Who's responsible for addressing child overweight and obesity? An analysis of health professional discourse

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Key – HP refers to Health professional in either the primary or secondary health setting

Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning"

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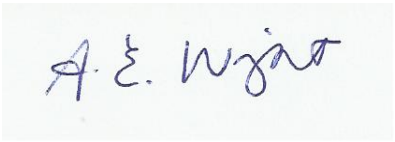

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Abstract

Overweight and obesity in children is an issue that has increasingly become the focus of the media and government agencies both in New Zealand and around the world. Despite this, within primary and secondary healthcare settings there are varying levels of response to what has been described as an epidemic with serious consequences to individual health status. This study looked firstly at the role and responsibility of health professionals in addressing overweight and obesity in children, and secondly, the barriers these health professionals face and the reasons for these barriers.

Semi structured interviews were conducted with seven health professionals including doctors and nurses from both the primary and secondary healthcare settings. The transcribed interviews were analysed using Foucauldian discourse analysis methodology to identify and explore the dominant discourses.

Four key discourses emerged as influencing the health professionals' perspective of whose role and responsibility it is to address overweight and obesity in children. These included the dominant medical discourse, which all the health professionals drew from first and then three subsequent discourses, the social, socioeconomic and cultural / ethnicity discourses. Whose role and responsibility it is to address overweight and obesity in children is poorly defined and reflects the complexity of the issue and the influence of multiple intersecting discourses. There are several recommendations from this research including: the need for ownership at government level; the need for additional services, support and resources for health professionals within both the primary and secondary healthcare setting; and the need to improve culturally acceptable practices to meet the needs of Māori and Pacific peoples.

Chapter One: Introduction

1.1 Background

Overweight and obesity are defined by the World Health Organisation (WHO) as an abnormal or excessive accrual of fat that may lead to health being impaired (2012a). In relation to Body Mass Index (BMI), overweight is defined as a BMI of greater than 25 and obesity as a BMI equal to or greater than 30 (World Health Organisation, 2012a). In simple terms obesity can be described as a condition that occurs because consumption of calories by an individual far outweighs calories that are expended (Alpert, 2009).

In New Zealand, and around the world, rates of obesity are climbing rapidly and it has been described as an epidemic (Alpert, 2009; Y. Wang & Lobstein, 2006). Within the New Zealand context 10% of children aged between four-14 years are considered to be obese, with a further 20% considered to be overweight and therefore at risk of becoming obese (Taylor, 2007). While these numbers are comparable to those of other western countries (Utter, Scragg, Schaaf, Fitzgerald, & Wilson, 2007), the situation in New Zealand also has a specific cultural and ethnicity dimension. A study completed by the Ministry of Health (MOH) in 2006/2007 showed that Māori and Pacific peoples are represented disproportionately to the rest of the population with 25% of Māori and 31% of Pacific children being over-weight and 13% and 26% of these groups, respectively, being obese (Ministry of Health, 2009).

Overweight or obesity in childhood increases risk of diseases such as cardiovascular disease, diabetes, muscular skeletal problems, sleep apnoea and asthma (Azzopardi, Sharma, & Bennet, 2006; Lobstein, Baur, & Uauy, 2004; Ministry of Health, 2012a). Being overweight or obese as a child also increases the risk of being overweight or obese as an adult (Ministry of Health, 2009) therefore increasing the risk of associated diseases (World Health Organisation, 2011).

The rise in overweight and obesity prevalence in children will therefore have significant flow on effects on the health system in the future. A study undertaken by Wang, Beydoun, Liang, Caballero, & Kumanyika, (2008), predicted that the cost of obesity to the United States' (US) health system would increase from 9.1% to 16-18% of the total

US medical expenditure. Bearing this in mind, overweight and obesity in children must be addressed with a level of urgency (Story et al., 2002).

1.2 Philosophical Approach and Research Aim

The aim of this research is, firstly, to explore the role of health professionals in addressing overweight and obesity in children in both the primary and secondary health settings. Secondly, it aims to explore the barriers that health professionals encounter when addressing overweight and obesity in children and the reasons for those barriers.

I chose to use a qualitative methodology for this research. Qualitative research has been described as 'a group of approaches that is concerned with the understanding of the experiences and behaviour, and the meanings and interpretations that people attach to these' (Holloway, 2005, p. 3). It is a methodology that is increasingly being used in health research because of its ability to, among other things, reveal insights into how patients and professionals think and feel about specific experiences, explore relationships between patients and health professionals and examine the influence of context and culture in shaping motivations, intentions and values (Holloway, 2005). These characteristics made the use of a qualitative methodology particularly appropriate for this research topic. It allowed me to examine health professionals' perceptions of their role in addressing overweight and obesity and influences on these perceptions. It also provided insights into the barriers faced by health professionals, why they think these barriers arise and allowed me to examine how their views are shaped by both the setting in which they work and wider societal influences.

A Foucauldian discourse analysis provided the philosophical underpinnings for this research. I chose this methodology to analyse semi-structured individual interviews that I undertook. This approach enabled a deconstruction of the texts in a way which considered the influence of context and culture, for instance, to be explored through a 'Foucauldian lens.' Of particular relevance for this research was the potential for this methodology to reveal insights into the way health professionals' practise is influenced by a Foucauldian understanding of: the power relations that exist between health professionals and children and their families; the exercise of discipline and surveillance in relation to the large body size; and the influence of competing discourses.

1.3 Assumptions

When undertaking research using a postmodern approach to discourse analysis it is important that the researcher discloses any potential assumptions that they may have about the research topic. This reflexivity ensures that the researcher then becomes situated within the research. It is described by Holloway (2005) as the researcher being aware of their own positioning and role and how these may affect the outcomes of the research. I acknowledge that my own subject position comes from working within the health profession and that I share many of the speaking positions of the interviewees. This is influenced by my having been a child health nurse for more than twenty years in several countries and having worked in a variety of settings and roles. Within the primary setting I have worked as a home-care nurse visiting children with on-going acute and chronic needs after discharge from the hospital. Within the secondary setting I have worked in acute areas including oncology and ear nose and throat as a staff nurse; neurosurgery and craniofacial surgery as a nurse specialist; and general surgery and orthopaedics as a nurse educator. I am currently working as a nurse educator within the secondary paediatric setting.

My interest in the way health professionals address overweight in children was first piqued when working as a nurse educator in the orthopaedic setting where there were a number of children admitted for conditions that were exacerbated by or a direct result of their overweight or obese status. I was aware at that time that even though we weighed these children on admission this was for the purpose of medication administration and surgery. A formal BMI was never undertaken and any advice around diet was given by way of an ‘information pack’ with no on-going support either within the hospital or the primary care setting. Responsibility for any changes firmly rested with the parents.

I also became aware that in the hospital setting there was a disproportionate number of Māori and Pacific children who were overweight or obese compared with other ethnicities admitted. This was also highlighted to me by the choice of topics I had chosen to focus on in previous academic papers I have undertaken which has led to a personal interest in the influence of culture and socioeconomic status on nutrition. As a health professional myself concerned about the lack of intervention for children who are overweight or obese within the hospital secondary setting, I decided it was important to find out whether health professionals within the primary or secondary health settings

believed they had a role and or responsibility to address overweight and obesity in children.

For the purpose of this research I have used the terms overweight and obesity, being the medical terms that are used to identify and describe body size in relation to height, weight and age of children. However I acknowledge that the use of these terms is problematic because they sit within medical discourse.

For the purpose of this research I have used the term child or children. This encompasses both children and adolescents up to the age of 16 years which is the cut off age for care within the paediatric secondary health setting in which I am based. I acknowledge that this may be different in other health care settings.

Throughout the findings I have used pseudonyms to protect the participants' identity and I have also referred to them as a Healthcare Professional (HP) in either the primary or secondary setting.

1.4 Justification for the Research

In recent years, overweight and obesity as conditions that affect economies and people's health have had intense media exposure and are recognised by governments around the world to be a major problem to be addressed. Society has been warned that there is going to be significant future cost to the health system (Finkelstein, Trogdon, Cohen, & Dietz, 2009; Y. C. Wang, McPherson, Marsh, Gortmaker, & Brown, 2011; Withrow & Alter, 2011) and that it is likely this generation of obese children are going to die before their parents (Grant & Bassin, 2007b). Although the future health risks associated with childhood obesity are well documented in the literature, currently there is lack clarity on the role and responsibility of health professionals in addressing overweight or obesity in children.

Within New Zealand and around the world, overweight and obesity rates in children have increased at an alarming rate over the last twenty years. Obesity is described as one of the most prominent modifiable risk factors of a number of important diseases (Ministry of Health, 2004b; World Health Organisation, 2012b). As a society we are becoming more inactive as we are influenced by the increasingly obesogenic

environment in which we live, including the influence of pervasive sedentary behaviours, high caloric diets and technology, (Grant & Bassin, 2007b; Maziak, Ward, & Stockton, 2007; Sturm, 2008; Swindon, 2008).

The New Zealand government has put in place several policies that aim to improve the health and well-being of the child and young person population, the latest being the Food and Nutrition Guidelines for Healthy Children and Young People (aged 2-18) which includes a section on obesity (Ministry of Health, 2012a). It states that intervention needs to occur early in order to prevent obesity but also acknowledges that there has been little success when targeting preschool children. Intervention prevention studies in older children are somewhat scarce too (Ministry of Health, 2012a). The Ministry of Health has developed a guideline for managing weight in children where interventions are focused in primary care and within community based initiatives (Ministry of Health, 2009). There have been other examples of more direct intervention within the primary setting, such as Healthy Eating Healthy Action (HEHA) (Ministry of Health, 2004a) and Fruit in Schools (Ministry of Health, 2006). However, the implementation of some of these programmes has been discontinued and within the secondary setting there have been no equivalent programmes directly targeting overweight and obesity.

Overweight and obesity is a complex problem which pervades many sectors of society including health and currently there are very few strategies in place that appear to address the problem successfully apart from bariatric surgery (Buchwald, Avidor, Braunwald, Jensen, & Pories, 2004; Treadwell, Sun, & Schoelles, 2008). The apparent lack of successful intervention strategies brings into focus the role of health professionals in addressing overweight and obesity: what level of responsibility do they believe they have and what are the perceived barriers that they face?

1.5 Structure of Thesis

The remainder of this thesis is divided into six chapters.

Chapter Two describes the Foucauldian philosophical and methodological foundations of this research and the methods employed in collecting and analysing the data. It also covers ethical considerations and a discussion of methodological rigour.

Chapter Three reviews international literature within three broad topic areas on overweight and obesity. Firstly, it describes research into the characterisation of overweight and obesity as a health problem, including how overweight and obesity is assessed. Secondly, it describes research into the societal influences on, and consequences of, overweight and obesity. Finally, it examines different perspectives on assigning responsibility for addressing overweight and obesity, including findings on the barriers faced by health professionals.

Chapters Four, Five and Six present the findings of this research arising from the analysis of interviews with health professionals. Chapter Four examines medical discourses associated with the use of medical terminology, the assessment of overweight and obesity, the right of health professionals to intervene, and how health professionals view their role in addressing overweight and obesity in the face of the obesity 'epidemic.'

Chapter Five presents findings relating to discourses that sit outside health settings but which influence the ability of health professionals to address overweight and obesity in children. Firstly, it examines social discourses that pertain to stigma and the normalisation of overweight and obesity. Secondly, it considers the influence of, and barriers arising from, culture and ethnicity. Finally, it examines how practise is influenced by socioeconomic disparities in the incidence of overweight and obesity among different communities.

Chapter Six examines how the health professionals interviewed view their responsibility, and that of State institutions and the individual, in addressing overweight and obesity in children. It reflects on the influence of the medical and non-medical discourses discussed in Chapters Four and Five to explore the complexity of this question of responsibility.

Chapter Seven discusses the key findings of this research in the context of Foucauldian philosophy and the established literature on discourses associated with overweight and obesity in children. It discusses implications of the study and proposes a way of conceptualisating the different roles of the health professions and others in addressing

overweight and obesity. Finally, it outlines limitations of this study and identifies areas for further research.

Chapter Two: Methodology to Method

2.1 Introduction

This research has explored how health professionals contribute to addressing the issue of overweight and obesity in children and the barriers that they face in so doing. This has been achieved by analysing the discourses that health professionals use to describe their experiences when assessing or intervening in children who present with overweight or obesity in primary and secondary health care settings. This chapter describes the methodology and methods that have been utilised. It describes the philosophical and methodological foundations of the research before considering the research methods employed in collecting and analysing the data.

I am aware that, as a health professional with a personal interest in this topic who also works with children in the secondary health setting, there is the potential for the research process to be exposed to researcher bias. This is addressed in a discussion of methodological rigour at the end of the chapter.

2.2 Methodology

2.2.1 Philosophical Foundations

For the purpose of this research I have adopted the philosophical position of social constructionism, using the methodology of discourse analysis developed by the French philosopher, Michel Foucault. Social constructionism challenges the view that the way we interpret our world is the result of our own subjective (and objective) observation and therefore interpretation. Instead, social constructionist observation theory suggests that our interpretations are shaped by social processes and interactions with each other (Burr, 1995; Grbich, 2007). Our ideas and interpretations are influenced by our surroundings, whom we meet and spend time with and the suggestions that are made to us.

This means that any single event, phenomenon or object has several discourses which could describe it. Discourses can be thought of as “language in action” (Danaher, Shirato, & Webb, 2000, p. 31). They have been referred to as the use of language in everyday text and talk, providing a frame of reference for interpretation of the world

around us. Burr (1995) described a discourse as referring to "a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events" (p. 32). Implicit within the concept of discourse is that their influence extends beyond words to shape actions and practise (Anderson & Grinberg, 1998).

By using discourse analysis this research has aimed to unravel the contributing discourses that have influenced how health professionals assess, and intervene in, children who are deemed to be overweight or obese. My own experience as a nurse in the surgical and orthopaedic paediatric settings is that although a child may be identified as overweight when weighed on admission, there is no regular formal assessment of weight or referral to a dietician carried out by either nursing or medical staff. However, I am also aware that overweight is a discursive construct and that I am drawing on a discourse that determines that children who have apparent body fat are overweight. The application of discourse analysis has enabled me to look at whether or not this discursive construction of obesity is utilised by paediatric health professionals in relation to children, whether it is made visible as a health issue in itself or, conversely, whether it is made invisible by other discourses.

2.2.2 Postmodernism

The term postmodernism is understood as distinguishing the contemporary scene from the modern (Cahoone, 1996). Modernity is a term that is used to describe how reason can be the dominating feature of our environment, for example, the emphasis on grand theories of social structure and action which search for a single truth. Although difficult to define, postmodernism's key concept is that it rejects the notion that there is social coherence and single truths (Cheek, 2000). Rather it proposes plurality and multiplicity (Cheek, 2000; Powers, 2001).

The term postmodernism was first used in the early 20th century by the German philosopher Rudolf Pannwitz to describe the 'nihilism' of western culture of that time (Cahoone, 1996). It has gained more momentum throughout the 20th century, especially in the 1980s and 1990s, during which postmodern debates have dominated many fields of study. The French philosophers of the 1960s such as Deleuze, Derrida and Foucault greatly influenced postmodern thought, although they may well have denied the placement of their work into the postmodern theory (Cheek, 2000). In relation to health,

Cheek (2000), explains how postmodernism challenges the prevailing notion that within a healthcare system there is a cohesion and common goal between all components and health professionals. Instead postmodernism problematises the perception of progress and advancement challenging whether developments within health are actually progressive.

Postmodernism seeks to analyse the specific contextual power relations that exist by observing the processes within specific situations rather than taking a generalist approach (Powers, 2001). Grand theories that aim to describe history and social structure of the human experience are rejected by postmodern thought (Cheek, 2000). Postmodernism highlights the way in which aspects of our reality that have become "truth" are in fact a result of social construction. Our ways of talking and acting do not reflect a position of neutrality within our world, but instead play an active role in the way we view our world.

Using postmodernist discourse analysis as an approach to research enables a researcher to explore the alternative to understanding *why* something is the way it is, instead of looking at the *how* historically something has been constructed to be that way. Postmodernism recognises that there are multiple perspectives and plurality of understandings for any aspect of social reality. It does not seek universal and essential truths; it emphasises that there are many positions from which it is possible to view any aspect of reality (Cheek, 2000)

Foucault's work has been consistently associated with postmodernism, although he claimed his work to be a 'history of the present' (Foucault, 1977, p. 31). There are, however, some similarities between Foucault and postmodernism. Foucault, too, believed that there are multiple positions from which to view any aspect of reality, and challenged the notion that knowledge is objective or value free. One of Foucault's key concepts is that of discourse.

2.2.3 Discourse

Foucault suggested that discourses systematically form the objects of which they speak, allowing, therefore, objects to have meaning applied to them (Mills, 2004). This is described by Foucault as the surface of emergence (Foucault, 1972). He explains discourse as 'ways of thinking and speaking about different aspects of reality' (Cheek,

2000; 2004, p. 22). According to McHoul and Grace (1993), who refer to Foucault's concept of discourse, it is "whatever constrains but also enables writing, speaking and thinking within specific historical limits"(p. 31). However, not all discourses are given equal status and presence and therefore authority (Cheek, 2000). Essentially discourses determine who can speak and with what level of authority and, conversely, who cannot (Ball, 1990).

For example, historical discourses in medicine can appear to be distinct from one another but may overlap and intersect at different times (McHoul & Grace, 1993). Therefore, discourses should not only be analysed in the present. Analysis should incorporate the history of practises and knowledge from the present reflecting back to the past (Foucault, 1977). Discourses are influenced by both historical and power components that create a multitude of changing meanings and definitions which occur over a period of time (Powers, 2001).

Discourses create discursive frameworks which in turn organise reality and ideas in a certain way, producing objects of knowledge. Foucault describes discursive frameworks as the organising principles of an episteme and they can be defined as much by what lies inside them as well as by what lies outside of them (Danaher et al., 2000). An episteme is described as the total set of relations that unite the discursive practises at any given period of time as they relate things to one another by classification and giving value and meaning (Danaher et al., 2000; Foucault, 1972). They determine how we make sense of what we know and what we say. These principles are mostly part of our unconsciousness and are more or less those things that are taken for granted (Danaher et al., 2000).

For example, a discursive effect of medical discourses is that clinicians and scientists are presumed to know the "truth" about ill health and have the authority to label it a disease and prescribe appropriate treatment (Cheek, 2000; Lupton, 1995; Rail, Holmes, & Murray, 2010). This example is a result of the health professionals being seen as a legitimate authority and having expert knowledge and understanding of the body. A discursive effect of social discourses is that of the body being viewed in relation to the presumed links between poverty, lack of education and general health all together.

For Foucault, discourses are also defined as bodies of knowledge that are associated with the concept of discipline. Discipline, in this sense means both scholarly discipline, such as the sciences or medicine and disciplinary institutions of social control, such as the prison or hospital (Foucault, 1977). This duality in meaning shows the historically specific relationship between disciplines and disciplinary practise (McHoul & Grace, 1993).

Subjectivity is recognised as key within the concept of discourse. Subject positions are constructed from within the influence of the discourse. Foucault proposed that the subject is not a coherent entity, but is in actual fact acquired as a result of everyday experience and exposure to discourses. For example, as Willig (2000) proposes, an individual can choose to take up a subject position or become positioned by an alternative discourse. As a result, discourses have a profound effect on the production of our own subjectivity and therefore ourselves as a subject. We are not a product of our own subjectivity; we are in fact created within discourses.

2.2.4 Power and Knowledge

There are also links between the concept of discourse and power and knowledge. Foucault claimed that the power relations that exist today are a result of three key conceptual changes: the development of the physical sciences; the industrial revolution; and the rise of capitalist nations (Powers, 2001). In Foucault's view these three events have shaped power relations because they changed the way that people were managed by the State (Powers, 2001).

Foucault had a particular interest in power relations. He described power as being everywhere, not because it embraces everything, but because it comes from everywhere (Foucault, 1976). Power is always in play and always being contested. He also described power, not as an institution or structure or something that we are bestowed with, but as 'the name that one attributes to a complex strategical situation in a particular society' (Foucault, 1976, p. 93). This is further explained by Danaher, Shirato, and Webb (2000), who state that Foucault believed that power wasn't held by particular individuals or groups but was in fact a set of relationships between groups within different levels of society and is subject to change with time and circumstances. Foucault (1976) also stated that where power exists so does resistance and that it is the multiplicity of the points of resistance by way of the role of adversary, target or support

that shape power relations. Foucault suggested that power wasn't solely repressive but could be seen as productive, especially in relation to the production of knowledge and subjectivity (Lupton, 1994).

Foucault argued that knowledge is intrinsically linked with power. This is in contrast to the belief that knowledge is objective, universal and ultimately truthful (Cheek, 2000). He recognised that knowledge and power are not the same thing, but that each incites the production of the other (Barker, 1998). He further contended that, contrary to popular belief, knowledge isn't something that pre-exists power controlling it from a value-free cultural perspective, but rather knowledge and power are intimately related (Barker, 1998). Foucault believed that this close relationship between knowledge and power influences the beliefs and behaviour of entire populations. This occurs by the sanctioning of expert knowledge (including medical) by governing bodies (Chambers & Narayanasamy, 2008; Cheek, 2000).

He also challenged the theories of the time which suggested knowledge constituted truth, that the how's and why's of life could be explained by knowledge and that knowledge was continually informing current civilisations and was not influenced by political considerations (Danaher et al., 2000). Foucault saw knowledge as being full of contradictions and unanswered questions and essentially was the result of some explanations winning out over others. These truths or current accepted ways of viewing the world are a product, not of objective observation, but of social processes and interactions (Burr, 1995). Foucault argued that power is exercised through various techniques and strategies such as the disciplinary tactic of panopticism.

2.2.5 Panopticism

Panopticism is a form of surveillance based on a system of permanent registration (Foucault, 1977) and is one way of being able to discipline and manage groups of people. The panopticon was designed by Jeremy Bentham in the late 18th century as a tower that would be placed in a central position within a prison so that the guards were able to observe every prisoner inside their cells without the prisoners knowing whether they were being observed or not (Foucault, 1977). The prison guards would also be able to be observed by the governor of the prison at any time (Cheek, 2000; Danaher et al., 2000). Therefore a constant state of potential, permanent visibility would be induced whether or not there was anyone observing. This surveillance, or sense of being

surveilled, resulted in self-discipline, compliance and docile behaviour because individuals acted as if they were under scrutiny at all times (Barker, 1998; Cheek, 2000). Foucault described the visibility provided by the panopticon as a trap: 'he is seen, but he does not see; he is the object of information, never a subject of communication' (Foucault, 1977, p. 200). He also saw the panopticon as an example of wider disciplinary forces at work, beyond the confines of the prison environment. It represented the way in which authorities could watch over, influence and monitor behaviour in institutions such as schools, hospitals, universities and the Army (Foucault, 1977).

Foucault described the 'clinical gaze' as a panoptic kind of "expert seeing" that is evident in contemporary health care, both when health professionals examine individuals or the control of whole populations by public health initiatives (Cheek, 2000). The body has become objectified under the medical gaze as a result of examination and therefore is productive of, and is subjected to, the discipline of certain types of knowledge (Foucault, 1977). This type of surveillance allows for the body to become part of a population which is defined as either normal or abnormal (B. Evans & Colls, 2009). Linking panopticism, power and knowledge is the overarching concept of governmentality.

2.2.6 Governmentality and Biopower

The relationship between knowledge and power described by Foucault can be seen in the connection of modern forms of governance and the discourses of the human sciences (Cheek, 2000). A key concept is Foucault's notion of governmentality, which is defined as the everyday techniques through which individuals and populations are expected to reflect upon, work on, and organise their lives and themselves as an unspoken condition of their citizenship (Ouelette & Hay, 2008). By combining the power and knowledge of various disciplines such as medicine, psychiatry and law, and by incorporating surveillance and discipline, it is possible for governments to control not only the individual but the entire population as *norms* for behaviour and wellbeing are established (Cheek, 2000).

Governmentality is characterised by the pervasive nature of power which includes techniques of surveillance and the disciplining of both individuals and entire populations ensuring they become both the object and subject of government (Foucault,

1979). It influences how individuals conduct themselves and their relationship with their own bodies as well as the relationship they have with other bodies within society (Danaher et al., 2000). Individuals shape and guide their own conduct by willingly accepting a level of surveillance and self-monitoring. Professional and medical discourses have emerged as a result of the growth of control and surveillance of societies through the exercise of discipline over the body and the general behaviour of populations (Chambers & Narayanasamy, 2008). By using the disciplinary institutions that Foucault describes, it becomes possible for the technique of governmentality to become widely dispersed (Rich, 2011).

