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Alarming ambiguities

An analysis of Norwegian public documents concerning child obesity

Master's Thesis Childhood Studies

Trondheim, May 2016

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Acknowledgements

First, to my supervisor, Professor Vebjørg Tingstad. For professional feedback and help with the thesis. Thank you for guiding me when I felt lost, for being available and interested in my study.

Second, to the staff at NOSEB, for teaching me the knowledge I have relied on and used for this thesis, and encouraging reflection and critical thinking.

Third, a thank you to my classmates from the reading room. For being a shoulder to lean on and a source of motivation throughout the process.

Trine Røsand,

May 2016

Abstract

In the public domain, overweight and obesity are usually presented as an alarming health problem in need of fixing. There has been an increase in average body weight in many counties across the world in the last 30 years. The reasons for this are numerous, and rest both in modern society, biology and personal lifestyles. Responsibility for altering the situation is also divided. The societal responsibility frame identifies it as society's job, while the personal responsibility frame defines it as individual's obligation. At the same time concerns around problem formulation, reasoning and responsibility to a broader extent are diverse and less obvious. Similarly, there are many perspectives and assumptions concerning children.

This study has looked at how overweight and obesity are understood and handled by the Norwegian Government and health authorities, and what ideas about children they rely on. Theoretically, this study has been informed by social studies of children and childhood, and sociology of health and illness. The method of document analysis has been used, and ten public documents giving premises for the Norwegian health care service were analyzed using thematic analysis. The child perspectives and understanding a phenomenon have been main perspectives in approaching the documents.

Findings from the study show that the documents rely on a certain hegemonic ideology concerning excess body weight, constructing it as a great problem. Main reasons are said to be a modern health debilitating society, and individual lifestyle behavior in terms of physical activity and diet. The responsibility is placed mainly on society, and societal solution proposed to handle the problem are changing personal behavior, regulating societal structures and prevention efforts. Children are positioned both as competent and dependent, within a landscape of various views focusing mainly on children's significance as future human beings. However, an important finding was the alarming ambiguities concerning both in the formulation of the "obesity problem", the logic behind it and the construction and positioning of the child.

Reliance lies on the ideology of overweight as inherently health hazardous, which together with simple explanatory frames may allow for moralizing behaviors in society towards overweight and obese individuals. Society's role in maintaining health in the population can cause pedagogies about the self being imposed on and affecting people. The ambiguous construction of children in society, and of overweight and obesity may lead to difficulties in implementing appropriate measures in handling the situation. There is a need for more research from social sciences, focusing on what the problem is presented to be.

Abbreviations

UNCRC – United Nations Convention on the Rights of the Child

WHO – World Health Organization

BMI – Body Mass Index

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1 Introduction

"Childhood obesity is one of the most serious public health challenges of the 21st century."

(WHO, n.d)

Obesity worldwide has more than doubled since 1980 (WHO, 2015), and childhood obesity is said to be a growing health problem globally, increasing parallel with adult obesity, to the point where it is referred to as an epidemic. American children today might be the first generation in risk of having a shorter life expectancy than their parents, due to obesity and the accompanying health problems (Hamid, 2009). The World Health Organization has stated that overweight related diseases are now so widespread that they are about to take over as the world's most important contributor to poor health (WHO, 2000). Obesity increases the risk for many serious illnesses, and is linked with social and psychological health, due to stigmatization and judgmental attitudes (Helsedirektoratet, 2010a). Severely overweight children have been found to have equally bad health related quality of life as children with cancer (Schwimmer, Burwinkle, & Varni, 2003), and Bruche (1975 in Øen, 2012c) explains obesity as a serious handicap in the social life of a child.

However, from another angle there are "size acceptance" scientist and activists who argue that the "obesity epidemic" is a socially constructed problem, both "methodically flawed, ideologically problematic and potentially harmful" (Pringle & Pringle, 2012, p. 150). They argue that the consequences of increasing obesity prevalence has been greatly exaggerated or are unclear (Gard, 2011), and go so far as to suggest that the causal link between weight and health, and the medicalization of obesity is nothing more than size discrimination (Rich & Evans, 2005). They question the reasoning behind this popular problem discourse, and highlight the effects the normality of body size, and deviations from it, has on overweight and obese people (Campos, Saguy, Ernsberger, Oliver, & Gaesser, 2006). With this in mind, what is really the problem with overweight and obesity?

Within the field of social studies of children and childhood there is an understanding of childhood as socially constructed (James et al., 1998). I argue that there is a need to get a better understanding of what the constructions of children are, and what they mean. This thesis aims to do this by adding to the understanding of the social and cultural ideas that underpins the view of overweight and obese children in the Norwegian health care service. Research on the topic of obesity and childhood obesity are mostly done from the field of medicine, where it is seen mainly as a medical phenomenon (Øen, 2012e). It is important to explore this topic from other

angles. A need has been expressed to connect the sociology of childhood perspective to studying children's health, to explore social and cultural contexts which frame children's lived experiences (Brady, Lowe, & Olin Lauritzen, 2015). Also a need for research focusing on the complexities, tensions and ambiguities of children's lives (Tisdall & Punch, 2012).

My interest in the topic comes from a background in early childhood education, focusing on nature and outdoor activities, and the importance of physical activity. Later from living in the USA, where the prevalence of childhood obesity is high, and highly visible. However, from personal experience working with children in Tanzania, Africa, the global paradox of the world's health situation is also visible, with both hunger and overweight affecting the population. Therefore, I want to look closer at how the phenomenon of overweight and obesity is understood and handled by the governing authorities in my part of the world, Norway. How is it talked about, and what are the arguments? What kind of knowledge and research based evidence are they building on, and what recommendations are given? In this study, ten public documents underlying the Norwegian health service have been analyzed, in order to look into the constructions of obesity and children, with the child perspective in the analysis.

1.1 Previous research

Tingstad (2009) conducted research on discourses on child obesity in Norway, with stakeholders involved in debates on the topic, focusing on television advertising. She found that informants did not mention television advertising as a reason for child obesity, but rather giving other reasons as inactivity, access and price to unhealthy food, change in lifestyle and development in society. Their rationale came from international obesity discourses, rather than scientific knowledge and evidence.

James and James (2004) suggest that in the UK children are still marginalized from taking personal responsibility for their own health by drawing upon specific constructions of children and childhood. Paradoxically, this is despite the Governments apparent novel commitment to promoting exactly this. They report that health policies fail to recognize and give weight to the standpoint of children, and children's agency. The focus is on the structural position children hold as the next generation, and the dominant discourse of childhood as a happy and innocent time, obscuring other potential problems children might experience.

Research on assumptions inherent in the welfare state's conceptions of childhood and it's well-being has found that "…welfare policies for children contribute to the preservation of children's dependent status, expressed mainly through their familialization." (Makrinioti, 1994,

p. 267). Familialization refers to the fusion of children into the inseparable unit of the family (Ibid.). Thus, children becomes “an open window to the family” (Ibid., p. 268), making parents to blame in situations of social criticism.

1.2 Purpose of the study

This study aims to understand the Norwegian Government and health authorities’ position towards the phenomenon of overweight and obesity, and the notions of children they build on. This was done using the method of document analysis, on relevant public documents giving premises and regulations for the Norwegian health care service. The reason behind this study comes from an impression of insufficient knowledge about the subject, and a curiosity about the documents view point, problem formulation and argumentation. The expected outcomes of the study are to add knowledge to health care personnel working with overweight and obese children, and for governmental department deciding children’s conditions. Through giving an insight into the cultural and social conditions for children, I hope to encourage a rethinking about professional behavior and attitudes. Øen (2012c) states that lacking knowledge and understanding amongst people can lead to worsened life conditions for people with obesity. Based on this statement, the thesis aims to add knowledge and increase understanding. A hoped for aim is also for the study to be a useful background for later studies about child obesity in the context of Norway.

1.3 Presentation of research questions

The main research question I want to answer through this study is:

How is the phenomenon of overweight and obesity described by national documents giving premises for the Norwegian health care service, and how are children conceptualized and positioned in these documents?

Subordinate research questions are:

1. What are the reasons given for the phenomenon of overweight and obesity?
2. Who are seen as responsible for increasing excess of body weight in the population, and what are the proposed solutions?

1.4 Scope of work

Many public documents concerning the topic in question were included in this study. Documents were chosen for relevance, as well as the scope of and the time frame of the project. The process of selecting documents will be explained in chapter 4. The study has looked at national documents about health care services in Norway, and can only report on the situation in Norway.

1.5 Structure of thesis

The thesis contains seven chapters. The first chapter is the introduction to the topic with presentation of the research question. Chapter two will give some background information about overweight and obesity, its prevalence and history, and the context of Norway. Chapter three discusses the theoretical framework of the thesis, and relevant theory useful for describing themes and topics emerged in the analysis. Chapter four is the method chapter, and will present the methodology behind the study, as well as a detailed description of the method of document analysis and thematic analysis used in the thesis. Chapter five, as the first analysis chapter, will present findings from the study concerning the phenomenon of overweight and obesity, while chapter six focuses on children's positioning within the empirical material. Chapter seven will conclude the thesis with a summary, some potential implications of the findings and suggestions for future research.

1.6 Explanation of terms used in the thesis

Children and young people: A child is any person under 18 years of age (United Nations, 1989). The terms young person, youth and adolescents, have less clear age-limits, but are used in the thesis to refer to older children.

Health care service: All institutions in society with the purpose to prevent, diagnose and treat disease, give nursing and care to sick people or to rehabilitate patients after injury or disease.

Overweight and obesity: Based on Body Mass Index (BMI), which is calculated by a person's weight in kilogram divided by the square of height in meter, overweight is defined as scores over 25, and obesity is scores over 30. In children, overweight and obesity are measured by plotting BMI on an age-growth chart.

2 Background

As presented initially, in media and other public domains, there are different opinions circulating about the phenomenon of overweight and obesity. Some of them seem to gain status as dominant perspectives, even though there is still a lot we do not know. The two main discourses are referred to as *the alarmists* and *the sceptics*, where the former advocate alarmingly about the increase and danger of excess body weight, and the latter are skeptical about the claims connecting weight to health (Gard, 2011). The knowledge people tend to lean on, comes academically from the medical field as well as a societal discourse with moral overtones, where concepts of shame, guilt and lacking individual control are prevalent. These discourses will be outlined further in the next chapter.

There are many typical models for explaining and creating solutions to the increase in average body weight. Some rely on environmental explanations, such as an obesogenic environment, where an inactive lifestyle and easily accessible unhealthy food is a driving force for weight gain, or the impact of media. While others focuses on personal behavior, blaming inactivity and bad diet, in a simple cause and effect explanation (Tingstad, 2009). When concerning responsibility towards overweight and obesity, there are commonly two different positions (Kersh, 2009). Societal responsibility frame view it as a society's job to work to prevent and repair bad health, offer good services, inform people and enforce structural conditions. While on the other hand, the personal responsibility frame gives individuals the obligation and responsibility to take care of ones own health, and blames individual conduct for the increase in weight.

Even though there are different opinion about the phenomenon, the complexity of overweight and obesity is also emphasized in contemporary literature. "Assessment and treatment of obesity in children and young people is a laborious and time consuming process, and far more than prescribing a 'green prescription' for healthy diet and increased physical activity" (Jåtun, 2012b, p. 93)[1]. Overweight and obesity is a very complex problem, with many causes and many reasons for the causes (Øen, 2012a), more in the case of children. I will come back to this further in the thesis. First, I will give some background information about overweight and obesity, and the context of Norway.

[1] Author's translation

2.1 The global obesity "epidemic"

As the heading suggests, the increase in overweight and obesity is said to be a global phenomenon. During the past 30 years, the new prevalence of excess body weight started to rise. "The worldwide prevalence of obesity more than doubled between 1980 and 2014." (WHO, 2015). In 2014, it was estimated that 41 million children under 5 years of age were overweight or obese (UNICEF, WHO, & World Bank, 2015). Much of the academic literature about overweight and obesity comes from the USA, and it is often one of the first countries to come to mind when taking about obesity. "More than one-third of adults and 17% of youth[2] in the United States are obese, although the prevalence remained stable between 2003-2004 and 2009-2010." (Ogden, Carroll, Kit, & Flegal, 2014, p. 806). However, the countries with the highest obesity prevalence are The Pacific Islands and Kuwait, with prevalence rates of obesity in American Samoa up to 74.6 percent[3] (CIA, n.d.). Other contributors to the academic literature on obesity comes from England and Australia. In England, the Department of Health says: "In England, most people are overweight or obese. This includes 61.9% of adults and 28% of children aged between 2 and 15." (Department of Health, 2015). Similar numbers are seen in Australia (National Health and Medical Research Council, 2015), and also here the prevalence seem to have flattened (Olds, Tomkinson, Ferrar, & Maher, 2010). Data show, in high income countries, that the risks of childhood obesity are highest in lower socioeconomic groups (WHO, 2016). The same is seen in terms of overweight and obesity in general.

Jutel (2009) argues that diagnosing contributes to maintaining the social order through the use of normality and deviance. We can see this through the use of BMI, which is employed to diagnose people with overweight and obesity. Through this use, BMI helps to determine deviance from normality, and thereby providing an explanatory framework and defining excess body weight as a problem. BMI has been used as a way to measure overweight since the naming of the term in 1972 (Eknoyan, 2008). After the first key studies were published in the mid 1990's, linking mortality and the rising rates of obesity, the WHO issued a report using new and lower criterion for overweight and obesity (Julier, 2008). These new benchmarks are still used today, even though there has been research casting doubt over the use of BMI on a population basis (Nevill, Stewart, Olds, & Holder, 2006).

[2] Youth here represents age 0-19 years.
[3] Data from 2007/2008

2.2 Health consequences related to overweight and obesity

According to medical references, overweight and obesity are linked with both physical and psychological problems. Medically it can increase the risk for development of many illnesses; type 2 diabetes, cardiovascular diseases, high blood pressure, several types of cancer and musculoskeletal disorders (WHO, 2015). Some obesity-related diseases may occur in childhood and adolescence, while others are first detectable in adult age (Jåtun, 2012a). In addition to medical problems, overweight may be connected to psychosocial problems. According to some theorists, overweight and obese children report more psychological problems than non-overweight children (Van Vlierberghe, Braet, Goossens, & Mels, 2009), and lower self-esteem (Wang, Wild, Kipp, Kuhle, & Veugelers, 2009). They are more likely to be bullied (Griffiths, Wolke, Page, & Horwood, 2006; Guo et al., 2010; Janssen, Craig, Boyce, & Pickett, 2004; McCormack et al., 2011), and less liked by other children (Koroni, Garagouni-Areou, Roussi-Vergou, Zafiropoulou, & Piperakis, 2009). In addition, obese children can have increased risk of developing body dissatisfaction, restrictive eating pattern and depression. In addition stigmatization towards overweight and obese people have been found in the health care service (Hansson, Näslund, & Rasmussen, 2010; Huizinga, Cooper, Bleich, Clark, & Beach, 2009; Schwartz, Chambliss, Brownell, Blair, & Billington, 2003).

2.3 Overweight and obesity in Norway

Even in Norway, one of the best countries in the world to grow up in (UNICEF Office of Research, 2013), there has been an increase in obesity amongst children and adults. 27 percent of the population in Norway is overweight, and 10 percent of these are obese[4] (Statistisk Sentralbyrå (SSB), 2013). Regarding children, the Child Growth Study found that 16 percent of eight-year-olds are overweight or obese, and of them 3.5 percent are obese (Hovengen, Biehl, & Glavin, 2014). We see also in Norway in the last years that the prevalence have been stabile[5] (Ibid.). However, trend researchers believe it is too early to determine whether it is a real stagnation (Øen, 2012a).

In Norway, as seen in other high-income countries, there are social differences in access and quality of health. These are making and upholding unequal conditions of health in the population, affecting children as well as adults. Socio-economic factors are present also in the prevalence of overweight and obesity (Grøholt, Stigum, & Nordhagen, 2008). Distribution of childhood obesity also depends on educational level, demographic and geographic (Biehl et al.,

[4] Numbers from 2012

[5] Between 2008 and 2012.

2013), and obesity has a higher prevalence in children of divorced parents (Biehl et al., 2014). Parental obesity more than doubles the risk for children to become obese in adult age (Whitaker, Wright, Pepe, Seidel, & Dietz, 1997). As we see here, some children are from an early age given a bad starting point for weight gain. In addition to having different starting points, children have various conditions for getting help, and the efficacy of the help provided varies. In the first place, children's access to treatment depends on parents; parents can choose not to seek or accept help with their child's weight. The decision to seek help can be difficult to make because of the norm of personal control in society, and within the health care service, that holds parents alone responsible for children's overweight (Edmunds, 2005).

The ideal of being thin is the prevailing societal standard in Norway, contributing to increased focus on body and weight. The Norwegian society has a strong focus on personal choices and being in control of our lives, which is seen as lacking in individuals with an obesity problem (Øen, 2012e). Values of shame and blame make up the cultural context in terms of obesity (Malterud & Ulriksen, 2010), causing an additional burden for obese people. We can also witness a high prevalence of young girl dieting, where most of these have normal weight, up to 27 percent of girls in Norwegian 10th grade reports dieting (Samdal et al., 2016). Norway is said to be a part of the western cultures where 'a moral imperative' has been developed to educate young people in order to avoid deviations from the normative ideal of the body (thinness) (Murray, 2008 in Wright & Halse, 2014). Instructions are linked with the wider neo-liberal project of self-making, where free choice and individual responsibility are important in order to become a certain health subject (Wright & Halse, 2014). A problematic issue with the thinness ideal is that it deems people with excess body weight to be out of control, while the thin and fit body represents empowerment and control, regardless of what measures were taken in making it so (LeBesco, 2004).

The World Health Organization (WHO) arranged a conference for Europe's health ministers in 2006, where a new charter was adopted for fighting the rapid increase in overweight, with a special attention to the unfortunate development in overweight amongst children. The charter aims to contribute towards putting the epidemic of overweight higher on the agenda, and work to implement effective measures in relation to diet and physical activity (WHO Europe, 2006). Norway has signed this charter. Working to reduce the prevalence of overweight and obesity, the Norwegian government has introduced various societal measures. One societal response has been the marking of nutritionally satisfactory food based on Nordic recommendations ("Nøkkelhullsmerkingen") (Øen, 2012b). Another response has been introducing a partly sponsored school fruit program, providing fruit and vegetables to school

children (Ibid.). Other preventive measures in Norway have been removal of candy at grocery store registers, as well as systematic weighing and measuring of children. Additionally, there are information campaigns, such as “five fruits a day”, informing the population in a positive manner.

Childhood obesity is a popular topic in the media, and since I started to work with the thesis, there has been many reports in the news. Some of the topics in the recent agenda have been about concerns regarding weighing and measuring in schools, and reporting about a recent WHO report sounding alarm about childhood obesity.

2.4 Context of the Norwegian health care service

Norway is a welfare state, meaning services for the population are covered by public schemes, to ensure health care, education and economic and social safety to all members of society. The Norwegian health care service is amongst the best in the world (Helsedirektoratet, 10.03.2015), and is organized under the Ministry of Health and Care Services. The health care system works with different layers of service on local, regional and national level. The primary health service is run by the municipalities, and range from health stations and school health service to general practitioners. The effort to reduce the development of obesity is initially assigned to the municipalities (Helsedirektoratet, 2010a). Formal responsibility is situated with the general practitioner, but also draws on the competences of other available resources in the municipality (Jåtun, 2012b). When diseases and problems are too severe or too complicated for the primary health service, patients are referred to the specialist health service, which is owned by the state.

