatives among food companies may result in healthier products. If CSR is corporate-led, concerns arise about the effectiveness of their programs. In developing a CSR strategy, for instance, the ABA announced that it would reduce the sale of soda in American schools. Some applauded this action, yet the ABA continues to sell juices and sports drinks considered high in sugars and fructose-glucose.⁵⁶ Furthermore, other corporate initiatives, such as increasing essential nutrients or dietary fibre, enable Big Food to define what is healthy. An eminent example can be found in the multitude of sugar cereal products marketed to children, many of which have front-of-the-package health claims claiming added iron or whole grains. Though, perhaps the problem with these products is not *only* that they are unhealthy, but that they are marketed to children as well.⁵⁷

As Brownell and Warner aptly write, “At the center of this issue is whether industry can be trusted to make changes that benefit the public good and can be responsible with the accompanying marketing.”⁵⁸ Allowing industry to set its own standards dilutes the ability of the public sphere to establish benchmarks and removes its direction and autonomy over policy. Public actors may be unable to construct their own knowledges when faced with authoritative and rival knowledges from private communities.

To be sure, “[k]nowledge is always made somewhere by particular persons reflecting on their place’s historical experience.”⁵⁹ Yet, the state or global public actors need to be able to construct knowledge based on their own experience. However, in the case of health, fatness, and obesity, public actors at either the global or local remain challenged to develop policy autonomously.

Conclusion

This paper has evinced the highly complex and political nature of the debate surrounding obesity and public policy. The very notion that obesity is a problem is contested in local spaces, while global authoritative knowledge, in turn, is changing local views on the issue of fatness and health. Within a debate of obesity, there are many grey spaces. Rival epistemic communities, such as the medical/health networks and Big Food, are constructing competing concepts of obesity. The result is a confused public sector with a limited ability to respond to the issue of obesity—if it chooses to do so at all. Communities of private actors are privatising and disaggregating health responsibility. Consequently, the public loses knowledge autonomy and policy capacity. Integrating the private into the public

may lead to imbalances that favour the private; yet, ignoring the private could result in weak policies.

Regarding obesity and overweight, it is evident the public is caught in a paradox: it cannot work with the private, and it cannot work without it. Public actors need to actively work towards autonomously developing their own views on obesity and overweight, so as to compete with the knowledge construction and goals of private actors. Only then will the public be able to conceptualise obesity in a way it sees fit, and whether it prefers a public, private, or public-private solution.

'Solving' obesity may appear simple, but until academics and public actors develop new public knowledge on obesity, the private sector will inform and direct all initiatives, including initiatives displayed on prime-time television and gardening programs at the White House.

NOTES

¹ The author would like to thank David McDonough and any anonymous reviewers for their feedback, as well as Patrick Fafard, Claude Rocan, and Michael C. Williams for promoting the exploration of these ideas.

² Obesity is "a condition of excess body fat that results from a chronic energy imbalance whereby intake exceeds expenditure." More precisely, "obesity" is a medical condition, defined as a body mass index (BMI) of higher than 30. The BMI is a comparative measurement between height and weight, in which weight is divided by height and squared. There are three classes of obesity. Class I falls in the BMI ranged of 30 to 34; class II, from a BMI of 35 to 39; and, class III is delineated by a BMI of over 40. Peter T. Katzmarzyk, "The Canadian Obesity Epidemic, 1985-1998," *Canadian Medical Association Journal* 166, no. 8 (2002), 76. Kelly D. Brownell and Derek Yach, "The Battle of the Bulge," *Foreign Policy* 151, no. November-December (2005).

³ Lieberman, Leslie Sue. "Evolutionary and anthropological perspectives on optimal foraging in obesogenic environments." *Appetite* 47, (2006): 4.

⁴ Maria L. Loureiro and Jr Rodolfo M. Nayga, "International Dimensions of Obesity and Overweight Related Problems: An Economics Perspective," *American Journal of Agricultural Economics* 87, no. 5 (2005), 1147.

⁵ Neville J. Rigby, Shiriki Kumanyika, and W. Philip T. James, "Confronting the Epidemic: The Need for Global Solution," *Journal of Public Health Policy* 25, no. 3/4 (2004), 421. Mickey Chopra, Sarah Galbraith, and Ian Darnton-Hill, "A Global Response to a Global Problem: The Epidemic of Overnutrition," *Bulletin of the World Health Organization* 80, no. 12 (2002), 953.