Chambers and Narayanasamy's (2008) interpretation of Foucault's notion of governmentality proposed that the way modern societies regulate and discipline their populations is by sanctioning knowledge, truth claims and the practises of human sciences. For example, the fact that most people accept, without thinking, that modern medicine is useful, valuable and good reflects a discourse that has evolved as a result of being told by many institutions such as governments, schools, the media and hospitals that this is truth (Lupton, 1995). This particular discourse is a powerful one because it renders invisible discourses about other alternative forms of medicine. Medicine has been characterised as scientific and hence valuable or, as alternative, and marginalised (Danaher et al., 2000).

Foucault introduced the notion of biopower, referring to concern with health, vitality and longevity of the population in relation to the interests of the nation and capitalist productivity (Guthman, 2009). Foucault describes biopower as power that controls a whole population rather than being concerned about power over the individual, ensuring that the population is not just disciplined but that it is regularised (B. Evans & Colls, 2009). This notion can be understood in terms of technologies that were developed out of the human sciences and used for controlling, analysing, regulating and defining the human body and its behaviour (Danaher et al., 2000). By regulating a whole population, responsibility for public health is shifted away from the State and its institutions back onto the individual (Willig, 2000). Under biopower, bodies are both monitored and regulated, which not only helps to maintain social order but also promotes health and productivity (B. Evans & Colls, 2009).

2.2.7 Discourse Analysis

Discourse analysis is the study of language, text, practises and images in order to identify discursive constructions. Specifically, Foucauldian discourse analysis offers a methodology that allows the deconstruction of the language, text, practises and images to give insights into the role of discourse in wider social processes of power relations (Willig, 2000). Foucault argued that different institutions, such as prisons and hospitals, became associated with thoughts and practise that set boundaries of knowledge development at different points of time within history and that these discursive rules essentially determine what can be said and by whom (Traynor, 2006). Discourse analysis is useful as a methodology as it enables the researcher to delve into the discourse to reveal these rules – the rules that determine whether society considers statements to be true or false. It challenges the 'taken for granted' aspects of our world and allows analysis of discourse from both a social and historical perspective (Traynor, 2006). The specific application of Foucauldian discourse analysis in this research is described below.

2.3 Method

2.3.1 Overview

This section discusses the recruitment of participants for this qualitative study, the interview process and the methods used to analyse the data. It then describes ethical considerations and how methodological rigour was ensured.

2.3.2 Recruitment

Paediatric health professionals, specifically nurses and doctors, from the Auckland region who were currently working in either primary or secondary services were invited to participate in the study via their professional body. An advertisement to recruit was sent out to members of the Nurses for Children and Young People group of the New Zealand Nurses Organisation and the New Zealand Paediatric Society by the administrators of these organisations on my behalf (Appendix 1). In addition one interviewee was recruited by word of mouth. I chose to interview across this selection of health professionals because they come into contact with children who are overweight or obese during either hospital admissions or community referrals for a reason other than their weight. This distinction is important as it highlights that weight was not the initial reason that children were being seen by these health professionals

2.3.3 Participants

I intended to interview eight participants but was only able to recruit a total of seven health professionals. However this number did not affect the findings as I managed to achieve data saturation with seven. These included: two doctors from within the secondary health setting; one doctor from the primary health setting, a general practitioner; three public health nurses; and one Tamariki Ora nurse. Six of the participants were New Zealand European and one identified as New Zealand Māori.

2.3.4 Interview Process

Data was collected by undertaking in-depth semi-structured individual interviews. In discourse analysis interview techniques that allow diversity and variation are emphasised and the interviewee is seen as being an active participant in the research (Potter & Wetherell, 1987). This type of interviewing allowed me to delve deeply into the social and personal aspects of the topic. I was able to not only observe the participant and identify non-verbal cues, but also to clarify any questions that were misunderstood and further explore the answers given. By conducting this type of interview I was be able to pay particular attention to language used and any references to other discourses. The questions asked were open and covered related broad topics such as those below:

- To what extent is there recognition of childhood obesity both by health professionals and wider society?
- Do they assess overweight in their practise?
- Do they discuss overweight and obesity with parents?
- What language do they use?
- What is their perception of whose role and responsibility it is to address childhood overweight and obesity?

Using the above broad questions I was able to first of all elicit their general view of overweight and obesity outside of the health setting before asking questions that were specific to their practise. This enabled me to see what other discourses influenced their practise.

Interviews took place over a forty five to ninety minute period in a place of choice of the interviewee. Interviews were taped using a dictaphone and transcribed by a

professional transcriber who had signed a confidentiality agreement. Interviewees were given the option of verifying the transcriptions. Five out of the seven participants chose this option prior to any analysis being undertaken. One participant made several changes to ensure that their identity would remain anonymous. The others were happy that the transcriptions were a correct account of the interview that had taken place.

2.3.5 Data Analysis

As previously discussed, discourses are described as the scaffolding of discursive frames which order reality in a certain way. At any point in time there are number of possible discursive frames for thinking, writing, doing and speaking about different aspects of reality (Cheek, 2004). With this in mind, when using a Foucauldian perspective to discourse analysis the end goal is to provide interpretive claims based on a description of power relations in the context of historically specific situations (Powers, 2001).

The analysis of this research used a Foucauldian lens to explore the discursive influence of space, specifically the health setting within which the health professional was working, on the speaking positions of the interviewees. I read and re-read the interview transcripts and listened to the recordings to immerse myself within the data. Then I looked for both similarities and differences in the way that the health professionals talked about and constructed overweight and obesity in children. The analysis also explored the influence of the discourses from the social, cultural, ethnicity and socioeconomic context by looking through the Foucauldian lens of governmentality and specifically biopower. This included analysis of the power relations and practises that were associated with each discourse and the influence of this on attitudes towards assessment of overweight and obesity in children. As part of the analysis a comparison was made of what was verbalised in the interviews with what has been written in peer-reviewed literature.

2.3.6 Ethical Approval and Considerations

Ethical approval was sought from Auckland University of Technology Ethics Committee (AUTEC) and approved on the 12/08/11 (Appendix 2).

Discourse analysis examines the way language, in the form of images, the spoken word or in writing can shape practise both politically and culturally. Therefore it is important to be cognisant of these influences. As stated in Chapter One, there are higher numbers

of Māori and Pacific children who are obese or at risk for becoming obese compared with other New Zealand children. Cultural factors can be a barrier to assessing these overweight or obese children. Taking these factors into consideration, it was important to have discussions with both Māori and Pacific advisors to ensure cultural safety at each stage of the research process.

My ethics application was considered by Dr Rhys Jones, Senior Lecturer Te Kupenga Hauora Māori, University of Auckland; Lorraine Heteraka-Stevens, Associate Director of Nursing, Māori Health Auckland District Health Board (ADHB); by The School of Health Care Practise's Kawawhakaruruhau, Auckland University of Technology, and by Tuliana Guthrie, Pacific Manager Provider Arm ADHB. A number of changes were suggested so that it better reflected both the potential impact on Māori as participants in the research and the potential outcomes of the research for Māori child health. An example of this was a suggestion to analyse findings in the context of evidence that shows that Māori get poorer health care in the New Zealand health system. In order to meet these suggestions I have been guided by Te Ara Tika (Hudson, Milne, Reynnolds, Russell, & Smith, 2010) which provides a framework based on Tikanga Māori for addressing ethical considerations that pertain to Māori. This framework includes the following:

Whakapapa

Within this context whakapapa refers to the quality of the relationship between the researcher and the participants. Te Ara Tika suggest that this relationship is developed with aroha or care, acknowledging that there may be risks for the participants and therefore there is a need to consider how these risks can be minimised. In the context of this research, to help minimise the risk to participants I developed a clearly written information sheet for participants that described the study in detail and what was expected of them as participants (Appendix 3).

Tika

Tika refers to what is right and good for a particular situation and in the context of research design and validity refers to how successful the research will be in achieving its proposed outcomes and the benefit it will have on both the participants and

communities. There is a consistent correlation between inequities in health for Māori when compared with non-Māori and this is a recognisable discourse within New Zealand. While participants themselves may not directly benefit from the findings, the analysis of the discourses that are referred to may have the potential to promote the advancement of practise knowledge and improvement of health outcomes for both Māori and non Māori children who are overweight or obese. Care also needed to be taken to ensure that the findings were framed in a way that did not stigmatise children. Participants were considered as partners in this research as they shared stories of their practise with me and I in turn undertook to share the outcomes of the study with them if they requested this. In terms of the outputs of the research they were asked to verify their transcripts and remove anything that they did not wish to be included.

Manaakitanga

As the researcher I also had the responsibility to act in a manner that upheld the participants' dignity, showed care was being taken and was culturally sensitive. In this context I consulted two Māori colleagues - Dr Rhys Jones, and Lorraine Heteraka-Stevens and asked them to provide cultural support throughout this research to ensure that I protected the rights of any Māori participants and also to help me ensure that any findings that pertain to Māori children were analysed and framed in such a way that they address the inequalities in health that exist for Māori (Appendix four).

Participants had the right to privacy and confidentiality. This was ensured by keeping the data collected in a password protected file on my personal computer and any printed documentation, such as the consent forms, stored in my supervisors locked filing cabinet. Participants were also offered the choice of using a pseudonym. As health professionals from all cultures were eligible to participate, in order to manage cultural diversity I informed myself of the necessary steps I needed to take to ensure that I respected the values, practises and beliefs of the cultures and social groups of participants. Three free counselling sessions at AUT (Appendix five) or a culturally appropriate support service of their choice were offered to a participant if they felt they were at risk of moral, psychological, physical or emotional harm during the data collection phase of the research. Participants were also told that they could withdraw from the research at any time during the data collection phase. None of the participants chose to do this.

Mana

In the context of this framework mana refers to acknowledging issues of power and authority and, when considering the risk, benefits and potential outcomes of the research, - who has the rights, roles and responsibilities. An important step in the research process that helps to protect participants is informed consent. This was gained by fully disclosing information relating to the study to the participants and ensuring that they all knew their participation was entirely voluntary. They were informed they had the right to participate, or not, and also that they had the right to choose not to answer questions if they did not wish to. In the context of ensuring that outcomes are equitable for Māori, any findings pertaining to Māori have been analysed in the context that Māori do tend to receive poorer quality health care in the New Zealand Health system (L Ellison-Loschmann & Pearce, 2005) as requested by Dr Rhys Jones.

I plan to deliver the results of this research by appropriate publication and presentation at relevant conferences.

2.3.7 Methodological Rigour

Discourse analysis is an interpretive process and acknowledges that there are multiple possible interpretations. Therefore it is vital that the process utilised to undertake the analysis is rigorously underpinned by the theoretical positions that provide the basis for the interpretation (Crowe, 2005). In this context methodological rigour can be evaluated by examining the clarity and explicitness in ontological and epistemological positioning and by ensuring a cohesiveness is maintained between this and the actual analysis undertaken and reported (Nixon & Power, 2007). Lincoln and Guba (1986), state that the researcher must abandon the assumption that truth is context free and that generalisations can be sought. Instead, they suggest that there are multiple realities that are socially constructed and that all human behaviour is "time and context bound" (Lincoln & Guba, 1986, p. 75). They further suggest a framework which includes four criteria for establishing trustworthiness (a term which is parallel to rigour) in qualitative data collection and analysis. These include the following:

Credibility

Credibility refers to the confidence in the truth of the data. The data collection must be carried out in a way that enhances the believability of the findings (Polit & Hungler, 1997). Lincoln and Guba (1986), suggested there were several ways in which to

improve credibility of qualitative research including prolonged engagement with, and persistent observation of, the interviewee. Investing sufficient time in the data collection process builds trust and rapport with the interviewee, which in turn enables increased scope and depth of the data collection leading to identification of the salient discourses (Lincoln & Guba, 1986; Polit & Hungler, 1997). Member checking and peer debriefing are both activities which provide an external check on the data collection process. Peer debriefing is considered by Lincoln and Guba (1986) as the most important technique for establishing credibility (Polit & Hungler, 1997; Rolfe, 2006).

In this study I have undertaken peer debriefing with my two supervisors which has helped me to explore aspects of the research design in further detail by drawing on their experience. Both have given written and verbal feedback throughout this process providing me with clarification each step of the way. In contrast when undertaking postmodern research it is difficult to undertake proper member checking given that the notion of a single truth is paramount. However, throughout the data collection phase of this study all participants have had the opportunity to review their transcripts prior to the data analysis stage and remove anything they wished and also to ensure that the transcripts were an accurate record. They have also been given the option to request a copy of the results of the study.

Reflexivity is another aspect of credibility and is defined as the process by which the researcher recognises that they are an integral part of the research. They acknowledge that their background and position has the potential to affect all aspects of the research process, therefore dispelling the notion of a neutral observer (Malterud, 2001). As a child health nurse myself I am aware that I position myself and am positioned within multiple shifting discourses that describe child overweight and obesity and that this could influence any interpretation of the data. However as Malterud (2001) states, if reflexivity is maintained, then personal knowledge can be a useful resource as long as there is a declaration of belief at the start of the study.

Dependability

Dependability refers to the stability of the data over time and is comparable to the term reliability in quantitative research. With discourse analysis, which propounds that there are many positions from which it is possible to view any aspect of reality, the positivist

notion of dependability is problematic as it is unlikely that reproducing the same findings across people and time would be possible (Ballinger, 2004).

Confirmability

Confirmability refers to the objectivity or neutrality of the data, meaning that two or more independent people would agree about the data's relevance or meaning (Polit & Hungler, 1997). This can be achieved by an inquiry audit which establishes that interpretations of the data are clearly derived from the data collected (Tobin & Begley, 2004). Potter and Wetherell (1987) suggested some alternatives for discourse analysis including: whether potential alternatives could be discounted; whether the overall account is plausible; and whether the account is similar to other studies that have been carried out with a discursive methodology.

As part of an audit trail I have kept records of the decision making processes throughout this research. Documents pertaining to the method, such as interview transcripts, have been filed in their entirety and the voice interviews have been stored electronically. I have also kept copies of my all my analysis throughout the research and have had regular feedback from both my supervisors.

Transferability

This refers to how easily the data can be transferred to another setting or group (Polit & Hungler, 1997), but as Lincoln and Guba (1986) note the data needs to be thickly descriptive in order for consumers to evaluate the fit the data has to another context. Thick description, because it explains the context of the data as well as its meaning, provides a basis for the reader's evaluation of the quality of the research.

2.3.8 Summary

This chapter has described the broad philosophical underpinnings of Michel Foucault that were utilised throughout this research. It then discussed the specific application of Foucauldian discourse analysis in relation to this research, the research process including the design of the research, the ethical considerations using Te Ara Tika (Hudson et al., 2010) as a guide and finally the steps that were undertaken to ensure methodological rigour have been explained.

Chapter Three: Literature Review

3.1 Introduction

An essential part of any qualitative research is a comprehensive review of relevant literature in order to establish familiarity with previous research, identify any gaps in knowledge and to help develop an argument for the research (Holloway, 2005). For this Foucauldian discourse analysis the literature reviewed has also provided the writer with an opportunity to examine how other researchers have applied Foucauldian concepts to develop an understanding of the research topic.

This chapter reviews international literature within three broad topic areas on overweight and obesity. Firstly, it describes research into the characterisation of overweight and obesity as a health problem, including assessment of overweight and obesity. Secondly, it describes research into the societal influences on, and consequences of, overweight and obesity. Finally, it examines different perspectives on assigning responsibility for addressing overweight and obesity, including findings on the barriers faced by health professionals.

3.2 Overweight and Obesity as Health Problems

3.2.1 Background

Worldwide obesity has more than doubled since 1980 and by 2010 there were an estimated 43 million children under the age of five years who were overweight (World Health Organisation, 2011). At the same time there has been a rapid increase in the production of knowledge within the field of obesity, mostly by those in health sciences and biosciences. The focus of this has been on defining or measuring obesity and predicting its global spread. The concept of an ideal weight has been embraced by those in the health industry, who go on to associate this with health, longevity and well-being (Barlow, 2007; J. Evans, Evans, & Rich, 2003).

The potential health consequences that are frequently associated with being overweight or obese include conditions such as hypertension, diabetes, heart disease and cancers (Alpert, 2009; Banning, 2005; Grant & Bassin, 2007a; Huang et al., 2009; Ministry of Health, 2009; Pagnini, King, Booth, Wilkenfeld, & Booth, 2009; Taylor, 2007; World Health Organisation, 2011). While there have been some challenges to the conclusive

nature of the relationships between overweight and obesity and these conditions, these relationships have been the basis for the formation of health related policies to tackle this "global health crisis" (Rich, 2010, p. 806). Public health discourse on obesity has instilled a sense of moral panic along with feelings of disaster and urgency as it is attributed to imminent health decline, disease and rising financial cost (Rich, 2010). It is during childhood that eating and activity patterns are established. Therefore this is not only the critical time for developing obesity, but an opportune time to intervene to prevent its development (Maziak et al., 2007).

3.2.2 The Medicalisation of Overweight and Obesity

In western medicine, bodies are defined as either being healthy (normal) or unhealthy (deviant) (B. Evans, 2006; Jeffrey & Kitto, 2006) and within medicine, obesity has been defined as a treatable disease (Salant & Santry, 2005), a disorder of the body and therefore able to be diagnosed. Foucault describes this defining of the body as the medical gaze (Cheek, 2000). The body is objectified within the parameters of the scientific and medical discursive frames allowing only certain aspects of knowledge whilst excluding others (Cheek, 2000). This medicalisation of the body does not imply simply 'illness' but suggests that it requires identification and classification which also includes subjective and value laden considerations that are socially constructed (Jeffrey & Kitto, 2006).

Colagiuri (2007) questions whether this medicalisation of obesity as a disease in fact clouds the issue of who is responsible for addressing the issue. Potentially it locates that responsibility in the health sector alone, attributing no responsibility to other sectors such as transport, agriculture, education and local government. As a result, the obese individual becomes a passive subject of disease and by association also of its medical treatment (Salant & Santry, 2005). The medicalisation of obesity benefits some specific sectors, including the pharmaceutical industry, where pills can be offered as a solution, and the diet industry, because obese and overweight people are the key market for diet plans and products (Dorfman & Wallack, 2007).

3.2.3 Assessment of Overweight and Obesity

For both adults and children the most common assessment/diagnostic tool of obesity is the Body Mass Index (BMI) scale. Measuring fatness using the BMI scale is a process which classifies bodies numerically from underweight to morbidly obese. It is a

measurement of weight in kilograms divided by height in centimetres with the thresholds between weight classes defined on the basis of percentiles (Alpert, 2009). Because body composition changes with normal growth for children, age and gender specific thresholds are required (Ministry of Health, 2009). Children who fall between 85th and 94th percentile are classified as overweight and those who exceed the 95th percentile are classified as obese (Alpert, 2009; Barlow, 2007; Reilly et al., 2010).

The BMI scale remains the most popular tool for measuring, defining and diagnosing obesity and it forms the basis for obesity policy and projections and targets (B. Evans & Colls, 2009) despite the fact that it is regarded by many as an inappropriate tool for the measurement of obesity, especially for children (B. Evans, 2006). For children, the inadequacies of BMI reflect the fact that in addition to height, the BMI scale must also include age. This is problematic as it relies on the assumption that all children grow at the same rate. It does not account for those who are muscular or athletic not does it take into account important factors such as differences in developmental stage, lifestyle or family history (Grant & Bassin, 2007b) and cultural differences (Rush, Plank, Davies, Watson, & Wall, 2003).

Obesity is a complex issue. It is inherently linked to multiple risk factors and behavioural patterns which need to be incorporated into any assessment of obesity in children and any plans to address the problem. These include: diet and exercise; social factors such as family and friends; environmental factors such as schools, communities and socioeconomic status; and also how food is marketed and priced (Banning, 2005; Mulvaney-Day & Womack, 2009). It is argued that clinicians should use BMI as a tool that triggers a more comprehensive assessment which takes account of other clinical information and risk factors (Barlow, 2007). The Ministry of Health (2009) guidelines also suggest that good practise when assessing overweight or obesity in children should include factors such as cultural influences, and social and socioeconomic circumstances and the level of health literacy.

BMI is afforded certain power as it gives an assumption that it provides truths about one's body through measurement. By being observable and providing measureable data it is seen to be valid. It is seen as a direct measure of health as there is an assumed linear connection between weight and health, where weight becomes a proxy for ill health based on the possibilities of being 'fat, unfit and unhealthy or thin, fit and healthy' (B.

Evans, 2006, p. 262). In America during the 1930s insurance companies found those individuals with a BMI between 20-25 had lower mortality rates than those with a BMI over 30, i.e. who were determined to be obese (Carryer & Penny, 2008). Higher BMI scores are also correlated with increased risk of developing diseases such as diabetes and heart disease. However, this excludes the possibility that obesity may be a symptom rather than the cause of these diseases (B. Evans, 2006; Reilly, 2010). As a measuring tool of obesity the BMI scale discursively produces the conditions of overweight and obesity which are then associated with co-morbidities and are considered a threat to health globally. As a result of this, obesity is a high priority on the public health agenda (J. Evans et al., 2003).

While overweight and obesity is framed as a health problem within the medical context, it is also important to examine the various societal influences on its construction. The following section reviews literature relevant to these wider considerations.

3.3 Overweight and Obesity in Society

3.3.1 The Obesity Epidemic

The WHO has declared obesity as a disease that is being seen in increasing numbers of countries and has made a number of recommendations to limit the global obesity epidemic including the development of a Global Strategy for Diet and Physical Activity (World Health Organisation, 2011). While there have always been overweight or obese people, use of the term epidemic to describe obesity (Gard & Wright, 2005) is a relatively recent phenomenon. It can be seen as part of the trend to medicalise ailments which have previously been seen as a result of moral failings, such as drunkenness which is now labelled as alcoholism (LeBesco, 2010). Use of the terms epidemic and disease when referring to obesity have been challenged by both social scientists and biomedical researchers (Rail et al., 2010).

The notion of childhood obesity as an epidemic has emerged as a result of a socially authoritative discourse (obesity science). The mobilisation of resources and the use of surveillance and regulation tactics is justified (Rail et al., 2010). Critics of the claim that there is a paediatric obesity epidemic state that use of the term epidemic to describe the current rates of obesity is a result of social construction. It is an example of how health

issues can be sensationalised by society (Boero, 2007; Grant & Bassin, 2007b; Mitchell & McTigue, 2007), as discussed below in relation to the influence of the media.

The use of the term epidemic, especially when used to describe an infectious disease outbreak, carries an expectation that members of communities will undertake whatever they need to do to protect themselves and their families from contracting the disease and therefore prevent the spread (Moffat, 2010). The tag epidemic in relation to obesity similarly drives persons to be self-protective and to distance themselves from the fat ('infectious') person (LeBesco, 2010). The construction of childhood obesity as an epidemic confirms its medicalisation: it is a disease that must be treated and cured.

These descriptions of overweight and obesity as a disease and an epidemic do not necessarily promote healthiness. Instead, particularly the use of the emotive term "epidemic", they incite a sense of moral panic resulting in 'blaming and shaming,' especially when used in relation to children. The level of public scrutiny and focus on obesity can result in prejudice towards overweight and obese individuals and as a result negatively impacts on the health of the community overall. LeBesco (2010) asks the question "why does fat have to be unhealthy?" and argues that overweight and obesity should be reconceptualised as a variation in body size and shape rather than necessarily causative of ill health and even death. This view is supported by the findings of a recent study undertaken by Ortega et al., (2012) that obese individuals who were fit had the same level of health as normal weight and fit individuals.

3.3.2 The Obesogenic Environment

The environmental influences on our behaviour can be categorised into: (1) physical environment, what is and is not available; (2) economic, the financial factors; (3) policy, the rules; and (4) social-cultural, the attitudes, beliefs, perceptions, values and norms of a cultural group (Swindon, 2008). Over the last 30 years changes in many of these factors have contributed to the development of an 'obesogenic' environment. For example, there has been a colossal increase in the availability of low–cost, energy-dense foods and beverages, and in technology such as cars, computers, gaming devices and televisions which lead to a reduction in bodily energy expenditure. These products are heavily marketed and have been seen as contributing to the commercial success of economic systems (Swindon, 2008).

Schwartz and Brownell (2007), use the term 'toxic environment' as a way to describe the environmental factors that have contributed to the increase in prevalence of obesity over the last 30 years. They argue that the key factors of human overconsumption are "flavour, variety, large portions, visibility and proximity" (Schwartz & Brownell, 2007, p. 79). In the US, as throughout the rest of the western world (including New Zealand), when driving along the highway people are exposed to numerous drive-in fast food outlets, advertisements for inexpensive high calorie snacks and soft drinks and high fat, high sugar snacks at petrol stations. Food is visible and easily accessible for people and spending on fast foods has increased astronomically since 1970 (Schwartz & Brownell, 2007).