Recommended treatment for overweight and obese children is concrete and achievable lifestyle changes. Goals are made in agreement with the family and the health care personnel, and gradually increases in extent through regular consultations. Lifestyle refers to ways or modes of living (Wold, 1989 in Fauske & Øia, 2003). The concept includes general habits and ways of living, interests, activities and social habits. The focus in terms of overweight and obesity is on healthy diet and increased physical activity. The role of the health care personnel is to be supporters and advisers, and to strengthen the patient and the family’s feeling of self-worth and competence (Jåtun, 2012b). The treatment of lifestyle change is very dependent on parent’s motivation and support in order to be successful, as today the most common attitude is to initially help the parents help the child (Øen, 2012d).

In treatment of child obesity, parents and health care personnel often prefer not to have the child present in conversations about weight (Jåtun, 2012b). Because children are considered

in need of protection, from talk about body and weight, and from hearing what parents say. The reasoning behind these attitudes comes from a worry that a great focus on children's weight, risks worsening their self-image. Further, there is a fear that developing bad self-image leads to eating disorders. However, studies show no increased incidence in eating disorders when doing professionally administered weight loss programs (Butryn & Wadden, 2005). Øen and Stormark (2012) suggests that health services for overweight and obese children are insufficient, and that more knowledge and a broader understanding of the obesity problem is needed.

In Norway, municipalities are responsible for health care services for overweight children with BMI up to 30. Generally, there are big differences in what kind of services are available and offered to children in different municipalities, a concern pointed out by the United Nations Children's Committee, and mapped in a recent report by UNICEF Norway (Aspelund, 09.09.2015). This relates also to health services. The Government has issued guidelines of weighing and measuring of children. However, these are only guidelines and health care personnel can chose whether to initiate this. The Association of Public Health Nurses do not support the new guidelines as long as they are not followed by increased resources for follow up with the children (Norsk Sykepleierforbund, 2011).We see differences with the locality of the children, and the local personnel they encounter.

Premises for the work, assessment and treatment of patients in the different health care services are specified in national professional guidelines. These guidelines are prepared by The Norwegian Directorate of Health, and take basis in directions from the Government. The Government reports on their politics, laws and values in health care laws and White Papers, stating how the health care service should be for the whole population. Further, strategies and action plans are often developed to concretize how these goals are to be achieved.

2.5 Norwegian childhood

In Norway, there is a dominant view of 'the competent child' (Kjørholt, 2004). It has generally been a protective state, yet focus on children's participation and citizenship has come with international children's rights discourses. The children's rights discourse has impacted the way children are viewed, from ideas about a natural and innocent child, towards qualities of competence, autonomy and rationality (Nilsen, 2008). This is aided by children's increased participation as consumers in a global market (Ibid.). Childhood in Norway is constructed alongside the social preoccupations and priorities of the capitalist countries in the western world (Boyden, 1990). Solberg (1990) reports that most Norwegian parents are content with leaving

their children without adult supervision at the age of 10, and confident on their children's ability to handle the situation. Norwegian children aged 10 to 12 are expected to participate in housework together with parents (Solberg, 1990).

It may seem as a paradox in the Norwegian society where children are considered competent actors at the same time as being considered as dependent. The western societies construct children as dependent to a higher degree, and for longer, than in other societies (Boyden, 1990). Age exerts a powerful and constraining force on children's lives in western conceptions of childhood (Kitzinger, 2015). "Far from being absent from social structure concepts of age are the main scaffolding around which the western conceptions of childhood are built…" (James & Prout, 1990, p. 222). It is a central feature of the social construction of childhood, structuring informal age grades, such as infancy, childhood, adolescence, as well as formal age classes, referring to a group of coevals progressing together through the age structure (James & Prout, 1990).

The Nordic countries are known for being child-centered, which is manifested in institutions and laws (Nilsen, 2008). The state and local authorities are expected to secure a good or proper childhood for its children, creating children as a distinct formal category in a formal sense in terms of law and public relations (Kjørholt, 2004). The traditional image of Norwegian childhood is an active, happy and healthy outdoor childhood (Nilsen, 2008). This is deeply rooted in the Norwegian culture together with the love for nature (Frønes, 1992). Childhood in Norway is viewed as a carefree time of play, a peaceful period within the protective care of the family. This romanticism of childhood has roots in the thinking of Rousseau (James et al., 1998). His idea was that children were by nature good, and that nature wanted children to be children and develop freely. Education needed to be adjusted to the natural level of maturation, and children would be harmed by being treated as adults (Fauske & Øia, 2003). Within a broad discourse of worry, the Norwegian childhood values are threatened by the negative influences of the modern childhood, which comes with new technologies and lifestyles, for instance sedentary activities such as television and computer games (Nilsen, 2008). To sum up children are seen as both competent and dependent in a child-centered Norwegian society, with a romantic view of childhood. In this background chapter, we have seen that overweight and obesity is a potentially health hazardous phenomenon affecting people both globally and in Norway, and there are different opinions surrounding it. Following, I will present some of the surrounding discourses and debates around excess body weight, and around children and childhood.

3 Theory

What separates general knowledge of observing and understanding our social environment from research, is that the researcher uses theories systematically both in the approach to the social world and to justify interpretations (Gudmundsdottir, 1992). The following chapter will outline the theoretical foundations behind my study, and give an overview over relevant academic approaches to children, childhood and obesity.

When looking at theory, two main topics will be outlined. First, the obesity discourse. What are the ideas behind different views of body and weight, and how can we understand the phenomenon of obesity? Why do we have a trend of increased weight in the population, what should be done about it, and by whom? The politics and various discourses on obesity are presented to situate the context around overweight and obese children. Second, I will present theoretical perspectives behind thinking about children. I have focused on conceptualizations of children from two opposing positions, presented as; the psychological discourse and the social studies of children and childhood. Further, I will present children's rights and theorizing about their citizenship. Together these topics constitute some perspectives of overweight and obese children, and will be used further in the thesis to situate the analysis of the empirical data.

Throughout the thesis, I will use the term discourse. A discourse is a used here as a "…self-contained set of interconnected ideas held together by a particular ideology or view of the world" (Rogers, 2003, p. 21). Each discourse has their own particular knowledge base, assumptions and explanations about how the world works, and a set of values and ethics (Ibid.). What I am looking to achieve by examining discourses is how phenomenon are understood and advocated, as discourses are "…tools by which we comprehend the social world, take action, construct ideas." (Wilhelmsen & Nilsen, 2015, p. 250).

3.1 Theoretical underpinnings

Theoretically, this thesis has been informed by social studies of children and childhood. The reason for mentioning my position within this field is to explore the epistemological and ontological assumptions and principles about the phenomenon under study, children. I will present the aspects of this paradigm that is relevant for my study. Within this field children are viewed as active social agents, and recognized as human beings in their own right (James et al., 1998). The meaning this has for my study is that the child perspective is a main influential concern. There are some characteristics within this field laying the foundation for my study. First, the view of children as a social category. Children are seen as a specific social group with

specific relationships with other social groups, upon which social forces operate to condition and structure children's lived childhood. The second, is the view of childhood as a social construction (Prout & James, 1990).

3.1.1 The socially constructed child

There are different models of theorizing children and childhood. The simplistic illustration shows the landscape of approaches towards studying children, and where my study is situated.

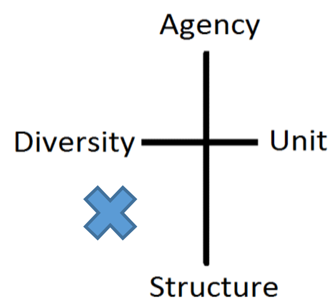

Figure 1: Theoretical field for the social study of childhood (Simplified model from James, Jenks, & Prout, 1998)

The socially constructed child is a model that locates children within particularism and determinism. Particularism means that children and childhoods are diverse depending on the spatial and temporal context, while determinism points to the way societal structures determines the lives of children (James et al., 1998). The model of the socially constructed child aims to deconstruct the phenomenon of children and childhood to show how they are built up (Jenks, 2004). "To describe childhood, or indeed any phenomenon, as socially constructed is to suspend a belief in or a willing reception of its taken-for-granted meanings." (James et al., 1998, p. 27). As a researcher, I am taking a standpoint in the belief that children and childhood are not a universal and natural concept, rather socially constructed. As a consequence, I will look at the social and cultural structures, particularly the discourses and ideas about children and childhood the health care service is based on, in the spatial and temporal context of the modern Norwegian society. Furthermore, how these structures affect present-day children, particularly overweight and obese children.

We can view this model within the general research tradition of constructionist social research. Constructionist research seek to replace fixed and universalistic conceptions of things with more fluid and particularistic conceptions (Weinberg, 2008). Social constructions are societal ideologies that often are so imprinted in people's mindset and actions that they are

difficult to detach and break down. Within a democracy, such as Norway, policymakers need to justify their actions. Justifications that often involves creation and maintenance of constructions (Schneider & Ingram, 2008). To understand how issues come to public attention and become part of the political agenda, the social construction is a critical factor (Rochefort & Cobb, 1994 in Schneider & Ingram, 2008).

> "Social construction theory has begun to play an important part in understanding how it is that public policy treats some people so much better (or worse) than others and what the implications are for citizenship and democracy" (Schneider & Ingram, 2008, p. 189).

These constructions also make up for the social and cultural structures children live within. This study will therefore focus on structure over agency. However, it is important to mention that in doing so children's agency and active contribution is not disvalued.

3.1.2 Sociology of health and illness

In discourses on obesity, the material bodies of children are under scrutiny. Because of this, the thesis will unify constructions of children and biology. It has been critiqued that the new sociological approaches to childhood often fail to incorporate the importance of embodiment in children's lives (James et al., 1998). As childhood obesity is a health issue, I will draw upon the sociology of health and illness. This is useful for seeing how health is constructed, and by extension, the construction of the phenomenon of obesity as non-health. The sociology of health and illness came into being, in many respects, as a reaction to and critique of biomedicine, the dominant paradigm in Western medicine (Nettleton, 2006). The field is concerned with understanding the body and the mind together, rather than the body in isolation, and looks at social and material causes of disease as well as subjective understandings and meanings of health and illness (Ibid.). The biomedical model of illness has been criticized for not being fully able to explain many forms of illnesses, based mainly on three assumptions. It presumes that illness always has a single underlying cause, that disease always is the single cause to illness, and that removal of disease results in return to health (Wade & Halligan, 2004). This thesis will have an understanding of health as a social phenomenon, as a product of complex factors both environmentally and socially (Bacchi, 2009). With this in mind, I will switch the focus to obesity discourses.

3.2 Discourses on obesity

"One of the most powerful and pervasive discourses currently influencing ways of thinking about health and about bodies is that of the 'obesity epidemic'." (Wright, 2012, p. 1).

The discourses of obesity, and the body as a discursive formation, informs the role of different professions and their part in framework creations through which the body is understood (James et al., 1998). In order to understand the discourses about obesity it is interesting to look at what is health, how is health defined? The World Health Organization (WHO) defines health as: "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (1948). This definition has been criticized for linking health with happiness (Saracci, 1997), and for being utopian, inflexible and unrealistic (Awofeso, 2005).

The obesity discourse is described as a framework of thought, talk and action concerning the body where weight is privileged as an index of well-being (Evans, Rich, Davies, & Allwood, 2008). When discussing discourses on obesity there are different aspects to consider. First, there are different opinions of the 'obesity epidemic'. Is it reason for the societal panic and construction of this as a 'problem', or is this propaganda from a group creating a problem that is not there? Within the discussion of the obesity epidemic there are two opposing positions, the *alarmists* and the *sceptics* (Gard, 2011). Both these positions use science as evidence for their cause, referred to as the social formation of knowledge, allowing the truth of certain things at particular historical moments (Rose, 1999 in Tingstad, 2009). What I want to achieve with outlining these discourses, is to encourage reflection about the way we think about weight and bodies.

3.2.1 The alarmist discourse – the medical crisis of obesity

When talking about obesity discourses, there is a dominant and popular discourse about obesity stemming from the medical discourse. The medical discourse on obesity focuses on health management and disease prevention, based on a rational ascetism, an expectation that the body will behave in regular ways (Murphy, 1995). The body is viewed as a machine, dismissing the mind. Grown out from this discourse is the alarmist discourse, sounding alarm about the health problem of excess weight. Here overweight is directly linked with ill health, and thinness is positioned as the universal good (Pringle & Pringle, 2012). It is also called the medical-scientific approach to obesity, because the facts the discourse stems from research. Obesity is positioned as different from and less than the normal body, which is defined by BMI.

Researchers within this position is often referred to as “anti-fat” scientist (Julier, 2008). This discourse places obesity as a threat to society because obese people impose a substantial economic burden, making it a national rather than individual issue. It is often accepted that when personal choices harms others, the state can rightfully limit people’s freedom for the social good (Leichter, 2003). We see examples of this in Norway, for instance with the ban on smoking in public areas.

Advocates for the alarmist position often use metaphors to convey their message. “Reasoning by using metaphors appears to give individuals cognitive shortcuts for making sense of new or complex societal problems and determining which governmental policies to support or oppose.” (Schlesinger & Lau, 2000 in Barry, Brescoll, Brownell, & Schlesinger, 2009, p. 8). Lackoff and Johnson (1980 in Barry et al., 2009) argue that metaphors are crucial in shaping peoples thinking. Within the obesity discourse the metaphors most often used is that of a war, as in the ‘war on obesity’ and the fight against obesity (Evans, 2010). This is used to mobilize attention and collective action. Additionally, the characterization of an “obesity epidemic” is widespread (Gard & Wright, 2005). It is used as a rhetorical device to explain the rising prevalence of obesity, using a term connected with disease and contagion. Main critiques against this use is that it creates a sense of chaos and panic, has the potential to invoke limitations on civil liberties, and it medicalizes obesity as a disease (Moffat, 2010).

The alarmists are aided in society by a moral panic about obesity, and the ‘tyranny of thinness’ in Western societies assisted by the biomedical discourse (Julier, 2008). This comes from a moral entrepreneurship within the medical field in the last two decades, where obesity (the description of physical shape) became characterized as a disease entity (Jutel, 2006). Media has also aided the alarmist position in placing the problem of obesity on the public and political agenda (Boero, 2007). Alarmist often rely on information from the WHO, and presents this problem as a global or worldwide issue, an aspect first proposed by the WHO in 1997 (Caballero, 2007).

There are generally two different disease models employed to overweight and obesity. Studies of the molecular reasons for overweight looks at individual genetics and sees overweight as a result of an inherent disposition. On the other hand, the lifestyle model of disease views personal choices and behavior as the major cause (Moffat, 2010). Further, there are different views on what needs to be done about the ‘obesity epidemic’, some argue for ramping up stigmatization by a shame-led public health agenda, while others advocate for more socially democratic solutions with broadly focused social policies and legislation (Gard, 2011).

There are big differences in being moderately overweight and being obese (Botterill, 2006), however the alarmist discourse often conflate the terms. The alarmist discourse build on a universality and normality of bodies and societies, or modern western lifestyles. A central argument made by Gard and Wright (2005) is that people have embraced the idea of an 'obesity epidemic' because it conforms to a familiar story about the decadence and decline of the Western world. Through this, hinting to a general effortless lifestyle in temporary societies, as a way to support the notion that modern societies are declining.

3.2.2 The sceptics discourse – obesity as a socially constructed phenomenon

«So what if the so-called 'obesity epidemic' is largely an illusion?»
(Campos et al., 2006, p. 59).

Contrary to the alarmist discourse is the sceptics discourse. This is a mixed group of researchers, influenced by feminism, post-structuralism and various strands of "critical social science" (Gard, 2011). They see obesity not as a problem, but as politics of exclusion. These critical scholars argue that the socially constructed obesity epidemic is flawed in the methodology claims are based on, ideologically problematic and potentially harmful because of legitimation of power relations (Pringle & Pringle, 2012).

Methodically flawed because some of the assumptions and facts they are relying upon are on some accounts not backed up by evidence, as presented by (Campos et al., 2006). First, they question the whole claim about an 'obesity epidemic', arguing that available data about average weight do not support the claim of an exponential pattern of growth typical to epidemics. Secondly, they argue against the link between morality and weight saying overweight leads to higher risk of mortality. They say that it is speculative, and at best weekly supported by epidemiological literature, and that we actually know little about the link between weight and morality. The third claim they contest is the use of BMI as a measure of health, because it sets inexact boundaries for healthy/non-healthy, and because many other factors contribute. Finally, that weight loss will improve health is questioned on the grounds of being an almost completely unsupported claim. Weight loss can be harmful for health, and some bodies are healthier with a higher amount of body fat.

These scholars challenge the popular obesity discourse based on the little consideration they give to the damaging features of the alarmist discourse, and the normalization of a

particular body shape (Gard & Wright, 2001). Damaging because bodies do not conform to the mechanical view of the body within the medical obesity discourse, which are using a simplistic calculation of energy in versus energy out. Thereby it allows for stigmatization of non-conforming bodies (Ibid.). Via ideological processes, the alarmist discourse legitimates harmful relations of power. However, there are concerns that the size acceptance the sceptics argue for can lead to apathy, by not appropriately pathologizing obesity and a normalization of bodies which undermines the potential harms of obesity (Moffat, 2010).

In line with the sceptics discourse is the increasing data showing how excess body weight can be good for you, which is called 'the obesity paradox' (Amundson, Djurkovic, & Matwiyoff, 2010). Research has shown that being overweight can give a better prognosis when diagnosed with diabetes type 2, than thin and underweight people (Costanzo et al., 2015). Also, overweight and obese patients had better outcomes and lower heart-related death risk compared with underweight patients (Sharma et al., 2014). The sceptics discourse is based on constructivism, cultural politics and the acceptance of body size. It looks past the constructed collective model of age-based change and development. This collective model is inscribed upon and through the individual body and mind of children, where there is a risk that 'difference' becomes pathologized as 'deviance' (Freeman, 1992 in James & James, 2004). The sceptics challenges individuals to set aside prior assumptions and learned truths about the world, to dig a little deeper and see how it is all constructed. So what we need to ask ourselves is: "What *kind* of a problem obesity is, what should be done about it, and by whom?" (Lawrence, 2004 in Rich & Evans, 2005, p. 345).

3.3 The politics of obesity

Within the politics of obesity, the political economy perspective to the obesity debate is important to note. Obesity is outside of being a personal bodily concern, involved in complex social, economic and political forces. There is a systematic distribution of power in this constructed public health crisis, and some who rewards from it (Julier, 2008). When talking about obesity politics there are generally two 'frames' for explaining and solving the obesity problem. One the one hand is the *social responsibility,* or environmental frame, while one the other the focus is on *personal responsibility* (Kersh, 2009).

3.3.1 The societal responsibility to excess weight

The societal responsibility position is highly linked with political economy and states that the society has the responsibility, through social structural arrangements, to prevent obesity

(Tingstad, 2009). Capitalism is blamed within this explanation frame, as obesity can be seen as a case of business success and market failure. With the societal responsibility, there are different ways to act. Soft or libertarian paternalism, means steering people's choices without eliminating freedom of choice, whereas hard paternalism focuses on strong governmental intervention, (Swinburn, 2008).

This position considers obesity as a consequence of our modern obesogenic environment, society is the cause therefore society is responsible. An obesogenic environment is defined by WHO as: "An environment that promotes high energy intake and sedentary behavior." (WHO, 2016). This has also been referred to as an 'toxic environment', where the food environment promotes over-consumption of calorie rich, and nutrient poor foods, and the physical activity environment leads to sedentary behavior (Schwartz & Brownell, 2007). There is an increasing consensus between obesity experts that altering the obesogenic environment is a crucial action towards reducing obesity (Caballero, 2007). "Humans are highly responsive to even subtle environmental cues, so large shifts in access, pricing, portions, marketing, and other powerful drivers of eating and activity will have major effects on weight." (Brownell et al., 2010, p. 380).

Structural conditions can potentially be seen as an attack against the privacy and individualism of citizens, and because of this, it might be difficult to get support for and be put in effect. Another aspect with this position to obesity is that it takes responsibility away from individuals, thus reducing blame on them, but also risks not recognizing individual's agency and competence. The way of linking environment to body weight may undermine the human factor.