⁶ For an interesting assessment of knowledge politics in the debate on global environmental issues, including climate change, see Radoslav S. Dimitrov, "Knowledge, Power, and Interests in Environmental Regime Formation," *International Studies Quarterly* 47 (2003).

⁷ "Knowledge" in this paper refers to the same definition used by John Agnew, in which knowledge means "explanatory schemes, frames of reference, crucial sets of assumptions, narrative traditions, and theories." It also refers to "depictions of social or physical processes", all of which are "the product of human interpretations of social and physical phenomena." John Agnew, "Know-Where: Geographies of Knowledge of World Politics," *International Political Sociology* 1 (2007), 138; Peter M. Haas, "Introduction: Epistemic Communities and International Policy Coordination," *International Organization* 46, no. 1 (1992), 4.

⁸ Emphasis added. This statement is often used by Realists (particularly Thomas Hobbes) to describe the anarchic nature of international relations. Quote from Robert G. Gilpin, "The Richness of the Tradition of Political Realism," *International Organization* 38, no. 2 (1984), 290.

⁹ David B. Allison et al., "Obesity as a Disease: A White Paper on Evidence and Arguments Commissioned by the Council of the Obesity Society," *Obesity* 6, no. 6 (2008), 1164.

¹⁰ Haas, "Introduction: Epistemic Communities and International Policy Coordination."

¹¹ Agnew, "Know-Where: Geographies of Knowledge of World Politics.", 139.

¹² Alexandre Palma and Silvia Maria Agatti Lüdorf, "Letter to the Editor: Towards Rethinking the Discourse on Obesity," *Obesity Reviews* 11 (2009).

¹³ Richard A. Gordon, *Eating Disorders: Anatomy of a Social Epidemic*, 2nd ed. (Oxford: Blackwell, 2000), 140.

¹⁴ James Ron, Howard Ramos, and Kathleen Rodgers, "Transnational Information Politics: Ngo Human Rights Reporting, 1986-2000," *International Studies Quarterly* 49, no. 3 (2005), 575.

¹⁵ R. Charli Carpenter, "Studying Issue (Non)-Adoption in Transnational Advocacy Networks," *International Organization* 61 (2007), 645.

¹⁶ Haas, "Introduction: Epistemic Communities and International Policy Coordination.", 2.

¹⁷ Oliver, *Fat Politics: The Real Story Behind America's Obesity Epidemic*, 62. Also see Gordon, *Eating Disorders: Anatomy of a Social Epidemic*, 144.

¹⁸ *Ibid*, 64.