The blame for overweight and obesity in children is often placed with the parents. Working mothers, for instance, are criticised for not being available to limit children's screen time when a child comes home from school or cook nutritious meals for their children (Boero, 2007). Parents, especially mothers, are also often held responsible for their child's attitudes and behaviours towards food as they are considered to influence the family mealtime environment and rituals around eating (Jackson, McDonald, Mannix, Faga, & Firtko, 2005). So on one hand there is the argument that parents should be responsible for their children's welfare by ensuring they have access to high quality nutritious food, limiting television viewing time and modelling a healthy lifestyle. On the other hand, these efforts and expectations are undermined by the massive marketing campaigns of manufacturers of fast food and the food that is offered in school canteens and vending machines. According to Budd and Hayman (2008), to address obesity there needs to be a paradigm shift away from blaming individuals for their lack of will power to control their eating and physical activity to one where there is recognition of the obesogenic environment in which we live.

3.3.3 Influence of the Media

Use of media is powerful in shaping the obesity discourse. Silk and Francombe (2009) looked at the way reality television, specifically 'The Biggest Loser,' individualises the obesity discourse within the United States by claiming that it is an issue resulting from an individual's "wrong" choices. The competitors are perceived to be unfit and unhealthy, a moral failure and accountable for their obesity (Silk & Francombe, 2009) and they are constantly reminded of this throughout the programme. In a culture where individuals are seen to have choice and to be responsible for themselves, being obese is

visual proof of a lack of will power and poor self-esteem (J. Evans et al., 2003; Greener, Douglas, & VanTeijlingen, 2010; Silk & Francombe, 2009).

The reality TV show 'Honey We're Killing the Kids' uses media as a way of assessing family's lifestyles to show how poor parenting can potentially lead to future illnesses such as obesity. The children's weight and height are measured and then transformed into their BMI. Their activity levels and weight are monitored and recorded and reassembled into a statement about their lifestyle, their current status of health and potential future risks to their health (Rich, 2011). This information is then used to give a future visual projection of what the child will look like and what their potential health will be like if they continue with their current lifestyle (Rich, 2011). Their parents are then asked how they could allow their children to continue with their current lifestyle and risk them ending up looking like what is projected for their future. This reinforces the perception that blame for the child's condition sits with the parents alone.

Use of particular techniques of surveillance, such as those described above, have allowed bodies to be viewed in terms of information which is then interpreted as truth. This information is captured and reassembled and individualised into simple readings of health. Reality TV has become the environment where individuals can be managed controlled and taught how to live better lives. (Rich, 2011; Silk & Francombe, 2009). There is a wider social anxiety about the vulnerability of children and the need for protection, the failures of parenting and the authority of the medical and institutional bodies which frame overweight and obesity as a moral imperative to address (Rich, 2011).

3.3.4 Stigmatisation of Obesity

Biomedical science claims a neutral standing, describing the aetiology of obesity as a positive imbalance between energy consumed and energy expended. However socially, obesity is neither neutral nor value free. Instead as above it is seen as a visual representation of lack of control and an outward sign of self-neglect and being irresponsible (J. Evans et al., 2003). This is described by Dorfman and Wallack (2007) in terms of framing which is described as how people make sense of what they see and hear by linking incoming stimulus to knowledge that they already have. The default frame around obesity is that it has a negative influence on an individual's appearance and is a result of overeating and therefore a lack of will power. The hyper visibility of

the body triggers assumptions (often incorrectly) about the fat person's ability to self-govern appropriately (LeBesco, 2010). Bodies have become a moral and political focus where the thin body is associated with moral worth and control and the obese body is associated with laziness and poor self-control (Greener et al., 2010). Even for children who are overweight or obese, the body is scrutinised and individuals are expected to attain for example 'normal' ranges of height and weight as described by the BMI scale (Henderson, Coveney, Ward, & Taylor, 2009).

For children the stigma associated with overweight and obesity can lead onto other issues such as depression and discrimination (Grimes-Robinson & Evans, 2008), as a child is often not equipped to deal with the prejudice and stereotyping that can impact on their social and psychological functioning (Maziak et al., 2007). Use of the term obesity has the potential to not only stigmatise the condition but also to limit a full understanding of its causes. It places blame on the individual, distracting from the wider social and economic setting and contributing to mental health issues and chronic disease (L. Cohen, Perales, & Steadman, 2005). The framing of obesity is also described by Schwartz and Brownell (2007) as of great importance: who or what is seen to be responsible for obesity significantly influences how the obese individual is perceived by society and what actions need to be considered for treatment and prevention (Schwartz & Brownell, 2007).

This and the previous section have reviewed literature on the framing of overweight and obesity firstly, as a health problem, and secondly, from a social perspective highlighting the complexity of the issue. The following section reviews the implications of this complexity when assigning responsibility for addressing overweight and obesity.

3.4 Responsibility for Addressing Overweight and Obesity

3.4.1 Governmentality and Bio-power

The Foucauldian concepts of governmentality and biopower, described in Chapter Two, are illustrated by the medicalisation of overweight and obesity and the development of population health agencies which monitor and track whole populations in regard to the obesity epidemic. Within the 'war on obesity,' the surveillance of BMI by monitoring is a mechanism of biopower (B. Evans & Colls, 2009). Measurement of children's BMI as an anti-obesity strategy is a way of regulating bodies at a population level rather than

disciplining individual bodies. Data on lifestyle, socioeconomic conditions, physical inactivity, and diet is collected and rationalised to generate recommendations that influence health practitioners within local health authorities and government agencies. For example, the US State of Georgia passed a law which mandated that all school-aged children were weighed twice a year by school staff. The law required that regular physical activities for children be offered by schools as well as the posting of aggregate BMIs on a public website (LeBesco, 2010). Other US states have legislated for "health and wellness councils" (LeBesco, 2010, p. 5) which comprise of representative members of the community who monitor nutrition and physical activity and emphasise the importance of healthy weight.

In the United Kingdom, a report by the House of Commons Health Committee (2004) suggested many strategies to halt the obesity epidemic and including annual measurement of children's BMI and the documentation of this on report cards. The aim was to identify and target preventative strategies at children who were overweight or obese as well as those who were on the cusp of the overweight threshold. This is an example of medicalising through measurement-based monitoring of all bodies (B. Evans, 2006). Legislation that targets the welfare of children is much easier to sell to the general public because it is widely believed that the state of children's health is a direct result of parenting practises (LeBesco, 2010). Children have often been the focus of policy that addresses obesity because they are seen not only as the most at risk but also as the most amenable to change.

Foucault claimed that health beliefs, perceptions and definitions of illness are constructed, represented and reproduced through language (J. Evans et al., 2003). These perceptions are specific to a culture and are never value free (J. Evans et al., 2003). The power, authority and truth of biomedical science ensures that there is no uncertainty seen in its narrative: the reader is asked to accept without question, for example, that obesity and overweight are without a doubt very negative things (J. Evans et al., 2003). Obesity scientists and clinicians are presumed to know the truth of obesity and therefore as a result have the moral and intellectual authority to classify it as a disease and recommend treatment (Rail et al., 2010). As a result of this authority, any contradictory knowledge can be marginalised and seen to be deviant. Consequently it can be rejected as idealistic and scientifically unsound (Rail et al., 2010).

Another example of the exercise of biopower is the way in which health professionals have engaged the media to help publicise the issue of the childhood obesity epidemic and raise its profile on both the public and political agenda. In 1995, the International Obesity Task Force was developed as a political agency to inform the world about the obesity epidemic and encourage governments to act swiftly to tackle this growing problem. By the beginning of the 21st century the obesity epidemic was recognised as a legitimate medical and societal problem. In the US this led to an enormous increase in funding for obesity research, from just $50 million in 1993 to $400 million in 2005 (Spiegal & Nabel, 2006).

3.4.2 Neoliberalism and its Emphasis on Individual Responsibility

Neoliberalism is a term used to describe the separation of the market from the State (Henderson et al., 2009). It is characterised by increasing forms of privatization: outsourcing of public services; increased public- private relationships; reduction in social welfare and decreased spending for social and health programmes (Browne & Tarlier, 2008). It is also characterised by an effort to shift the responsibility of caring from the public arena onto the individual. A neoliberal government promises to hand the care of the self back to the individual. Powerful discourses such as taking control, being responsible and empowered become the norm and are equated with common sense (Guthman, 2009). People are encouraged to see themselves as individualised, active and responsible for their own well-being (Guthman, 2009; Larner, 2000).

Under the neoliberal gaze the fit healthy body is a marker of self-control and capability whereas the obese body is one that is viewed as a cost to the tax payer and therefore a cost to the State (Guthman, 2009). The healthy body has come to signify the citizen who is 'morally worthy' (LeBesco, 2010, p. 2), exhibits discipline and control over his or her own body and contributes to society.

This neoliberal perspective is consistent with Foucault's concept of governmentality. The State operates from a distance, at population level, ignoring the needs of the individual. While the State may, for example, collect statistics of individuals' BMI, this does not lead to intervention. Instead, the expectation is that the obese person should 'confess' to their obesity, recognise that they are a burden on society and accept a moral obligation to do something about it (LeBesco, 2010).

An example of the neoliberal influence on the exercise of biopower comes again from Georgia in the United States. Bill boards showing photos of overweight boys and girls carried messages such as “big bones didn’t get me this way, big meals did” and “chubby kids may not outlive their parents” (Crary, 2011). These were accompanied by online videos and opportunities to follow conversations via the social networking site Facebook. The campaign has caused outrage among parents, activists and academics who feel that these tactics will lead to further stigmatisation and bullying of an already marginalised group of children. (Crary, 2011; Smith, Gately, & Rudolf, 2008). In response, the Georgia Children’s Health Alliance stated that these measures were necessary in order to shock parents of obese children out of denial and into action, laying the blame and the responsibility to fix the problem firmly in the hands of parents (Crary, 2011).

3.4.3 The Case for Greater State Intervention Through Public Health

Paradoxically, despite the emphasis of neoliberalism on individuals taking responsibility for ‘care of the self,’ it is the underlying principle of a free market that some authors see as directly contributing to overweight and obesity. On the one hand, obesity can be seen as a result of the success of neoliberal economics, where consumers are buying more food, cars and equipment. While these acquisitions enable individuals to live a more comfortable lifestyle, subsequently they are required to expend less and less bodily energy to meet basic needs (Grant & Bassin, 2007b; Swindon, 2008). On the other hand, countries that have adopted the strongest neoliberal or market orientated politics have shown more pronounced increases in health disparities (Browne & Tarlier, 2008). Obesity is more prevalent among the poor or disadvantaged, further adding to the existing health disparities (Maziak et al., 2007).

Tackling childhood obesity using an individual focus has proven to have limited success and there is a growing interest in addressing the wider underlying influences such as the built environment, social interactions, food marketing and pricing to name a few (Maziak et al., 2007). There has been recognition that it is environmental determinants rather than genetics that have changed, calling for a collaborative wide-reaching community approach to address overweight and obesity (Grant & Bassin, 2007b). Dorfman and Wallack (2007) suggest that there has been a change in the way obesity is framed, from primarily being an individual’s responsibility to one in which policy

approaches can be adopted that encourage health promoting behaviours throughout a population.

Reflecting this change in attitude, government is seen as having a key role in addressing overweight and obesity through developing and implementing a range of public health measures. Action required from government includes: provision of leadership to set the agenda and lead the way; advocating for a response that encourages engagement from all sectors to enhance action; implementing policies that create healthier foods; and promote activity environments with an aim to decreasing the obesogenic environment (Swindon, 2008). Movements seeking solutions for obesity and for environmental sustainability, reduced congestion and urban liveability have much in common and collaboration between these movements will create a greater pressure for change and more cohesive action (Swindon, 2008). In order to provide solutions that are optimal the aim should not be to impinge on individuals' freedom of choice but rather to make the unhealthy choices expensive to the individual as well as corporations and governing officials (Maziak et al., 2007).

It was only when the prevalence of childhood obesity started to appear in the media regularly around 2002-2004 that the New Zealand government started to consider action (Swindon, 2008). National plans for action, such as the HEHA public health initiative, were developed and the reduction of obesity was identified as one of the government's public health objectives. HEHA was designed to encourage healthy eating and increased physical activity within a multitude of environments such as preschools and schools, low income family home environments and primary healthcare settings (Ministry of Health, 2004a). Then in 2006 the then Labour Government announced a four year campaign called 'Mission On', the aim of which was to improve nutrition and increase levels of physical activity of people less than 24 years of age. When this programme was launched, Helen Clark, the then Prime Minister, said that unless something changed in our living environment and the way we approach the modern lifestyle it may be possible that the current generation of young people would be the first to die before their parents (Grant & Bassin, 2007).

The introduction of the HEHA strategy reflects recognition that education and teaching strategies alone will not be sufficient to address overweight and obesity and that a focus on the wider obesogenic environment is required. This needs to include addressing the

physical environment, ensuring healthy food choices are more affordable and changing attitudes about marketing of food to children (Sacks, Swindon, & Lawrence, 2008). Government policy aimed at reducing obesity has the ability to reach the wider community including those populations that are disadvantaged socioeconomically and have higher rates of obesity (Sacks et al., 2008).

3.4.4 Schools and the Surveillance of Overweight and Obesity

In the UK there has been a strong policy focus on initiatives which control and regulate children's potentially obese bodies. School children in the United Kingdom are now subjected to a range of surveillance practises to monitor their lifestyle both in and outside schools. Surveillance in the school environment is not brought about by the school alone but is situated within a network of organisations and is influenced by knowledge circulating about health and obesity (Rich, 2010). These surveillance techniques have been designed to empower the individual to self-govern appropriately, i.e. lose weight (LeBesco, 2010).

Some of the surveillance techniques used in schools include weighing children and lunchbox checks. B. Evans and Colls (2009) investigated the surveillance of children in school by the UK National Child Measurement Programme. Under that programme child health technicians conducted BMI assessments in order to identify children who were overweight or obese and those who were at risk for being overweight or obese.

Rich's (2010) study looked at the growing body of work in surveillance studies and in particular the increasing incidence of collecting data about children's weight and health within the context of the school environment. Participants in Rich's (2010) study stated that, as a result of the surveillance carried out in their school, children had a hyper awareness of, not only their weight, but the weight of their peers. Some of the young women that were interviewed stated that they had to make themselves as thin as possible as the pressure to look good was so huge. Rich (2010) notes that for these young women the moralising of obesity is closely related to the discursive regimes of beauty and ideals of the feminine form. This is an example of how using Foucault's concept of the panopticon to understand how bodies are disciplined and normalised through health discourses gives some insight into how individuals self-regulate themselves (Rich, 2010). Foucault (1977) describes the use of panopticism as making it possible to "perfect the exercise of power" (Foucault, 1977, p. 206). In Rich's (2010)

study this is seen as the power exercised by those collecting the data by surveillance and the effect of the surveillance on the students themselves as well as their peers.

3.4.5 Barriers for Health Professionals in Addressing Overweight and Obesity

This chapter has previously described the medicalisation of obesity, labelling it as a disease that can be treated and cured. While this clearly locates health professionals as part of the collaborative approach in addressing overweight and obesity in children, several authors have found that there are a range of barriers which can limit their effectiveness in fulfilling this role. For example the social obesity discourse constructs obese bodies as being lazy and expensive, on the assumption that there is a relationship between obesity and ill health (Rail & Lafrance, 2009). This discourse is so powerful that it even affects those health professionals who specialise in caring for the overweight or obese individual (Schwartz, Chambliss, Brownell, Blair, & Billington, 2003).

In a study by Greener et al., (2010) health professionals were reported to view obesity as a 'socio-ecologically determined problem' (p. 1042). The health professionals that were interviewed identified three main barriers to weight loss in the population: the beliefs and motivation of individuals; socio-environmental barriers; and the inability of existing health services to effectively deal with weight management.

Moffat (2010) proposes that as a society our ability to recognise childhood overweight and obesity has declined as we have forgotten what children's bodies looked like in the past. Society has normalised the perception of the overweight or obese child (Smith et al., 2008). In England, a study undertaken by Reilly (2010) showed that not only do parents fail to recognise that their child is obese but health professionals also under-diagnose paediatric obesity when completing a subjective assessment. This has led to substantial under-diagnosis of paediatric obesity by health professionals (Reilly, 2010). Under-diagnosis of overweight and obesity is further supported by Huang et al., (2009) who undertook a study that showed paediatricians identified weight status with the same level of inaccuracy as parents when completing a subjective assessment. As a result, from the biomedical health professional perspective, the opposite of moral panic and alarmism appears to exist: rather there is a sense of apathy and under-assessment in the face of the normalisation of obesity (Moffat, 2010).

Health professionals in the primary health care setting are seemingly well placed to address child overweight and obesity although, as Barlow, Bobra, Elliot, Brownson and Haire-Joshu, (2007) state, the health care setting focus is on the health consequences of obesity rather than the visual of obesity. The primary health care setting also provides for evaluation and treatment based on family based interventions which improve health behaviour (Barlow et al., 2007). However, even in the primary care health setting there are a number of documented obstacles to addressing overweight and obesity, including lack of patient motivation, futility of treatment and lack of time (Barlow et al., 2007; Small, Anderson, Sidora-Arcoleo, & Gance-Cleveland, 2009).

Added to this is weight bias and discrimination. As stated previously, modern society idealises thinness and sees obesity as deviant. More often than not the blame is placed on the individual. Studies with both adults and children have shown that overweight and obese individuals are subjected to bias, bullying and ridicule. Overweight children find that excessive weight gain can be the least socially acceptable and most stigmatising condition in childhood (Grimes-Robinson & Evans, 2008). A consequence of this is that they can be disadvantaged in the health setting (Schwartz & Brownell, 2007). A study of health professionals who work with obese patients found that these obesity specialists exhibited a significant anti-fat bias Schwartz, Chambliss, Brownell, Blair and Billington, (2003). Despite the medicalisation of obesity being a 'disease' that is treatable, these health professionals were significantly influenced by the social construction of the term obesity where terms such as "lazy, stupid and worthless" are associated with obese people. Blame is placed back on the individual despite the professional's knowledge that obesity can be caused by genetic and environmental factors and not simply just by the individual's own behaviour (Schwartz et al., 2003).

There is also the issue of sensitivity of labelling a child as overweight or obese because of the stigma attached to that diagnosis (Smith et al., 2008). Primary health care providers who took part in a qualitative study by Walker, Strong, Atchinson, Saunders and Abbott, (2007) were found to fear offending parents when they raised the issue of the child being overweight. This was because of the potential to jeopardise the relationship between parents and the health professionals. Another view that was shared by both the health care providers and the families interviewed was a perception in terms of the success of treatment, there was a perception that "nothing works". Despite the

evidence that if obesity is not dealt with it can predispose an individual to having other significant health issues, some health care providers appear to view obesity as a life style issue rather than a medical one.

3.6 Summary

This chapter has reviewed the international literature within three broad topic areas on overweight and obesity. The first being the medicalisation of overweight and obesity within western medicine. The use of BMI as an assessment tool that measures and classifies bodies has had the effect of labelling the body as normal or deviant, healthy or unhealthy. This has had the effect of overweight and obesity becoming firmly positioned within the health arena. Secondly, it has examined research on wider societal influences, including the implications of the labelling of overweight and obesity as an epidemic, the influence of the obesogenic environment and portrayal of the issue in the media. The negative construction over overweight and obesity by society is exemplified by its stigmatisation. Finally, this chapter has examined different perspectives on assigning responsibility for addressing overweight and obesity, including the relevance of the Foucauldian concepts of governmentality, biopower and surveillance. A key aspect is consideration of the relative roles of the individual and the State, with prevailing neoliberal views emphasising the predominance of individual responsibility. As a consequence of uncertainty in assigning responsibility health professionals have been found to face a range of barriers.

Chapter Four: Analysis - Medical Discourse

4.1 Introduction

This chapter presents findings relating to the medical discourse on overweight and obesity in children arising from the analysis of interviews with health professionals. This emerged as a dominant discourse, reflecting the medicalisation of overweight and obesity as described in Chapter Three. Firstly, this Chapter examines how terminology has constructed overweight and obesity as medical conditions and of the problems for health professionals associated with the use of that terminology. Secondly, it discusses how health professionals assess overweight and obesity in children and the benefits and difficulties associated with different assessment methods. Thirdly, it examines how the medicalisation of overweight and obesity and the nature of power relations in the medical setting, have given health professionals the right to intervene. Finally, it explores how health professionals view their role in addressing overweight and obesity in the face of the obesity 'epidemic.'

4.2 The Large Body as Defined by Medical Terminology

As previously discussed in Chapter Three, from the medical perspective, overweight and obesity are terms that are defined by charts that plot an individual's BMI and categorise an individual's body as either normal or abnormal by weight,. This categorisation is an example of what Foucault described as a 'dividing practise' (Foucault, 1977, p. 99), where individuals are grouped according to differences. A consequence of defining obesity in medical terms is to give it the status of a medical problem with the implication that there is a medical solution. The individual's overweight or obese body then becomes the object of the medical gaze, is labelled as requiring medical intervention and therefore becomes the subject of medical practise. Once the overweight or obese body has been identified and classified as such, the body becomes recognised as being in an abnormal and potentially diseased state.

The dictionary definition of overweight is "weighing more than is normal or permissible or required" and of obese is "very fat" where fat is defined as "having a large amount of excess flesh or being corpulent" (*Oxford paperback dictionary and thesaurus,* 2009). This is usually by reference to a visual representation of the body. Another adjective that is routinely attached to overweight when describing obesity is 'grossly,' which

infers something that is disgusting or repulsive, unacceptable and serious. Using these terms it soon becomes apparent why their use for example to describe a child or young person's body could be problematic for health professionals.

> *I tend to come at it like "Have you been worried about your child's weight?" try and get where they're at before you come out and go, "well actually you know they're obese". I don't think people like that being thrown at them because it's hard when you're their GP; you have to keep your on-going relationship with them as well. So you don't want to go "your child's fat, what do you want to do about it?"*
>
> Debbie HP Primary

Even the word weight can carry negative connotations when linked to the body, either in describing individuals as being *under* an ideal weight and *over* an ideal weight. The dictionary definition refers to weight as "the heaviness of a person or thing" (*Oxford paperback dictionary and thesaurus*, 2009). Clearly, use of any of the words available to the health professional to describe overweight carries with it a significant potential for offence to be taken. At a fundamental level a relationship is influenced by interaction between individuals and Debbie recognises that the way she interacts with the child and family influences her ability to maintain an on-going relationship with that family. By using the medical terms "overweight or obese" when referring to her clients she could potentially jeopardize that relationship.

However, Debbie also recognises that, as the health professional, she has the ability to shape the relationship as she essentially holds the position of power in that setting. By being mindful of the verbal interactions that she has with the child and family and choosing not to use the medical terms to describe weight, offence is not caused as easily and the relationship is maintained. This apparent tension between medical practise and the influence of social etiquette is discussed further in Chapter Five.

Problems associated with the use of the above terminology also extend to the way in which the terminology distinguishes between overweight and obesity. Foucault talks about "grids of specification"(Foucault, 1972, p. 46) as a way of dividing, contrasting and classifying. This concept can be applied to distinguish between the way the terms overweight and obesity are used by health professionals. In the medical setting, obesity and overweight are distinguished by the BMI (as described in Chapter Three). Outside the medical setting, overweight as a term can be interpreted as 'just over my ideal

weight' and not really a problem, whereas being obese is visually obvious without requiring reference to an individual's weight, for example:

> *I think people can handle being overweight. They can see that being overweight doesn't mean they are totally unhealthy but obesity is almost like you're just a small group of people that are really, really, really, really fat.*
>
> Kelly HP Primary

Kelly is describing a dividing practise when of the terms overweight and obese are used. Anyone labeled obese is considered to be "really, really, really, really fat" and by association 'really' unhealthy. They are in a condition that lies outside of what is considered to be acceptable to both health professionals and members of society. As a term, obesity holds a significant amount of power as it is socially constructed as being negative, with connotations such as, lazy, unhealthy, worthless and a potential cost or burden to society in the future as previously discussed in Chapter Three (Chambers & Narayanasamy, 2008; Rail & Lafrance, 2009).

However, by avoiding the term obese the child's condition remains hidden, which makes it difficult for the health professional to address the problem. Recognising this, Kathy expressed the view that there were some benefits to using the word obese:

> *Well it's a negative word but it's also about, like if you just say you're a little bit overweight, you might be overweight but they often don't deal with the issue, but when people are told they are obese they think "okay, maybe we need to do something about this".*
>
> Kathy HP Primary

While Kathy acknowledges that 'obese' is a negative term, she sees that it can also be used as a shock tactic to mobilise people into action and to make them realise that their child has a problem that they should do something about. She recognises that the term overweight doesn't have the same effect as the word obese because overweight can be seen as a common, thus normal and acceptable state of being by some in society. If overweight is common in a family group then those members may not be able to recognise it and are less likely to take any action.

By using the word obese, the child's body becomes the object of Kathy's gaze as a health professional. The child's weight status is medicalised and the body is now

viewed as having the potential to be in a diseased state. The use of the word obese makes the body very visible and this is described by Foucault as a "surface of emergence" because the condition has been brought into consciousness, named and objectified (Foucault, 1972). The child and family both become the subjects of Kathy's interventions as Kathy positions herself as an expert giving her the power to intervene, she brings the obese state of the child into the family's awareness so that issue can be addressed.