> People with problems are nearly always divided into innocent victims on the one hand and those who are to blame for their own misfortunes on the other. And there are no better innocent victims than children, unless they are dogs, cats or horses. (Gomm, 2004, p. 253).

It is possible that when society is viewed as responsible for people's problems, people are positioned more or less as victims of the society they live in. Victimizing people can give probability to legislative and regulatory actions in order to create solutions. Schwartz and Puhl state that: "Most threats to children are considered societal problems to solve." (2003, p. 57). The alternative to this position is to view people as competent to take responsibility for own health.

3.3.2 Personal responsibility frame, taking responsibility for individual matters

The frame of personal culpability sees maintenance of personal health a moral obligation of citizenship (Julier, 2008). The individual consumer is responsible for own lifestyle choices, and for acting healthy and in morally acceptable ways (Tingstad, 2009). Within this discourse, moral values are connected with body weight. The slender body represents ethical and responsible choices, whereas the large body is positioned as irresponsible and abject (Wright & Halse, 2014). It is argued that the truths and interventions associated with the obesity epidemic are not contributory to health of populations, and rather contribute to dividing people, with damaging effects. This is done on the basis of moral judgements about appearance, weight and lifestyle. As the obesity discourse is interpellated in whole populations, decisions about own and other people's lives are made based on the risk of obesity (Wright, 2012). Within the issue of personal culpability there is a strong tensions about the causes of obesity. Research focus on individual blame in two ways. First, by stating directly that people are to blame for 'allowing' themselves to become obese, and their failure to live up to moral obligation. Second, people are indirectly blamed by focusing on personal behavior determinants for obesity (Gard, 2011).

This position is deterministic in its reasoning, viewing the body as biologically predisposed to gain weight, through influences of taste and hunger (Guthman & DuPuis, 2006). Within this discourse, the responsibility is directly on the individual, risking a condemnation of people who fails to owe up to this responsibility. Citizenship in relation to obesity concerns the moral opprobrium directed at individuals with lifestyle diseases, because they are perceived as disregarding appropriate lifestyle decisions. In this way, they are abandoning their responsibilities, and therefore their rights, as citizens contributing to the general good (Wright, 2012). Øen (2012a) states that one of the biggest challenges in reversing the obesity epidemic is the stigmatizing and judgmental attitudes in society towards people with overweight and obesity. However, in terms of overweight, children themselves are rarely blamed for obesity, however the parents, and more often the mother, is seen to be responsible (Moffat, 2010).

Within the personal responsibility frame, there are several ethical concerns. One of them is the morality in implying individuals are solely responsible for own health, when structural and situational are important factors (Guttman & Ressler, 2001). It is suggested that factors in the modern food environment compromise biological and psychological systems that govern eating and weight (Brownell et al., 2010). As such, there is a paradox in terms of personal responsibility, where individuals only partly can be held responsible, because their agency is restricted by societal structures. People are urged to adopt a healthier lifestyle which is

predicated on the assumption that they are capable and free to make wiser choices (Leichter, 2003).

> Implicit in this view is the Aristotelian notion that a person is responsible only for those acts that he or she freely and voluntarily chooses. Thus people who act involuntarily, through either coercion or unavoidable ignorance, should not be held responsible or blamed for their actions. (Ibid., p. 609).

These notions of freedom of choice are intertwined with aspects of social inequality, which are connected with both health in general and overweight in particular. Both in terms of exercise and eating, people's choices are not always simply free and independent, but rather influenced by powerful environmental factors (Brownell et al., 2010).

3.4 Biopedagogies: pedagogizing individual behaviour

The concept of biopedagogies draws on the concept of 'biopower' by Foucault, meaning the governance and regulations of people and populations through bodily associated practices (Foucalt, 1978 in Wright & Halse, 2014). It describes the values and practices disseminated through informal and formal education working to instruct, regulate, normalize and build understandings of the physical body and the virtuous bio-citizen (Wright & Halse, 2014). In other words, biopedagogies are understood as "…disciplinary and regulatory strategies that enable the governing of bodies in the name of health and life" (Wright, 2012, p. 8). By bringing together the idea of biopower and pedagogy, the term helps to understand of the body as a political space, and health care policies as pedagogical site with a power to teach, as they engage people in meaning making practices (Wright, 2012).

It is argued that biopedagogies situate individuals under constant surveillance as well as urging for increasing self-monitoring, often through increasing their knowledge around obesity risk and prevention (Wright, 2012). The system of control this represents can become a constant within a 'totally pedagogized society' (Bernstein, 2001 in Wright, 2012) that encourages methods to evaluate and monitor the body. "In effect, individuals are being offered a number of ways to *understand* themselves, *change* themselves and *take action* to change others and their environments." (Wright, 2012, p. 2). It is argued that a 'caring' state actively operate to control its population both through surveillance and encouraging towards personal responsibility and self-regulation (James & James, 2004).

Even though these discourses on obesity affect the lives of overweight and obese children, it is important to note that children do not simply and passively absorb cultural stereotypes. They actively understand and use them to comprehend own bodies as well as its relationship with other bodies (James, 1993 in James et al., 1998). However, "When children's play is adopted for obesity prevention strategies, the emerging public health discourse may have a disproportionate influence in shaping children's play as a health practice." (Alexander, Fusco, & Frohlich, 2015, p. 228). When studying reshaping of play, it was found that the emphasis of physical play over sedentary play, both affect children in their daily lives and potentially their well-being, as enjoyable and creative sedentary play is undervalued (Ibid.). In terms of food and identity shaping in children, research found children engage in discourses about food and moral evaluation linked with food choices (Dryden, Metcalfe, Owen, & Shipton, 2009). Meaning children may take up messages about morality in evaluation of personal food choices.

3.5 Research showing uncertainties around overweight and obesity

There are different explanations about why people become overweight and obese, as mentioned initially. Research have contributed with various evidence on this topic. Lack of physical activity is a common explanation for excess body weight, however, there are uncertainties about the role of physical activity in terms of weight. Recent research found that increased energy expenditure do not burn extra calories after a certain point, meaning that above moderate activity level total energy expenditure plateaus (Pontzer et al., 2016). This indicates that diet is the key to weight loss, not exercise. Research found that people with active and inactive lifestyles have the same average daily energy expenditure (Pontzer et al., 2012), and there are studies showing that physical activity cannot be said to be a sole cause for the increase in overweight and obesity (Dwyer-Lindgren et al., 2013). Further, overweight is found to lead to inactivity, however, inactivity is not found to lead to overweight (Metcalf et al., 2011).

Within the uncertainties about overweight and obesity in science, there is a recent finding that the intestinal flora can be an additional contributing factor to the pathophysiology of obesity (Turnbaugh et al., 2006). Additionally, antibiotics in food and drinking water is suggested to be associated with increasing risk for obesity in children (Wang et al., 2016). It has also been found that duration of sleep is consistently associated with increased risk for obesity in children, less so in adults (Nielsen, Danielsen, & Sørensen, 2011). As I have shown a glimpse of here, there are within the scientific research on overweight and obesity, many aspects that remain uncertain. Now I will change the focus over to children.

3.6 Conceptualizing children

In understanding how children are conceptualized and positioned in different ways by adults, I will present two opposing positions; the psychological and the social studies of children and childhood. They are often distinguished with the notions of 'becoming' and 'being' (James et al., 1998). "Whilst the 'being' child is seen as a social actor actively constructing 'childhood', the 'becoming' child is seen as an 'adult in the making', lacking competencies of the 'adult' that he or she will 'become'." (Uprichard, 2008, p. 303). These notions have been argued to create dominant constructions of children as either competent or incompetent (Seland, 2010), and to demarcate knowledge of human development as either fluid or fixed (Lee, 2001). I agree with these arguments; however, I will use these positions to show different views of children, where they come from, and what they mean. These discourses are important because: "Children's lives are lived through childhoods constructed for them by adult understandings of childhood and what children are and should be." (Mayall, 1996, p. 1). Now, what are these understandings?

3.6.1 The psychological discourse

Within both psychology and sociology, there are many different perspectives. The field of social studies of children and childhood has criticized psychology on various holds, amongst other the view of childhood as a universal phenomenon and children's development in natural stages. These are the perspectives I will focus on. One dominant psychological position has viewed children as cognitively deficient based on biology. Three concepts are central; 'rationality', 'naturalness' and 'universality' (Prout & James, 1990, p. 10). Rationality is the universal mark of adulthood, where childhood is a period of learning. The naturalness refers to the natural order of development into adulthood, which is universal and follows the same path for all humans (Ibid.). In this thinking children develop similarly, and they are cognitively deficiency in certain ways until they reach a given stage. The behaviorist approach within psychology is also relevant to mention here, which is based on the assumption that behavior can be measured, guided, and changed, meaning children's behavior can be modified (Woodhead & Faulkner, 2008). Children are within this position seen as human becomings, in development to become competent and rational adults (Ibid.).

Within the psychological position, the general view is of natural growth. There is a focus on children's development and normality, with a view of development as taking place through stages. The main theorist behind this idea is Jean Piaget, and his theory of cognitive development happening through a linear sequence of stages (Rogers, 2003). These stages are

closely linked to biological processes, and have almost universal character (Fauske & Øia, 2003). Within this view knowledge-acquisition and decision making (acquired and moral reasoning) is seen as conducted in lonely autonomy (Mayall, 1998), where personal relationships and social experience are not given weight. The cognitive development approach is based on the assumption that cognitive structures are more important, than experience and exposure to information (Horstman & Bradding, 2002). Horstman and Bradding (2002) report that professionals dealing with sick children, mainly are influenced by their perceived level of cognitive development, when deciding what information to give about their illness and treatment. Children are constructed as deficit, with limited abilities because of age and developmental stage.

In this thinking, children's dependency and need for protection are linked with age (Mayall, 2015). Powerful established concepts in the western world continue to link age to competence, even though they have been recently challenged within psychology (Ibid.). Children are judged to lack competence to make decisions on their lives because biological maturing is connected to psychological capacity (Ibid.). Here childhood is naturalized through the child's body. "Children's social identities as children are understood as a 'natural' outcome of their bodily difference from adults and their trajectory of physical development prized in terms of the 'futurity' of the nation." (James et al., 1998, p. 143). Perspectives of researching children deriving from psychological theory were "…primarily based upon adult concern for the reproduction of social order." (Prout & James, 1990, p. 14). Children were only passive representatives of the future generation.

It has been argued that despite the criticism of the psychological position, the resistance to new ways of thinking about childhood comes from this position being situated in society as 'regimes of truth' (Foucault, 1977 in Prout & James, 1990). Meaning that these ways of thinking functions as self-fulfilling prophecies, by these dominant ideas being incorporated into, and taught to, individuals thereby reproducing as truths. Breaking this cycle of truth might therefore prove difficult (Prout & James, 1990). Solberg (1990) gives an example of how constructions of children do not only affect them, but also acts as self-validating. She reports how children were given different degrees of responsibilities from their parents, and on seeing how the children performed these responsibilities; conceptions of age and competence were validated.

Within the psychological position, children are often conceptualized in terms of "needs". A focus on children's needs prioritizes and promotes their psychological welfare. However well meant, this practice contains many latent beliefs and judgements about children. A person in need hold connotations of helplessness and passivity, and implications about dire consequences

if needs are not met (Woodhead, 1997). "Conceptualizing childhood in terms of 'needs' reflects the distinctive status accorded to young humanity in twentieth century western societies." (Woodhead, 1997, p. 61). The focus on cognitive development within the psychological position has been criticized for being both individualistic and adultist (Mayall, 1996), where the social studies of children and childhood emphasizes more children's influences of and on society, as well as children's own voices and perspectives.

3.6.2 The social studies of children and childhood

The opposing view is fronted by the 'emergent paradigm' in the field of social studies of children and childhood, which came into being as a reaction to developmental psychology and socialization theorizing of children (Prout & James, 1990). The view has been aided by recent trend in society fueled by the UNCRC (United Nations, 1989), and children's rights are an important aspect. Within this field, children are viewed as competent and resourceful social actors. The thinking has shifted to viewing children as human being, and as I have mentioned previous, children and childhood are seen as socially constructed, rather than a natural and universal category.

Children are often constructed in society as different. Children are different from adults and dependent on adults in certain ways. However, it is important to distinguish between natural, biological dependencies and socially constructed dependencies (Mayall, 2015). An example of this is the protection of children from fears about adult behavior, creating a social construction of children as dependent on adult protection (Mayall, 1996). "The immaturity of children is a biological fact of life but the ways in which this immaturity is understood and made meaningful is a fact of culture." (Prout & James, 1990, p. 7). The explanation of social facts of childhood by the use of biological facts has been called 'the semantics of biology' (Hastrup, 1978 in Prout & James, 1990).

According to Mayall (1996) children have competence in health maintenance and in handling disease. They manage their daily life health maintenance and adjustment activities, and seek to maintain their own health and well-being, but are limited by social control and expectations (Ibid.). We read about children with cancer, their competence in handling disease and difficult information, and their desire for information and viewing adults as fragile in Bluebond-Langner (1978 in James et al., 1998). Some position children as responsible for their own health. Some websites dealing with children's health are filled with messages of how children can take responsibility for own health, and view children as competent from early age as long as they are presented with information, instructions and encouragement (Wright &

Halse, 2014). While often seen in contrast to children's needs, children's rights is prominent within this position, (Woodhead, 1997).

3.7 Children as right's holders

Children are excluded from full rights as citizens, for instance the right to vote and make decisions about own health. Instead, they have specific rights because of their status as children stated in the UNCRC (United Nations, 1989). I will not mention all the rights this convention pertains, rather present those relevant for my study.

Article 24 concerns children's right to the highest attainable standard of health, to facilities for treatment of illness and rehabilitation of health, and to equal access to health care services (United Nations, 1989). Meaning children with overweight or obesity has the right to equal access to treatment independent on where they live. According to Article 24, we can see in Norway that children has unequal access and quality of health care services. As shown in chapter 2.4, there are differences in location, what municipality the child lives in, as well as the health care personnel the child encounters, affecting children's health care service. Similarly, there are big social differences in the distribution of overweight and obesity in the population. In accordance with this, some children are withheld from their right to equal access to health care. Because of the positioning of children in society, with little or no political voice, their ability to complain about access to health care is low.

Article 12 states children have right to an opinion and to express it freely, and to have their opinions given due weight in accordance to age and maturity (United Nations, 1989). This article has relevance for overweight and obese children in meeting with the health care service, as they have a right to be heard about their situation or treatment. In order to be heard, a space for listening needs to be offered. Article 13 expresses children's right to seek, receive and impart information (Ibid.). Children have a right to receive information about their condition and treatment. These rights are quite vague, as they do not mention how they are to be achieved. Therefore, potentially easily avoided or minimally upheld. Finally, article 3 concerns the best interest of the child as a primary consideration (Ibid.).

Children are entitled to have all their rights upheld in all sectors of society. To situate children's position, I will bring in children's legal rights in general. Legal rights reflect how children are viewed in society. In Norway the UNCRC was ratified in 1991, and implemented into the Norwegian law in 2003 (Ministry of Children, Equality and Social Inclusion, 27.01.2015). Concerning Article 12, this right was originally only given to children age twelve and older in the Child Welfare Act and the Children Act. However, in 2004, because of

comments from the Committee on the Rights of the Child, this age-limit was lowered to children age seven and older, and does not exclude younger children (United Nations, 2008). The age of criminal responsibility in Norway is 15, meaning that a person is not considered of a sound mind before this age, and therefore not accountable for his or her own actions (Justis- og beredskapsdepartementet, 20.05.2005). Rights to voting, driving, sexual activity and drinking alcohol (limited), is 18 years. These rights illustrate children's special position as rights holders, yet at the same time not liable and in need of special protection from certain activities.

3.7.1 Protectionist and liberalist view on children's rights

The two positions within the discussion on children's rights can be linked to the two positions within the conceptualizations of children. The protectionists see children as still incompetent, and in need of protection by adults, whereas the liberalists see children as competent citizens deserving the same rights as adults (Franklin, 1995; Freeman, 1992).

The protectionists argue that children are vulnerable and dependent of adult protection. While it is reasonable to argue for protection of children, protection is mostly accompanied by exclusion in some ways (Qvortrup, 1990). The protectionist approach is a paternalistic approach that pertains the risk of acting against children's interests by focusing on their vulnerability. This offers an ideology of control diverting the attention away from socially constructed oppressions of children (Kitzinger, 2015). Statements such as: "Every child has the right to be a child" are common from this position, and it implies adults obligation to protect children against too heavy responsibilities, measured against their stage of maturity (Solberg, 1990, p. 135). During the 19th century children were protected from areas of adults and public life under the pretense of protection, leading to disable and disenfranchise children as citizens with the emergence of the 'welfare child' (James & James, 2004). With the 'welfare child' children "…became largely confined to a state of dependency and to the social worlds of the school and the family" (Ibid., p. 36). The welfare child is in need of protection.

The liberalists, on the other hand, view children as the same as adults, therefore also deserving of the same rights (Moosa-Mitha, 2005). The conceptualization of children as equal to adults in terms of rights, cut across the 'adultist' conception of children as subordinates. Liberalists argue that children are competent, but made incompetent by adult attitudes. They believe children should be liberated from the imprisonment of childhood (Burr & Montgomery, 2003). In recognizing children's rights and their competency, this position often prioritizes children's right to participation over protection.

3.8 Citizenship and children's role within society

Citizenship is linked to children's legal position, because the law set boundaries for what children are allowed to do, and thus how they are allowed to participate as citizens in society. The term refers to an individual's full membership of a community (Marshall, 1950 in James & James, 2004). It is one aspect of personhood that involves having political, civil and social rights. Within this understanding children are seen as potential citizens only, having limited civil and social rights, and no political rights (James & James, 2004).

Being socialized into a 'good citizen' is a commonly ascribed task of childhood, positioning children as human becomings valued for their future contribution to society rather than their current presence and contribution (Hill & Tisdall, 1997). The recreation of generations is crucial for the sustainability of any society, making the goal to be that children develop into useful societal adults (Fauske & Øia, 2003). This way the inherent goal of children is to become adults, and the inherent meaning of a lifecycle is determined. However, these inherent goals are social constructions. A construction that determines life situations for human beings, specifically the human beings categorized as children. This construction legitimizes adult centered premises for children's lives, and positions adult society's needs as a priority over children's own needs and interests (Ibid.).

Are children viewed as citizens, or just future citizens? Children are given a dual status in time, both as people now, and as people for the future. There is a tension between concern for the quality of children's experience in the present, and ascribed remit of civilizing children (Newson and Newson 1970 in Halldén, 1991). The idea of children as future citizens are strong in the modern society, where the most part of children's lives are in school. The school constitutes a field where children act, which is structured by adult control and adult's views of children (Qvortrup, 2001). Curriculum for the school's content is designed by adults without children's influence, and contains knowledge children are expected to learn in order to become civilized and useful citizens. The future of the social world rests on the shoulders of children.

3.8.1 Social investment

The social investment perspective is for a new welfare state intended to sustain a different economy central to the modern states, which is the knowledge-based economy. The thinking came out from a need to redefine the welfare state to adapt to the new socioeconomic circumstances in the post-industrial era (Morel, Palier, & Palme, 2012). Developing policies focused on preventing rather than repairing is central to this new thinking, and there is an aim to modernize the state in order to better address the new social needs and risks of modern

societies (Ibid.). A concerted child-focus highly important for maintaining a production system based on knowledge, which is sustainable, efficient and competitive. Children, as the coming generation, will as the working-age cohort need to sustain the retirement population (Esping-Andersen, 2002). The importance of prevention, positions childhood as the center of attention. This gives rise both to optimism and worry as the increase in skill requirement implies a comparative rise in the importance of preconditions for good life. "Social investment in children now will diminish welfare problems among future adults." (Esping-Andersen, 2002, p. 51). Future and societal benefits of children are the focus within this thinking, yet children are also citizens here and now.