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- ¹⁹ Ibid, 65.
- ²⁰ Ibid, 65.
- ²¹ Deborah McPhail, "Who Has a Weight Problem: Globalization, the "Obesity Epidemic", and the World Health Organization," *Women and Environments* Fall/Winter (2005), 24.
- ²² Haas, "Introduction: Epistemic Communities and International Policy Coordination", 18.
- ²³ Anne-Marie Slaughter, *A New World Order* (Princeton: Princeton University Press, 2004), 4.
- ²⁴ Agnew, "Know-Where: Geographies of Knowledge of World Politics", 139.
- ²⁵ Haas, "Introduction: Epistemic Communities and International Policy Coordination."
- ²⁶ Oliver, *Fat Politics: The Real Story Behind America's Obesity Epidemic*, 50.
- ²⁷ Gordon, *Eating Disorders: Anatomy of a Social Epidemic*, 145.
- ²⁸ Allison et al., "Obesity as a Disease: A White Paper on Evidence and Arguments Commissioned by the Council of the Obesity Society", 1170-1.
- ²⁹ Oliver, *Fat Politics: The Real Story Behind America's Obesity Epidemic*, 50.
- ³⁰ Ibid, 50.
- ³¹ Claire A. Dunlop, "Policy Transfer as Learning: Capturing Variation in What Decision-Makers Learn from Epistemic Communities," *Policy Studies* 30, no. 3 (2009), 289.
- ³² Kelly D. Brownell and Kenneth E. Warner, "The Peril of Ignoring History: Big Tobacco Placed Dirty and Millions Died. How Similar Is Big Food?," *The Milbank Quarterly* 87, no. 1 (2009), 278.
- ³³ Companies and brands belonging to the ABA include Coca-Cola, Dr. Pepper, Kraft Foods, Nestlé Waters North America Inc., PepsiCo, XI Energy Drink Corp, and others.
- ³⁴ Brownell and Warner, "The Peril of Ignoring History: Big Tobacco Placed Dirty and Millions Died. How Similar Is Big Food?," 297.
- ³⁵ Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases, *Diet, Nutrition and the Prevention of Chronic Diseases*, (Geneva: 2003, World Health Organization).
- ³⁶ Ibid, 65-66.
- ³⁷ Ibid, 275.
- ³⁸ Ibid, 275.
- ³⁹ Oliver, *Fat Politics: The Real Story Behind America's Obesity Epidemic*, 144.
- ⁴⁰ Regina G. Laurence, "Framing Obesity: The Evolution of News Discourse on a Public Health Issue," *The Harvard International Journal of Press/Politics* 9, no. 3 (2004), 57.
- ⁴¹ Oliver, *Fat Politics: The Real Story Behind America's Obesity Epidemic*, 51.
- ⁴² Allison et al., "Obesity as a Disease: A White Paper on Evidence and Arguments Commissioned by the Council of the Obesity Society", 1170-1.
- ⁴³ Ibid, 1170-1.
- ⁴⁴ Oliver, *Fat Politics: The Real Story Behind America's Obesity Epidemic*, 54.
- ⁴⁵ Words of Dr. Steven Blair of the Cooper Institute in Dallas cited in: Ibid, 144.
- ⁴⁶ Neville J. Rigby, Shiriki Kumanyika, and W. Philip T. James, "Confronting the Epidemic: The Need for Global Solutions," *Journal of Public Health Policy* 25, no. 3/4 (2004), 429; Oliver, *Fat Politics: The Real Story Behind America's Obesity Epidemic*, 144.
- ⁴⁷ Rigby, Kumanyika, and James, "Confronting the Epidemic: The Need for Global Solutions", 429.
- ⁴⁸ Laurence, "Framing Obesity: The Evolution of News Discourse on a Public Health Issue", 57.
- ⁴⁹ Brownell and Warner, "The Peril of Ignoring History: Big Tobacco Placed Dirty and Millions Died. How Similar Is Big Food?," 265.
- ⁵⁰ Ibid, 266.
- ⁵¹ Oliver, *Fat Politics: The Real Story Behind America's Obesity Epidemic*, 144.
- ⁵² Ougaard, "Private Institutions and Business Power in Global Governance", 390.
- ⁵³ Ibid. Page 387. Slaughter, *A New World Order*, 4.
- ⁵⁴ Sharon Friel, Mickey Chopra, and David Satcher, "Unequal Weight: Equity Oriented Policy Responses to the Global Obesity Epidemic," *BMJ* 335 (2007), 1242.
- ⁵⁵ Ibid, 1242.
- ⁵⁶ Brownell and Warner, "The Peril of Ignoring History: Big Tobacco Placed Dirty and Millions Died. How Similar Is Big Food?," 267.

⁵⁷ Ibid, 283.

⁵⁸ Ibid, 283.

⁵⁹ Agnew, "Know-Where: Geographies of Knowledge of World Politics", 142.

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By Jacqueline J.Y. Cho Jacqueline Cho is currently interning with the African Union Partnership Team at the United Nations, and was an intern at the Office of the United Nations High Commissioner for Human Rights at the time of writing. She is also [!]. Disaggregate them by multiplying; this is how one makes them communicate. From the Cambridge English Corpus. The fact the victims were both sectarian and ethnic outsiders makes it difficult to disaggregate these elements of their identity. From the Cambridge English Corpus. In future work we hope to disaggregate the insurance products into investment-linked products, which are likely more risky than endowment funds. From the Cambridge English Corpus. Many translated example sentences containing "disaggregating" – Russian-English dictionary and search engine for Russian translations. [...] that, in this context, disaggregating the data, based on [...] the current Millennium Development Goal indicators. Disaggregation is the breaking down or separation of something into constituent parts or elements. You can disaggregate just about anything. – Albert Einstein. Disaggregation is one of my favorite strategy and problem solving tools. I have to admit I thoroughly enjoy disaggregating problems and situations since it often provides the "AHA" moment of clarity. Yet, it is also one of the most difficult tools to master. For the majority of problems, there is no simple framework, template or recipe.