John alludes to how using the term 'obesity' in reference to children implies that a level of blame is being conferred on the parents or caregivers, as the child cannot be held responsible for themselves and has little or no control over what food is brought into the house. The parents become positioned as being responsible for the condition of their child.

> *When the term obesity is applied to adults there's a degree of blame attached to it. Like if you call an adult obese it can't help but have a slightly derogative connotation to it and I think if you use those terms to describe children that same connotation gets applied to their parents who are raising them. I think that's partly why people don't like raising it and talking about it in an individual basis. It's a mighty loaded term.*
>
> John HP Secondary

The insinuation of blame that goes hand in hand with using the term obesity also highlights how children are intrinsically linked to their families and cannot be viewed in isolation. John describes the term as "mighty loaded," which is a metaphor drawing on the notion of a gun that will go off with the flick of a trigger and cause a lot of damage. Deconstructing the use of this term in reference to overweight and obesity reveals that there is a concern that if a health professional raises overweight and obesity with families, there is potential for a whole range of responses and emotions that may potentially be negative for the child and family.

4.3 Assessment of the Large Body Size

As previously discussed in Chapter Three, Foucault referred to the 'medical gaze' as 'the act of seeing or the way in which disease; illness and healthcare are thought about and viewed' (Cheek, 2000, p.26). The majority of health professionals interviewed expressed the view that there is a tendency to view overweight individuals as normal,

based on visual observation. This indicates a shift in the frame of reference for the 'medical gaze' resulting from the increased numbers of overweight children being seen in both the primary or secondary health settings.

As a result health professionals, who are deemed to be the experts in examining the body, find it challenging to visually identify what a child within the "normal weight range" according the BMI scale looks like (Smith et al., 2008). Identifying overweight or obesity using the BMI scale overcomes this difficulty by giving both empirical and objective evidence and as a result weight becomes medicalised by measurement.

> *It's a very fine line from being a normal weight and technically fitting into overweight and so just eyeballing them, on that end of the spectrum it's going to be very difficult because it's a matter of a kilo to tip the into overweight*
>
> Karen HP Secondary

This demonstrates a reliance on the need to use the BMI scale in order to make that differentiation between what is defined as normal weight range versus the overweight range. The eye on its own is not a reliable assessment tool.

The difficulties of visual assessment were also discussed by John in relation to the setting in which he practises i.e. a clinic within the secondary health setting.

> *"I kind of make a judgment based on eyeballing them….the ones in the overweight category probably not so obvious and in actual fact the way clinics are run they are often not plotting their centiles till after they [the family and child] have left anyway and that might be some days later when I'm checking the letter and then it's kind of like 'oh I wasn't quite expecting that'".*
>
> John HP Secondary

John uses the term "eyeballing" meaning that he looks at the child or young person and makes an assessment of weight based only on what he sees. He was aware that he probably wasn't accurate at picking up the overweight children because they weren't as obvious but also showed surprise when comparing his 'eyeballing' with what was being plotted onto a BMI percentile chart sometime after the consultation. The eye is shown to be ineffective at picking up subtleties of information and as a result the overweight body only becomes visible to the health professional when it is weighed and measured and plotted on the chart.

John also makes the reference to particular constraints on assessment of overweight imposed by the setting in which he works. Even if children have their height and weight measured at the clinic, it is not a priority to check how the information translates on the BMI percentile chart at the time of the consultation. Clinics are constrained by the appointment time available. In addition, the children coming through this particular clinic were not being seen in relation to a primary diagnosis of overweight or obesity but for other unrelated medical problems. As a result, the assessment and treatment of overweight or obesity was not within this health professional's 'brief'. Consequently, overweight or obesity is not especially visible in this setting or 'space' because it is not the focus of the visit.

Sue verbalised the importance of the charts in her visits to families as a way of determining weight rather than relying solely on a visual assessment.

> *Yeah it's one of the things you do as soon as you're entering the weight and length because they want to know too. Sometimes people are worried that someone said they were under when they are actually well over.*
>
> Sue HP Primary

Sue's comment was made in relation to the importance for a family that their baby was weighed and measured and that that information was recorded and shared with them. There was an increased level of concern from mothers if their baby had been judged by other members of their community or family to be small. Weighing and measuring of the baby is a discursive practise of the health professional which provides a level of visibility and provision of 'truth' both for the health care professional and the family. For the mother this is important, as the results will hopefully confirm that she is doing a good job in nurturing her baby while for the health professional it is once again empirical evidence and an objective measurement.

4.4 The Large Body Size and the Right to Intervene

Healthcare professionals have a social responsibility to promote health and wellbeing by way of education, advocacy and partnership (Nutbeam, 1998). When a child and family come into either the primary or the secondary health care setting they become both the subject and object of the health professional's gaze. Kathy's comments present a

discourse which considers that as a health professional she should be able to talk about issues that relate to health – she is mandated to do so as a health professional.

> *I think as a health professional, particularly, you've got to be able to say…We say your blood pressure is not good, we tell them their heart is not working or whatever. Why can't we tell them there's something wrong with your weight?*
>
> Kathy HP Primary

Kathy suggests her role as a health professional confers on her the right to intervene, to 'point' health issues out and bring them into spoken consciousness. The body is able to be read as an anatomical atlas (Foucault, 1973) which is created via the medico-scientific gaze (Lupton, 1994). Health professionals have the power to label the body as either deviant or normal, and as either controlled or in need of some control (Lupton, 1994).

Use of the BMI allows the body to be analysed and read by the health practitioner to find the signs that may lead to what is the truth about that body (Danaher et al., 2000). This is an example of a discursive practise where the health professional draws on an established knowledge base of what constitutes overweight and obesity. It is described by Foucault as micro-power, a concept which explains how discourses shape the ways that bodies are understood and function (Danaher et al., 2000).

> *Often I'll show them on a chart; this is where they are on the chart and what will happen if they continue on the path that they are going.*
>
> Kathy HP Primary

Use of the BMI chart as a visual tool can hold considerable disciplinary power as it defines what is considered to be normal or abnormal. As noted above, this is a dividing practise and brings overweight and obesity into the realm of the heath professional's gaze and therefore permits their intervention. The use of the BMI chart ensures that overweight becomes visible to the parents or caregivers. Foucault talks about this in terms of 'the examination': 'a surveillance that makes it possible to qualify, classify and to punish' (Foucault, 1977, p. 184). With the chart capturing information about the child, it justifies the need for intervention from health professionals and puts them in a position of power.

The chart is a way of capturing written information that also enables the health professional to predict a trajectory for the future body by inferring potential problems if the child continues to gain weight. Foucault discusses the 'power of writing … as an essential part in the mechanisms of discipline' (Foucault, 1977, p. 189). A number objectifies the body and gives permission for the health professional to track and monitor the child's weight loss. It is a level of surveillance that suggests the individual can be empowered to self-govern appropriately.

Debbie constructs overweight and obesity according to her view of the world, which is conditioned by the medical discourse. She makes reference to the relationship that is evident between herself as a doctor and the power that comes with that position.

> *Often they are judging themselves, so having it pointed out to them is an uncomfortable thing. They know they are overweight but when a doctor says it to you, it's kind of like, oh.…*
>
> Debbie HP Primary

Debbie is alluding to the effect on a patient of having a doctor point out the fact that they are overweight or obese. The problem becomes real and possibly serious once framed as a medical problem. This is a discursive effect of the obesity discourse where doctors are often held in high regard and are seen as a legitimate authority because of their expert knowledge and understanding of the body: the doctor is deemed to be the expert and is presumed to know the medical truth about obesity.

Foucault (1977) talks about how different spaces dictate disciplinary power. This refers to the way in which bodies are regulated, maintained and understood and is most often observed in institutions such as schools, prisons and hospitals (Nettleton, 2001). In the medical space, the doctor holds the disciplinary or corrective power. When Debbie verbalises to the families attending her clinics that there is a problem of overweight or obesity, she is exercising the power that she holds within that environment.

While the right to intervene emerged as an effect of positioning oneself in this dominant discourse, there was also recognition that this 'right' is conferred by expectations of social responsibility as a driver for health practise. In this next excerpt there is awareness from Meg that, as a health professional, she has particular concerns about the consequences of young people being overweight.

> *If you see an overweight kid you're thinking "oh my god they're going to get bullied". I would think you know, "keep this kid healthy, you don't put this kid out there looking obese".*
>
> Meg HP Primary

Meg recognises that the exercise of her medical judgment has the potential to influence outcomes outside the health setting. This is an example of the extension of the power relations that exist between health professionals and the children and families that they care for. Here Meg highlights her concern for the potential health and social consequences of obesity for young people. In a study completed by Janssen, Craig, Boyce and Pickett (2004), it was clear that a child who was either overweight or obese was more likely to be victimised by peers than those who were of normal weight size. Puhl (2007) described the stigmatisation that is directed at overweight and obese children as being relentless with long lasting psychological, social and health related effects (discussed further in chapter 5). By "putting the child out there" Meg is referring to the world outside the family environment where the child becomes the object society's gaze. In this environment, the child may be bullied as a result of being different and not fitting in to the rules that society has set around acceptable body shape and size.

While she is advocating for the child Meg is also insinuating blame on the parent or caregiver by saying "you don't put this child out there looking obese". The child or young person hasn't done this to themselves; it is the responsibility of the parents or caregivers to ensure that they "keep this kid healthy". Although Meg is exercising judgment from a position of power in the medical setting, she is motivated too by her concern for the wider wellbeing of the child.

4.5 A Different Perspective of Intervention in the Large Body Size

While the medical discursive practise was dominant it was not the only practise identified by participants in relation to the right to intervene. Kelly draws on a different discursive construct, arguing that as a health professional her focus should not be on the number that is shown by weighing a child. Instead, the focus should be on holistic lifestyle changes required to lead to weight loss.

> *By weighing people , they are just focused on the weight whereas you're there to try and change behaviours more than focus on the weight…I think if you focus too much on standing on scales, children will often set themselves up to fail….if you don't weigh then you don't see that*
>
> Kelly HP Primary

By not repeatedly weighing, and instead shifting the focus from weight to lifestyle, the body is no longer the object of the health professional's gaze. The child becomes the subject of the health professional's gaze and their overweight or obesity can be recognised more subtly. The overweight or obesity remains visible, as a consequence of an initial assessment, but ongoing intervention can continue without causing offence or attaching stigma.

Kelly gave the example of the effect of using numbers shown by weighing:

> *Okay, well say I weigh 100 kilos and I've got to get down to a goal weight of 60. They see that as huge, whereas if you get them doing things you can see weight going off them, you can actually monitor it just by visual.*
>
> Kelly HP Primary

Here Kelly is saying that by weighing children the focus is on the numbers. When there is a significant difference between a current weight and the ideal weight it may impact on a family's or an individual's ability to be able to do anything about it. For children and families the chasm between the numbers is seen as insurmountable. By focusing on lifestyle changes that are attainable, the children lose weight more easily. This is a more holistic approach to addressing overweight and obesity. Kelly focus was on the 'bigger picture' lifestyle perspective.

4.6 The Large Body Size as Out of Control

There are increasing numbers of children who are overweight or obese, both here in New Zealand and around the world (World Health Organisation, 2012b). As noted in Chapter One, overweight and obesity affects approximately 30% of the child and youth population in New Zealand (Taylor, 2007). The growth in the rates of overweight and obesity has been labelled an 'epidemic' (Alpert, 2009; Greener et al., 2010; Sturm, 2008).

Epidemic as a term on its own refers to ‘a situation in which a large number of people have caught the same infectious disease’ (*Oxford paperback dictionary and thesaurus*, 2009). Use of the term epidemic to describe obesity is something of a misnomer, in that obesity is recognised as a non-communicable disease by the World Health Organisation (World Health Organisation, 2012a). However, use of the term epidemic to describe its increasing prevalence within populations suggests that it is something that can be ‘caught’ from someone else, is spreading through the population and is therefore communicable or infectious and needs to be avoided. Despite the fact that this is not the case, the use of this term contributes to the marginalisation of overweight and obese individuals within society.

From a historical perspective Foucault described the response to an epidemic as requiring the medical gaze to be extended beyond the body to all aspects of society or causal factors that contribute to the epidemic including geography and weather, for example (Lupton, 1995). The effect of this is that the medical and social spaces overlapped which meant that medicine was regarded as a ‘general technique of health’ and not just a means to curing the ill (Lupton, 1995, p. 23). This concept of a holistic approach to responding to an epidemic is in contrast to the role that health professionals who were interviewed saw for themselves.

> *Going through the phase of it’s an epidemic, it’s a global crisis and all the rest of it is important, it’s how you spark up lobby groups to get societal change to take place. But at some stage if you are talking about what health professionals can do with individual patients then it has to mature beyond “it’s terrible and it’s huge and it’s a giant disaster to here’s something really useful that’s been shown to work that you can do in your practise”.*
>
> John HP Secondary

> *I don’t think so much, because all we’ve got to deal with is the one person in front of us at the time, I think obesity is more of a public health, general policies kind of problem…I mean we are the ambulance at the bottom of the cliff…we can try and change that one person, but we’re not actually changing all the things that led to that person being overweight or led to a lot of people being overweight in the first place.*
>
> Debbie HP Primary

John describes the use of terms such as ‘epidemic and global crises’ as useful in order to raise awareness at a social level, but suggests that they are irrelevant to healthcare

settings where health professionals are dealing with one person at a time. Debbie also alludes to the fact that, as a health professional, she has to help the person in front of her while not necessarily being privy to all the circumstances that led that person to her practise. She is suggesting that overweight and obesity as core issues essentially sit outside healthcare and within the community. For these health professionals the spaces in which they work influences what they can do within that space. They only see one person at a time so that dealing with overweight and obesity at a population level, which is what the use of the term epidemic suggests is required, is out of their scope of practise.

Debbie expressed the view that healthcare settings are the 'ambulance at the bottom of the cliff': once the person is at the GP practise they are already overweight or obese. The use of this expression recognises that the problem is being addressed backwards, by treating its consequences rather than its cause. The term has been used in the same context by the New Zealand Herald when it described an increase in the funding for obesity surgery as the 'ultimate ambulance at the bottom of the cliff' (Editorial, 2010). This increase in government spending has been described by critics as a tendency to 'park the ambulance in the wrong place' (Editorial, 2010). In contrast, 'placing a fence at the top,' would mean adopting interventions that help prevent children from becoming overweight or obese in the first place. The use of the 'ambulance' idiom also suggests a view that healthcare settings such as the hospital and GP practise are spaces that only respond to the here and now. Workers in those settings can deal with conditions as they are presented but cannot be held responsible for what occurs prior to seeing the child of young person.

Meg refers to a literal definition of the term epidemic and reflects on its negative impact because of its association with disease and phenomena that are out of control.

> *When I think of epidemic I think of it as like it's huge and uncontrollable. It's something that's really kind of out there, you know, that has medical health implications, that is probably out of control….an epidemic is kind of a trait that society instinctively goes "oh my God" they're afraid of it so it's not a good word to attach to it [overweight and obesity]*
>
> Meg

Meg suggests that referring to overweight and obesity as an epidemic cause's society to be afraid of it. By being afraid of the overweight and obesity epidemic, there is a suggestion that there is some danger to move away from. Children who are part of this epidemic are then marginalised by their peers, reinforcing the stigma associated with being overweight or obese (discussed further in chapter 5). The word obese creates a binary - those who are overweight or obese and those who are not, with the former placed within a wider group of individuals ('the epidemic') that are seen to have no self-control or will power.

4.7 Summary

This chapter has described findings relating to the influence of the medical discourse on the way in which health professionals address overweight and obesity in children. Overweight and obesity have been medicalised through terminology. The words overweight and obesity have precise meanings, based on the BMI, giving them the status of a medical problem and implying that there is a medical solution. In Foucauldian terms, the use of this terminology represents a surface of emergence which allows the large body to be put under the medical gaze. Some of the health professionals interviewed reflected on non-medical definitions of the words overweight, obesity and related terms, commenting on why the use of them to describe a child or young person's body can be problematic for health professionals.

The health professionals commented on difficulties associated with assessment of the overweight child. Visual assessment can be difficult because overweight is seen as normal. Measurement addresses this problem and some interviewees highlighted how the use of the BMI and associated charts allows them to demonstrate to parents that a problem exists and mandates their intervention. However, in some situations health professionals place less emphasis on measurement as a method of prompting action. In these situations, more emphasis is placed on advocating the behavioural changes needed to lose weight.

The medicalisation of overweight and obesity gives health professionals the right to intervene. However, some health professionals interviewed also commented that the scale of the obesity 'epidemic' is something to which they cannot respond to. Their ability to intervene is limited to the individual child and family who present in the medical setting, while the epidemic is an external problem, something for others to deal with.

The following chapter describes findings on the ways in which social, cultural and socioeconomic discourses influence the practise of health professionals in addressing overweight and obesity.

Chapter Five: Analysis - Non-Medical Discourses

5.1 Introduction

This chapter presents the results of interview analyses relating to discourses that sit outside health settings but which ultimately impact on health professionals' ability to be able to address the issue of overweight and obesity in children.

Firstly, it examines social discourses that pertain to stigma and overweight and obesity as normal. Secondly, it considers the influence of, and barriers arising from, culture and ethnicity. Finally, it examines how practise is influenced by socioeconomic disparities in the incidence of overweight and obesity among different communities.

5.2 The Social Discourse

5.2.1 The Large Body as a Stigma

Large body size is the physical and most immediately apparent characteristic of obesity. For overweight and obese children, their identity may often be constructed by their large body size. However, obesity is also socially constructed in a number of ways, one of which is a state that is stigmatised. The term stigma means severe disapproval of or discontent with a person on the grounds of characteristics that distinguish them from other members of society (*Oxford paperback dictionary and thesaurus*, 2009). For the child or young person it is their overweight or obese body that distinguishes them from those who are not or, even more so, from the ideal slim, athletic build aspired to by much of society (Greener et al., 2010). This is another example of a dividing practise where individuals can be grouped according to differences. Through this practise the body becomes constructed as a terminal point that is the site of "social action, power and resistance" (Powers, 2001, p. 20), and has to fit within what is socially defined as normal.

Another definition links stigma to shame: stigma is a mark of shame and to stigmatize is to brand something as disgraceful (*The Oxford Paperback Dictionary*, 1979). Overall, the 'mark' of being overweight or obese has negative or shameful connotations for the overweight individual along with potential consequences for quality of life.

A health related quality of life survey undertaken by Keating, Moodie and Swinburn, (2011) showed that adolescents who are overweight or obese have a lower level of social and physical functioning than their normal weight peers. The study measured whether others wanted to be the overweight adolescent's friend and whether the overweight adolescent was teased or not. Another quality of life study by Tsiros et al.,(2009) found that obese adolescents' quality of life scores are the same as those of children who have cancer. When it is children who are overweight the stigmatisation is also placed on those who care for them, as they are judged as not providing a level of care that ensures the health and wellbeing of their children.

The socially constructed stigma of obesity is one of the contributing factors that made overweight and obesity a "taboo" subject for health professionals to talk about. Taboo refers to something that is prohibited (*The Oxford paperback dictionary*, 1979). As a result of this taboo status, an explicit reference to a child being overweight or obese can be interpreted as being impolite and has the potential to cause offence. These potential consequences have a silencing effect, limiting the extent to which overweight and obesity can be discussed and addressed.

Foucault (1977) talks about the body as an object and target of power: it is described as the 'ultimate site of political and ideological control, surveillance and regulation' (Lupton, 1994, p. 23). Here, the effect of the panopticon has extended beyond the prison environment and now pervades society. An individual becomes subject to a certain gaze: once their body complies with rules and regulations, it then becomes a useful body (Foucault, 1977). In contrast to this, the overweight or obese body is socially constructed as one that does not comply with social rules, is not useful and is instead a burden on society. Meg talked about the difficulty in naming the child as overweight with parents:

> *It does come back to the stigma and the self-esteem and you know it's really hard to kind of approach them and say "Look you are overweight significantly, we need to do this," they're like "I can't do that."*
>
> Meg HP Primary

Here Meg acknowledges that the stigma associated with being overweight has an effect on whether the health professional can express their concern to the overweight or obese child and parents because of the potential impact on the child's self-esteem which may

already be low. Health professionals are well aware of the negative connotations that are attached to the status of overweight and obesity when they raise it with families. Meg uses the word *significantly* to emphasise the word overweight which gives it more importance; the child is not just a little bit overweight. For this health professional it is imperative that she talks with the families and intervenes.

The health professionals interviewed talked about the stigma that is attached to the physicality of the overweight or obese body in terms of the need to be polite. It became evident that this had a constraining or silencing effect on their ability to be able to talk about overweight and obesity with children and their families. For Debbie, while she is aware that being overweight or obese is a problem for children, it is difficult for her to verbalize this to her patients as she is concerned that raising the child's body size as an issue may be perceived as her being rude or offensive to the patient and/or family.

> *I think everyone knows it's [obesity] a problem but it's kind of still something that's not polite to talk about, I guess it's mainly to do with, you're talking about something that is body image, the actual person rather than something they are doing or something separate*
>
> Debbie HP Primary

There are competing discourses here, the first being that from a medical discursive perspective Debbie is identifying weight as a problem that requires intervention (a discourse that was discussed in Chapter Four). The second is that she is constrained by social etiquette and the need to be polite regarding verbalising this to her patients and their parents. There is a fear of talking about it, as to identify the child as being overweight or obese is seen as "not polite". Such confrontation is something that may upset or offend the individual. While the health professional may have the best intentions, their identification of a child as being overweight or obese may be seen as a negative judgment on the personal failure of the parents. In contrast, being polite shows good manners and is seen to be socially correct. Within society, I suggest, it is polite to make positive comments about bodies that fit in with what is socially constructed as acceptable. But it is impolite to make comments about those bodies that do not fit within that construction.

There were varying levels of relationships between the health professionals in this study and the families that they had interactions with. These ranged from the short term

relationship that exists within the acute hospital setting, in contrast relationships in the community setting, where the health professional is more likely to work in partnership with families over an extended period of time. One of the difficulties in talking to families about a child being overweight or obese was the possibility that it may jeopardise these relationships, particularly for those health professionals in the primary care setting. As a result there was a level of tentativeness in their speaking positions, the tension being that as a health professional a large part of their job is to discuss issues pertaining to health and disease. Despite that, the relationship that they have with families is one that is based mostly on families actively seeking healthcare advice. A large part of the health professional's job is to discuss issues with families pertaining to health and disease. The health professionals responded to the tension by taking steps not to offend when discussing a child's weight with family, principally by being careful in their choice of language.

For example when Debbie talks to children and their families about the child being overweight or obese, she is having to break the social rules of engagement and runs the risk of losing her rapport with the family.

> *You could just throw something like "your child's fat by the way" you've got them on the back foot to start with and you're never going to be able to work with them to try and change them*
>
> Debbie HP Primary

For Debbie, it was very important that she was able to maintain the on-going relationship with her families. Causing offence through confrontation and choosing inappropriate language could threaten the relationship between her and the family so that the family moves away from her practise.

Here there is an obvious cross over between the medical discourse and a 'social etiquette' discourse. The health professional's desire to diagnose, treat and intervene competes with the knowledge that it is not polite to talk about overweight and obesity. This tension arises because the language that is used to describe overweight and obesity, although originating from the medical discourse, is also socially constructed and hence commonly understood as being negative and undesirable.

The consequence of being polite and not identifying and talking about overweight and obesity in relation to the child or young person is that the issue remains invisible and can be a constraint to clarity (Aronsson & U Satterlund-Larson, 1987). In contrast, by pointing it out to families it becomes reconstructed as a problem and therefore visible. As noted in Chapter Four, Foucault (1972) describes this as a surface of emergence; talking about and naming overweight and obesity brings it into consciousness for the family where previously it may not have been evident. If a health professional is unable talk about overweight or obesity with a child's parents, then the surface of emergence does not exist.

The reference to *"the actual person rather than something that they are doing or something separate"* also makes the issue of overweight or obesity very personal to the individual. As noted above, once 'named' it could be construed by the parents that the health professional is placing blame on them for the physical state of their child. This comment indicates a view that overweight or obesity is something that does not manifest on its own but is a result of an individual's own actions, such as over consumption of food. The child's body then becomes perceived proof of parental failure: it is visual evidence that overweight or obesity is real and the health professional can see it. It can't be hidden. Within a health setting this visibility enables the child or young person to become the subject and object of the medical gaze.

5.2.2 The Exception – the Acceptable Large Body

Some of the health professionals interviewed referred to a discourse that recognises the age of the child affects the perception of weight. For example, anecdotally there is a social construction of a "bonny bouncing baby" which usually implies that a baby is chubby and is perceived as a desirable state for a child of a certain age. This is in contrast to a baby that is perceived to be small and becomes socially constructed as being unwell or behind in its development.