3.8.2 Children as a minority group

Children's role in society in the present, positions them as a minority group within the triangle of children, parents and the state (Mayall, 1998). "Key to understanding this is the concept of generation as a tool for deconstructing their social positioning as a group and as individuals in interaction with adult individuals and groups." (Mayall, 1998, p. 276). Within medical encounters, children are doubly dependent, both on parental and medical staff behavior as well as on the goals of the health service (Mayall, 1998). Children are viewed as subordinates in the division of labor. The health care arena helps us understand children's minority status when considering the division of labor. Children's ability to act and take some control over self-maintenance is severely constrained by adult agendas (Ibid.). The formal agenda and social policies emphasizes the cognitive over the physical and emotional, creating a subordination (Ibid.). It is generally unquestioned in European societies that children are dependents, and therefore have it best if they subdue to adult understandings of their best interest (Qvortrup, 1990). Children as dependents lack individuality as free citizens (Davidoff, 1990 in Mayall, 1996). Their dependent status makes children into a private matter, which is seen in the reaction to intervention by outside agencies or people as unwarranted and illegitimate (Qvortrup, 2008).

As mentioned previously the western societies are characterized by a strong age segregation. By fixing adults and children as different within the law with an age-based criteria, children has been bestowed with a status of non-personhood and minors (James & James, 2004). The culturally prescribed difference and particularities of children are given strong hold in society through social policy and the law. They work to ground, control and legitimate power imbalances between children and adults as natural status differences, based on age. By doing so they are making them resistant to challenge and critique (Ibid.). Children are in society almost always determined and/or constrained by adults. Almost all political, legal and

administrative processes have great effect on them, but the opposite way children have little or no influence back (Prout & James, 1990). Children are under adult power in all areas of society, and unquestioning obedience are wanted. These construction affect children's self-confidence, and view of themselves (Kitzinger, 2015).

We have seen throughout this chapter that theoretically, when understanding and thinking about both the phenomenon of overweight and obesity, and children and childhood, a strong tendency towards ambiguity and obscurity emerges. There seem to be lacking clear and knowledge based explanations to the obesity problem, the popular societal discourse is connected with moral overtones, and we see various views concerning children's positioning. Through analyzing public documents, I aim to see if they give a clearer image of this phenomenon. Following, the next chapter will describe and explain the method used in the study, before theories will surface again to help present my data, contextualize it and discuss the findings from this study.

4 Method

My study was designed to investigate the phenomenon of overweight and obesity, and the notions of children and overweight that is meant to regulate the Norwegian health care services. The method used for data selection is document analysis, and an analysis was done on ten public documents giving premises for this regulation. The data was analyzed using thematic analysis, a method giving the researcher a flexible and inductive way to analyze data. In qualitative document analysis, there has been said to be a tendency amongst researchers of non-transparency in how data was analyzed, and how results were achieved (Bowen, 2009). I believe this can affect the credibility and reliability of the findings, thus consequently the following chapter aims to explain both data collection, data analysis, and choices made throughout the study, explicitly. The method chapter will begin with outlining the methodology behind the study. The method of *document analysis* will be explained, and the reason behind the choice of method. Following documents as data sources are discussed, as well as the context and sampling of the documents. All documents included in the study will be presented, and the way the data was analyzed will be described in detail. As with all research there are limitations with the study. These will be discussed, as well as ethical reflections of relevant aspects in the research.

4.1 Methodology

Methodology refers to the theoretical underpinnings of the research (Somekh et al., 2011). It relates to how to get information, and the best way to get the information we are looking for to answer the research questions. The *epistemological* and *ontological* orientations behind the research makes up the philosophical assumptions behind the research methodology (Neuman, 2011). It is important for the researcher to be reflexive and aware of these assumptions, in order think clearly about own research. Epistemology is the theory of getting knowledge. The epistemological orientation behind this research is an interpretist position, meaning that we need to interpret subjective meanings and social actions to understand a certain reality. An interpretist approaches the data with questions, rather than hypotheses (Bryman, 2012). Ontology refers to how we understand reality. The ontological orientation in this thesis is based on constructivism, meaning that there is no single reality, rather reality is constructed; and we need to understand the context of the construction (Ibid.).

Qualitative research differs from quantitative in that it concerns an in-depth exploring and understanding of the real world, whereas quantitative research is usually based on verifying certain hypotheses on a macro level using numbers and statistics (Neuman, 2011). The study in

this thesis is an *inductive qualitative research*, meaning that it approaches the social world in an exploratory manner in order to understand, describe and explain a social phenomenon (Rapley, 2007). There are different aims of inductive qualitative research. The study undertaken is a *descriptive research*, meaning that the purpose of the research is to describe a social phenomenon, and to answer the research questions (Neuman, 2011).

The pre-position of the researcher is an important aspect relevant to the study. I come from Norway, and am familiar with the cultural context in which the study in undertaken. Because of this, I might not have the same critical distance from what is under study, as a researcher coming from another culture (McCracken, 1988). A large number of assumptions comes with this sense of cultural familiarity, and creates a potential bias in research. Trying to create distance to the familiar social traditions and practices is important when undertaking research, but it can be a difficult task to achieve. However, it is the task of the sociologist to render the ordinary anthropologically strange (Garfinkel, 1967 in Gomm, 2004). With this starting point, I have endeavored to create a theoretical distance to the social world under study.

4.2 Research design

The study was designed from a problem-driven starting point. Problem-driven document analysis are initiated by questions about currently inaccessible phenomena, where texts are believed to provide answers (Krippendorff, 2013). Researchers with this starting point tend to be concerned with real-world, and with epistemic problems, which are problems of not knowing something deemed important (Ibid.). The problem in this research was the construction of overweight and obese children in the documents, and this problem was converted into research questions. The analysis in the thesis was conducted manually, as this was considered appropriate due to the interpretive nature of the study.

4.3 Data selection

Documents were used as primary sources in my study. There are different names used in referring to the method of using documents as sources, the two main terms are *document analysis* and *content analysis.* I will use the term document analysis. A main reason for this is the ambiguous meaning of the term content analysis, referring to a method of data collection in quantitative research, while naming a method of data analysis in qualitative research (Schreier, 2012). The term document analysis was considered more suitable, as it is more descriptive of the method.

In short, document analysis is a systematic examination of documents. Documents are referred to as 'social facts' because of the socially organized ways in which they are produced, shared and used (Atkinson & Coffey, 2004). Additionally, they "…often enshrine a distinctively documentary version of social reality" (Ibid., p. 59). Precursors of the method of document analysis are suggested by certain scholars to date back to the 17th century, with the exegesis of the Bible and Freud's dream interpretations (Kuckartz, 2014). Still the scientific beginning of the method, under the name of content analysis, was around the 20th century. It had initially journalistic roots from quantitative studies of the press, but also a wide use in propaganda analysis during World War II (Ibid.). The original quantitative nature of the method has historically lead to definitions such as: "…a research technique for the objective, systematic and quantitative description of the manifest content of communication" (Berelson, 1952 in Kuckartz, 2014, p. 31). Yet, through time it has also been used in social scientific research on political symbols, historical and anthropological data, as well as psychotherapeutic exchanges (Krippendorff, 2013).

The documents I used are chosen for their use as *social facts,* in order to understand the construction of, and structural frames that politically are intended to give premises for the health care service. In order to form empirical knowledge from documents, data need to be examined and interpreted to draw out the meaning and get an understanding of the text (Bowen, 2009). On this account the context of the documents have been explored, and a systematic method of data analysis have been used for interpreting the data. Document analysis is a method that, contrary to many other qualitative methods for data collection, contains text and information that have come into being without a researcher's intervention (Ibid.). However, the researcher still plays a major part in obtaining the data. Many choices need to be made before the final documentary sources are ready for analysis.

A hermeneutical approach was adopted in analyzing the documents. Hermeneutics is defined as the art of interpretation, or the techniques involved in understanding texts (Kuckartz, 2014). The reasoning behind this is that without understanding a text, only detached characters, words and structural information about them can be analyzed. However, when there is an interest in the semantics of texts, understanding and interpretation needs to be addressed. Kuckartz (2014) recognizes five hermeneutic rules for qualitative text analysis, which were used during the analysis. First, the researcher needs to reflect upon own preconceptions about the research question, and secondly, to work with the text as a whole. The third rule says it is important to make oneself aware of hermeneutic differences, meaning that we can only understand text through interpretative processes. Fourth, it is important to pay attention to topics

and themes, and where in the text they appear. Lastly, one need to try to differentiate between discovery and application of codes and coding. I have used these rules while doing a systematic analysis. The reason for this is a belief that findings from the analysis will be stronger represented if they are seen together with the broader understanding of the documents. It has been suggested that, in social science, texts outlining systematic and detailed methods for working with documents are, more or less, absent (Prior, 2003), and that documentary sources have become increasingly neglected (McCulloch, 2004). If it is an undervalued method in social science, and without much detailed literature, then why was this method chosen?

4.3.1 Reasons for choice of method

There were both theoretical and practical reasons for choosing this method. Theoretically, the main reason for choosing this method was an interest in investigating into central public documents to explore what they express. With this in mind, document analysis was the appropriate method. Additionally, it came from a personal theoretical curiosity to learn and try the method of document analysis. Practically, the timeframe and scope of the study was an influential reason for choosing the method, and I chose to focus on one method alone, in order to conduct an in-depth study into the theme of interest. Originally, in the process of working out the final research question, I considered doing a fieldwork, however, because of ethics and the sensitivity of the topic, belonging to the category of health-related research, fieldwork was ruled out. Additionally, I considered initially doing interviews with health care professionals, but because of access and accessibility, it was disregarded.

There are many advantages with document analysis as a method of data selection, as presented by Bowen (2009). The use of the term data selection is a chosen wording as document analysis is a method that selects existing data instead of collecting it from scratch. Because of this, it is said to be an efficient method. However, it is necessary to add that this efficiency depends on documents being accessible and easy to find. Most documents are in the public domain, and easily available for researchers, which is an advantage with this method. It is also a cost-effective method. Further, a major advantage, especially with the sensitive topic of this thesis, is the lack of obtrusiveness and reactivity. Finally, documents as a data source are stable, exact and provide a broad coverage.

Bowen (2009) also presents some limitations with document analysis. It might provide insufficient detail to answer a research question, as documents are produced for purposes other than research. Documents might have low retrievability, as they might be impossible or difficult to access. Additionally, they might contain biased selectivity as they might be written for

specific purposes, and purposely avoid or select out certain elements. However, it is important to mention that these limitations are presented as potential flaws rather than major disadvantages, and that document analysis generally is a method that offers benefits, which clearly outweigh the disadvantages. Buckingham (2009) discusses the political uses of research, or of the claims made about research, and the relations between research and policy-making. In his article, which I will come back to in the last part of my thesis, he situates his analysis within a broader discussion of the nature and limitations of 'evidence-based' policy-making.

4.3.2 Documents as data sources

Documents contain special characteristics in their nature of being texts. "Documents provide a mechanism and vehicle for understanding and making sense of social and organization practices" (Coffey, 2014, p. 367). Research with documents should not only pay attention to the collection and analysis of documents, but also incorporate an understanding of the context of the documents. That is to say the socially organized ways documents are produced, shared and used (Atkinson & Coffey, 2004). The importance of the context of the documents comes from the fact that documents do not stand alone, but documentary reality depends on the intertextuality of texts (Ibid.). Public documents convey objective statements, however, all texts are socially produced and build upon certain values and viewpoints. Rapley (2007) explains that analyzing texts is as much about exploring what is said as exploring what is not said.

Documents are written by a certain author, and with certain a reader in mind. In order to understand the overall system of construction, exchange and utilization of documentary material it is important to address the authorship and readership, both actual and implied (Atkinson & Coffey, 2004). Because they are 'recipient designed', they will reflect implicit assumptions about who the reader will be. Creating a document, as in social interaction, social actors monitor and shape their actions according to the implied recipient's imputed responses and evaluations. The recipient corresponding to what Mead referred to as the 'generalized other' (Ibid.). Public documents usually require readers to have an understanding of the institutional and political context in order to have a competent understanding of them. In writing texts, authors have an opportunity to establish a consistency throughout, and compose it as a persuasive version of the truth (Gomm, 2004). Public documents are often not identifiable by an individual author or authors. "Their very anonymity is part of the official production of documentary reality" (Atkinson & Coffey, 2004, p. 70). The documents in the research often have an implied ownership, such as The Norwegian Directorate of Health, and The Ministry of Health and Care Services, rather than visible human agencies expressing opinions and beliefs.

Atkinson and Coffey (2004) explain how this absence of an implied author in documents can be a rhetorical tool for the construction of authoritative accounts, implying the existence of a reality independent of individuals.

Public documents are a genre or document type that can be recognized by a distinctive style and conventions. They have a distinctive use of linguistic registers, meaning "…the specialized use of language associated with some particular domain of everyday life" (Atkinson & Coffey, 2004, p. 59). Public documents contain a uniform format, often with a basic underlying structure. According to Atkinson and Coffey (2004) documents are often used to create "…a certain kind of predictability and uniformity out of the great variety of events and social arrangements" (p. 61). They represent one of the most essential features of the bureaucratic mode of social organization: the reconstruction of persons and courses of action in terms of the categories and rules of the society (Ibid.). For the theme of this thesis, this is to say that people and health problems can only be recorded, handled and reported if they can be made to conform to standard formats. This work of standardization and organization, transforming diverse circumstances and people into documentary form, allows for relatively predictable and standardized ways of processing. Further, for policy makers to set achievement targets and to measure outcomes (Atkinson & Coffey, 2004). These official categories and classificatory systems do not simply describe, but are also actively take part in creation (Ibid.).

These public documents will have been restricted in some ways, as there are written guidelines indicating what needs to be covered. Shared understandings and expectations exists of what these types of documents should contain, and about their use. Drafts are composed, read and commented upon, to ensure these shared intentions and cultural assumptions (Atkinson & Coffey, 2004). The documents need to be endued in the appropriate linguistic register, adapted to the institutional demands and expectation (Ibid.). Prior (2004) claims documents enter into the social world in a dual relation, as a receptacle and as agents in their own right. The need to recognize documents as things are emphasized, over simply focusing on content.

Analyzing public policy as a certain type of document is interesting. With the constructivist understanding I bring to the analysis, I will direct attention to the ways presentations of phenomenon can play a role in giving premises for how the population should live their lives, because the notion of policy conform to a particular understanding of governmental roles (Bacchi, 2009). Policies are said to be problematizing activities, in order to take actions to "fix" something, the existence of a problem in need of "fixing" need to be ascertained (Ibid.). With a better understanding of the types of documents analyzed in this thesis, the process of sampling will now be explained.

4.3.3 Sampling

In document analysis, similarly to methods generating data, the actions of the researcher is central in producing the material as 'data'. It needs to be discovered, physically collected and selected, and many decisions needs to be made on relevance. Therefore, the sampling of documents for document analysis is an essential part of the research. The most important aspect to remember when locating texts is that they are informative for the research questions. Documents deemed informative in this study were; documents guiding the health care personnel working with overweight and obese children, and the documents that these guidelines were built upon. Sampling of documents can be done using different techniques.

The documents in this study were chosen using a *snowball sampling*, which is a multistage technique starting with an initial sample unit, and applying a given set of criteria growing in size until a termination criterion is reached (Krippendorff, 2013). Underlying snowball sampling is the idea of intertextuality, meaning that units of text are connected (Ibid.). I chose this method because of my unfamiliarity with the field, and a belief that it was the best method to ensure inclusion of all relevant documents on the topic. The document *Prevention, assessment and treatment of overweight and obesity in children and young people: National Professional Guidelines for the primary health service* was the starting point, and considered a main document for the topic of the thesis. This was decided because it is a main document guiding how professionals should work with overweight and obese children. In the document other documents were mentioned, which either the document build upon, or had relevance for topic. Following, these documents made references to new relevant documents, which were included, until no new relevant references were found. "Snowball sampling naturally terminates when the process generates no new references." (Krippendorff, 2013, p. 119).

Criteria for choosing documents were as mentioned, their relevance for the topic of overweight and obesity in children and young people. However, it was necessary also to implement some constraints to ensure a manageable size of data. I wanted to use documents applicable today and/or has given premises and regulation for the documents applicable today. A timeframe was set to include only documents that were published between the years 2002 to 2015. All the documents used in this thesis are public documents, easily assessable and available for everyone to read.

4.3.4 Overview of documents

Table 1: Overview of documents analyzed:

Documents original title:	Author's translation:	Pages:
Helsedirektoratet (2010) *Forebygging, utredning og behandling av overvekt og fedme hos barn og unge*. Nasjonale Faglige Retningslinjer for primærhelsetjenesten	The Norwegian Directorate of Health (2010) *Prevention, assessment and treatment of overweight and obesity in children and young people*. National Professional Guidelines for the primary health service	100 pages
Helsedirektoratet (2010) *Nasjonale faglige retningslinjer for veiing og måling i helsestasjon- og skolehelsetjenesten*	The Norwegian Directorate of Health (2010) *National professional guidelines for weighing and measuring in health stations and school health services*	50 pages
Helseforetakene (2007) *Utredning og behandling av fedme i spesialisthelsetjenesten – barn og ungdom*	The Regional Health Authorities (2007) *Assessment and treatment of obesity in specialist health services – children and youth*	47 pages
Helsedepartementet (2003) *Resept for et sunnere Norge*: folkehelsepolitikken. St.meld nr.16. (2002/2003)	The Ministry of Health (2003) *Prescription for a healthier Norway*. Public Health Policy. White Paper number 16. (2002/2003)	184 pages
Helse- og omsorgsdepartementet (2015) Melding til Stortinget. *Fremtidens primærhelsetjeneste – nærhet og helhet.* Meld.St. 26. (2014-2015)	The Ministry of Health and Care Services (2015) Message to the Parliament. *The Primary Health Service of the future – closeness and unity. Message to the Parliament number 26.* (2014-2015)	169 pages
Helse- og omsorgsdepartementet (2009) *Samhandlingsreformen. Rett behandling – på rett sted – til rett tid.* St. Meld. Nr. 47. (2008-2009)	The Ministry of Health and Care Services (2009) *The Cooperation Reform. The right treatment – at the right place – at the right time*. White Paper number 47 (2008-2009)	150 pages
Departementene (2004) Handlingsplan for fysisk aktivitet 2005 – 2009. *Sammen for fysisk aktivitet.*	The Ministries (2004) The action plan of physical activity 2005-2009. *Working together for physical activity*. (English translation provided)	87 pages
Departementene (2007) *Barnas Framtid.* Nasjonal strategi for barn og unges miljø og helse 2007-2016.	The Ministries (2007) *Children's Future.* National Strategy for children and young people's environment and health 2007-2016	36 pages
Departementene (2007) *Oppskrift for et sunnere kosthold.* Handlingsplan for et bedre kosthold i befolkningen (2007-2011)	The Ministries (2007) *Recipe for a healthier diet.* Action plan for a better diet in the population (2007-2011)	122 pages.
Departementene (2009) *Regjeringens strategi for forebygging- Fellesskap – trygghet - utjevning*	The Ministries (2009) *The Government's Strategy for prevention. Community – safety – equalization.*	62 pages
	Total:	1007 pages

4.3.4.1 Information about the document sources

There are four different authors of the documents included in this thesis. I will give a short presentation of each here, which will together with chapter 2.4, give some insight into my empirical material[6].

The first author is The Directorate of Health, which is a professional and authoritative body under the Ministry of Health and Care Services. The directorate work to strengthen the health of the population and develop good health services.

The second author is the Regional Health Authorities, which consists of the health regions in Norway: North, Central Norway, Southeast and West. The regional health authorities are owned by the Norwegian Government, and has the responsibility for the specialist health service in their region. The Government has full managerial prerogative, which is attended to by the Ministry of Health and Care Services.

The third author is the Ministry of Health and Care Services, containing also the Ministry of Health, which was the title of the previous ministry before 2004 with many of the same areas of responsibility. The ministry has the overall responsibility for ensuring the population good and equal health and care services.

The last author are the Ministries, meaning several ministries have joined to produce the document. As such, they represent the voice from the Government. The following figure shows the political hierarchy of the authors of the documents in the thesis:

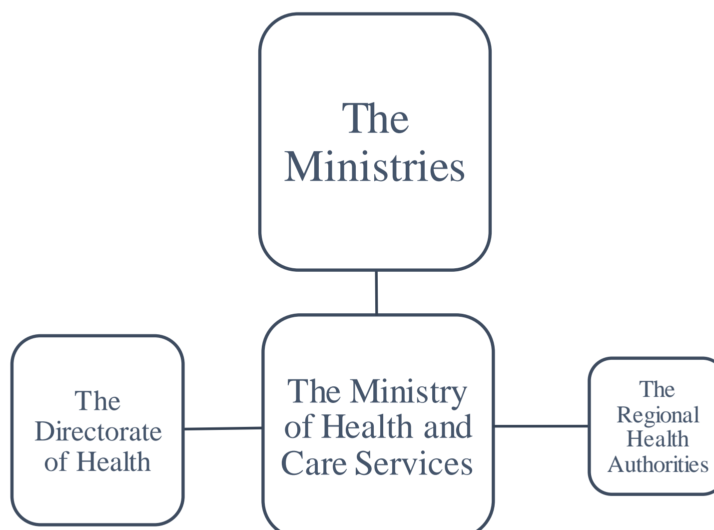

Figure 2: Illustration of hierarchy and relationship between document authors

[6] The information is gathered from various Governmental and health authority webpages.

4.3.4.2 Information about the documents

Table 2: Summary of type of document and main aim:

Title: (Author's translation)	Type of document:	Main aim with the document:
Prevention, assessment and treatment of overweight and obesity in children and young people: National Professional Guidelines for the primary health service	Guidelines for the primary health service on how to work to prevent, assess and treat overweight and obesity in children.	Ensure professional justifiable work with overweight and obesity issues in the primary health service, and contribute to a good cooperation across the levels in the health service.
National professional guidelines for weighing and measuring in health stations and school health services	Guidelines for how to conduct weighing and measuring in health stations and school health services.	Contribute to early identification of children with growth deviations, and reduce the negative consequences for the individual. Get a data foundation for implementing and evaluate measures on individual and population level.
Assessment and treatment of obesity in specialist health services – children and youth.	Recommendations for assessing and treating obesity in children in the specialist health service.	Promote an unitary service for overweight people in all health regions.
Prescription for a healthier Norway: Public Health Policy.	White paper on public health policy. Strategies for improving the public health in Norway for the next ten years.	The aim is a healthier Norway through politics which contributes to more years of life with good health in the population as a whole, and to reduce social differences in health.
The Primary Health Service of the future – closeness and unity.	Message to the Parliament with assessment of and recommendations for the health services in the municipalities.	More services should be offered in the municipalities, prevention work should be strengthened, more patient participation. Achieve a common understanding of the societal mission now and in the future.
The Cooperation Reform. The right treatment – at the right place – at the right time.	White paper on a new health reform with focus on creating good cooperation between health care sectors	Better coordinated services to answer patients' needs. Better effort to limit and prevent disease. Better answering to demographical development and change in disease.
The action plan of physical activity: Working together for physical activity	Action plan on how to improve physical activity in the population	Better the public health through increased physical activity in the population
Children's Future: National Strategy for children and young people's environment and health	National strategy on environmental and health concerning children	Highlight the environmental and health challenges most important to children, contribute to realizing politics and lay premises for future work

Recipe for a healthier diet: Action plan for a better diet in the population	Action plan on how to improve the diet in the population	Better health in the population through a healthy diet
The Government's Strategy for prevention. Community – safety – equalization.	Governmental strategy on how to work with preventive activities in society	Government want to put more focus on prevention in order to repair less.

4.4 Data analysis

In presenting my data analysis, I will try to be as transparent as possible about my analytical procedures. In the beginning, I read about *qualitative content analysis* to approach my empirical data, because it seemed to be an appropriate method for analyzing documents. The three important characteristics with qualitative content analysis is that it is systematic, flexible and it reduces data (Schreier, 2012). However, when beginning to work on the analysis and building a coding frame it became clear that this method had certain limitations making it difficult to use. Mainly, I discovered that it was too structured and systematic for my analysis, and my hermeneutic approach did not fit well with the data reduction characteristic, as I felt that much of the potential nuances and ambiguities in the documents would get lost. I found through trial and error, that thematic analysis was a better match for my material and research question. Being a novice researcher and doing the study alone, thematic analysis can be a useful method for figuring out analysis (Braun & Clarke, 2006). The method seemed to give me a more accessible and flexible approach to analyzing (Ibid.).

Thematic analysis is a minimally organized and interpretive form of analysis for identifying, analyzing and reporting themes and patterns in empirical data (Braun & Clarke, 2006). It is in a broad family of analysis methods used to :"…identify commonalities and differences in qualitative data, before focusing on relationships between different parts of the data, thereby seeking to draw descriptive and/or explanatory conclusions clustered around themes" (Gale, Heath, Cameron, Rashid, & Redwood, 2013, p. 2 of 8). Thematic analysis or coding has been said to be *the* most renowned method (Schreier, 2012), and suggested to be a foundational method for qualitative data analysis (Braun & Clarke, 2006). It is an analytic method focused on how categories relate (Schreier, 2012), fitting with my analytic and interpretive research.

My study has looked at both manifest and latent meanings of the documents, meaning both the literal and fairly obvious meaning, as well as the more context-dependent and hidden meaning (Schreier, 2012). However, the latent meaning have had the stronger focus in light of

the study's qualitative nature, where it is common to investigate deeper into understandings. The following sections will focus on the systematic analysis of the documents, which I did through various phases. The first phase of the analysis consisted of a *thematic reading*. The second phase was focused on *summarizing* the data material and selecting relevant and non-relevant parts of the document. In the last phase, I conducted the *systematic analysis* using the method of thematic analysis.

4.4.1 Thematic reading

First, the sampled relevant documents were printed and categorized into folders. Then all of the texts were read through to get a broad understanding, and a rich picture of the topic. This decision was made in order to get a better overview of the documents before beginning to break down the data. "The first step you take in analyzing qualitative data should always be hermeneutical or interpretive in nature and involves reading the text carefully and trying to understand it." (Kuckartz, 2014, p. 50). Braun and Clarke (2006) calls this first phase "familiarizing yourself with your data" (p. 87), and say it provides a bedrock for the analysis. In the first read-through, notes were made on relevant sections for the topic, as well as on interesting themes and sections, to begin outlining reoccurring themes. During the initial phase, as well as during the rest of the analysis, I wrote memos. Memos are short notes or reflective comments regarding the content made throughout the research process, which can act as building blocks for the research report (Kuckartz, 2014).

This first phase was necessary to understand the material, and to begin outlining main themes and content. During the initial phase, some topics were especially looked at:

- Children and young people
- Kindergarten, school and after school care
- Health station and school health services
- Patient/user participation
- Children's rights
- Parents, guardians and family
- Groups with special needs
- Childhood, upbringing
- Overweight, obesity
- Diet, nutrition and physical activity

4.4.2 Summarizing and selecting

Following the thematic reading, I summarized each document and marked out relevant parts of the material. First, I made a summary to structure for myself the main messages and positions of each documents. Case summaries were written after reading each document, meaning a systematic and ordered summary of the characteristics of the document relevant to the research question (Kuckartz, 2014). This was an important step because all the documents in the research have different agendas, and different focus points. I needed to find the common messages in the data, and to familiarize myself with each of the texts.

Second, I began selecting what was relevant and not in the empirical data, in order to limit the focus to what was applicable for the research question (Schreier, 2012). The marking of relevant material did not cause a major challenge. This was because the public documents are long and cover many themes, whereof children and obesity were only mentioned in small parts of the material. There is a risk of introducing a substantial bias when selecting material, because aspects that do not fit a preconceived notion can be disregarded as irrelevant. There are some strategies useful for avoiding biases, one is to use a coding frame for selecting material (Schreier, 2012). A simple coding frame was build consisting of the two categories; relevant and irrelevant. These were defined with the relevant-category as a broader category, to be on the safe side not to exclude any potentially relevant material. While the irrelevant-category was more narrowly defined. This coding frame was helpful when selecting relevant material.

4.4.3 Thematic analysis

Phase three, was the structured analysis of my empirical material. This phase was made easier because of the two previous phases of familiarizing myself with the data. Still, it was a difficult process. Because of the type of material, very vast and with excessive varieties, I had to find my own way to analyze which made sense to the data material and my research question. I handled this by first designing a test coding frame, and conducting a trial analysis. The coding process will be explained here in detail because: “Coding is not a precise science; it’s primarily an interpretive art.” (Saldaña, 2009, p. 4). The test coding frame was very extensive and had many subcategories. Forming of categories is a part of any mental activity, however in research, they are used to organize what emerges from the data. A category is a group of content with shared commonality (Krippendorff, 1980 in Graneheim & Lundman, 2004).

The main categories were decided upon with a combination of methods for category construction. I used a concept-driven or deductive strategy, meaning basing the work on previous knowledge (Schreier, 2012). The research questions were the deciding factor on the

main categories. However, the content of the data material, which had become apparent in the previous phases of analysis, was also determinant for the main categories. With a hierarchical way the main categories, consisted of sub-categories. Because of the descriptive and problem-focused nature of the study, the subcategories were developed using a data-driven strategy. The inductive nature of qualitative research was present, meaning the subcategories were decided upon while going through the empirical material (Braun & Clarke, 2006). Categories were developed from paraphrasing, generalizing and abstracting the original data (Kuckartz, 2014), and from using the strategy of *subsumption.* It means categories are created while working through the material, and concepts are subsumed into existing categories, or create new ones if they do not fit (Schreier, 2012). Using the strategy of subsumption involves that main categories are already decided upon, so the researcher has a perspective for looking at the data (Ibid.). Because I had already decided upon the main categories, this strategy was considered appropriate. The strategy of subsumption was done until the point of saturation was reached, meaning a finish-point is met when the material does not produce any new insight, and no new categories (Strauss & Corbin, 1998 in Schreier, 2012).

I used the pilot coding to note the frequency of use of the different categories, and to classify the material. The next step after structuring and generating categories was do define them. It is important for a researcher to be consistent and have a clear understanding of the categories. I made simple category definitions stating what kind of statements should be included where. This was only a methodological device in order to make analyzing the material easier for myself, and to ensure consistency. Following, I used the information from the trial coding to see what categories were consistent throughout the documents. I looked for patterns and connections, and created a final, and more limited, coding frame. There were two reasons why I found this useful, first to see the significance of each category in the material, and second to get an overview over the content of each document.

When the trial analysis was completed, I revised the final coding frame, based on the trail coding, the memos and case summaries, before beginning the next step of the analysis. Looking back on the notes made earlier, gave a deeper understanding of the documents, and acted as a lens to view the coding frame in light of the documents as a whole. With the final coding frame in place, I color-coded all the empirical material using this frame, and created a coding sheet noting again the frequency. Coding sheets were used to facilitate comparison between the documents and to register the prevalence of the categories.

4.5 Challenges with analysis

I focused here on challenges with analysis, because in my case the data selection phase, apart from a smaller issues and the time consuming aspect of deciding on relevant documents, was without much challenge. Analyzing the data however, proved more difficult. The document analysis in this study was an interesting process, and I learned a lot as a researcher. An interesting discovery, was that through writing the thesis and working with the topic of overweight and obesity, my standpoint changed. I set out to do this study with the belief that childhood obesity is a serious health problem, which we need to 'fix'. Interestingly, I was not aware at the time that I had positioned myself against the topic. However, while working with the topic, I realized this and started to open my eyes to a different understanding. The perspective I ended up having, when analyzing the material was more open, asking: What kind of a phenomenon is overweight and obesity?

The main challenges with analyzing my data came from an underestimation of the genre public documents. I found document analysis to be a challenging method as I had limited knowledge about systematic data-analysis, particularly concerning analysis of governmental documents. Because of this, I had to change my method of data analysis and spent a great amount of time on the analyzing process. There was a great diversity in the data sources, where each document has different content, and a different view and agenda towards the topic of childhood obesity. Additionally, they covered different issues: overweight and obesity in children, weighing and measuring, health politics, physical activity and diet. This lead to the creation of a coding frame, which appropriately covered the material. I found it difficult to build a coding frame that fit all the material, and many revisions were done throughout the process. Delimiting myself was a challenge, and many steps of delimitations were taken in order to narrow the focus into what was relevant to answer the research questions. Related to this, the second challenge I experienced when analyzing the data, was deciding on the interpretation and meaning of the material. Sometimes meanings were stated quite clearly, while other times I struggled to decide on the category or meaning. The solution was to make category definitions to my coding frame, where I wrote what type of statements fitted into each category.

4.6 Reliability and validity

The terms reliability and validity are often argued inappropriate in qualitative research because of their positivist origins (Schreier, 2012). They have been used to ensure the production of universal truth from producing objective knowledge. This is referred to as the 'the crisis of legitimacy' (Rapley, 2007, p. 128). Instead, in interpretive research, terms like credibility,

transferability and trustworthiness are used. However, I believe that reliability and validity can be used in qualitative research as well. Conducting research in a systematic way, with transparency in all steps and on how conclusions were made, is considered a different notion of reliability, proper for qualitative research (Steinke 2004 in Schreier, 2012). Validity in qualitative research is used in two senses, in a narrow sense referring to the usefulness of your instrument to capture what it set out to, and in a broader sense concerning the overall quality of the study (Schreier, 2012).

To ensure reliability in qualitative research two criterions are important, to study the quality and examine the trustworthiness (Golafshani, 2003). Simply speaking, it is a way to convince others that your claims and interpretations are credible and plausible, and that your argument is based on your data material (Rapley, 2007). Throughout the study I have given consideration to every choice made, and documented both pragmatic and theoretical issues guiding the process of the study. All decisions are presented with the underlying reason, creating a transparent research process in order to ensure validity and reliability. As well in the choice of method of analysis these aspects were considered, because of the flexibility of thematic coding I was able to analyze the data with a very data-driven way. Validity is ensured by focusing on the content of the data, rather than shaping the data to fit into a specific strict method.

4.7 Limitations with the study

As a researcher, it is important to be reflexive about oneself, and the possible influences one can have on the research process. In this thesis, one possible weakness was my inexperience as a researcher. The method of data collection and data analysis was unfamiliar, and because of this the study came together through a phase of trial and error. My inexperience also concerned reading public documents, and with the national and local health care system in Norway. Apart from being time consuming, there is a risk that certain aspect might have been overseen or lost, on account of unfamiliarity. This applies both in terms of data selection and data analysis. Any novice researcher might experience these risks, yet they are important to recognize. By awareness, a consideration is payed to these issues leading to the researcher to try to avoid potential negative consequences.

Conducting the study alone, without help from other researchers might be a weakness, for two reasons. First, because people construct meaning differently and it is difficult to see all relevant meanings alone. Second, because of consistency, to ensure other people read the

material in the same way (Schreier, 2012). According to Kuckartz (2014), it is preferable with multiple coders because it improves the quality of the work, and go as far as saying "There is little doubt that coding by only one person is unfavourable and should be avoided." (Ibid., p. 75). The time frame and scope of the study, made it not possible for me to bring in a second coder. However, I believe the transparity in this method chapter has been one step in ensuring the reliability and validity of the research.

It can be discussed whether to see the reliance on only one method as a weakness. Bowen (2009) state that the qualitative researcher is expected to seek convergence and validation by using multiple, at least two, methods. However, it is my view that the use of only one method does not constitute a defect, as long as the results are reported correctly. That is to give a fair representation of the findings. An issue when working only with documents, is that you cannot confirm your conclusions and understandings, as is possible when researching people. Documents do not give you that safety, which leaves a great responsibility on the researcher to give a fair representation. Reporting correctly also involves refraining from any inferential 'leaps' (Schreier, 2012), meaning to make inferences about things outside of the actual findings. Documents construct particular kinds of representations, but cannot be used as surrogates for other kinds of data (Atkinson & Coffey, 2004). Triangulation of data are presented as a means to ensure credibility, yet my opinion is that using one method in a systematic and transparent way also can guard against accusations of biases and unreliability. Bowen (2009) suggests that for studies with an interpretive paradigm, documents may be the only necessary data source. The use of document analysis as the only method is in this research not considered a weakness. This is because of the interpretive paradigm of the study, and the considerations taken in reporting the results.

4.8 Ethical reflections

When doing research there are always ethical considerations to reflect on. Document analysis presents less ethical dilemmas and considerations as it is an unobtrusive measure, meaning a study that does not involve asking people directly or observing people (Esterberg, 2002). However, it is essential to keep it in mind. The ethical consideration most relevant for my study was the issue of subjectivity.

Working with documents is a method considered to be less influenced by subjectivity, however, it is important to remember that what documents are being read, how they are read and the meaning they make to the specific reader are shaped by the individual (Rapley, 2007).

“Reading is an activity, not the passive receipt of information” (Atkinson & Coffey, 2004, p. 72). Subjectivity is one of the ethical reflections present in any research, being with people or with documents. The researcher always comes into a research setting with a certain pre-understanding and stock of cultural knowledge, as well as a set of values and opinions. Qualitative methods will always be impacted by subjectivity. It is not to be avoided, but it is important that the researcher is aware of it. By being aware, a person can take measures to try to avoid it, by double-checking the reasoning behind one’s questions, analysis and ways of action. A researcher must be reflexive and evaluate oneself continuously. In the presence of texts, it is possible to interpret words and sentences in a certain way depending on one’s own background. This is where a systematic research method is helpful. It gives readers the possibility to trace back and find the origins of conclusions made by the researcher to decide on the accuracy. This chapter has outlined the research design, the different steps of the study and the analysis. With the method and methodology in mind, it is time to move on to the next chapter, which will outline and discuss the results of the study.

5 The governmental discourse on obesity: affirmative reasoning – ambiguous content?

This chapter presents and discusses the empirical material from the ten public documents included in my study, focused on the first part of my research question: *How is the phenomenon of overweight and obesity described by national documents giving premises for the Norwegian health care service?* The following chapter will present and discuss findings from the second part of the question: *how are children conceptualized and positioned in these documents?* Throughout both chapters, I use the term discourse, as it is defined in chapter 2. In the end, I will tie these two chapters together to conclude the findings and discuss some possible implications. I want to emphasize the context of public documents as discussed in chapter 4, with specific target groups and purposes.

In this chapter, I have chosen to focus on three main themes, based on the content of my empirical material. First, what language, in terms of *concepts and words,* are used in the documents? Moreover, in what way are they used to describe, and make claims and justifications about the phenomenon of obesity? Following, what is the *reasoning* behind this phenomenon? Who or what is said to be the cause of the increase in average body weight? Finally, the third focus has been about *responsibility* for, and the solution proposed to handle this issue, which is claimed to be escalating and presenting a huge challenge in society.

Before beginning to present my findings, I believe it is important to disclose my position on the topic of overweight and obesity. Theoretically, I have positioned myself within both discourses on obesity, the alarmist and the sceptics (Gard, 2011). This means that I do not deny that obesity represents a health challenge for many people and societies, or that it may continue to increase in proportion if health authorities do not initiate adequate solutions. However, I also believe that to underestimate the challenge of obesity can be just as harmful to individuals as the simplistic and overwhelming negative focus on excess weight. With this double perspective, have engaged with and looked critically at the governmental documents.

5.1 Words and concepts: Describing obesity through an alarming language

In this chapter, I will look at the language used in the documents when talking about overweight and obesity. It is said that language is power, and it can be used in many different ways, with significant meaning for people's understanding of a topic. One can question whether the documents use language as rhetoric in order to justify or create support for their cause or measures. This first main category contains the intentions and problem formulation of the

phenomenon of overweight and obesity, which are expressed by the documents. One of the intentions of this study was to see how the phenomenon is understood in national documents. Overweight and obesity represent a serious health problem for many people, and they put a challenge on society in terms of resources for treatment and for the public health. This viewpoint is evident in the empirical material.