> *So in younger children there's this acceptance of a kind of norm which is above what a healthy weight and size range might be….And there is a lot of angst and concern about children who are thought to be not growing that well.*
>
> John HP Secondary

When a baby is tiny everyone thinks that there's something wrong with that baby.

Sue HP Primary

The value placed on 'chubby' babies reflects a view that their size is a sign of health, good nutrition and, in some communities, wealth. Davidson and Birch (2001) described how mothers from minority ethnic groups considered a fat baby to be a sign of good parenting compared with a thin baby, which was seen as a reflection of parental neglect. In some communities, a baby may even be within the normal weight range but is still viewed in a less positive light than the apparently more healthy, but overweight, 'bonny' baby (Keenan & Stapleton, 2010).

There is considerable power from the gaze of society – others looking in and making a judgement that a mother is, or is not, doing a good job based on the size of her baby. Societal value judgements associated with what is normal and desirable in terms of babies' body size are clearly different from those associated with older children.

I've got a huge child, she's enormous but she's also above the top line for head and length you see. I saw her this week but she's going to be 6 ft 4 when she grows up. You know, I said to the mother, breast fed babies – don't worry. She has got rolls of fat here because she's totally breast fed, you can't overfeed a breast fed baby…. Everyone around her [the mother], her parents in law and that are like…oh, because they're used to formula.

Sue HP Primary

Parents are often surveilled by others, such as family members, to see how they are caring for their children. In this instance the judgement is made on the mother's ability to provide adequate nutrition for her baby. The mother becomes both the subject and object of scrutiny from members of society who consider themselves experts and able to judge or divide the normal from the abnormal. Foucault (1977) states "judges of normality are present everywhere….it is on them that the universal reign of normative is based"(p. 304). In this situation the "judges of normality" are individuals expressing concern over the apparently large size of a baby. They are influenced by their own experiences and interpretations of what constitutes healthy nutrition for babies.

5.2.3 Large Body Size as Increasingly Normal

As discussed in Chapter Two, the increasing normality of the large body size has been attributed as a causative factor to childhood overweight and obesity. Families may not

recognise that their child is overweight or obese if all family members are overweight or obese as well or there are large numbers of overweight or obese people within their immediate communities. It does not become evident until that child or young person steps out of that social environment where they become subject to a different interpretation of their body size.

> *Because of the degree of normalisation and the kind of lack of awareness you're actually bringing up a problem that people don't think of as a problem necessarily. So you are not only raising it but having to do a sales pitch to convince a family of why you think it is a problem*
>
> John HP Secondary

Overweight and obesity within some families and communities becomes invisible because of a degree of what John called "*normalisation"* as a result of its high incidence. The power of normalisation of overweight and obesity is that the frame of reference of what is normal and abnormal has become blurred for some families. Hence John has to do a "*sales pitch*" to convince families that being overweight or obese could affect the health of their child. It is only when the child enters the medical space that John has the opportunity to get the message across. In this way the involvement of the health professional represents a surface of emergence for problematising the child's body size that would otherwise remain hidden because of the prevailing social or cultural discourses.

5.3 The Cultural/Ethnicity Discourse

5.3.1 Culture and Ethnicity

During the interview process it became apparent that the influences of culture and ethnicity in addressing overweight and obesity in children are significant, especially for those health professionals based within the primary health care setting. Within the context of this analysis, culture refers to the ideas, customs and social behaviours of a certain group in society (A. Cohen, 2009) and ethnicity is referred to by Ford and Harawa (2010) as a 'context specific , multi-level, multi-factorial social construct that is tied to race and used both to distinguish diverse populations and to establish personal or group identity' (p. 252). While the terms are sometimes used interchangeably, it is important to distinguish between them in order to understand certain discourses, even though these discourses do overlap.

In particular, the health professionals interviewed made reference to Māori and Pacific children having greater rates of overweight and obesity than non-Māori and non-Pacific children. This is a discourse that is proven 'true' by statistics or empirical evidence that is collected at government level (Ministry of Health, 2003). This is another example of a dividing practise where children have been grouped according to their ethnicity and information has been collected in regard to their weight in order to illustrate rates of obesity within certain ethnic groupings.

5.3.2 The Large Body as the Result of Competing Cultural Discourses

There is a discourse that socially constructs Pacific people as bigger than non-Pacific people. In addition, from an anthropological cultural perspective some Pacific cultures value a larger body size (Metcalf, Scragg, & Willoughby, 2000). In other words 'big is beautiful'. There is also a discourse that presents Pacific people as making poor food choices and consuming high caloric foods without considering that their choices are influenced by cost, peer influence and time restraints (Dewes, 2012; M. McCabe, Fotu, Mavoa, & Faeamani, 2010; Teevale, Thomas, Scragg, Faeamani, & Nosa, 2010). Furthermore, the impact of western lifestyles and the move from rural to urban areas that occurred with migration to New Zealand has influenced the levels of obesity within Pacific populations through changes in diet (Dewes, 2012). In this next excerpt Kelly makes a generalisation that is based on her own moral judgments.

> *I deal with a lot of Pacific Island young people with huge obesity issues there; I'm just appalled at the number of young people that have takeaways every night*
>
> Kathy HP Primary

Here Kathy is buying into a cultural stereotype around the types of food that Pacific people eat. This is an example of the outside looking in and making a judgment: surely these young people could make a better choice. Kelly is showing dismay or even disgust at individuals' choices around the regular consumption of takeaway food by using the word "appalled" which implies a sense of horror. Using this term she is verbalising her own values and moral judgments that insinuate a lack of individual responsibility. While Kathy is exercising a dividing practise based on cultural stereotypes, she is also influenced, I suggest, by the medical discourse as she draws upon an unspoken norm of what she considers is a healthy diet.

5.3.3 The Large Body Size as an ethnically Determined Norm

There is also a discourse, reflecting ethnicity rather than culture, that the large-body size of Pacific and Māori peoples is genetically determined. Rush, Freitas and Plank (2009) undertook a study that compared body size, composition and fat distribution between New Zealand Europeans, Māori, Polynesian (the authors' terminology) and Asian Indians which indicated that those who were Polynesian or Māori had a higher BMI with less body fat than those of the other ethnicities. This was also the case for Māori and Pacific children who had a higher BMI than those from a European background when their body fat percentage was similar (Rush et al., 2003). When Meg works with young people from a Pacific background she takes this into account when undertaking an assessment. She acknowledges that there can be ethnic differences within body types.

> *When I work with Pacific Island people and they probably have a bit of weight, they put on weight like that; I probably would give them more leeway than I would somebody who was European.*
>
> Meg HP Primary

Here Meg refers to a large body size which could be interpreted as 'normal' for peoples of Pacific ethnicities more so than those from a European background. Giving more "leeway" to young people from Pacific ethnicities that may be overweight or obese allows Meg not to intervene with any urgency and potentially ignore it: it is just the way 'they' are. On one hand Meg is referring to the construct that those from a Pacific background tend to be bigger sized people and have a higher BMI in relation to body fat percentage (as described above). On the other hand, Meg's reference to the way in which Pacific people *"put on weight like that"* indicates an acknowledgement of culturally determined aspects of obesity and overweight.

5.3.4 Practitioners as Outsiders

There is an apparent discourse which positions the health professional as an outsider. In this context, the discourse appeared to be derived from ethnic and cultural differences between the practitioner and the families with whom they interact. However, this sits within a wider discursive framework in which health professionals may be viewed as an outsider by patients, irrespective of background, reflecting the nature of the power relationship between the two (Foucault, 1973). The positioning of practitioners as outsiders, I propose, has an impact on their ability to engage with the families to discuss overweight or obesity. This was evidenced by the following excerpts where both Debbie

and Kelly spoke about how their own cultural identity as New Zealand Europeans/Pakeha influenced their practise.

> *You've got to get buy in and you've got to appreciate where the family is coming from too and sometimes for me the people that can probably say it as it is are people that are within their own culture. Some Māori providers can go in there and say this is what you need to do and you know, you're killing your kid, da, da, da, da, and that's fine. They get away with it. I could never get away with doing that.*
>
> Kelly HP Primary

> *It's hard because you really need someone that's from their culture, I think. That's the easiest way to get them engaged and to get them to listen.*
>
> Debbie HP Primary

Kelly uses the term "buy in" which suggests health professionals desire a level of commitment and compliance from the families. She also goes on to say that this can occur more easily with people from within the health professional's own culture because of the greater empathy and mutual respect derived from an overlap in values and experiences. These conversations, Kelly suggests, can be more direct and that this type of confrontational shock tactic would be more likely to be tolerated by the parents. Statements such as this would be perceived as being free of culturally or ethnically based value judgments. But for Kelly who positions herself as an outsider these tactics would have some consequences such as alienating her from the family. Furthermore, as a primary healthcare practitioner Kelly needs to be able to maintain a relationship with the family for future interactions.

Both Kelly and Debbie acknowledge that for them, the success of intervention depends on it being delivered in a culturally sensitive manner and that this affects both the "*buy in*" of the family and the success of any intervention. Foucault states that power and knowledge are intrinsically linked (Danaher et al., 2000; Foucault, 1977). Here it is evident in that cultural knowledge gives a health professional from within a family's own culture a certain level of power with respect to the way in which they communicate with those families.

Kelly spoke about some of the 'barriers' that exist and expressed that her own cultural identity was a potential constraint on working with some of these families.

I would say is the very fact that I'm Pakeha can be a barrier

Kelly HP Primary

Use of the word "*barrier*" indicates that her cultural identity in some way prevents her from being able to do her job effectively. This indicates a shift in power relations that occurs when she deals with Māori families. While the health professional is usually in a position of power and feels mandated to intervene in issues that pertain to health, in this instance she is perceived by families as having limited understanding of their cultural identity. This can have a negative influence on the effectiveness of the care provided to Māori families (Bacal, Jansen, & Smith, 2006).

Debbie also emphasised the constraints on effectiveness arising from cultural differences, but went on to expand this discourse to focus attention on the current lack of Māori and Pacific health professionals.

They don't want a lot of white people standing up and going we think this and we think that, but I think again that's hard. Where do you get that resource from? We all know it's better if we can have Māori and Pacific Island workers out there with them but where do you magic them up from?

Debbie HP Primary

Here Debbie identifies the tension between the ideal and the reality of healthcare delivery for Māori and Pacific peoples by recognising that healthcare workers from these ethnic groups do not currently exist in any great numbers.

5.3.5 Developing Culturally Acceptable Practises

Recognition of these various discourses of culture and ethnicity enables discursive interventions to be developed that are culturally acceptable or appropriate. Kelly referred to involving resources that were relevant to specific communities as a way of reaching families and gave the example of how church is a central component in many Pacific people's lives with up to 90% of Pacific people attending church (Wright & Hornblow, 2008).

We've got a fantastic Pacific Church focus where they have free fitness evenings and everyone goes. Like the whole family, extended whānau and kids are doing it and adults are doing it and it's a real social occasion and that's really great.

It's this thing with the Pacific families where the church is so important, so to bring it into that sort of environment you can see how that would work.

Kelly HP Primary

Kelly suggests that using the church space to run exercise classes is a way of encouraging Pacific people to engage as it is an environment that is familiar, that can be social and fun and that belongs to those specific communities. The church as a space has a specific power, it is a vital part of Pacific culture and a central component within these communities (Dewes, 2012). The 'do-ability' can then be seen as a collective one between those who attend rather than an individual family having to make all the lifestyle changes on their own.

This is an example of the power of discourses creating certain spaces in which a health interaction can occur. Because the church space is one that traditionally looks after spiritual health as opposed to physical health, health promoting activities that occur inside are not subjected to the medical gaze. The power sits within the space and there is a level of collective ownership from the ethnic groups who attend the church illustrating Foucault's contention that discipline is not just imposed upon individuals (Danaher et al., 2000).

5.4 Socioeconomic Discourse

5.4.1 Large Body Size as Socioeconomically Determined

There is a discursive practise that links the cause of being overweight or obese to being poor, rather than taking into consideration other influences such as cultural beliefs and practises or the obesogenic environment. This practise is exemplified by the reporting of statistics on the incidence of obesity and overweight by socioeconomic grouping. For example, Utter et al., (2010) found that there was a higher incidence of overweight and obesity in adolescents in areas of high deprivation. It reflects a discourse in which choices around food and lifestyle are seen as being primarily influenced by financial constraints and the communities and environments with which individuals interact.

This discourse challenges the neoliberal discourse, which positions obesity and overweight within a neoliberal framework. There is the expectation of individuals to take care of themselves, control, achieve, modify and improve themselves and their bodies thereby making fatness a personal choice (Guthman, 2009). However, the

opposing socioeconomic discourse contends that the freedom to exercise this 'choice' is a function of wealth, and as the gap between rich and poor becomes bigger so too do the health disparities (Browne & Tarlier, 2008). As a result, overweight and obesity is more prevalent in those areas of socioeconomic deprivation (Maziak et al., 2007).

Both Kelly and John make reference to the impact on choices around food and what is a priority for families who are financially compromised.

> *I think the other barrier is we may not be in a recession but the low income families are still hurting. They are still in that recession. They haven't seen any improvement. So you've got people still living in a very financially stretched, as far as just paying, getting through paying their rent, telephone, power, those things. They are just in survival mode.*
>
> Kelly HP Primary

For these families their choices are limited, yet from a neoliberal perspective individuals are expected to be able to monitor and manage their bodies and their children's. Kelly states that not having the financial means is a barrier for these families to be able undertake this monitoring and management. They are blocked by their financial means, they are, as he says, "just in survival mode". Using the term *survival*, Kelly is suggesting that these families are focusing on meeting the basic needs of life and have no room for choice, for instance in the type of food they consume. Governments that adopt a more neoliberal philosophical position tend to further marginalise these families (Townend, 2009).

John also talked about the tension between choices around diet and other priorities faced by families with limited financial resources.

> *So if you're likely to get up at the same time every day, have a kind of a set routine and have the financial ability and kind of freedom to think about these things then you are more likely to carry them out, and if you're worried about whether you can pay the rent, about how sick your child is, about a whole lot of other kind of important distracting factors, then maybe it [healthy food] takes a lesser priority.*
>
> John HP Secondary

John recognises that if there are significant other worries or stressors then these can distract families from making food a priority. He also states that having a routine may

have an effect on whether considerations around food choice take priority. This can be interpreted through the Foucauldian lens as the individual being disciplined or having the ability to self-regulate (Foucault, 1977). An individual who makes the 'right' choices for themselves is seen as a success of neoliberal governmentality. Individuals are responsible for looking after themselves and they are monitored in their ability to do so (B. Evans, Rich, Davies, & Allwood, 2008). In this case individuals are monitored by society at large for their ability to regulate their own body weight. However, those families who have other priorities and do not conform to this neoliberal ideal may be judged deviant and marginalised because they have overweight or obese children and perhaps are overweight or obese themselves.

Kelly gave several examples of the effect financial constraints have on families' abilities to make healthy food choices for the children

> *I think I do believe that low income families are compromised by poverty and money and so you know they're choosing choices that will fill the children up but may not necessarily have a healthy content. There's a lot of white bread and cheese, there is a lot of meat that's really fatty, cheaper as far as cost goes and they eat a lot of potatoes and rice, things that are very inexpensive.*
>
> Kelly HP Primary

Kelly said that she felt families were "*compromised by poverty*". For these families there is a level of food insecurity (Signal et al., 2012) which denotes that the choices they are able to make as a result of poverty tend to be less varied with lower intakes of fruit and vegetables. Food insecurity has been found to correlate with overweight and obesity (Signal et al., 2012; Tyler & Horner, 2008). As Kelly says, families are basing their choice of food for their children on what will fill them up rather than the nutritional content.

5.4.2 Large Body Size as Geographically Determined

Geographical variations in the socioeconomic status of individuals and communities are also reflected in differences in the prevalence of overweight and obesity: the poorer the community, the greater the proportion of the population that is overweight or obese (Lee, K Mullen Harris, & P Gordon-Larson, 2009). Kathy and John both referred to the geography of obesity and how in poorer communities the perception that obesity is 'normal' affects the extent to which it is seen as a problem. Kathy commented on how she really notices the differences in the numbers of overweight or obese children in

different parts of Auckland. In particular she talked about the contrast between West Auckland and the North Shore.

> *I work out west and I work on the North Shore and think these kids are skinny over here, whereas I come out west and it's like 'Oh My Gosh' we have a huge amount of fat, obese children.*
>
> Kathy HP Primary

The North Shore of Auckland has a higher socioeconomic status with only 4.7% of meshblock areas considered to have high levels of deprivation, whereas Waitakere (West Auckland) has a much higher percentage – 30.9% (Day & Pearce, 2011). These numbers provide what is deemed to be 'truth by statistics' in relation to deprivation but fail to show any of the contributing social factors. Kathy is reminded and apparently shocked at the high numbers of overweight and obese children that are evident in West Auckland compared to the number she sees in the North Shore.

In this next excerpt John is describing a binary by comparing normalisation of obesity within certain community groups based on socioeconomic factors.

> *A Decile 10 school –I mean just if you kind of look out at the playground with all the kids playing there aren't that many children that look obviously overweight and so while there is normalisation there's different degrees of normalisation so if you plonked a whole lot of significantly obese children amongst that school population, they'd kind of stand out. Whereas if you go to a lower decile school where the rates of obesity are much higher, they don't stand out so much and if they don't stand out so much that therefore is normalisation isn't it?*
>
> John HP Secondary

John is referring to how the socioeconomic differences that are evident between communities affects the perception and degree of overweight and obesity as normal within those communities. He gives an example of a dividing practise where those children who attend a decile ten school, which reflects a community that is socioeconomically well off, have fewer numbers of children in their playgrounds who are overweight or obese compared with a lower decile school, which is associated with areas of deprivation and higher rates of overweight and obesity. Colls and B.Evans (2009) found that some policies that focus on obesogenic communities construct these communities as homogenous and compare them against those lifestyles that are thought

to be ideal. Lower socioeconomic communities are considered to have higher rates of obesity because they are judged to lack the knowledge of the "right way to live" (Colls & Evans, 2009, p. 1014). Poverty brings with it not just financial constraints but also less knowledge, through a lack of education about what a healthy diet and lifestyle actually is.

5.5 Summary

This chapter has described findings relating to the influence of social, cultural and socioeconomic discourses on the way in which health professionals address overweight and obesity in children. Overweight and obesity are accompanied by significant societal stigma that represents an alternative dividing practise from that associated with the medicalisation of overweight and obesity (Chapter Four). Health professionals interviewed commented on the way in which this stigma results in overweight and obesity being a difficult subject to raise as an issue with children and their parents. This is particularly a problem for health professionals in the primary sector who often need to maintain long term relationships with the children and their families.

The way in which society constructs overweight and obesity is also influenced by the normalisation of these conditions. The frame of reference for what constitutes a 'normal' weight has changed. Parents who themselves are overweight or obese, or are surrounded by others that are; do not recognise the same condition in their child.

The health professionals interviewed reflected on a number of cultural and ethnicity discourses associated with overweight and obesity. These included increased incidence of overweight and obesity among Māori and Pacific people, the traditional valuing of the large body size by Pacific cultures, the stereotyping of poor food choice and the large body size as an ethnically determined norm. Health professionals recognised that culture can be a barrier, with practitioners often seen as outsiders. One interviewee reflected on the value in developing culturally acceptable practises, such as bringing intervention measures out of the medical setting and into a more culturally-familiar space.

Several of the health professionals interviewed recognised the socioeconomic construction of overweight and obesity: low income families face financial constraints and may not have the education to enable them to make healthy food choices. This

discourse challenges the prevailing neoliberal philosophy of government in which overweight and obesity, among other things, are the result of individual choice and, in Foucauldian terms, a lack of self-regulation.

The health professionals interviewed recognised that these social, cultural and socioeconomic discourses intersect with the medical discourse (described in Chapter Four) to influence the ways in which they address overweight and obesity. This intersection of discourses is discussed further in Chapter Six, which presents findings on who health professionals consider is responsible for dealing with overweight and obesity.

Chapter Six: Analysis - Who's Responsible?

6.1 Introduction

As discussed in Chapters Three and Four medicine has constructed overweight and obesity as a health problem. However, despite its medical construction health professionals recognise that the medical health setting only deals with the consequences, rather than the causes, of overweight and obesity. Those causes lie elsewhere, outside of the medical space and beyond the influence of the health professional.

This Chapter examines how health professionals view their responsibility, as well as that of State institutions and the individual, in addressing overweight and obesity in children. Health Professionals' views on their own role are predominantly driven by the medical discourses discussed in Chapter Four. In contrast, their views on the role of the State and the individual draw on the wider set of social, cultural and socioeconomic discourses described in Chapter Five. It is the intersection of the medical and other discourses which complicate considerations of assigning responsibility: the health professionals interviewed recognised that, despite a sense of 'medical futility', addressing overweight and obesity in children requires a collaborative effort between themselves, the State and the individual.

6.2 Is the State Responsible?

As discussed in Chapter Five, from a neoliberal perspective responsibility for managing the body falls not on the State but on the shoulders of the individual and this is as much the expectation for the overweight and obese individual as for the population as a whole. Obesity is socially constructed as a problem that is self-imposed by individuals and is a result of the way they choose to lead their lives. This construction thus places the responsibility for addressing overweight and obesity onto individuals, rather than the State. Individuals are expected to act responsibly, make the changes they need to, and conform to what is considered normal (B. Evans et al., 2008). Foucault describes this as disciplinary power, where the mass surveillance of populations has the effect of individuals self-regulating their behaviour (Foucault, 1977; McHoul & Grace, 1993). Populations rather than individuals become objects of surveillance, analysis and intervention as a way of restoring control.

In the first excerpt immediately below John alludes to the State's emphasis on freedom of the individual by comparing a democratic way of governing, which gives freedom of choice and ultimately ensures that individuals are responsible for the choices that they make, to that of a communist State in which he suggests there is more limited freedom of choice. In the latter case, the State is responsible for the actions of individuals as a way of controlling the population. This can be interpreted as a paradox, since the end result under the processes of governmentality that operate under both systems is the control of individuals' conduct at the population level. Chapter Two defined governmentality as combining the power and knowledge of various authorities such as medicine, psychiatry and law, and incorporating surveillance and discipline to control not only the individual but the entire population by establishing 'norms' (Cheek, 2000).

> *We vote politicians in to deal with the big problems that face our society, not that politicians necessarily are going to be able to absolutely influence this, because it's so multi-layered. Unless you had some sort of incredibly communist approach where everything gets dictated by the State, which we're not going to ever have. We've kind of got a free market economy where high calorie, nice tasting, easy to overeat stuff is readily available and will continue to be most likely.*
>
> John HP Secondary

There is an expectation from society that those who are voted into positions of power will instigate solutions to the problems that feature at a societal level. However John is suggesting that the ability of the government to put policies in place that might achieve certain desirable social outcomes is limited. This is because it does not want to restrict the operation of the free market economy. Rather, the pursuance of neoliberal policies that encourage competition are preferred. As a result, responsibility for the self is seen to be the norm within communities (Guthman, 2009). So while on one hand there is a desire from parts of society for the State to put policies in place to help 'fix' overweight and obesity, on the other hand the effect and success of a neoliberal free market economy prevents this from occurring: society does not want a 'Nanny State' or, as John verbalised, a communist regime.

As a result the neoliberal approach has the effect of making the individual responsible for their own actions. When this is applied to the overweight or obese child or young person there is an expectation from the State that those caring for them will exercise this individual responsibility by regulating and controlling their children's bodies. Foucault

(1976) referred to this governance and regulation of individuals and populations though practises associated with the body as 'biopower' which refers to the governance and regulation of individuals and populations though practises associated with the body.

6.2.1 Are Schools Responsible?

Responsibility for child health and wellbeing has increasingly moved into the educational environment. No longer do schools just have to provide the basics of education – reading, writing and arithmetic. They are also now involved in health promotion of both body and mind and tasked with not only guiding children to meet academic standards but also delivering well rounded individuals equipped to make the right decisions and take on the world. There is however a tension that exists for schools: in striving to meet national academic standards in the core areas of literacy and arithmetic, subjects such as health education have the potential to be overlooked (Openshaw & Walshaw, 2010).

The school environment is ideal for health promotion as most children attend and are the responsibility of the school for six hours a day, five days a week. This gives schools the opportunity to promote healthy eating and implement exercise regimes, in accordance with the New Zealand education curriculum (Ministry of Education, 2007b). Children in the school environment are placed under a level of surveillance where they are encouraged to monitor their own bodies through education around healthy eating and increased activity (B. Evans et al., 2008). Within the same setting they also come under scrutiny from their peers.