However, there are still ambivalence and ambiguity in the documents about what kind of a problem obesity is. This was a very interesting finding when analyzing my empirical material, because throughout the documents there are affirmative assertions about overweight and obesity. Clear messages about what it is, the reasoning and ways to 'solve' it, and where responsibility lies. Ambivalence is defined as having two opposing feelings simultaneously, or being uncertain about feelings, while ambiguity is defined as having or expressing more than one meaning (Cambridge University Press, 2003). These ambiguities will be presented throughout the chapter. First, I will start by explaining how the documents describe obesity through an alarming language.

5.1.1 Stating a problem

I found that the empirical material gives clear messages that overweight and obesity are a problem. All of the documents addressing overweight and obesity mention this. First, let us look at what a problem is. There are different definitions, but the word is usually used either to describe something which is difficult to deal with, or to refer to a puzzle or challenge which needs to be solved (Bacchi, 2009). Thus, initially we can see the choice of wording creates a problem formulation. Rather than relying on more neutral words, such as a phenomenon or issue, the chosen word used to present overweight and obesity is surrounded in negative connotations. The problem stating in the documents are sometimes clearly expressed by referring to: *"The obesity problem"*, or saying: *"Obesity is a complex and complicated problem…"*. The aspect of having excess body weight is often linked to health problems, as stated by the Ministries: *"Obesity brings with it a number of health problems"*.

Other times the problematic nature of overweight and obesity is presented more indirectly. For instance, with this quote where the risks of obesity are stated quite alarmingly:

"Many believe we are facing a global epidemic, with great consequences." (Helsedirektoratet, 2010a, p. 8).[7]

The document does not provide a commentary to this statement providing the reader with an opinion about the accuracy. Nor are any other views presented, thereby making this statement out to be a 'fact'. However, both before and after this quote there are statements about the increasing prevalence of overweight and obesity, and the health risks it brings with it. This adds to an understanding that this phenomenon is a global problem with great consequences, meaning negative results. Such as understanding indicates that the authors of the documents are positioned within the alarmist discourse, see chapter 3.2.1. The use of the terms global and epidemic here build on information from the WHO, an organization who are seemingly influenced by and advocate alarmist's standpoints.

One typical way to show the problematic nature of this topic is to refer to the high increase in prevalence of overweight and obesity. It is frequently stated in the documents that overweight and obesity is an increasing phenomenon.

"Today half of all adults and one in five children in Europe are overweight (Body Mass Index >25)." (Helse- og omsorgsdepartementet, 2009, p. 43).

"Numbers from amongst others The World Health Organization (...) show increasing prevalence of overweight and obesity both in developing and industrialized countries." (Helsedepartementet, 2003, p. 171).

"The prevalence of overweight and obesity (in Norway) is increasing in all age groups and all parts of the population, which will become an increasing challenge for the health service to handle." (Departementene, 2007b, p. 64).

As we see, overweight and obesity are affecting many people nationally and globally, both adults and children. It is often stated, as we also see here in the second quote, that overweight and obesity are a problem worldwide. The increase in prevalence in Norway is also stated. However, the last numbers show the prevalence has been stabile (Hovengen et al., 2014). Interestingly, there are also several statements referring to uncertainties about increasing overweight, such as this quote illustrate:

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[7] All quotes from the empirical material are translated from Norwegian to English by the author.

"The increase in the proportion with overweight and obesity in the population seems to have accelerated the last ten years, and the weight gain seems to have been greatest amongst the young." (Departementene, 2007b, p. 108. Emphasis added).

It is hard to find a consistent message about increasing overweight and obesity. Thus, the argument that excess body weight is an *increasing* problem, might not be as clear as it is presented to be on many occasions by the documents. However, the documents do portray it as a problem.

Within the Law of patient rights under § 2, the patient have rights to necessary health help from the specialist health service when: "The patient has a prognosis with regards to length of life or a non-insignificant impaired life quality if the health help is postponed." (Sosial- og helsedirektoratet, 07/2004. Author's translation). The document *Assessment and treatment of obesity in specialist health services – children and youth* states that this is considered met in terms of overweight in children. This discloses something about how the Regional Health Authorities view obesity. They see it as a health problem that shortens length of life or significantly impairs life quality. In the document *Prescription for a healthier Norway: Public Health Policy,* the definition of health from the WHO (1948) is criticized for implying a direct correlation between health and a good life. The document views health rather as an investment factor for 'the good life'. Positioning overweight and obesity as a health hazardous problem, and relying on the alarmist discourse's causal link between excess weight and bad health (Pringle & Pringle, 2012), as shown previously, thus situates overweight and obesity as interfering with 'the good life'.

However, within this standpoint there are also statements showing ambivalence towards the "dangers" of overweight. The document *Prescription for a healthier Norway: Public Health Policy* spends much space on the problems of overweight and the risk for diseases. Yet, in a small paragraph following this, it says:

"Recent research have shown that it is not the overweight in itself that is the main problem, but rather the inactivity that underlies the overweight. If one corrects for physical fitness, one finds no increased risk with overweight. Overweight in itself is thus not connected with an increased risk for various diseases and conditions, as long as one is in good physical shape." (Helsedepartementet, 2003, p. 172).

When it comes to the 'dangers' of overweight, The Ministry of Health give contradicting messages. Placing overweight as a health hazardous problem, while at the same time saying that the risk of diseases is connected to inactive lifestyle rather than the overweight itself. They change position here to say that physical shape is rather the problem. This correspond to the critique from the sceptics discourse, that the scientific evidence does not support the claim of a causal relationship between weight and health, which the alarmists advocate for (Campos et al., 2006). Even if it is a small paragraph in one document, it alone creates a contradiction in the document's line of reasoning, which is interesting in the understanding of the 'obesity problem'. The problematic nature presented in the documents in relation to excess body weight, and the lack of references to any claims made by the sceptics discourse, see chapter 3.2.2, suggests that the Government and health authorities relies heavily on the alarmist discourse of obesity, see chapter 3.2.1. This point is further assisted by the use of alarmist metaphors.

5.1.2 Metaphors: epidemic and war

One political means, used in the documents advocating for the problematic nature of overweight and obesity, is the use of metaphors. A metaphor is defined as an expression for something that is used to refer to something else, in order to show or suggest similarity (Cambridge University Press, 2003). Out of the seven documents included in the analysis, which addresses overweight and obesity in-depth, all refer to obesity metaphors one or more times. There are two metaphors used. The most common one refers to obesity as an epidemic. Some statements simply mentioning it in passing. *"…the global obesity epidemic"* or *"overweight epidemic"*, while others use the metaphor in conjunction with the health consequences of this problem, or when stating an alarming increase of the 'problem'.

> *"We are facing a global epidemic, with great consequences for health and welfare."* (Helsedepartementet, 2003, p. 171. Emphasis added.).

> *"In all of the western world there are reports about an 'epidemic' of overweight."* (Helsedepartementet, 2003, pp. 14-15. Emphasis added.)

> *"The prevalence of obesity has increased dramatically globally the last 10 years, and as part of this epidemic the number of children with overweight increases in many parts of the world."* (Helseforetakene, 2007, p. 4 Emphasis added.)

The metaphor explaining the increase in excess weight as an epidemic, makes comparisons between overweight and obesity and epidemic diseases. There are various opinions about the term epidemic (Green et al., 2002). Generally, it is used to communicate risk and refers to something spreading at a concerning rate. It is often linked with disease and contagion. Using the term epidemic always communicate something harmful to individuals, something unattractive. One thing is for sure, whatever epidemic is spreading; you do not want to have it. This is what the use of epidemic in the documents indirectly says about overweight and obesity; it is unattractive and harmful, and a disease that you need to be careful not to 'be smitten by'. As discussed in chapter 3.2.1, it has been common for alarmists of the 'obesity problem' to use the term epidemic in describing its high increase in the last years.

The other metaphor used in the documents refers to the work on decreasing the prevalence of excess weight as a war. This metaphor was not used as often, only in two of the documents analyzed. I chose to include it, because I believe the occurrence of it tell something important about how overweight is viewed. Additionally, it is a metaphor that is commonly used when talking about overweight and obesity (Evans, 2010). Both the Directorate of Health and the Ministries refer to fighting overweight.

> "*We hope the guidelines will be of help for health care personnel and collaborators in fighting the problem of overweight*" (Helsedirektoratet, 2010a, p. 4. Emphasis added.).

> "*...fighting the rapid increase of overweight*" (Departementene, 2007b, p. 8. Emphasis added).

Use of the word fighting paints a picture of a war, where overweight and obesity is something that needs to be combated. In a war, there are often two sides fighting against each other, one good and one bad. In this case, thinness is the good side and fatness is the enemy. The problem of overweight represents a threat for health. It is possible also to see this fight as necessary since fatness is 'attacking', meaning it is increasing in prevalence and deteriorating our public health. Additionally, it can insinuate a need for unity. When fighting a war it is important to unite and fight together. Faced with a rapidly spreading 'disease', collective actions need to be taken to stop it.

So what does this use of metaphors mean? A metaphor is a rhetorical device which can be used politically to mobilize attention and action. Using metaphors helps shape how people think about an idea, and about what should be done about it (Barry et al., 2009). By using this metaphor, the Government and health authorities can advocate for the position that overweight

and obesity are a problem, and persuade the population into action towards this threat. This can be seen especially in the statements that refers to an epidemic together with talking about health consequences and increased prevalence. The use of metaphors helps shift the population towards a certain agenda. In this case, to stand together as a national family to stop a health threatening problem. Often these metaphors are stated in reference to the WHO. There is a formulation in the documents constructing excess body weight as a problem, an argument strengthened by use of metaphors. Let us look further into what kind of a problem it is.

5.1.3 Risk and disease

The way overweight and obesity are a problem is often presented in the documents through the negative health risks or consequences excess weight can lead to. These statements are often in the beginning of the topic, as an introduction. There are differences in the ways in which the terms risk and disease are used, leading to an uncertainty of meaning about the 'obesity problem'. First, I will look at the word risk. Generally, it is frequently stated in the documents that obesity is a risk factor for development of a number of diseases, as these quotes exemplify:

> *"Overweight and obesity can give a number of negative health consequences of psychological and physical nature."* (Helsedirektoratet, 2010a, p. 10. Emphasis added).

> *"Overweight in child years gives a significantly increased risk for overweight and obesity in adult age, with consecutive increased risk for developing amongst others diabetes, cardiovascular disease, strain disorders and reduced longevity."* (Helseforetakene, 2007, p. 2. Emphasis added).

Here there are suggestive statements about the link between excess body weight and bad health. As seen in chapter 2.2, we have access to knowledge showing that overweight and obesity can be a risk for health problems and diseases. Sometimes excess body weight is said to *be* a health problem, with risk for serious consequences. This can be seen in the following quote in relation to children:

> *"Overweight and obesity amongst children is a significant health problem which can have serious consequences for the child's psychological and physical function and for morbidity in adult age."* (Helsedirektoratet, 2010b, p. 1. Emphasis added).

We see here that overweight and obesity are viewed as a health problem in itself. Adjectives such as significant and serious are used to convey importance, going as far as to talk about death. An interesting part to notice here is the wording: *can have*. Meaning that there is a risk for serious consequences towards health when being overweight and obese, however, this is not a given. So to sum up, having excess body weight is seen by the documents as a factor, or sometimes as a health problem, which increases the risk for development of diseases and potentially for morbidity. The documents recognize overweight and obesity as a cause for disease, however, do not mention the possibility that it might be a symptom of disease or health problems (Evans, 2006).

While overweight and obesity are mentioned in the documents in some places as a health problem in itself, still further, as I will show here, they are also mentioned as a disease in itself. This quote from *Recipe for a healthier diet: Action plan for a better diet in the population* shows how overweight and obesity is mentioned together with other serious diseases:

> *"...a number of diseases and health problems such as diabetes, cancer, cardiovascular disease, gastrointestinal diseases, overweight/obesity, malnutrition and eating disorders."* (Departementene, 2007b, p. 63).

In this document, overweight and obesity are named as a public disease, as well as a chronic disease, in line with diabetes and allergy. In another document, *The Cooperation Reform: The right treatment – at the right place – at the right time,* overweight and obesity are mentioned amongst a group referred to as lifestyle diseases, and overweight is presented together with diseases like type 2 diabetes and cardiovascular diseases. Medicalizing overweight and obesity as a disease categorizes overweight people as patients needing to be cured (Moffat, 2010). Even though it might take some of the focus away from the understanding of overweight as caused by personal behavior, it contributes to an understanding of excess body weight as inherently unhealthy and undesirable (Evans, 2006). This is criticized on many holds from the sceptics discourse (Campos et al., 2006). Additionally, medicalizing overweight and obesity allows it to be viewed as a public policy problem (Botterill, 2006), thus in need of collective social action.

In other instances, the risks connected to excess body weight are presented as a direct consequence, rather than a possibility. These statements do not contain the words: *can be*, *risk for* and *may lead to*, but rather say *is*, and by doing so, they present a deterministic viewpoint. "Determinism is the general philosophical school of thought that states that for everything happens, there are conditions such that, given them, nothing else could happen" (Appiah-

Sekyere, 2013, p. 1032). Determinism is often contrasted with free will, suggesting that individuals do not have agency to change their 'destiny'. These deterministic statements were more limited in number in the documents, but present in more than one document. The document *Prescription for a healthier Norway: Public Health Policy* says that weight gain with more than 20 kilo after 18 years gives reduced lifespan. As stated here, weight gain leads to reduced lifespan, but there is no direct reference to why and no evidence is given. The statement is said together with the diseases that overweight and obesity can be an increased risk factor for, therefore most likely referring to this. However, the way it is stated, it seems like the weight itself leads to shorter life expectancy.

Similar logic can be seen in *The Cooperation Reform: The right treatment – at the right place – at the right time*, with the following quote about diabetes:

> *"The Norwegians of the future will to a greater extent than today get challenges related to an increasing extent of lifestyle diseases; increased proportion of overweight and obesity leads to more people getting type 2 diabetes with a consecutive new increase on the prevalence of cardio vascular diseases…"* (Helse- og omsorgsdepartementet, 2009, p. 79. Emphasis added).

This statement is deterministic in many ways. First, that we will in the future get challenges due to more lifestyle diseases. Second, that overweight and obesity directly lead to diabetes type 2, and again that consecutive to this comes more cardiovascular diseases. In relation to treatment of overweight in children, the document *Prevention, assessment and treatment of overweight and obesity in children and young people*: *National Professional Guidelines for the primary health service* states that professionals should:

> *"Assess the psychosocial strains the child and the family are experiencing as a result of the overweight."* (Helsedirektoratet, 2010a, p. 53).

Overweight is seen as a direct determinant for psychosocial strains, rather than as a risk for problems. We can witness this on the phrasing of the sentence, if there were uncertainties about the presence of any psychosocial strains, the word *if* or *whether* would have been present. As we have seen, there are deterministic links suggesting a causal link between weight and life expectancy, diseases and psychological problems, thereby dismissing alternative situations, namely having excess weight and being healthy.

With these varying viewpoints on overweight and obesity, we see clear ambiguities from the Government and health authorities about what kind of a problem it is. The ambiguities were found in many of the documents analyzed. The empirical material does not have a unanimous and clear standpoint on the risks of excess body weight. While sometimes talked about as a *risk for disease*, other times it is presented as a *disease in itself*, termed both as a public, chronic and lifestyle disease. Øen (2007), also found ambiguities around what kind of a problem obesity is, in research into health care personnels' perceptions of the 'obesity problem'. One final aspect, which I want to highlight, is the common use of the terms overweight and obesity hand in hand. There are differences between the two terms and the risk they potentially have on the body (Botterill, 2006). Sometimes the documents purposely use one rather than the other, thereby showing difference. However, often the concepts are conflated, thus providing further ambiguities about the problem of excess body weight.

5.1.4 Normality and deviance

Normality and deviance are opposing concepts, and dependent on each other for meaning. The relationship between the two are asymmetrical, as normality is valued and often taken for granted, while deviance is degraded and scrutinized (Franck, 2013). The concepts are present in the documents, where weight gain and overweight are expressed as something unwanted and with negative connotations, in terms of deviance from the normal. We can see this in the following quotes from the document *Prevention, assessment and treatment of overweight and obesity in children and young people: National Professional Guidelines for the primary health service,* stated in reference to children's weight development and overweight:

> *"...prevent unfortunate development."* (Helsedirektoratet, 2010a, p. 36).
>
> *"...development of unwanted weight gain."* (Helsedirektoratet, 2010a, p. 13).
>
> "*health hazardous weight development"* (Helsedirektoratet, 2010a, p. 40).

Also in the document *Assessment and treatment of obesity in specialist health services – children and youth,* it is referred to as: *"...a worrying development..".* Weight gain is something the Government and health authorities view as unwanted, unfortunate and directly health hazardous, and it is something we need to worry about. Within these quotes, there is an inherent reasoning that the human body has a desired normal weight. In reference to preventing further

weight gain in children, the Norwegian Directorate of health want to implement: *"Measures that normalizes or limits the weight gain…"*. It signals that something needs to be done to stop weight gain.

The following quote from *National professional guidelines for weighing and measuring in health stations and school health services* is about the aims of weighing and measuring children:

> *"The Government's main target with the national professional guidelines for weighing and measuring in health stations and school health service is to contribute to early identifying the proportion of children and young people with growth deviation, i.e. deviations in weight, length/height and head circumference, and to reduce the negative consequences this can have for the individual."* (Helsedirektoratet, 2010b, p. 6. Emphasis added).

The quote has two interesting elements. It refers to overweight and obesity as a deviation, signalizing something outside of the normal, and there is an inherent attitude that deviations leads to negative consequences. We see here a reliance on normality as a positive standard for human bodies, and deviance form normality as something negative. Even looking at the word overweight, we can see a connotation of normality. The Gale Encyclopedia of Medicine (1999 in Jutel, 2006, p. 2270) defines overweight as ''an abnormal accumulation of body fat, usually 20% or more over an individual's ideal body weight''. Being overweight essentially means that your weight deviates from what is normal and ideal.

Concerning the aim of the guidelines for weighing and measuring of children, the same document state it will:

> *"…give opportunity to discover individuals who are in danger of developing underweight, overweight or obesity"* (Helsedirektoratet, 2010b, p. 6. Emphasis added).

So what does this tells us? Straying outside of the normal needs to be discovered, and it is something people are in danger of. Danger signalizes a risk of something bad, of harm and injury. As with normality, having a correct body weight is the norm and the goal, and if the weight exceeds this, it is wrong and needs to be limited. What is excluded in this reasoning are the arguments from the sceptics discourse that human bodies are not a homogenous group, that overweight can also have some protective qualities in terms of disease, and that weight loss in itself can be harmful to people, see chapter 3.2.2. The problem of overweight and obesity is

stated convincingly by the document, as I have presented, although surrounded by various visible, and more hidden, ambiguities about the problem in itself. Now, let us look at how the documents present the reasoning behind the increase in average body weight in the population.

5.2 Reasoning: Simple logic behind a complex subject

The findings presented here answers the subordinate research question: *What are the reasons given for the phenomenon of overweight and obesity?* The reasons are an important part of the overall understanding of overweight and obesity, because it says something about the cause but also gives indication about the remedy. The logic was not hard to find in the documents. As the title suggests, there was generally a simple reasoning, relying on excess body weight as a simple problem – solution, or a simple equation of energy. The subcategories, as I will go on to explain, represents easy problem and solution explanations, giving the phenomenon an indication of being uncomplicated. The balance between energy intake and energy consumption is viewed by the Government as absolutely crucial for body weight, seen in *Recipe for a healthier diet: Action plan for a better diet in the population.* The document also state that small changes in the energy balance can lead to significant increase in body weight over time. The Directorate for Health and the Ministry of Health seem to agree with this argument:

> *"Generally speaking overweight and obesity are caused by a long term positive energy balance."* (Helsedirektoratet, 2010a, p. 18).
>
> *"When the average weight and the proportion of overweight/obese in the population increases, this implies that we have too high energy intake in relation to the energy consumption."* (Helsedepartementet, 2003, pp. 171-172).

Reliance is here on energy balance, seeing excess weight as a direct result of unbalance in food calorie intake and calorie consumption through physical activity. This is a simple explanation model, and does not take into consideration individual differences in human bodies. An understanding based on energy balance is within the biomedical model of thought (Wade & Halligan, 2004). A potential benefit with this explanation model can be the exemplification of the relationship between food intake and physical activity. However, there are also problems with this way of explaining because it makes it easy to condemn people with excess weight, seeing as it is such a 'simple' solution. By focusing on personal behavior, the individual is

indirectly blamed for not being able to balance energy intake and consumption, thereby acting morally wrong (Gard, 2011).

Generally in the documents, the reasoning is low physical activity and unfavorable diet. Another common reference is simplistic reasoning such as this quote about why people are overweight.

> *"Unfortunate diet habits, inactivity and long daily time spent on television and other screen activity are the most common reasons for overweight."* (Helsedirektoratet, 2010a, p. 10).

> *"Less activity, increased passivity, as well as easier access to food with high energy content are generally perceived as the most important reasons for the global obesity epidemic."* (Helsedirektoratet, 2010b, p. 14).

Explanations like this sends a message to people that it is just to eat more favorable, be more active and use less time on screen activity, and you will be slim. Again, the phenomenon is presented with simplistic explanations. A problem with this logic is that it undervalues emotional and social aspects connected to food, exercise, body size and health (Evans, 2006).

Other reasons for overweight were also present in the empirical material, individual reasons such as medical, hereditary or genetic causes. What was interesting was that these references were limited in number. With the few references to molecular reasons for obesity, we see that the Norwegian Government and health authorities rely mostly on the lifestyle model of disease in order to explain and 'fix' the obesity issue (Moffat, 2010). I will not go further into the content of these biological causes, but rather go on to discuss the three most common explanation for the 'problem' of overweight and obesity.

5.2.1 Modern society's health debilitating lifestyle, high in calorie – low in activity

A common explanation for the increase in overweight and obesity amongst the population is societal changes in modern societies. There are direct messages about this in the documents. Our modern society leads to people living health debilitating lifestyles. As I will come back to later, the expressed intentions by the Government are to change the structural conditions in society, to facilitate for healthy lifestyles and healthy choices in the population. This is an indication that policy makers in Norway, in their documents, find the structural conditions in society today insufficient. This category of the problematic modern society is therefore important to understand the reasoning behind and solution to overweight. The following quote

was stated in relation to the changes in our modern day lifestyle, and illustrates its problematic nature:

> *"During the last half of the twentieth century there were changes in lifestyle which have serious consequences for health. Put to the extreme: Previously we struggled ourselves towards disease and death – now we consume ourselves towards the same, and we do it in seated position."* (Helsedepartementet, 2003, p. 28).

The quote start out by stating the serious consequences of our modern way of living. Further, it informs the reader that this quote is an extreme statement about our lifestyle, linking it directly to disease and even death. Even though it might be a situation put to the extreme, the quote is still very alarming and frightening, and holds many meanings about the phenomenon in focus. Also, it says something about the reasons and accountability for excess weight, which I will come back to later.

The document *The action plan of physical activity: Working together for physical activity* states that:

> *"It is (...) well documented that also Norway is affected by the modern society's health debilitating lifestyle that amongst other include decrease in level of activity."* (Departementene, 2004, p. 2).

People do not need to be physically active as part of daily life anymore, because the societal structures have changed. It seems like the modern society's health debilitating lifestyle is something that exists in itself, and a phenomenon that has come externally and affected Norway. The following quote, from the introduction to *Recipe for a healthier diet: Action plan for a better diet in the population*, concerns the neo-liberal consumer market, and structural changes in families and work life:

> *"Globalization, international trade and technological development have led to increased diversity on the Norwegian food market. Changes in family structure and work life affects the meal pattern, and an important change is that a growing number of meals are consumed outside of the home."* (Departementene, 2007b, p. 7).

Here we see the focus is on the changing diet in our modern society. The explanation relies, as exemplified with these two quotes, both on the decrease in physical activity, and changed diet

in the modern society. *The action plan of physical activity: Working together for physical activity* adds to this explanation by saying that many of the challenges, skills and experiences we earlier got as a natural part of everyday life, we now need to actively seek out and prioritize. Social, economic and material conditions need to be accounted for to explain why people are less physically active and eat differently (meaning worse). As such, it is hard to say there are simple reasons and solutions to obesity, as body weight is interconnected with wider societal conditions. With the focus on modern society, individuals are not blamed, rather one can say they are "victims" of the unhealthy society they life in. One of the commonplace explanations for overweight and obesity is our obesogenic environment (Caballero, 2007). This is in line with the familiar story of decline and decadence in the western world (Gard & Wright, 2005), as well as the discourse of worry in Norway (Nilsen, 2008). Instead of treasuring modern societal and technological innovations and development, and seeing their opportunities, previous decades are often commemorated.

Some of the common reasons given for this change in society is the changes the modern lifestyle has brought with it. The following quote in *Prescription for a healthier Norway: Public Health Policy* says something about why we see an increase in type 2 diabetes:

> *"..increase is partly due to increased life expectancy, but also structural changes in society with less demand for physical activity and changes in diet with increased energy intake* <u>*that results*</u> *in overweight and obesity."* (Helsedepartementet, 2003, p. 165. Emphasis added.).

We see here a causal link between societal change, excess body weight and disease (here type 2 diabetes). There is also a deterministic link, saying our modern society will result in overweight and obesity. These are simplistic arguments which underestimate many important facts. First, that a great part of the population in the structurally changed societies are active, and have healthy diets. Second, that many people in society are also slim, and there are many healthy overweight and obese people.

5.2.2 Physical activity – the main reason for and solution to excess body weight

This subcategory concerns physical activity as a reason for and solution to the 'problem' of overweight and obesity. Physical activity was the most mentioned category of all in my empirical material. While diet and physical activity very often were mentioned together, physical activity was the most prevalent and given most focus. Physical activity is defined by

the Ministries as: *"All bodily movement produced by skeletal muscles resulting in a substantially increase in energy consumption beyond resting level"*. Decreased physical activity, or increased inactivity, is presented as a main reason for increasing overweight in the population, as well as for health in general. The document *Prescription for a healthier Norway: Public Health Policy* states that physical inactivity is becoming the great health problem of the future. In *The Cooperation Reform: The right treatment – at the right place – at the right time,* it is said that physically inactive people lose eight to ten good years of life compared to physically active. Further, we see the great problem decreased physical activity is becoming for health, both in terms of life expectancy and as a health problem for the future. Physical inactivity is blamed further than just for causing overweight, it leads to bad health in general and shorter lifespan. The following quote, from *The action plan of physical activity: Working together for physical activity*, fittingly illustrates this point:

> *"Physical inactivity leads to overweight and development of diseases, and this is becoming a big health problem."* (Departementene, 2004, p. 19. Emphasis added.).

Here we see the focus on physical inactivity as a reason for the population's increase in weight. From this quote, it is hard to tell whether physical inactivity or overweight leads to development of diseases. Nonetheless, this direct causality is a very deterministic statement, not leaving much attention to the complexity of the phenomenon.

When talking about decreasing physical activity in the population, daily inactivity is often put forward as the problem. In *Children's Future: National Strategy for children and young people's environment and health,* it is stated that both adults and children are less physically active in daily life than previously. The document *Prescription for a healthier Norway: Public Health Policy* states that reduction in daily activity leads to insufficient psychical activity in potentially as much as 70 to 80 percent of all Norwegian children. Compared to activity in spare time, it is rather activity in daily life that is presented as the problem.

I have placed increased screen time under the category physical activity because it is generally known as a sedentary activity, therefore affecting inactivity. Mentioning of sedentary activities were limited in number in the documents, and seemingly not given a great emphasis as contributor to the increase in obesity. However, it was present and therefore adding to the explanation. The document *Prevention, assessment and treatment of overweight and obesity in children and young people: National Professional Guidelines for the primary health service* state that increased screen time can contribute to development of overweight, as it reduces

physical activity, increases food intake and, not least, children are said to be influenced by food advertising. In the document *The Cooperation Reform: The right treatment – at the right place – at the right time*, the benefits of physical activity in school is emphasized. One of the benefits is said to be reduced time spent watching television in spare time. Children's spare time activities such as watching television and playing video games are thus given as a cause for inactivity. Blaming media for child obesity happens in two ways, by keeping children passive in front of screens and for advertisements for unhealthy food directed at children (Tingstad, 2009). Both of these factor are suggested in the documents, however, similar to the findings of Tingstad (2009) media is little emphasized in my empirical material.

We understand that the documents value physical activity; so how much activity are we recommended to get? The main goal for better public health through increased physical activity in the population are:

> *"Main goal 1: Increase the proportion of children and adolescents who are moderately physically active for at least 60 minutes each day.*
> *Main goal 2: Increase the proportion of adults and elderly who are moderately physically active for at least 30 minutes each day."* (Departementene, 2004, p. 20).

Moderate physical activity is said by the Ministries to correspond to activity with an intensity similar to brisk walking. As discussed about weight, also here there seem to be a normative standard for all people, which is viewed as good. All individuals should be active for a certain amount of time, the amount differing due to age. The problem of our modern inactivity is stated by the documents to lie in our daily activity use. Thus, in relation to children, the message is that their 60 minutes of moderate physical activity should happen daily. Large parts of children's daily life is spent on play-activities. As a result, children's play should be physically active, in order to ensure sufficient daily activity. This construction of active play as preferable over sedentary play can have effect on children's lives and well-being (Alexander et al., 2015).

While physical activity is presented as an 'obvious' reason and a solution, there are also a lot of ambiguity and ambivalence in the documents concerning physical activity. It is remarked several times and is an interesting issue in the contrasting and sometimes contradictory arguments concerning overweight. There are different areas where this is evident. First, concerning activity in itself. The document *Prescription for a healthier Norway: Public Health Policy* states that people today exercise more than before, however, increased physical activity in spare time can only partly make up for reduced daily activity. A lot of daily activity

is needed throughout the day to be 'sufficiently' active, and through activity, we can avoid excess body weight. At the same time as expressing this, the documents still say that only a little amount of activity is enough to give health benefits.

> *"Research shows that it takes less physical activity to reduce the risk for disease and death that previously presumed. For physically inactive even a modest increase in daily level of activity will give considerable health reward in terms of reduced risk for disease, better life quality and increased functioning in old age."* (Helsedepartementet, 2003, p. 28).

The documents state that decreasing activity level is a reason for overweight. However, in *The action plan of physical activity: Working together for physical activity* it is stated that there is insufficient data about level of activity in children. Therefore, we cannot say anything certain about development of activity in children over time. Physical activity in spare time is said to be stable, and there is little knowledge about activity connected to house chores and other daily tasks. Activity in work life shows however a marked decline. The decline in daily physical inactivity is partly surrounded by uncertainties, however a said to be a great contributor to the increased average body weight in society. It is *believed* that there is a decline in physical activity, and an indicator of this is the weight increase, which has happened in the last decades. In the same document, the following quote is stated in relation to the uncertainties about decreased physical activity:

> *"Research shows that the Norwegian people do not exercise less than before. Still the total level of activity has decreased, and much indicate that the reason for this is reduced everyday activity."* (Departementene, 2004, p. 19).

Again, we witness a kind of speculation giving room for new questions. Is there a class difference here that the documents do not talk about? Even though there are uncertainties about decreased level of activity in the last decades, these remain speculations in the documents since they are not supported by evidence. Some reasons the documents give for speculating this, is the general weight increase in the population, and an indication towards inactivity in daily life. It is part of the hegemonic discourse related to simple models of explanation, without much support in contemporary research. Leaps of faith are suggested to be common in the alarmist obesity discourse, where uncertainties are lost in favor of clear answers and statistics are

inflated (Botterill, 2006), and personal conviction and speculations are mixed in with scientific data (Gard & Wright, 2005).

As part of the blame on increasing inactivity in children, the documents mention increased screen time. Media is a rather common scapegoat for problems in society that are far more complex than being linked to a simple matter of cause and effect (Buckingham, 2000). In *Children's Future: National Strategy for children and young people's environment and health* it is stated that much indicate that children are less physically active than before, and time used for sedentary screen activities are often used as measures of inactivity. However, it is also references to research showing that screen time is not related to less physical activity, as seen in *The action plan of physical activity: Working together for physical activity:*

> *"...the survey 'A digital childhood?' shows no negative correlation between use of computer games and other spare time activities amongst children in Oslo (..). There are many indications that those spending a lot of time in front of the computer also engage in much outside activities, and that computer use happens at the expense of other sedentary inside activities."* (Departementene, 2004, p. 13).

To put it simply, it is said here that reduced screen time does not result in increased activity level, rather to more time spent on other sedentary activities. Screen time is continuously used within public discourse as an argument for decreased physical activity when discussing child obesity. However, there are at the same time contradictory evidence to this claim. It is especially interesting to see the strong focus put on physical activity, in different ways, when research show uncertainties about the relationship between physical activity and weight. The uncertainties in the empirical material about physical activity, is comparable to uncertainties in scientific research about the effect of physical activity on body weight, see chapter 3.5. We have seen there is a strong reliance physical activity in terms of preventing and repairing weight gain. Next the question is; what role does diet play?

5.2.3 Effect of the diet on prevalence and treatment of overweight

Diet was a highly prevalent subcategory in my empirical material, as a reason for and solution to overweight and obesity. Generally, the documents say people are overweight because of a diet that is high in fat and sugar, and a way to solve this is to get people to eat healthier. So what is a healthy diet presented to be?

> *"A healthy diet fulfills the health authorities' recommendations for nutrition, at the same time as being varied, tasteful and in line with the individual's cultural values. It is the sum of what is eaten and drunk, how much and how often, that is decisive in the long run. Regular meals is a substantial part of having a healthy diet."* (Departementene, 2007b, p. 8).

The first sentence of this quote gives a lot of power to the health authorities. What they deem to be healthy at a certain point in time constitute a healthy diet. Furthermore, personal values, total and long-term diet, as well as regular meals are presented as important for eating healthy.

Let us look at what is seen to be the problem with our present day diet. Generally, a high intake of energy dense food, which means rich in fat and sugar, and sugary drinks are given as the problem. In *The Cooperation Reform: The right treatment – at the right place – at the right time*, this is said to be an independent cause of overweight and obesity. Dietary fiber also comes in to the explanations for obesity in the following quote from *Recipe for a healthier diet: Action plan for a better diet in the population:*

> *"WHO concludes that it is convincing documentation that intake of dietary fiber and regular physical activity, decreases the risk for obesity, and that high intake of energy dense foods (i.e. foods with much fat and sugar) and inactivity increases the risk for obesity."* (Departementene, 2007b, p. 109).

Fat and sugar are the enemies here to good diet, whereas dietary fiber is given as a way to avoid overweight. The classification of particular foods as inherently good or bad, healthy or unhealthy, links food with not only morality, but also to food items whose value may change over time. There is a tendency for people to incorporate messages about food into evaluation of their own diet choices and further, themselves (see Coveney, 2006).

What does a healthy diet do to our bodies?

> *"Diet affects our health throughout life. Nutrition and diet is of vital importance for growth and development (...). Additionally diet affects from early on in life health as adult and the risk for developing chronic diseases."* (Departementene, 2007b, p. 7).

Interestingly, if we look at the etymology of the word obesity, it comes from the latin word obesus, which means "whatever has eaten itself fat" (Haubrich, 1997). The roots to the word are from "ob", meaning over, and "edere" which means to eat. We see here that even in the original meaning of obesity lies an assumption that diet is the cause. Someone who is obese is

someone who has eaten himself or herself fat. This reference is interesting also, as a new report from The Norwegian Institute of Public Health shows that an unhealthy diet, together with high blood pressure and smoking, are the most important risk factors for death in the Norwegian population (Folkehelseinstituttet, 2016). Diet is thus important both for avoiding overweight and for the general health.

Diet is also a topic where we see some ambiguities. It was mentioned in the document, but with less focus than physical activity, because there seem to be a unanimous understanding that a healthy diet is important for health and weight. The uncertainties here consist of references to how the Norwegian diet has improved over the last 30 years, and lack of knowledge about the relation to excess body weight. Many of the documents refers to the positive change in the Norwegian diet the last years. The following quotes from *Recipe for a healthier diet: Action plan for a better diet in the population*, state that:

> *"The most important positive changes are reduction in the diet's fat content, saturated fats and trans fats, and an increase in the consumption of vegetables and fruits. This has contributed to the significant decline in mortality from cardiovascular diseases since the 1970's."* (Departementene, 2007b, p. 9).

> *"In Norway the population generally has abundant supply of food and basically good opportunities for having a healthy and varied diet."* (Departementene, 2007b, p. 9).

The diet has improved; we have good supply of food and good opportunities to stay healthy. Then how do the documents explain why people's average weight is increasing?

> *"Despite the fact that most people have had relatively good knowledge of the most important dietary advice for a long time, we see that it has not led to changed consumption in the desired direction in all parts of the population."* (Departementene, 2007b, p. 111).

This quote tells us that despite good knowledge, parts of the population do not take dietary advice seriously and into action. It suggests that there might be something missing, some knowledge or factors that we do not know enough about. There is a potential for this explanation to lie in complexities around food choices. People in modern societies are said to be "blissfully free" at the same time as "terribly alone" in terms of food consumption, relating to an almost unlimited access to food, and challenges of choice and responsibility (Tingstad, 2009, p. 180).

Challenges we cannot escape, because food is a necessity and something we need to take a stance towards.

There are also some contradictory evidence about the link between diet and overweight saying that:

> *"Longitudinal studies amongst children (...) have not shown clear link between energy intake or composition of diet and development of overweight. Intake of sugary drinks is the exception."* (Helsedirektoratet, 2010a, p. 22).

Amongst children, the knowledge base does not have a clear understandings of the links between diet and body weight. However, in Norway improving diet is a measure frequently advocated for, see chapter 2.3. Advocating for healthy diet is an important measure for altering habits with many people. Yet, there is also a concerning aspect when children take up nutritional morality in evaluation of own food choices (Dryden et al., 2009), and when we see a high prevalence of young girls dieting (Samdal et al., 2016). Similar to the informants of Tingstad (2009), who were people from health authorities, nutrition and consumer stakeholder, my empirical material places modern society, unhealthy diet and physical inactivity as the main reasons for the "obesity problem". However, within these simplistic explanations are messages about the complexity of overweight and obesity.

5.2.4 Overweight and obesity is a complex condition

There are, as we have seen, quite simple explanations for and solutions to the 'obesity epidemic' in the documents, even though they are surrounded by ambiguities. While at the same time an interesting finding in my empirical material is the high frequency of mentioning of overweight and obesity as a complex condition. This is in direct opposition to the previous theme about excess body weight being a simple problem – solution phenomenon. Overweight and obesity as a complex issue is sometimes stated in regards to the treatment in the health service. *Prevention, assessment and treatment of overweight and obesity in children and young people: National Professional Guidelines for the primary health service* refers to it as a complicated condition to treat, both for the health care service and for the patient. Further, it relays that treatment has varying results. This concerns especially children, as we see in *Assessment and treatment of obesity in specialist health services – children and youth:*

> *"As it is especially challenging to treat overweight while the patient is in a growth phase it rests a greater responsibility for this on the specialist health service than what is the case with adult obesity."* (Helseforetakene, 2007, p. 2).