> *I still think that schools have some responsibility to provide good food choices and having policy around nutrition. One of the best policies in school is to say "we only have water in this school…"So I think schools are gradually taking on a role in eating and healthy eating and role modelling themselves, all my schools have fruit in schools.*
>
> Kelly HP Primary

Kelly is suggesting that schools are ideally placed to take on a level of responsibility to put policies in place relating to healthy food options, away from parental influence. As Lupton (1995) states, there is an ideological objective of health promotion and public health initiatives which is to accomplish "a continuing good health status for all" (p. 2). While Kelly's suggestion is consistent with policies that many schools do already adopt, it is in complete contrast with the notion of freedom of choice associated with the

neoliberal discourse described above. Clearly, there is a suggestion here from Kelly that the reach of neoliberalism may have gone too far and that it is time for the State, through its education system, to intervene.

Within New Zealand exactly this situation has occurred. In June 2008 the then Labour-led government proposed schools police the types of food brought into the school environment in order to ensure that they were healthy (Walton, Waiti, Signal, & Thompson, 2010). There was a huge public outcry and accusations of the State interfering with parental rights to feed their children as they choose. With the change to a National-led government in February 2009, this policy was removed (Walton et al., 2010) and the guidelines now state that schools have a duty to promote healthy food but cannot enforce it (Ministry of Education, 2007a). This is an example of the success of neoliberal policy; society does not want regulation around what their children can eat and cannot, they want freedom of choice.

Kelly went on to say that within the schools with which she is involved, she does encounter teachers exercising their health promotion duties in relation to what is in children's lunch boxes.

> *But what's really good, all the schools I go to, they now sit down in the classroom to eat. They don't go outside and it's about seeing what's in the lunchbox. The teachers are aware. Every lunchtime, it's almost like health promotion. "Wow, John I really like what you've got in your lunchbox".*
>
> Kelly HP Primary

Teachers have now become the surveyors and judges of what is healthy and what is not. As Foucault describes they are the "judges of normality" (1977, p. 394) in their surveillance. The classroom has become the space in which teachers can undertake this surveillance and it is justified on the grounds of health promotion. They can see what is inside each child's lunchbox and have taken on the role of health promoter reinforcing healthy food choices by verbally praising the child. This is described by Foucault as a mechanism of disciplinary power and surveillance (Danaher et al., 2000; Foucault, 1977; Lupton, 1995) where the teachers are intent on regulating what the children are bringing to school for lunch. This level of surveillance is possible within the school setting as the teachers are in a position of power, the children are the subject of their gaze and the food they bring in becomes the object of their surveillance. By association,

parents surreptitiously also come under scrutiny from those who are doing the lunchbox checks.

Schools are also able to address the overweight and obesity issue because they are ideally placed to "get kids up and moving". The New Zealand curriculum mandates that physical education is part of a school's timetable (Ministry of Education, 2007b).

> *I think school is a good place to try and get these kids up and moving and I think they do. They encourage the kids to do sport. They take them out and do sport with them. Having said that, there are still kids in the classes that are overweight.*
>
> Debbie HP Primary
>
> *Often a lot of those young people aren't put into sports clubs and stuff like that because they haven't got the money.*
>
> Kathy HP Primary

School is the place where opportunities exist for all children to be involved in physical and sporting activities. It is a separate space from the home and, as Kathy states above, some children may not participate in sporting activities outside of school because their families don't have the financial means – their choices are limited by their socioeconomic status. So by promoting physical activity, schools offer some children opportunities that they may not have had otherwise. But as Debbie also recognises, this opportunity can only have so much influence: it doesn't necessarily change the fact that a child may be overweight. The influence of diet and physical activity outside of the school setting can be the more predominant contributing factor.

There is significant power that can be afforded to a space in regulating behaviour (Danaher et al., 2000). While the education environment is one that is very regulated and structured, it has only limited influence on what happens outside of the school gates where the power to make decisions shifts back to the individual and the family. The influence and power of a space is emphasised in Kathy's quote below.

> *Schools try their best by having policies that you're not allowed chips and fizzy and stuff like that at school. Like primary schools, yeah, and they do try but by the time you get to high school and you've got two bakeries and dairy across the road and a takeaway across the road from the high school, making good money.*

Kathy HP Primary

Kathy suggests that policies around food can have some success within the space that is controlled by the school, especially in the primary school environment where the surveillance and regulation of children is arguably easier than in secondary schools. Once children move on to high school their level of independence increases. They control food choices and these choices are influenced by the proximity of the now accessible consumer marketplace. Kathy implies that these food venues enjoy a steady patronage from high school students. So while the education system is an agent of the State which can have some influence around food and exercise within the boundaries of the school gates, beyond those gates, individual responsibility takes over in the self-regulation of body size.

John talked about "health literacy," which refers to accessing, understanding and using information to make health decisions (Pearson & Saunders, 2009). A person who is health literate is able to think about and make decisions relating to aspects of their health (Deal, Deal, & Hudson, 2010). The drive for health literacy targets children in the school setting. The aim of this long term strategy is to ensure children understand how different choices and behaviours impact on their health. John uses food as an example of where changes can be made. Once again, he identifies the school environment as being a place to influence changes in behaviour that are difficult to address outside of this setting.

> *So what you want is Joe public to be reasonably literate about health issues, which means not about being able to read and write to a particular level, it's to have an adequate understanding of things that affect your health…so the kind of school garden project sort of things. It seems like that's potentially one little thing that helps. So that increases the healthy food literacy amongst those kids. It's done in a setting with a whole bunch of kids. In a school setting, you can access a big chunk of the child population through that means. That's the kind of level I think that is going to make any long term affect.*

John HP Secondary

The desire for individuals to be 'health literate' and have an understanding of what health means and how they can be more healthy themselves is another example of the influence of neoliberalism. As John states, within the school setting there is the ability to access large numbers of children and expose them to experiences and life skills which they may not have encountered previously, such as growing a garden. There is the hope

that once they have had this experience it will be transferable to other settings. The aim is to create positive change by educating the child to take responsibility for making the 'right' lifestyle choices in the future. Schools can do this without having to directly engage the parents. The result is that the children are empowered to be able to make changes within their own lives. As discussed in Chapter Two, Foucault stated that power is intrinsically linked with knowledge. By equipping children with knowledge, they are in a position to exercise power within their home environments even if it is just the power of suggestion. John also mentions that education for the purpose of achieving health literacy is done with a "*whole bunch of kids*"; it doesn't specifically single out those children who are overweight or obese.

6.2.2 Is Public Health Responsible?

Public health is a role of the State in relation to making and implementing policies that promote health and result in healthy populations. Public health initiatives are a form of governmentality where the population is both the subject and object of the gaze of government. These initiatives are designed to have a disciplinary effect at an individual level that benefits the population as a whole. Another way to describe this is using Foucault's term 'biopolitics' which refers to the way in which public health policies are developed as a way of keeping individuals fit and healthy and therefore able to contribute to society in a positive useful way (Danaher et al., 2000).

As previously discussed in Chapter Three, an example of a public health initiative was the *HEHA* plan, a Ministry of Health initiative from 2004-2010 (Ministry of Health, 2004a). Its aim was to improve health outcomes at a population level through education and change at an individual level. Under the current National-led government the initiative has been discontinued, reflecting the adoption of a more neoliberal perspective (Roper, 2011).

In this next excerpt, Debbie suggests that child and youth obesity is indeed a public health issue:

> *I think obesity is more of a public health issue, it's got to be a general policy thing; it's like taking GST off fruit and veges.*
>
> Debbie HP Primary

Debbie gives an example of a potential government policy that would benefit public health promotion in relation to overweight and obesity: taking Goods and Services Tax

(GST) off fruit and vegetables, thereby making it more affordable for families to choose the healthy option when shopping. Kelly also expressed the view that removing GST from fruit and vegetables could be a way of making these food groups more accessible to those who need them most.

> *We've got the elections at the moment and they're talking about taking GST off vegetables and fruit so that is going to make it more accessible for the people, the low income families that often have obesity as an issue.*
>
> Kelly

At the time of interviewing Kelly, the differing political parties vying for power were announcing their proposed policies. The Labour Party, whose policies traditionally have a softer neoliberal approach than the National Party (Roper, 2011) proposed taking GST off fruit and vegetables. Kelly draws on the socioeconomic discourse to identify that it is often low income families who are overweight or obese (as discussed in Chapter Five), so this kind of public health initiative could help make healthy food groups more accessible to those who are constrained by their socioeconomic situation. As a health professional who works in a low socioeconomic community Kelly could see that this initiative could be beneficial to the families with whom she works. Such a policy would promote healthy eating as a way of achieving an improved health status within poorer communities and the State would be seen to be acting in the best interests of these population groups. However, as with the *HEHA* plan described above, such an approach is not in line with the neoliberal perspective of the National Party, who regained power in the 2011 election, and Labour's proposed initiative to reduce GST on fruit and vegetables has not come to fruition.

Kathy was also adamant that overweight and obesity is a public health issue:

> *It's a public health issue, yeah definitely, because it has to be addressed in that area. People are out there; in the hospital it's too late by the time you've got the complications.*
>
> Kathy HP Primary

Foucault (1977) talks about the "art of distribution" (p. 141) in relation to the spaces in which disciplinary actions can take place. Kathy is suggesting that overweight and obesity needs to be addressed in the public health space, in other words out in the community. It is in this space that the population can be accessed, placed under a level of surveillance and in which disciplinary actions can take place.

Kathy indicated that once there are complications from obesity and the individual has moved into the hospital environment as a result, the underlying causes couldn't be fixed. She is linking obesity to ill health – "it's too late". This suggests a sense of hopelessness; the individual is now 'diseased', and obesity has become superseded by the complications. This view contradicts the medical discourse (discussed in Chapter Four) that has medicalised obesity as a disease: Kathy is saying that responsibility for addressing overweight and obesity does not sit within the hospital setting but, in fact is a societal problem, and responsibility for addressing it lies in the public health setting.

Sue, who works with Māori children and families, specifically within the community setting, refers to the potential for solutions to be developed based on alternative discourses being considered in a complementary, rather than a competitive, light. She verbalised her view of a shared responsibility between the State and the individual at a whānau level.

> *Within your whānau, it's our individual responsibility isn't it and also a collective responsibility and in terms of local body or government responsibility to make it easier for people to do something about it and I think in Waitakere there's all sorts of things that are available, for example, The Green Prescription.*
>
> Sue HP Primary

This is an effect of biopower by way of the public health discourse. If the State puts resources in place that are easily accessible, then individual families are equipped to take on the responsibility to make use of them. Sue gives the example of the "Green Prescription," a Ministry of Health initiative that is available nationwide to support individuals and families to get active and as a result lose weight and improve their health outcomes (Ministry of Health, 2012c). While it relies on individual families ultimately taking responsibility for their own wellbeing, a public health initiative is the catalyst for this to occur. It indicates recognition by the government that, even within a framework of neoliberal governmentality, there is a role for the State to provide guidance, if not regulation.

6.3 Is the Individual Responsible?

Children are vulnerable, dependent and impressionable (Purcell, 2010). As a result, they rely on their parents to make choices on their behalf. There is an onus on parents to take responsibility for the promotion of their child's health and well-being. Accordingly the focus of this section is not on the individual responsibility of the child but on that of the parent or caregiver.

As will be clear from the preceding discussion, the notion of individual responsibility is a key element of neoliberal discourse and is a recurring discourse in considering the causes of, and responsibility for, addressing overweight and obesity. Kathy was very 'black and white' about assigning responsibility for overweight and obesity. She referred to Pacific young people as having "*huge obesity issues*" but when asked whether she thought culture makes a difference, she went on to say:

> *No, if you're overweight you're overweight….when I do home visits and I look at the mother and father I think well, the whole family has to change*
>
> Kathy HP Primary

Kathy implies with this statement that the responsibility lies firmly with the individual, irrespective of factors such as culture or socioeconomic status. Although Kathy makes this judgement about the body based purely on its visibility and potential health status from a position influenced by the medical discourse, she is, as well, drawing on the neoliberal discourse which places the individual as responsible.

In contrast, in this next excerpt, Karen identifies that a tension exists between the neoliberal discourse of individual responsibility and those which recognise a societal influence.

> *It makes me really think its [overweight and obesity] a societal thing, because I mean part of it is individual choices but part of it is going to be a lot of those society influences that are very difficult at an individual level to change.*
>
> Karen HP Secondary

Societal influences are wide-ranging, including factors such as the obesogenic environment (from the number and location of supermarkets and a built environment that is not conducive to outdoor play (Tyler & Horner, 2008)) and the cultural makeup

of a community (Discussed in Chapter Five). These factors influence a family's ability to make what are deemed 'healthy choices'. Families are also constrained in their choices by their financial means (Hofferth & Curtin, 2005) or as John referred to in Chapter Five, by 'financial freedom' in order to have a choice. The socioeconomic discourse sees individual responsibility as being constrained by other influences.

In this next excerpt Meg suggests that individual responsibility also involves other parties assuming their share of the overall responsibility. This starts with the government providing the necessary resources to enable health professionals to be in a position to help families with the changes that they need to make at an individual level. There are some similarities here with Sue's comments on the role of public health, discussed above.

> *It's the government's responsibility to put the resources there so that we can support them and give them information. When it comes to the young person it's theirs and their family's responsibility to try and change, you know? It's our responsibility to give information and support them to create change and it's the family's responsibility to do that.*
>
> Meg HP Primary

The family becomes the subject of Meg's gaze as she positions herself as a health professional with both the power and the responsibility for offering information and help, while recognising that ultimately it is the family who must take responsibility for acting on her advice. At the same time, Meg places the family under a level of surveillance. This surveillance is in the form of ensuring that they have the information and support that they need to be able to make changes in their lifestyle that will lead to a decrease in the weight of the child or young person. She is inadvertently instigating a form of discipline that Foucault (1977) described as a 'specific technique of power that regards individuals both as objects and as instruments of its exercise' (p. 170).

In the next two excerpts both Debbie and Meg compare overweight and obesity with smoking in relation to where blame and responsibility lies. It is interesting that these health professionals referred to smoking when talking about overweight and obesity: both are viewed as high profile potential risks to the health status of populations. And their profile is one that is influenced as a result of biopower, previously discussed in

Chapters Two and Three (Danaher et al., 2000). Meg framed overweight and obesity as a personal failure and an individual's responsibility.

> *It's become one of those things within the culture of health care. You know that you shouldn't smoke, you shouldn't be obese.*
>
> Meg HP Primary

Smoking has become something that is considered socially unacceptable as a result of strong campaigning, resources and intervention from a government level. There is an accepted discourse around "you know you shouldn't smoke – it's bad for you". This same analogy has been applied to obesity by Meg: - individuals should know that they shouldn't be obese. However there is a significant difference between the two. For example, food is essential to life whereas smoking is not. Smoking can be 'invisible': unless a person is seen smoking or carries the odour of tobacco smoke, others cannot tell whether they smoke or not. Smoking is therefore something separate from the body, unlike overweight and obesity which are clearly visible: the individual is unable to separate themselves from their body.

Meg used the expression "*within the culture of health care*" suggesting that in her particular case, the discourse of individual responsibility reflects the fact that she is positioned in the health care setting. It is Meg's position as a health professional that gives her particular knowledge of the negative sides of smoking and obesity. Because she has this knowledge, she believes it is the individual who must take responsibility to avoid these outcomes. Debbie provides a contrasting view below.

> *With smoking you can blame the cigarettes or you can blame whoever got you started on them, or …..I will quit one day, but if you're overweight it's kind of like oh….*
>
> Debbie HP Primary

For Debbie there is a distinction between an individual's responsibility for smoking or not and for being overweight or obese. In relation to smoking blame can be placed on the cigarettes themselves (or rather their addictive quality) or even on the person who introduced the individual to the smoking habit. In contrast, she suggests that an individual who is overweight or obese has only themselves to blame. This individual responsibility with respect to obesity is further emphasised by its visibility. While a

packet of cigarettes can be put away out of sight, an obese person can't "quit" eating or hide their body. The body is an intrinsic visual representation of the obese individual. There is a discourse that individuals who are overweight or obese reach this condition by simply eating too much and so they are individually responsible. In the case of children, this responsibility or blame is passed on to those who are responsible for the children's care.

6.4 We Can't be Responsible!

As discussed in Chapter Four, overweight and obesity has increasingly become medicalised both by the medical profession and also through societal processes which label the overweight or obese as 'sick' or diseased and therefore in need of medical intervention. Framing obesity as a disease implies that there is a cure. It is also a way of creating a binary: those who are overweight or obese are therefore 'sick or diseased' and those who are thin are therefore 'healthy'. Despite this medicalisation of overweight and obesity, on the whole those health professionals who were interviewed in this study did not think that the health setting is the right space in which to address overweight and obesity.

> *No (*it's not a health problem) *because by the time it gets to be a health issue, you've almost missed the boat, you kind of need to get in before it happens*.
>
> Debbie HP Primary

Despite overweight and obesity being constructed as a health problem, Debbie is suggesting that it not a problem that can be dealt with effectively in the health setting, which in this context refers to both the community and the hospital. Rather it is the consequences of overweight and obesity that constitute it being a health problem rather than the child or young person being overweight or obese. Debbie uses the phrase '*you've almost missed the boat,*' inferring that it is too late to address the weight issue by the time a child or young person is seen by a health professional. Here Debbie has drawn a line between health and society and firmly places the responsibility for addressing overweight and obesity within the latter space.

Health professionals' perceptions and views and the way they 'speak' are influenced by the space in which they have work. Foucault described this as the influence of space on speaking positions and that spaces can either enable or disable certain roles (Danaher et

al., 2000). The hospital space, which operates within the discursive frame of a diseased - based model of health care (Foucault, 1973), mandates certain ways of speaking. It is from this space that John expresses the view that overweight and obesity are not primarily a health problem:

> *I mean it [overweight and obesity] has a few health affects but I don't think it is primarily a health problem, if you're talking about something that affects 20 or 30% of the population that's outside of health, that's a society problem.*
>
> John HP Secondary

John suggests that overweight and obesity are social problems. It is within society that these problems need to be addressed. While he does acknowledge that there are health effects, he sees these as secondary consequences of being overweight and obese. For children these consequential conditions include disorders such as cardiovascular disease, musculoskeletal disorders and type two diabetes (Ebbeling, Pawlak, & Ludwig, 2002; World Health Organisation, 2012a). In dealing with these consequences, the health professional is only dealing with the here and now aspects of overweight and obesity. From this setting, John considers he does not have any control over the contributing factors that led to the child or young person becoming overweight or obese in the first place.

This discourse that health is not responsible for (early) intervention contradicts the construction of overweight and obesity as a health problem, not just by society but also by the medical profession themselves. As Evans et al (2008) state, overweight and obesity has become strongly medicalised and in this context it is constructed as a physical abnormality that requires medical intervention. It has been labelled as a disease (World Health Organisation, 2011) which suggests it also requires diagnosis, intervention and cure, all of which sit within the medical discourse.

In this next excerpt, Debbie recognises that health is only dealing with the consequences of overweight and obesity once these have become manifested as a 'problem'.

> *Also the other thing is I don't know if there is any consistency or idea for what level you say something. At what level you need to step in. We tend to wait till it's really obvious….we tend to just ignore it until it is a problem.*
>
> Debbie HP Primary

Debbie is suggesting that the health profession doesn't see the need to intervene until the medical consequences of the condition are evident. The 'condition' of being overweight therefore can essentially be ignored. It is the visual representation of the "really obvious" obese body that is the influencing factor for this health professional 'stepping in,' by which time there are potentially also health consequences. Foucault (1972) wrote about the way that objects emerge. In this case, overweight and obesity appear to emerge only when a condition that is an effect of being overweight or obese is identified and then pathologised leading to treatment and possible cure. Only then does it become the object of the health professional's gaze, but as a predisposition to disease rather than a disease itself.

This suggests a limit on the power of the neoliberal public health discourse where overweight and obesity are viewed as an individual's responsibility up until they are having some consequential effect on the child or young person's health. This is a by-product of biopower. Control is not concerned with the individual body but control of the population as a whole (B. Evans & Colls, 2009). When this is combined with biopolitics, which Foucault describes as the disciplinary techniques which control and discipline individual bodies, there is the ability to control bodies not only at population level but also at the individual level (B. Evans & Colls, 2009).

The overweight or obese child is the responsibility of their parents. It is only when the child's body is perceived as overweight, and deemed a problem, that the health professional is implicitly permitted to "step in". This health professional is influenced both by the space in which she works and by the strength of biopolitics and the public health discourse – which, all suggest individual responsibility for weight.

Another issue, identified by Debbie, is the fact that obesity has only recently been referred to as a 'disease' in its own right. As noted in Chapter Four, it is this medicalisation that constructs obesity as the responsibility of the health profession. However competing discourses indicate that the health sector is not able to take responsibility for overweight and obesity, it is already busy dealing with the consequences of.it.

> *This is kind of a new problem and everyone is kind of going, "Well I'm already busy doing this and I'm already busy doing that." No one wants to kind of own it.*
>
> Debbie HP Primary

While this lack of ownership (by health professionals) appears to primarily reflect resourcing issues, I suggest that it could also indicate the influence of the neoliberal public health discourse. As Debbie said, health professionals are too busy, which arguably puts responsibility for addressing overweight and obesity back on the individual. Overweight and obesity are constructed as health risks that are a consequence of lifestyle choices. As Lupton, (1995) states, individuals are encouraged by health promotion to evaluate their own risk of disease and to then modify their lifestyle choices accordingly.

Karen compares the management of eczema with the management of overweight and obesity and infers that individuals can be encouraged with some education from a health professional to manage eczema with success; however the same is not true when managing weight.

> *Eczema, that doesn't necessarily need a physician to manage it, it just needs patient education and once again that's quite a good example where there's a lot of personal factors that the person can change, but there's probably very good hand-outs for Eczema. There's also very good evidence that you do this and you will get better. Whereas around obesity there is not that same kind of we give a patient hand-out on improving diet, increasing physical activity, lifestyle changes – their weight will go down. So it's probably very hard to engage people in taking that time to do it.*
>
> Karen HP Secondary

Dealing with chronic health problems requires individuals to comply with the treatment suggested to them. While an information booklet provides guidance, individuals must take the ultimate responsibility for themselves in order for the treatment to be successful. Karen verbalised that there was good evidence with respect to eczema treatment that "you do this and you will get better," leading to high rates of compliance. From the health professional's perspective eczema is a disease that can be 'managed' and individuals are able to do this 'managing' themselves. Karen is suggesting that a physician needs to manage the treatment of overweight and obesity, but she also recognises that the level of management required makes this unlikely to happen.

When Kelly, who works as a nurse in the primary care environment, was asked who she thought was responsible for addressing overweight and obesity in children she answered that it was one of shared responsibility across different providers and the family.

> *I think to be honest; I think it's anyone that's involved with that child. I think a school has some responsibility, I think their GP has some responsibility and the Public Health nurse if she's aware of it, I think the family has some responsibility. I mean some families will take the responsibility seriously and work with their child or whatever, but I do think that in any given situation the more people that try to support that family in any way they can, the more likely they are to have success.*
>
> Kelly HP Primary

Kelly makes the point that the more services that are wrapped around the family the more likely that there is going to be success. With this approach of shared responsibility it makes it possible for health professionals to make a difference as they are not held to be solely responsible for the outcomes. However, the success of any collaboration does rely on communication between the services involved. From the family's perspective, there is more chance of success because it removes the totality of individual responsibility from them.

This view does, however, contrast with the discursive notion of the neoliberal public health discourse which promotes individual responsibility by way of self-regulation. It also goes against the medical construction that overweight and obesity is a problem of health and it is often only once medical advice has been given or sought that overweight and obesity becomes visible. Lupton (1994) stated that when care is shared between patients and the medical profession it is usually because a problem does not have a solely medical solution. This is true for overweight and obesity in children: it is multi-layered and complex with many contributing factors. Kelly's comment highlights the significance of the spaces in which each of the health professionals are working. In the primary health care setting there is an approach that is seen as more holistic and long term that enables the 'wrapping around of services' for families.

6.5 Where Are The Resources?

Despite an evident growing concern around child obesity and the impacts that this may have on the health system in the future, the health professionals interviewed felt that

there are a lack of services available to help health professionals address the issue within their respective working environments. This is despite the increasing attention that overweight and obesity receives from the media, national governments and also from international health agencies such as the World Health Organization (World Health Organisation, 2003).

Karen verbalised the tensions and frustrations that exist when a child is identified as overweight or obese. There is little that can be done with that information - there is no referral pathway within the hospital environment.

> *Yeah but then if you are going to identify and you've got no intervention, what is the point of identifying? Like it's very hard to identify someone, realize and then have nothing to do, it would be much easier to convince the clinic nurse that we need to identify all these children in clinic because there was something that we were going to do about it. If we're not going to do anything about it, it's very easy for them to ask what's the point?*
>
> Karen HP Secondary

There are competing discourses at play here. There is the public health discourse, which describes overweight and obesity in alarmist terms such as 'epidemic' and 'global crisis' competing with the medical discourse that indicates a formal assessment is futile because of a lack of resources. Karen identifies the lack of a referral pathway in the hospital setting. I suggest that this arises from hospitals being spaces that intervene with 'here and now' medical and surgical problems. It infers that overweight or obesity is not an acute problem and therefore a hospital is not the place to provide services for addressing it. Hospital referral services are targeted at intervention rather than prevention. This is yet another barrier for health professionals addressing overweight and obesity. It illustrates that in the hospital setting, medicine is more reactive than proactive.

Karen also talked about how frustration at the lack of resources extends to situations in which a family is trying to be proactive, having identified a need themselves.

> *It's very hard because there's no one to refer to if they are interested. If they say yes, we've realized our diet is not very good and yeah as a family we are not very active, it's very difficult to take it that next step and go, "That's great. You've identified that you'd like to make change. Go see……" Well then the flip side is that there is no one…..*

Karen HP Secondary

In this next excerpt, Karen recognises the value of referral pathways for conditions such as diabetes and asthma.

> *You know diabetes – there would be a diabetes team, so you identify and refer; asthma you identify and refer, you identify it, hand out asthma education.*
>
> Karen HP Secondary

Where there is a specialist team to which a patient can be referred, then it makes identification of a condition more relevant. There is an established team of people who will take on the responsibility of dealing with the condition. When there is no referral pathway, the health professional who identifies that a child is overweight or obese has to also take responsibility for the next step: intervention. This may not be easy in the clinic setting of a hospital environment.

The need for referral reflects the fact that there are specialty practise areas within the hospital setting. Health professionals don't tend to be generalists, but rather they operate within boundary lines drawn by specialty. As a result there is a culture of referral to those who are the experts in the particular area. A lot of doctors in the hospital setting do not consider overweight and obesity to be within their scope of expertise. Their expertise lies with the medical consequences of overweight.

John and Debbie both expressed concern at the lack of specialist referral pathway in Auckland:

> *There's no service in Auckland, no service I'm aware of anyway. So no I wouldn't normally refer on…I sometimes have offered our dietetic service for advice. I don't kind of push it too much because they are a limited resource and if they were spending all their time giving advice to overweight children that's all they would spend their time doing.*
>
> John HP Secondary

> *If we tried to refer every child we saw who was overweight to like a dietician for proper longer appointment time, more discussion around it, there just isn't that service available. There isn't a public dietician who is prepared to just sit and talk to all these families.*
>
> Debbie HP Primary

While John, in the secondary setting, identifies a potential point of referral he suggests that these 'specialists' are a limited resource. This statement implies that these specialists would be quickly overwhelmed by the sheer number of referrals, which could easily become their entire workload. Debbie, in general practise, concurs with John and refers to the way in which the numbers involved are the constraint to referral on to a dietician.

Kelly acknowledged that she had to be "innovative" in the way that she advised changes could be made to food choices because of the lack of access she had to a specialist service.

> *We actually don't have access to what you might call a dietician or nutritionist. So we have to be innovative about how we go about the food changes.*
>
> Kelly HP Primary

Kelly saw that implementing changes to families' food choices was part of her role as a public health nurse in the primary care setting, but only because of the lack of a specialist service available to families. As a nurse in this setting, she is accustomed to being more of a generalist. She isn't constrained by the rules and regulations which dictate what can and cannot take place in the hospital setting. Her role allows her to be more autonomous and independent in her interactions and decision making with families.

John made reference to the hospital setting not being equipped to deal with the sheer numbers of individuals who are now overweight and obese - there are simply too many.

> *I mean if you just take the numbers involved, it's not something that is going to be able to be dealt with in secondary care [hospital] health settings.*
>
> John HP Secondary

Foucault said that different spaces allowed different activities to take place. The hospital space is one that deals with disease and illness and rules and regulations about what can take place within its walls (Foucault, 1972). Despite the recognition that obesity is a major risk factor for a variety of chronic diseases (World Health Organisation, 2012b), John expressed the view that it [overweight and obesity] was not something that could

be dealt with in the secondary care setting, because of the immense size of the problem. Foucault (1980) talked about the hospital as needing to be an effective place of therapeutic action and that it "must function as a curing machine" (p. 180). Perhaps John is alluding to the barriers to 'curing' overweight and obesity which dictate that it shouldn't be dealt with in this setting.

John referred to the numbers again in reference to general practitioners, suggesting that difficulties with addressing overweight and obesity in children is not only limited to those within the hospital setting.

> *I'm sure GPs are in the same boat as the rest of us and just think if I just refer this kid I'd be referring how many?*
>
> John HP Secondary

By using the idiom "*in the same boat*" John suggests health professionals are all in it together – facing the same issues with regard to the numbers of children who may require intervention with their weight. This phrase is often used to describe being in a situation with other people in the same predicament and can portray an image of being in a slightly precarious or overloaded and unstable situation. While the medical discourse emphasises the role of the health professional as an expert who can identify problems and solutions, there is an air of defeatism in John's language. It suggests that health professionals are overwhelmed by the problem and this contributes to the sense of being unable to deal with it. Overweight and obesity is to an extent hidden by the sheer numbers involved, which in itself is a paradox.

This final excerpt from John summarizes the overall feelings of the health professionals interviewed who all feel it is too hard to do anything, that they are constrained by the setting in which they work, by their need to refer these children on to specialists who are not available and the general lack of time available to them.

> *Personally most of the time it's in the too hard basket to be briefly honest. Nobody likes to kind of admit that but I think that's fair comment. There's a lot of barriers to raising it, doing anything about it, all of that.*
>
> John HP Secondary

6.6 Summary

This chapter has described the findings about whom health professionals consider are the persons responsible for dealing with overweight and obesity. These findings illustrate the intersection of the medical and social, cultural and socioeconomic discourses described in Chapters Four and Five. Foucault's notion of governmentality or neoliberalism seems to prevail, placing the responsibility for addressing overweight and obesity primarily on the shoulders of the individual.

However, several of the health professionals interviewed thought that the State also has a role to play in dealing with overweight and obesity, specifically through schools and public health. Schools are a space in which teachers can exercise surveillance and discipline, through monitoring and regulating the food that children may consume. However, the role of schools was seen to be constrained by, in Foucauldian terms, the influence of space. Outside the school gates, overweight and obesity remain the responsibility of the individual. In discussing the role of public health, some health professionals reflected on the influence that the socioeconomic discourse has: public health was seen as a way of dealing with the influence of poverty on overweight and obesity.

The health professionals interviewed also recognised that, as part of a collective responsibility, they have an enabling role to help families address overweight and obesity in children. However, in general, the focus of this responsibility lies around dealing with the health consequences of overweight and obesity, rather than the conditions themselves or the causes of these conditions.

One of the reasons for this focus on the health consequences is that health professionals feel their ability to address overweight and obesity is hampered by a lack of specialist referral services. There is recognition by health professionals that referral services (in general) are reactive rather than proactive: they respond to health problems rather than prevent them happening. Some interviewees also commented on the probability that, if appropriate referral services did exist, they would be quickly overwhelmed. A further barrier is the inability to demonstrate to families that solutions are achievable. One interviewee also identified the lack of ownership of the problem as yet another key barrier to addressing overweight and obesity in children.

Chapter Seven: Discussion and Recommendations

7.1 Introduction

The aim of this research has been to explore through Foucauldian discourse analysis how health professionals in both the primary and secondary health care settings address child overweight and obesity. Discourse analysis enables the researcher to uncover the discourses which are dominant but also to explore ones that lie hidden. Using this methodology I have identified four key discourses. The dominant one is the medical discourse, which constructs overweight and obesity as a potential risk for medical conditions. It is this discourse that health professionals draw from first as it guides their right to intervene in matters that pertain to health. The subsequent discourses identified, are social, socioeconomic and cultural ethnicity discourses, and all sit outside of the realm of health but influence the ability of health professionals to intervene in addressing overweight and obesity in children.

This chapter examines the key findings of this research in the context of Foucauldian philosophy and the established literature on discourses associated with overweight and obesity in children. I will discuss the implications of the study and propose a way of conceptualising the different roles of the health professions and others in addressing overweight and obesity. Finally, I will outline the limitations of this study and identify areas for further research.

7.2 The Difficulty for Health Professionals

7.2.1 Overweight and Obesity are a Medical Problem

There is an evident complexity for health professionals in addressing child and young person overweight and obesity that results from the intersection of the dominant discourses. As discussed in Chapter Three, medicine has embraced overweight and obesity as conditions that require diagnosis and intervention (Powers, 2001). This is not unique to these conditions: reflecting on the rise of medicine as a dominant feature of modern society, Foucault (2004) said "… whenever we want to refer to a realm outside medicine we find that it has already been medicalised" (p. 14).

Foucault characterised the exercise of power by the modern State as 'biopower'. According to Greco (2009), "Biopower is premised on the recognition that life, the life

of individual bodies and the life of populations, is a fundamental political resource in a modern context increasingly characterised by inter-state competition"(p. 16). In other words, it is in the interest of the State to look after the health and well-being of its population. One of the characteristics associated with the rise of biopower is the emergence of clinical medicine as a means of achieving the goals of improved health and well-being of the population (Greco, 2009). It is this context that has led to the widespread medicalisation of deviations from the 'norm' in relation to the body. As discussed in Chapter Three medicalisation of a condition is the process by which non-medical problems become defined and treated within a medical framework, usually in terms of illnesses which require both identification and intervention. This process can be influenced by socially constructed subjective and value-laden considerations (Jeffrey & Kitto, 2006).

A key construct of the dominant medical discourse is the right to intervene. The medicalisation of overweight and obesity essentially gives the health professional the right to intervene as the body comes under the medico-scientific gaze (B. Evans et al., 2008; Foucault, 1973; Lupton, 1994). The health professionals interviewed recognised that intervention happens once the child is overweight or obese, not prior to these conditions occurring. The reactive nature of intervention is consistent with the premise that medicine, especially in the secondary health care setting, generally responds to health conditions that already exist.

However, obesity is not only a medical condition; it is socially and culturally constructed in varying ways by society and by individual groups within society. This research found that it was difficult to analyse the dominant discourses in isolation. All four discourses contribute to and essentially problematise the health professional's ability to intervene.

7.2.2 Barriers to Intervention

Despite the medicalisation of overweight and obesity there are still numerous barriers standing in the way of health professionals effectively addressing the issue. The nature of these barriers reflects both the setting within which the health professional practises and also the health professional's own beliefs and values, which are in turn influenced

by the society in which they live. That is, the barriers are a consequence of the influence of a set of other social, cultural, ethnicity and socioeconomic discourses.

Barriers Arising from the Social Discourse

This research found that even though overweight and obesity are medical terms which describe someone who fits within a certain parameter according to the BMI, health professionals are loath to use these terms because of stigma and offence that often attaches. Use of the medical terminology essentially creates two dividing practises: the medical discourse classifies individuals as being either overweight or obese, or not; but the social discourse alludes to fat, lazy, and irresponsible or the thin, fit and healthy respectively.

As a result of its medicalisation, health practitioners are faced with addressing overweight and obesity in children, yet the need to maintain a relationship with individuals and their families can often prevent use of the terminology of overweight or obese. Cohen et al., (2005) discuss how the use of the word obesity places blame on an individual's shoulders without taking into account other contributing factors such as socioeconomic issues that influence how individuals are able to live their lives. They suggest that use of the word obesity does not improve health outcomes for individuals but instead can cause mental health problems because of the prejudice and the stigma that comes with that label.

As argued in Chapter Five, the stigma that is attached to the physicality of the overweight or obese body has a silencing effect on the health professionals' ability to talk about overweight and obesity. This silencing effect emerged as a result of the need to be polite. Hill, Ide, Ikuta, Kawasaki, and Ogino (1986) described politeness as "one of the constraints on human interaction whose purpose is to consider others' feelings, establish levels of mutual comfort, and promote rapport" (p. 349). Health professionals become trapped between wanting to name overweight and obesity and the consequences of doing so. This is an example of the how the dominant medical discourse is influenced by the social discourse, which comes into play in the health setting.

However, other research has found that the health professional's use of the terms overweight and obesity can be separated from their socially constructed negative connotations, in contrast to when this language is used by lay people or friends. Some of

the participants in a study undertaken by Grey et al., (2011) stated that because they trusted the health professional's knowledge, expertise and authority there was medical justification in them using the terms overweight and obese. Therefore, in contrast to the constraint of politeness, the status that health professionals hold within society can mean that the medical language used to describe weight provides opportunity for discussion. The use of BMI charts is one example of how health professionals attempt to communicate overweight and obesity in non-judgemental medical terms. This keeps overweight and obesity within the medical discourse and can be seen as a way of negotiating past the stigmatism.

Barriers Arising from Cultural and Ethnicity Discourses

It also emerged that health professionals face difficulties in engagement arising from the cultural / ethnicity discourse. The practitioner is positioned as an outsider with families from Māori and Pacific cultures when they are not from that culture. This 'outsider' discourse emerged during the New Zealand health reforms of the 1990s when the opportunity for the development of formalised Māori healthcare providers came about because of a recognition that Māori were best cared for by providers from within their own culture (L Ellison-Loschmann & Pearce, 2005). These reforms reflected evidence of less favourable health outcomes for Māori (L Ellison-Loschmann & Pearce, 2005) highlighting the importance of having culturally appropriate health providers. Similar needs have been identified for peoples of Pacific origins (Ministry of Health, 2001).

Another barrier that arises from the overlap between the cultural and ethnicity discourses is the perception by both communities and health professionals that large body size is normal. This desensitisation or 'normalisation' is based on: disproportionate representation of overweight and obesity among Māori and Pacific people; the traditional valuing of the large body size by Pacific cultures; the stereotyping of poor food choice; and the large body size as an ethnically determined norm (Dewes, 2012; Goulding et al., 2007; Ministry of Health 2001; Wright & Hornblow, 2008). This desensitisation to overweight and obesity is further influenced by the wider social construction of the large body size as normal in the face of its increasing incidence among the population as a whole, as discussed in Chapter Four.

A result of this desensitisation is that in some cultural or ethnic sectors of society overweight and obesity may not be identified as a problem. This is in contrast to

western cultures, where bodies that don't conform to the lean, fit and healthy ideal are labelled as deviant and out of control (Lupton, 1994). In western cultures the variations that exist in hair colour or height are accepted as normal diversity in populations, whereas being overweight or obese is a variation in body size that is defined as a problem that requires intervention (Carryer & Penny, 2008).

A consequence of the large body size being seen as 'normal' or 'not a problem' in relation to those of Pacific ethnic backgrounds is that there is the potential for health professionals to initially overlook or give more 'leeway' to these children. The health professionals interviewed for this research indicated that there is a level of acceptance of overweight and or obesity from within the health profession as well as from within these cultures themselves.

However, of the various discourses that lead to this acceptance, there is some evidence that the 'big is beautiful' discourse has become less of an influence (Tobias, Paul, & Li-Chia, 2006). This is the result of Pacific cultures increasingly taking on western values where the thin and fit body is seen to be a sign of not just health but of success (M. McCabe et al., 2010; M. P. McCabe, Ricciardelli, Waqa, Goundar, & Fotu, 2009). As stated in the Ministry of Health (2010) food and nutrition guidelines, perceptions of body size and beauty are changing in Pacific youth aged between 12-18 years. One in four Pacific youth identified themselves as being overweight and more than half were trying to lose weight (Ministry of Health, 2010). The potential effect of this shift in the influence of different cultural discourses is that overweight and obesity in Pacific communities will become more visible and, consequently, more easily be addressed.

Barriers Arising from the Socioeconomic Discourse

There is also a socioeconomic construction of the large body size as normal, which again can result in a lack of visibility and hence intervention by health professionals. In contrast to the emphasis of the prevailing neoliberal discourse on individual free choice, the socioeconomic discourse identifies economics as a root cause for overweight and obesity within communities (Utter et al., 2010). These two competing discourses therefore place responsibility and blame in different ways. The neoliberal discourse suggests that overweight and obesity are a result of poor individual choices, whereas the

socioeconomic discourse infers that financial circumstances limit choices that individuals are able to make in the first place (Kumanyika, 2008). The higher rates of overweight and obesity in poorer communities is evidence of the influence of socioeconomic status (Lee et al., 2009). As a consequence, barriers associated with the large body size as normal are likely to be greater for health professionals working in some communities than in others.

7.3 Assigning responsibility

7.3.1 State Versus the Individual

Another consequence of the intersection of discourses is that health professionals recognise that it is difficult to assign responsibility for addressing overweight and obesity in children. As discussed in Chapter Three and Chapter Four, overweight and obesity in children and the wider population has been presented as one of the big issues within society and health settings and is often described in terms of an 'epidemic' (Alpert, 2009; Boero, 2007; Monaghan, Hollands, & Pritchard, 2010; Sturm, 2008). As a result, there is an expectation from both society and the health professions that the government in power has a responsibility to implement policies to address overweight and obesity.

As described in Chapter Two, Foucault introduced the concept of biopower, under which it is in the interest of the State to look after the health and well-being of its population. How the State achieves that outcome can vary: on the one hand there is the concept of 'the Nanny State' which infers extensive control and intervention, and on the other there is the neoliberal perspective, whereby the State exercises biopower by assigning the responsibility for health to the individual (B. Evans & Colls, 2009).

The exercise of biopower by the modern New Zealand State is strongly influenced by neoliberalism and this is true with respect to the way overweight and obesity is addressed. There is an expectation that the government will take some responsibility in addressing overweight and obesity in children, however, society doesn't want to be told what to do. This is an effect of the success of neoliberalism, which not only creates an environment of competition between markets but offers freedom of choice and is also a way of shifting responsibility for 'care' back onto individuals (Guthman, 2009). The effect of individual choice by proxy becomes individual responsibility.

This tension between the role of the State and individual responsibility is illustrated by considering the role of schools and public health in addressing overweight and obesity in children. Schools are recognised as an apparatus of the State and are an ideal place for health promotion activities in relation to overweight and obesity to occur because they are the place where the child and young person spends most of their time outside of the home environment (Story, Nanney, & Schwartz, 2009). Schools are run by timetables, rules and regulations and they have the power to regulate and monitor what happens during school hours. It is a physical space in which Foucault's concept of biopower can flourish and surveillance and monitoring can occur with little effort (B. Evans et al., 2008).

However, the role of schools is constrained by the influence of spatial boundaries. Outside the school gates, overweight and obesity remain the responsibility of the individual, although the boundary between these two spaces is blurred. As discussed in Chapter Five, the influence of the non-school space has pushed into the school space, with parents objecting to schools setting policies around the types of food that may be brought to school. Conversely, actions such as developing health literacy within the school setting have the potential to make an impact on the home environment, thereby making children potential agents of change.

Public health and medicine interact and complement each other in promoting and maintaining health and wellbeing. There are obvious differences too: Public health responds to the population's health needs whereas focus of medical care is on the individual by way of diagnosis and treatment (Mann, 1997). When this differentiation between public health and medical care is defined it is easy to see why health professionals, reflecting a predominantly medical discourse, see the responsibility for preventing overweight and obesity in children sitting outside of the health care setting. From a neoliberal perspective, the role of public health is to enable families to take action rather than to impose interventions (Lupton, 1995). This suggests that the role of the State and the individual can be complementary, although ultimately, the responsibility for addressing overweight and obesity falls back on the individual.

7.3.2 Health Professionals and the Influence of Health Setting

While the preceding discussion has focused on the role of the State (through its agencies) and the individual in addressing childhood overweight and obesity, the fact that health professionals exercise their right to intervene shows that they do recognise some responsibility lies with them. From a Foucauldian perspective, health professionals can be seen as agents of the State and therefore have a role in the exercise of biopower (Greco, 2009).

However, this research found that there were varying levels of acceptance of responsibility among health professionals. This acceptance was influenced both by the health profession within which they practised and also their practise setting. As discussed in Chapter Six, Foucault talks about the influence of space; it allows certain discourses to be heard and certain actions to be taken. The level of responsibility accepted by health professionals and the way in which they fulfill their obligations varies significantly with health setting. These variations are discussed below.

Nurses in the Primary Care Environment – the Role of Generalists in the Community

Those practitioners who identified themselves as nurses and worked in the primary care setting tended to accept more responsibility than those practitioners in the secondary care setting. Health professionals working in the primary setting saw themselves as having mixed responsibilities. In their role as public health nurses they have responsibility to both prevent overweight and obesity and to address its health consequences.

The influence of the social, socioeconomic and cultural discourses has a significant impact in the primary practise setting. Most often children and their families weren't being seen in a clinic, but within their homes or school environments. I suggest that a practitioner is more likely to be influenced by cultural and socioeconomic factors when in the family home compared with the hospital or clinic setting. There is also a shift in the power relations when visiting families at home. While as a health professional they have power that is associated with their knowledge of disease processes, when crossing the threshold into the home the power shifts. The health professional's speaking position now comes from a place of tentativeness, as they are aware of the individual' s home as being a place of privacy and freedom of choice (Sye, 2008). This is also

corroborated by a study undertaken by Lindahl, Liden and Lindblad (2011) who found that while nurses felt empowered by their knowledge they also felt disempowered by the healthcare setting being the home.

Poulton and West (1993) described the true concept of primary healthcare as 'encompassing not only medical care but also health promotion and illness prevention strategies' (p. 918). This sits alongside the public health discourse and it was within this concept of care that these practitioners practise. They see that they have a role to play and that they have to be cognisant of the influences of the other competing discourses in order to undertake that role with any level of success (Edvardsson, Edvardsson, & Hornsten, 2009).

However, there was some difference in how that role was expressed. One of the primary care nurses didn't focus on weight at all but chose to concentrate on lifestyle changes. This suggests she was more influenced by the social, socioeconomic and cultural discourses rather than the medical discourse. This approach to addressing overweight and obesity has been found to have had success elsewhere. A quality of life study undertaken by Eriksson et al., (2010) found that education in lifestyle interventions from primary health care workers had a positive effect on the weight and mental health of those who were obese and at risk of cardiac disease.

Doctor in the Primary Care Environment

The practitioner who identified as a doctor working in the primary care setting also accepted more responsibility than those practitioners in the secondary care setting. However, unlike the primary health care nurses, this responsibility was primarily fulfilled by dealing with the health consequences of overweight and obesity. There was very little evidence that doctors in the primary setting have any involvement in the prevention of overweight and obesity.

This doctor was influenced less by the cultural and socioeconomic discourses compared with the social discourse and the need to be polite in order to maintain relationships with the families she saw, as discussed in Chapter Five. This finding is consistent with that reported by Walker et al, (2007) from a study that looked at primary care clinicians views when treating childhood obesity. These authors found that the sensitivity of bringing a child's weight status up with parents could potentially breakdown the

relationship and was one of the reasons why weight was not always discussed. The lesser influence of the cultural and socioeconomic discourses on the practise of this health professional could be explained by the fact that children and their families generally go and see the doctor in their clinic setting. I suggest that although these practitioners have on-going relationships with families, they are often not privy to all the circumstances that influence their patients' lives and are essentially responding to existing health conditions.

Doctors in the Secondary Care Environment

There was a different level of acceptance of responsibility expressed by those health practitioners working within the secondary healthcare setting. These doctors were only focused on addressing the health consequences that children presented with, reflecting a dominant influence of the medical discourse within the hospital setting. For these practitioners, the conditions of overweight and obesity themselves, rather than their health consequences, were seen to be a result of the competing discourses that sit outside of health. This is supported by Greener et al., (2010) who suggested that health professionals viewed overweight and obesity as a 'biological reaction to adverse social conditions' (p. 1047). As discussed in Chapter Four, in the secondary health setting the response to health needs is predominantly a reactive one.

Doctors, Irrespective of Setting

Doctors in both the primary and secondary health care settings felt constrained in their ability to fulfill their responsibilities by a lack of time and resources. This lack of support services and clinician time has also been reported by several other authors as a key barrier to addressing overweight and obesity in children (Bocquier et al., 2005; Story et al., 2002; Turner, Shield, & Salisbury, 2009).

There is a sense of futility which, while not absolving these practitioners from their responsibility, comes from their not having time to address overweight and obesity and there being a lack of specialists to refer the patients on to. There is a level of frustration for these practitioners: they are aware of the health consequences of overweight and obesity in children but are essentially not well equipped to address it effectively within their medical settings; they are the ambulance at the bottom of the cliff.

This notion of futility not only arises from the sense of being physically removed from the causes of overweight and obesity but also from the scale of the problem, i.e. the 'epidemic' or 'global crisis' referred to in Chapter Three and Chapter Four. These terms have been socially constructed as a way of describing the increasing rates of obesity and can be seen as a tool of governmentality: a way of sensationalising an issue and alerting the wider population. By referring to obesity as an epidemic or global crisis there is, in effect, an expectation of those individuals who are overweight or obese to self- regulate their own bodies as a way of controlling the crisis or 'epidemic'. Danaher, Shirato and Webb (2000) refer to this as an emergence of understanding by individuals, where they are encouraged to apply a process of self-governing and essentially become individually responsible. For children this is a difficult challenge. They are unable to respond as individuals and they rely on their parents or caregivers to respond on their behalf. Dealing with overweight and obesity at a population level, which is what the use of the term epidemic suggests is required, is out of the scope of practise of those professionals working within the secondary care setting as they are dealing with one family or one patient at a time. The health professional's reach of practise is ultimately limited by the setting in which they work.

Influence of setting: an example of assessment in different medical spaces

An example of the variation in practises undertaken depending on which setting health professionals work in is that of the formal measurement of children. In the primary care setting a more holistic approach to health is undertaken and involves showing the extent of a child's weight problem to families using a chart. Edvardsson et al.,(2009) described the charts as being a way of allowing nurses to be objective in helping parents to visualise their child's overweight and so raise weight issues with parents.

In contrast, in the secondary healthcare setting formal measurement is often not seen as a priority and there is a reliance on the 'eye' to determine a child's weight status. Often this is influenced by both lack of time in the clinic setting and the fact that obesity is not often the primary diagnosis (Chapter Four). Barlow, Bobra, Elliot, Brownson and Haire-Joshu (2007) found that paediatricians did not use BMI charts because they felt they could identify obesity visually. However a visual determination can be problematic because of competing demands or, for example because these children are now seen as fairly normal.

The secondary health setting is founded on either confining or re-establishing individuals to a state of health (Cheek, 2000). The child and family come under the intensity of the medical gaze when they enter the secondary healthcare setting allowing doctors to construct an account of what is going on inside the child and then to connect signs and symptoms with particular diseases (Powell & Biggs, 2000). However, because the health professional is invariably focusing on the other conditions that preempted the visit, there is the potential for overweight and obesity to go unnoticed. This means that the connections between the presenting conditions and overweight and obesity are not necessarily made.

7.4 Implications

7.4.1 The Spectrum of Responsibility

The previous sections have discussed the role and responsibilities of the State, the health professionals and the individual in addressing overweight and obesity in children. It is evident that the boundaries between these roles and responsibilities are not always well defined, reflecting the influence of contrasting discourses. This lack of definition has implications for a collective response to dealing with overweight and obesity. In order to intervene effectively, the parties involved– including health professionals – need to know where they fit in the big picture. They also need to know that those other parties understand and are effective in delivering the services that lie outside of the medical setting.

Drawing on Foucault's notions, I would argue that one way of understanding the roles of the various parties is to conceptualise them as a 'spectrum of responsibilities' (Figure 1). At one end of the spectrum sits the State and its agencies such as schools and public health. The responsibility assigned to these parties is the prevention of overweight and obesity through dealing with their causes. This is a proactive role that is primarily the construct of social, cultural and socioeconomic discourses. These agencies are able to fulfill this role through surveillance and disciplinary power, which they exercise in relation to society as a whole, or in distinct spaces such as schools.

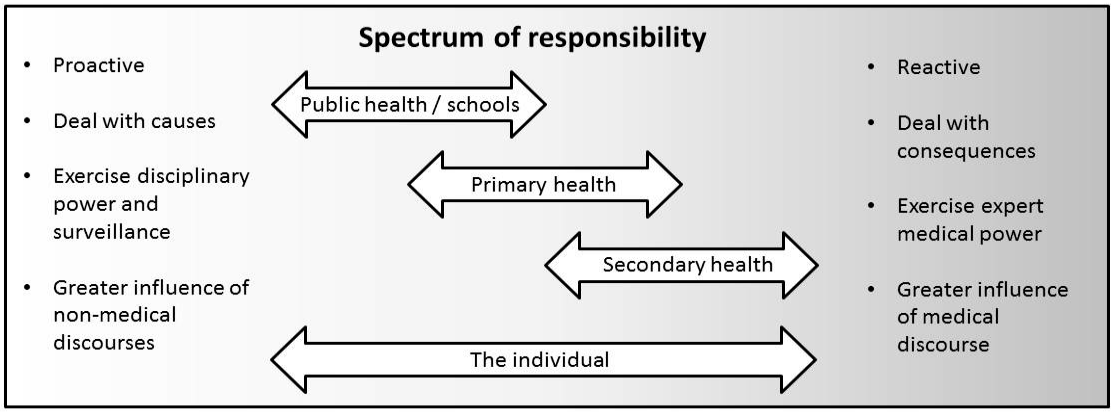

Figure 1 –The Spectrum of Responsibility

At the other end of the spectrum are health professionals working in the secondary health setting. The responsibility assigned to these parties is to address the health consequences resulting from overweight and obesity. This is a reactive role that is primarily the construct of the medical discourses. These agencies are able to fulfill this role through the power relations that exist in the medical space.

Between the two ends of the spectrum lies the primary health setting. Health professionals working in this setting, I suggest, have mixed responsibilities, both to help prevent overweight and obesity and to address its consequences. These dual roles reflect the intersection of the medical and non-medical discourses. These health professionals draw on the power relations that derive from the medical setting to influence outcomes outside that space, but this ability is constrained to a greater or lesser extent depending on the strength of competing social, cultural and/or socioeconomic discourses.

Individual responsibility lies across the spectrum, or in parallel to it. According to the neoliberal perspective, the individual has the freedom to exercise choice in relation to diet and lifestyle and so must take responsibility for the consequences of those choices (Guthman, 2009). This gives the individual the ability to prevent overweight or obesity occurring. Moving to the other end of the spectrum, once overweight or obese, an individual has the freedom to seek and follow guidance from primary healthcare professionals to reduce weight in order to avoid potential health consequences. Finally, once hospitalised as a consequence of health effects, the individual has a role to play in their return to good health, for instance by making the necessary lifestyle changes to

reduce the risks associated with conditions that are a result of being overweight or obese.

However, it is necessary to balance the neoliberal perspective on individual responsibility with constructs arising from cultural and socioeconomic discourses on overweight and obesity. The reality is that not all individuals have the same freedom of choice: some are poorer than others and some are influenced by particular cultural perspectives. So while individual responsibility extends in parallel along the spectrum, it is constrained to a greater or lesser extent by the influence of these other discourses.

7.4.2 Better Support for the Health Professions

The identification of where the roles and responsibilities of different parties lie on the spectrum described above provides clarity around some of the problems these parties face when the attempt to address overweight and obesity. It also identifies where along the spectrum potential solutions to these problems should be targeted. At the proactive end of the spectrum, there is a need for leadership to provide direction for a coordinated collective response to childhood overweight and obesity. Health professionals interviewed in this study identified a lack of 'ownership' of the problem (Chapter Six). The Ministry of Health, for instance, has included diabetes and cardiovascular disease in its health targets for 2012-2013, recognising that they are the leading cause of morbidity in New Zealand. However, the health targets don't mention overweight and obesity as a predisposing factor for either of these diseases (Ministry of Health, 2012b). This appears to indicate a lack of ownership at government level. In order to more effectively address overweight and obesity, this question of ownership needs to be resolved.

At the reactive end of the spectrum, there is an apparent need for additional services, resources and support for health professionals working in the secondary sector. The current lack of pathways of referral for the family within the hospital setting confirms the prevailing neoliberal viewpoint that the responsibility for addressing overweight and obesity rests with the individual, outside of the hospital space. It is likely to be the case that referral services are best located within the primary health care setting because of the need of these services to focus on causes and prevention. As discussed above it is in the primary setting that health professionals are more influenced by the social, cultural / ethnicity and socioeconomic discourses and are therefore better equipped to work with children, young people and their families for the longer term.

There is also a need to provide support for those operating in the middle of the spectrum, the primary health sector, for instance, by improving the delivery of culturally acceptable practises. Within the context of culture and ethnicity there have been several government strategies over the last twelve years aimed at addressing a dearth of health care professionals who identify as Māori or Pacific. These include the Primary Health Care Strategy (Ministry of Health, 2001), He Korowai Oranga (Ministry of Health, 2002), The New Zealand Health Strategy (Ministry of Health 2000) and The Child Health Strategy (Ministry of Health 2001). These initiatives all identified a need for greater numbers of Māori and/or Pacific health workers so that care can be provided to these populations by individuals from the same ethnic and cultural background. Despite strategies and initiatives being put in place at government level to put ownership of Māori and Pacific health back onto these ethnic groups, there has been little improvement in numbers of Māori and Pacific healthcare workers with, for instance, only 2.8% identifying as Māori in 2008 despite Māori making up 14.5% of the population (DeSouza, 2008).

Participants in this research commented that it is possible to develop culturally acceptable practises by way of offering services within settings that are culture bound such as the church for Pacific communities. As discussed in Chapter Five, taking health care to an environment that is culturally appropriate may make it more relevant to these groups of people. Whilst this isn't a new finding there are clearly gaps in achieving culturally appropriate practises for both Māori and Pacific peoples.

I suggest that there is the need for further education for health professionals in ways to effectively address overweight and obesity with children and their families. Within the primary care setting, Jacobson and B Gance-Cleveland, (2010), described a 'chronic care model' (p. 246). This is a framework that is used to promote evidence-based care for practise change which encourages improvement strategies that are responsive to local needs. These practise changes provide both the provider and the child/ family with:

> '…s*elf-management support* using relationship focused methods such as motivational interviewing, family education and monitoring to increase child and family skills and confidence; *decision support for providers,* including

> utilisation of evidence-based guidelines; *delivery-system redesign* to promote better care and follow-up of identified patients; and *clinical information systems,* to provide data to evaluate the progress the practise is making in meeting its goals (Jacobson & B Gance-Cleveland, 2010, p. 246).

Another study by Jurkowski et al., (2012) suggested that parents should be utilised as agents of change in childhood obesity prevention and that this could be done by engaging parents in the development, implementation and evaluation of a programme targeting childhood obesity prevention. This would be a way of better integrating the parents' socio-cultural context and as a way of improving acceptance of the programme, ensuring cultural relevance and participation (Jurkowski et al., 2012).

There are also programmes such as HENRY (Health Exercise and Nutrition for the Really Young), a United Kingdom (UK) based programme which trains health and community practitioners to work with parents in addressing obesity or lifestyle concerns with babies or preschool children (M. C. J. Rudolf, Hunt, George, Hajibagheri, & Blair, 2010). WATCH IT, another UK programme, trains a non health professional, in motivational and solution focused approaches to help families make lifestyle changes (M. Rudolf et al., 2006). Within New Zealand there is also the 'All Kids in Action' programme which is based in Northland and encourages children to participate in activities which get them active (Hope, 2011). These programmes meet evidence based practise guidelines for including nutrition, physical activity and motivation and are also family centred.

I was unable however, to find evidence of comparable initiatives within the secondary setting, which is consistent with the placement of this setting at the reactive end of the spectrum of responsibility.

7.5 Limitations

7.5.1 Methodology

This research employed the methodology of Foucauldian discourse analysis as a way of uncovering the dominant discourses that shape the ability of health professionals to address childhood overweight and obesity. The methodology has proven to be effective, allowing four dominant discourses to be identified and examined.

However, it is recognised that by its very nature this is a subjective methodology. It must be acknowledged that that narratives of my participants within the postmodern frame are both time and context bound, giving just a here and now interpretation of reality that may change as time and contexts also change (Grbich, 2007). My interpretation of the interview transcripts and findings will be just one of many, having been influenced by my own experiences and perceptions. While recognising this subjectivity, the findings of this research are consistent with those of a substantial body of peer-reviewed literature.

7.5.2 Methods

The principal limitations of the research method were the small size and limited diversity of the population sample, with only seven participants in total (four nurses and three doctors). There were only two health professionals from the secondary health setting recruited and both of those were medical professionals. The reach of the research could have been enhanced by also interviewing nurses from the secondary setting, as a way of investigating the contrast in roles and responsibilities within that setting by eliciting other discursive practises. Also including other health professionals who come across overweight or obese children in their work such as physiotherapists and dieticians may have enhanced this research further.

However, while recognising the limitations of sample size and diversity, this was a qualitative study and therefore was no requirement to quantify the significance of the findings. The fact that there was often similarity in the responses of interviewees indicates a convergence of views: interviewing further participants may not have added any more new information.

The use of semi-structured interviews could be seen as limiting the flexibility of the questioning. However, I would argue that using this technique did provide sufficient room to use follow-up questions to delve deeper into the responses of participants. This added richness and further depth to the interviews that may not have been provided by fully-structured questioning. However, without any structure at all the interviews may have failed to deliver the information necessary to meet the objectives of the research.

Finally, this research has also been limited by time constraints: the topic is vast and complex and I have necessarily limited my analysis to the dominant discourses and how these impact on health professionals' ability to address overweight and obesity in children. Doubtless there are further underlying discourses and subtleties that sit within the medical, social, cultural and socioeconomic discourses.

7.5.3 Suggestions for Future Research

This research has investigated addressing overweight and obesity in children from the perspective of health professionals. It has highlighted barriers health professionals' face that arise from discourses and their practises which can be seen as peripheral to the health setting. A complementary piece of research would involve moving out of the medical setting and into the communities and homes of overweight and obese children and their families. It could examine the alternative construction of overweight and obesity by the discourses arising from these very different settings. What barriers do families face in dealing with overweight and obesity? Who do they think is responsible for addressing overweight and obesity in their children? What are the dominant discourses in this setting? Another complementary piece of research could look further into the responsibility of addressing overweight and obesity by focusing on the government and its agencies such as schools or community groups that sit outside of the health sector but sit within the spectrum of responsibility. Research of this nature has the potential to reveal areas of commonality with this research, perhaps suggesting where to best target interventions for addressing overweight and obesity in children.

7.6 Conclusions

This research has found that there is complexity for health professionals in addressing childhood overweight and obesity. While a dominant medical discourse has medicalised these conditions and gives health professionals the right to intervene, their ability to exercise this right is influenced by considerations arising from intersecting social, cultural, ethnicity and socioeconomic discourses.

There is significant uncertainty about who is responsible for addressing overweight and obesity in children. In particular, contrasting discourses place emphasis on the individual and the State respectively. The place of the health professional on the spectrum of responsibilities varies with practise setting. Health professionals working in

the secondary setting have a predominantly reactive role, focusing on dealing with the health consequences of overweight and obesity in children. Those in the primary setting, and more so nurses than doctors, have both a reactive and a proactive role. Being in the community setting, these health professionals are more likely to recognise socioeconomic and cultural influences on overweight and obesity and be able to intervene accordingly.

Any attempt to deal with some of the barriers for health professionals in addressing overweight and obesity, for instance those that arise from social convention and socioeconomic disparities, lies well beyond the medical scope of practise. However, there are barriers within the health sector that have been identified. These include the provision of specialist referral services and culturally acceptable practises.

Addressing overweight and obesity in children is a complex issue that requires a collaborative approach involving the many stakeholders outlined in this research. As a health professional myself, I believe that we, working alongside other professionals, communities and families, can make a difference in dealing with a problem that children themselves cannot be expected to fix. Statements such as ‘this generation will die before their parents,’ need to become statements of the past as we work together to rectify the problem of overweight and obesity in children.

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Appendix One

Invitation to participate

"Addressing overweight and obesity in children and young people by health professionals: A discourse analysis"

If you live in the Auckland area I would like to invite you to participate in a study that is looking at how health professionals manage overweight and obesity in children and young people. I am interested in the issues and challenges around addressing this issue and how weight is 'constructed' in health environments. If you would like to participate it would involve being interviewed for about 90 minutes by me and sharing your insights and experiences. The questions would be semi-structured and be like a dialogue / conversation between the two of us. This research is being undertaken as fulfillment of the requirements of a Masters of Health Science at AUT University.

If you think you may be interested in taking part please read the attached participant information form.

Anna Wright – (PG Dip Health Science) – AUT University

Appendix Two

M E M O R A N D U M

Auckland University of Technology Ethics Committee (AUTEC)

To:	Tineke Water
From:	**Dr Rosemary Godbold** Executive Secretary, AUTEC
Date:	12 August 2011
Subject:	Ethics Application Number 11/183 **'Addressing overweight and obesity in children and young people by health professionals: A discourse analysis.'**

Dear Tineke

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 11 July 2011 and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 12 September 2011.

Your ethics application is approved for a period of three years until 12 August 2014.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 12 August 2014;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics/ethics. This report is to be submitted either when the approval expires on 12 August 2014 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Anna Elizabeth Wright annaewright@ihug.co.nz, Deborah Payne

Appendix Three

Participant Information Sheet

Date Information Sheet Produced:

18/06/2011

Project Title:

"Addressing overweight and obesity in children and young people by health professionals: A discourse analysis"

An Invitation

My name is Anna Wright, I am a post graduate student at Auckland University of Technology (AUT) with a specific interest in childhood and youth overweight and obesity. This research is the thesis component of my Masters Degree.

I would like to invite you to participate in this piece of research that will look at how overweight and obesity is constructed by health professionals and how this affects assessment of, and interventions for, children and young people who come into the health environment.

Participation is voluntary and you may withdraw at any time prior to the completion of the data collection without any adverse consequences.

What is the purpose of this research?

Obesity in children and young people in both New Zealand and overseas has become an issue of epidemic proportions. I aim to explore the multiple factors and challenges that contribute to addressing the issue of obesity and overweight in children and young people in the health environment, using a methodology called discourse analysis. On completion of the research I plan to disseminate the findings through appropriate conferences and publications.

How was I identified and why am I being invited to participate in this research?

You have been identified as a health professional who is either a Doctor or a Nurse with current experience in child health. You live in the Auckland area and have responded to an advertisement via your professional body or have passed on your details through the

effects of snowballing. This is why I have chosen to invite you to participate in my study.

What will happen in this research?

This research project involves me as the researcher interviewing you for up to 90 minutes in one single session. I will be asking you a series of semi-structured questions around assessment of, and intervention in, childhood and youth overweight and obesity. Interviews will take place in a small, quiet interview room on the Auckland University of Technology campus or in a place of your choice. The interviews will be recorded by audiotape and will be transcribed by a transcriber at a later date so that I can analyse the data. The transcriber will sign a confidentiality agreement. Prior to analysis of the data I will return your transcript to you for verification and you will have the opportunity to delete or amend any of the data collected.

What are the discomforts and risks?

While I don't envisage that there will be any discomforts for you, sometimes stories from practice can raise some disquiet for people.

How will these discomforts and risks be alleviated?

If at any stage during the data collection process you feel uncomfortable or at risk you have the right to withdraw without any consequences to yourself and the data collected from you will not be used in this research. You also have the right not to answer any question that you feel uncomfortable about. If the data collection process has caused you any discomfort or stress AUT will provide up to 3 free counselling sessions.

Confidentiality will be maintained at all stages of the research and you may choose a pseudonym. Your name will only appear on the consent to participate form and those forms are kept in a locked filing cabinet in my supervisor's office on the AUT North Shore campus. Your name will not appear in the research itself.

What are the benefits?

Often the paediatric nurse or doctor is the first point of contact when a child or young person who is overweight or obese comes into the primary or tertiary health care environment. While you may not directly benefit from the findings, this research does have the potential to promote the advancement of practice knowledge and improvement of health outcomes for children and young people who suffer from overweight or obesity. You may, however, enjoy the opportunity to reflect and talk about your own practice.

How will my privacy be protected?

Signed consent forms will be kept in a locked filing cabinet in my supervisor's office on the North Shore campus of AUT. Any data collected will be stored in a password protected file on my personal computer. Potentially identifying details will be removed from the transcript. Both data and consent forms will be destroyed after 6 years.

What are the costs of participating in this research?

There may be cost for you to travel to the interview, in which case I will reimburse these costs with petrol vouchers. Individual interviews may last up to 90 minutes.

What opportunity do I have to consider this invitation?

You will have 2 weeks to consider whether you wish to participate in this research and if I haven't heard from you I will follow up with a phone call or email. If you require any further information on the project please contact me as per my details below. Once again to reiterate, you may withdraw from the research at any time during the data collection phase without any adverse consequences.

How do I agree to participate in this research?

If you agree to take part in this research you will need to complete a consent form which I will post out to you for you to fill in and return in the prepaid addressed envelope. If you wish to contact me with further questions please do so via the researcher contact details given below. I will also go through the consent process again at the start of the interview.

Will I receive feedback on the results of this research?

If you indicate you would like to receive feedback on the results of this research I will email a copy of the report out to you on completion of the research.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisors: Dr Tineke Water tineke.water@aut.ac.nz phone 921-9999 x7335 or Dr Debbie Payne debbie.payne@aut.ac.nz phone 921-9999 x7112

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz* , 921 9999 ext 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:
Anna Wright

Email address annaewright@ihug.co.nz

Project Supervisor Contact Details:

Dr Tineke Water

Email address tineke.water@aut.ac.nz phone 921-9999 x7335

Dr Debbie Payne

Email address debbie.payne@aut.ac,nz phone 921-9999 x7112

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference*

Appendix Four

Associate Director of Nursing – Mäori Health
Rangatahi Office, Level 15
Auckland District Health Board
Private Bag 92-024
AUCKLAND

26th April 2011

Tënä koe

Re: Addressing overweight and obesity in children and young people by health professionals: A discourse analysis"?"

To whom it may concern,

I have read and understood the research protocol for the proposed study "Addressing overweight and obesity in children and young people by health professionals: A discourse analysis"?"

I endorse and support this specific research project and believe that the researcher Anna Wright will continue to seek advice on matters pertaining to relevance to Māori and their whänau; engagement with Māori stakeholders including but not limited to Iwi, Hapu; processes to inform Māori health development; and appropriate dissemination pathways. Improving obesity related disease and outcomes for Māori and their whänau, and removing inequalities between Māori and non- Māori is an important and urgent health priority.

This study may lead to a deeper understanding of barriers that impact on childhood obesity and may lead to interventions and assessments to improve clinical practice and there by improve health outcomes in particular for Māori.

If you have any further queries in regards to my letter of support please feel free to contact me directly.

Noho ora mai

Lorraine Hetaraka Stevens
Ngäti Kahu, Te Arawa, Ngätirangi
Associate Director of Nursing – Mäori Health

E-mail: LorraineHS@adhb.govt.nz

021 2258540

25/06/2011

The application looks good, Anna.

I think the main issue from my perspective is how the findings related to Māori children and young people are analysed and framed. Particularly to be able to identify and critique deficit or 'victim-blame' analyses (for a good discussion of this, see Hauora IV - Chapter 1 - especially the paragraph in the middle of page 5 beginning with "The new society…")

It would also be useful to interpret your findings in the context of evidence that shows that Māori tend to get poorer quality care in the NZ health system. And also in the context of literature on health professional discourse around Māori health/inequalities (e.g. see the attached article). Even though that may be a bit further down the track, it would pay to be thinking about these things as you are developing your interview questions and doing interviews etc.

Just a few thoughts anyway. I'm happy to be involved as things progress.

Ngā mihi,

Rhys

(Dr Rhys Jones Senior Lecturer Te Kupenga Hauora Māori, University of Auckland)

Appendix Five

AUT UNIVERSITY STUDENT SERVICES

MEMORANDUM

TO	Anna Wright
FROM	Kevin Baker
SUBJECT	Psychological support for research participants
DATE	8th June 2011

Dear Anna
I would like to confirm that Health, Counselling and Wellbeing are able to offer confidential counselling support for the participants in your AUT research project entitled:

"Addressing overweight and obesity in children and young people by Health Professionals. A discourse analysis"

The free counselling will be provided by our professional counsellors for a maximum of three sessions and must be in relation to issues arising from their participation in your research project.

Please inform your participants:

- They will need to contact our centres at WB219 or AS104 or phone 09 921 9992 City Campus or 09 921 9998 North Shore campus to make an appointment
- They will need to let the receptionist know that they are a research participant
- They will need to provide your contact details to confirm this
- They can find out more information about our counsellors and the option of online counselling on our website: http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing

Yours sincerely

Kevin Baker
Head of Counselling
Health, Counselling and Wellbeing

Appendix Six

Consent Form

Project title: "Addressing overweight and obesity in children and young people by health professionals: A discourse analysis"

Project Supervisor: Dr Tineke Water and Dr Debbie Payne

Researcher: Anna Wright

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 02/06/2011
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participants signature:.....……
……
Participants name:.....……
……
Participants Contact Details (if appropriate):……
……..
……..
……..
……..
Date:

Approved by the Auckland University of Technology Ethics Committee on 12th August 2011 AUTEC Reference number 11/183 *Note: The Participant should retain a copy of this form.*

AUT UNIVERSITY **POSTGRADUATE**

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Student ID No	9807165	**Name**	Anna Wright
Faculty	Health and Environmental Science	**School/Dept**	Nursing
Programme	Master of Health Science	**Year of submission** (for examination)	2012
Research Output	**Thesis** ☒ **Exegesis** ☐	**Dissertation** ☐	**Points Value** 120
Thesis Title	Who's responsible for addressing overweight and obesity in children? An analysis of health professional discourse		

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Student's Signature A. E. Wright **Date** 4th May 2013