References are made in the documents to overweight and obesity as a vulnerable topic, something which requires special consideration from health personnel. It is also said to be a long term treatment, needing follow up of patients. We can see also here that the simple problem – solution reasoning made by the Government is not sufficient for handling the challenge of increasing overweight and obesity in the population. In terms of children, there are references in the documents saying we do not have enough knowledge. In *National professional guidelines for weighing and measuring in health stations and school health services* it is said that we know little about health consequences of overweight in child years. Additionally, it is said that the reasons for underweight, overweight and obesity amongst children and young people are complex. Further, there are also uncertainties about the treatment of overweight and obesity, and the effect of lifestyle change.

> *"Lifestyle change is the primary treatment approach of overweight amongst children and young people, but because of insufficient documentation of long-term effect this type of treatment must so far be regarded as research and development work."* (Helseforetakene, 2007, p. 2).

There is a lack of knowledge about the effect of the obesity treatment given to children. The treatment with healthy diet and increased physical activity is not sufficiently researched in terms of long-term effect and consequences.

There are also ambiguities about increasing overweight and why. It is a complex phenomenon and the documents expresses uncertainties in the knowledge about why people get overweight.

> *"Probably there is a combination of diet and other factors which contributes to the increased prevalence of overweight and obesity amongst children and young people."* (Helsedirektoratet, 2010a, p. 23. Emphasis added).

> *"We cannot determine whether it is changes in energy intake or energy consumption that has caused the weight gain. Probably it is a combination of both conditions."* (Departementene, 2007a, p. 29. Emphasis added).

Contrasting to the simple explanations given as reasons for overweight and obesity as showed previously, we see that excess body weight is presented as a complex condition that we still lack knowledge about. The complexity concerning obesity in the documents reflects the voice of Norwegian professionals saying it is both laborious and time consuming (Jåtun, 2012b), and a complex problem (Øen, 2012a). Further, the complexity corresponds to uncertainties around why people become overweight and obese, a brief selection of recent uncertainties has been presented in chapter 3.5. So far, we have seen that the documents view overweight and obesity as a problem. The overall picture is, however, that the phenomenon is surrounded by simplistic explanations yet in a backdrop of complexity, Further, I will present the 'who' and 'how' proposed by the documents to 'fix' it.

5.3 Responsibility: Societal burden or personal obligation?

Is obesity viewed by the documents as a phenomenon highly conditioned by the socioeconomic environment, or as a disorder of individual behavior? The following part will present findings concerning the subordinate research question: *Who are seen as responsible for increasing excess of body weight in the population, and what are the proposed solutions?* The empirical material has a clear opinion about responsibility, it lies with the society. It is a public commitment towards the overweight and obesity, and people's health. Within this responsibility many of the documents highlights the importance of cooperation between different sectors in society, and maintaining the health perspective in all areas of society. The way the Government sees health and maintenance of weight, is related to the social responsibility frame towards obesity (Kersh, 2009). The documents give great emphasis to this.

One illustrative way to explain the collective thinking regarding health (which excess weight is presented as a threat to) is the use of the word *public health*. It is used frequently in the documents, and even in the title of the document: *Prescription for a healthier Norway: Public Health Policy*. Public health refers to health as something common and shared within a society, making health a public matter rather than a personal responsibility. The communal attitudes towards health is also found in the title of the document: *The action plan of physical activity: Working together for physical activity*. It seems to be a societal responsibility to contribute to good health in the population, in line with the concept of biopedagogies (Wright, 2012). Further, a focus on a common public health is in line with the societal system of the welfare state.

Let us look closer at why society is responsible. One of the reasons given in the documents is because of the economy and sustainability of society, which in terms of ill health is threatened by personal habits and choices.

> *"Good health contributes to economic development and poverty reduction through improvement of children's learning ability, positive demographic changes, increased productivity in the work life, reduction in disease related expenses for households, increased savings and hence increased investments."* (Helsedepartementet, 2003, p. 21).

The focus on the importance of good health lies here in economic savings and investment. Overweight and obesity are said to be a challenge to society in terms of economic costs, because people with excess body weight constitute a burden in terms of health care costs and loss of productivity in work life.

Another common reason in the documents is due to social differences in health, which comes from political and societal affairs. This is present in the distribution of overweight and obesity in Norwegian children (Grøholt et al., 2008). The document *Prevention, assessment and treatment of overweight and obesity in children and young people*: *National Professional Guidelines for the primary health service* states the prevalence and development in overweight and obesity follow socioeconomic conditions, as well as educational level. Further, the document clearly states societal responsibility:

> *"Structural conditions like living conditions, environment, social network and residence represent crucial conditions for the individuals' opportunities to establish living habits which prevents development of unwanted weight gain. This is the society's responsibility."* (Helsedirektoratet, 2010a, p. 13)

The conditions for averting weight gain goes outside the health care service, to more general societal conditions structuring people's lives. Similar to Tingstad (2009), I found that society is largely seen as responsible for the phenomenon of overweight and obesity. This might have connection with Norway being a welfare state, where actions of individuals affect the public in a higher degree than in more libertarian states. The focus on societal responsibility for health and preventing weight gain correspond to the recent WHO report on "Ending Childhood Obesity". There the emphasis is placed on the environmental, and on governments and

stakeholders to "recognize their moral responsibility for acting on behalf of the child to reduce the risk of obesity" (WHO, 2016, p. vi).

A potential problem with the reliance of societal responsibility is the surveillance and control it leads to, both over individuals and the population. However, it would be to disclaim responsibility from the Government and health authorities if weight was made into an entirely personal responsibility. Further, there is a benefit with the societal responsibility frame, because it minimizes stigmatization towards overweight and obese people compared to actions focused on personal responsibility. I will go on to focus on some of the ways in which society works to achieve better health and less overweight in the population. I found three main societal measures in my empirical material, which are recommended to 'fix' the obesity 'problem'.

5.3.1 Changing personal behavior towards a healthier population

One common way for the documents to advocate for better health in the population is to change personal habits through societal measures. These include informing, influencing, affecting, encouraging and motivating individuals towards better or more 'correct' habits, attitudes and lifestyles. Half of the documents refers to this as part of the societal responsibility towards people's health. I found this subcategory interesting because of the significance of meaning. It accepts and promotes public interference into private lives. For is not the food you eat and the way you live your life a private matter? However, it represents a soft paternalism from the state, as it relies on steering choices of people, rather than controlling them (Swinburn, 2008).

The document *Recipe for a healthier diet: Action plan for a better diet in the population* express that people trust health messages coming from health authorities. However, it also says that information measures has generally better impact amongst groups in the population with long education. As such, this way of working has better effect with certain people in the population. People are here urged towards self-monitoring (Wright, 2012), and it seems like the Government and health authorities here recognize individual's ability and freedom to take wise choices (Leichter, 2003). However, it can seem as though people with long education have better preconditions to be good bio-citizens (Wright & Halse, 2014), than those with shorter education. Thereby societal reliance on habit and attitude change in the population can work to uphold social differences in health.

Societal influence into people's lives is related to personal responsibility, as we see there in the quote from *Prescription for a healthier Norway: Public Health Policy*:

> *"The individual have a responsibility for own health and will in many areas have choices and stand responsible for their choices. But the society can and should influence the choices through informing, adding/supplying knowledge and influence attitudes."* (Helsedepartementet, 2003, p. 6. Emphasis added.).

Personal responsibility and social responsibility are linked, something I will come back to. However, we also see that influencing choices is not only something society can do, but it is clearly expressed this is something society should do for their population. Society knows better and therefore should teach and affect people's choices for their own best interest. It also goes well into the personal by: *"motivating for an active lifestyle*". The society is expected to take measures to motivate the population for a 'correct' lifestyle.

Some statements in the documents go further than motivating for change, but more actively promote changing habits and behaviors of people. *The National Professional Guidelines for weighing and measuring in health stations and school health services* shows this by using an interesting choice of words. The document states that measuring before puberty status is a *"favorable time to break any unfavorable health related lifestyle habits"*. To break something in this sense means to interrupt, and it implies that health related lifestyle habits, that are not acceptable, should be stopped. The document does not refer to any specific habits, rather any habit considered to be unfavorable by health authorities, at any point in time, needs to be interrupted. The power hold by the health authorities here is evident, as guidelines such as these, are documents giving directions and legitimacy for professional actions.

The following quote was stated in reference to shifting focus from medications to personal effort and lifestyle guidance.

> *"Doctors and others who are working in the health service shall use their knowledge and competence to influence health behavior and living habits."* (Departementene, 2004, p. 63).

The quote here says something about where knowledge and competence lies, within health care professionals, as well as where it does not lie, within patients who are in need of guidance. As we see with biopedagogies and the findings presented in this category the state is urging individuals to self-monitor and govern own body. The population is given a certain way to understand themselves through biopedagogies about their body and their health (Wright, 2012). This is linked with a wider neo-liberal project of self-making (Wright & Halse, 2014), which can be said to be strong in the Norwegian society with the focus on personal control of own life

(Øen, 2012e). However, it has been suggested that changing individual behavior for the good of the population is unlikely to work, as long as there are no incentives for action (Olson, 1965 in Botterill, 2006). Summing up, changing personal behavior is one important aspect in the documents towards better health and less overweight, which involves knowledge from professionals influencing individual's lifestyles.

5.3.2 Altering structural conditions to facilitate for personal responsibility

Another way presented in the documents as a way society should work to 'fix' the overweight and obesity 'problem' is to make it easier to be healthy. They want healthy choices to become the path of least resistance, and an easy choice, for all the population. This gives directions about society having the responsibility, but also that they want people to take up their personal responsibility. *Recipe for a healthier diet: Action plan for a better diet in the population* state that structural measures aimed at making it easier to be healthy, to a greater extent reaches the whole population. This way of working to ensure a healthy population are then more likely to reach everyone. However, it is also a way which may create governmental limitations to people's freedom to have the lifestyle they want. The way presented here to 'tackle' the obesity issue is linked with the previous category on the modern day health debilitating lifestyle. It is a solution, concerning changing structures in society so people eat healthier and are more active. In relation to changing personal behavior, as discussed previous, this category emphasizes harder paternalism from the state (Swinburn, 2008).

The following quote was stated after information about society's responsibility for influencing attitudes:

> *"Knowledge dissemination and attitude influence must however be supplemented with other measures. These measures can be structural changes, which makes the healthy choices easier and more attractive. They can also entail that the health hazardous choices are made less accessible."*
> (Departementene, 2004, p. 7)

Together with measures towards affecting individual choices, society should also create structural boundaries on the access of healthy and unhealthy food. One way communicated in the documents to create structural conditions facilitating for a healthy lifestyle, is to address marketing of and access to unhealthy foods for children. Another is to create ease of access to nature and play areas, and facilitating for bike paths and safe routes to school. The document *Recipe for a healthier diet: Action plan for a better diet in the population* propose a measure to

investigate opportunities for use of economic incentives to promote a healthy diet. These first two actions towards bad health and excess body weight I now have presented are measures for both repairing and preventing bad lifestyle habits. Prevention, as a measure in itself, is an important focus throughout the documents.

5.3.3 Preventing overweight and bad health

In question about how to handle the increasing weight in the population, and how to keep the population healthy, it is a clear message in the documents that prevention is important. Different reasons are given in the documents about why. It has the possibility to reduce social differences in health and to save society economic and social costs related to the health care sector. It helps avoid future overweight and diseases, saves individuals from strain, and it is important because experience show it is difficult to achieve lasting weight reduction once overweight. Prevention is also an important focus in the social investment perspective for a new welfare state (Morel et al., 2012).

"Prevent more to repair less" is the main focus of the document *Prescription for a healthier Norway: Public Health Policy*. We also see the focus on prevention in other parts:

> *"The central reasoning for focusing more on preventive effort is that it will be an investment in the future, both human and economic. Therefore it can be said that good prevention is good community building."* (Departementene, 2009, p. 11).

> *"Chronic diseases have also significant consequences for society at large, for instance through lost work force, high social costs and expenses for treatment and rehabilitation. Society will in other words in many ways benefit from preventing more of the diet related chronic diseases, and the potential is great as we know that the diet can be influenced and changed through targeted measures."* (Departementene, 2007b, p. 9).

The focus in these quotes is both on people and on societal benefits. High social cost related to chronic diseases means overweight and obese people threaten the social order, as they are said to be, or a leading to development of, chronic diseases. The documents focus on municipalities as good spaces for prevention work, in line with the Law on municipal health care services (Helse- og omsorgsdepartementet, 2011). Interestingly though, we see big differences in health in different municipalities (Aspelund, 09.09.2015), meaning that prevention measures can have different emphasis in various municipalities.

One action the Government takes in preventing bad health and overweight is the use of measuring and surveillance. In *Prevention, assessment and treatment of overweight and obesity in children and young people: National Professional Guidelines for the primary health service* is says that measuring of height, weight and calculating BMI represents a good gradation of overweight, both on individual and population level. The document *National professional guidelines for weighing and measuring in health stations and school health services* is, not surprisingly, supportive of surveillance of children's health. In the introduction of the document the first sentence is:

> *"Regular health examinations with measurements of head circumference, height and weight gives valuable information about children's health, growth and well-being."* (Helsedirektoratet, 2010b, p. 5)

Further, it is said also that the goal of the guidelines, is to identify the proportion of children with growth deviation, and reduce the negative consequences this can have for the individual. Measuring of children is therefore in their own best interest, as well as surveilling the population. The Government recognizes in *National professional guidelines for weighing and measuring* their reliance on the WHO's recommendations for closer monitoring of children's growth. Surveillance and measuring reflects traditional pattern in Norway of close state regulation, and is a way to show that the state are doing something (Tingstad, 2009). On the other side of the responsibility spectrum, is individual responsibility for own health.

5.3.4 The paradox of personal responsibility

Contrary to the reliance of social responsibility, is the personal responsibility frame for explaining and 'solving' the obesity problem (Julier, 2008). This frame is present in the empirical material, however only indirectly. Individuals are not blamed directly by scrutinizing their behavior, however they are indirectly given blame through strong focus on physical inactivity and unhealthy diet as the reasons for excess body weight (Gard, 2011). Personal culpability was mentioned few times, yet often when mentioned it was in relation to the overall societal responsibility. The personal responsibility paradox was evident in the documents, see chapter 3.3.2. Even though the documents state an individual obligation to take good choices to ensure good health, the society recognizes their obligation for creating structures facilitating this. The following quotes are good examples of the paradox of personal responsibility:

"When the differences follow clear social patterns, it is not individual's conscious choices of lifestyle that first and foremost underlies it" (Helsedepartementet, 2003, p. 47).

"The Government's opinion is that the work to prevent health problems to a higher degree needs to be based on the society's responsibility for the health of the population. Each one of us has a significant responsibility for own health, and it is important to respect individual's authority and influence over their own life. But the individual's latitude is limited by conditions outside the individual's control. Even health behavior like smoking, physical activity and diet are largely affected by economic and social background factors which the individual has not chosen. As long as the systematic differences are caused by inequalities in society's distribution of resources, it is the responsibility of the community to affect this distribution in a more fair direction." (Departementene, 2009, p. 15).

The societal responsibility goes further than only taking responsibility for overweight and obesity, but towards responsibility for all societal factors affecting the health and life conditions of the population. In the documents, the Government view people's lifestyles in conjunction with general politics, and social and economic circumstances. People's citizenship in maintaining personal health is seen in context with wider societal structures, making it unfair to keep individuals fully responsible for their health choices. Social differences are given as a main reason why it is inappropriate or unfair to rely solely on individual responsibility for health. With the personal responsibility paradox, the Norwegian Government thus situates obesity as an embodiment of social inequalities.

5.3.5 Children's health: a parental responsibility?

Concerning childhood obesity, it is uncommon to target children as responsible. In relation to personal responsibility in childhood obesity, it is generally put on parents (Moffat, 2010). This view is also evident in the documents. As mentioned before, personal responsibility was only indirectly blamed, another way this was done was by emphasizing the importance of parents in relation to child obesity. Children's dependency on parents include references made to dependency on guardians and family. This was the most common category, most mentions in frequency and in all but one document. The parents as children's most important resource and something the child has, was also referred to. Some references were made to adults need to control children's choices. Regarding both treatment of overweight and obesity, lifestyle

change and prevention of overweight, the involvement of parents and of the family was strongly emphasized. To turn an unfortunate development was said to require great effort directed towards the whole family. In *National professional guidelines for weighing and measuring in health stations and school health services* motivation for lifestyle change, with discovery of weight deviation in the child, was said to: *"require effort from the parents."*. Further, it is said:

> *"The family needs to be actively involved in assessment, diagnostic and treatment, and change in living habits should include the whole family."* (Helsedirektoratet, 2010a, p. 11).

Changing development of overweight in children requires effort from parents and needs to include the whole family. This corresponds with what Øen (2012d) says about the treatment of childhood obesity in Norway, mainly focused on helping the parents help the child. Children's involvement is rarely mentioned in the documents.

Parents' need for information is also emphasized in the documents in terms of development of overweight in children. In *National professional guidelines for weighing and measuring in health stations and school health services* it is stated that parents or guardians need to get information, and they are the target group for written information. While *"Adolescents must get customized information."*. When it comes to giving information about aspects affecting children's lives, the main information is directed towards the parents. Parents' responsibility also regards surveillance. In reference to children's recommended level of daily activity, *The action plan of physical activity: Working together for physical activity* says that parents have a main responsibility for ensuring children are 'sufficiently active'. Sufficiently active refers to the Government recommendation of 60 minutes of moderate activity each day.

References to children's risk of bad health or overweight being connected to parents were common, which shows that children's lifestyle and/or health depends on their parents. Parents' responsibility for children's health means that when children develop overweight, the blame is put on parents, and is often linked with assumptions about the quality of parenting (Gard & Wright, 2005). Blaming parents in situations where the child is targeted by social criticism is common in a welfare state (Makrinioti, 1994). As seen in chapter 2.3, children's outlook in terms of overweight, and their treatment, depends largely on parents. As such assigning responsibility on parents in terms of child obesity, might position children as passive concerning own body, and in a stronger dependency on their parents. The focus on children will continue in the next chapter to look further at how children are positioned in the documents in terms of their role in society.

6 Children's positioning: various constructions facing the future

In this second chapter of the analysis, I will focus on the second part of my research question: *how are children conceptualized and positioned within the documents*? Children's positioning has been a main theoretical perspective throughout the analysis. Are children present in these texts and if so, how are they talked about? Here, in chapter 6, I have chosen to focus on three main themes which emerged from my data. Children as *citizens with rights* is the first focus, how are they positioned within the broader discussion on children's rights? This links in with the debate around whether children are *human becomings or human beings*, important in the present or only focused on in terms of the future. The last theme in this chapter concerns *social investment*, and the way childhood is constructed as the fundamental life phase for societal sustainability.

My position within this topic comes from my pedagogical background and the views of children inherent in the social studies of children and childhood. I want to move away from the polarization and dichotomies which have characterized child research (Tingstad, 2015), and aim for a more dynamic theorizing of children and childhood. This means that I view children as resourceful human beings and recognize their agency, while acknowledging the structural conditions and constraints on their autonomy. Children are, from my perspective, both autonomous and competent, and at the same time vulnerable and dependent. Many of the documents I have analyzed use the term: children and young people. Since I do not aim to differentiate between young children and older children, I will mainly just use the term: children, to refer to all individuals under 18 years (United Nations, 1989).

6.1 Citizens with rights – what rights do children have?

Children's citizenship has been said to be limited in terms of their rights (James & James, 2004). Within my empirical material there were mixed messages about children as citizens with rights. On certain points it was recognized, however on others more unclear. The documents made references recognizing children's rights, and children's involvement and capacities were expressed. Let us now look at how this was articulated. Under the heading "Applicable politics for children and young people" in the document *Children's Future: National Strategy for children and young people's environment and health,* The UNCRC is recognized as "*fundamental for all work with children and young people's environment and health.*". This statement recognizes children's rights as a fundamental value, which is in line with the implementation of the UNCRC into Norwegian Law (Ministry of Children, Equality and Social

Inclusion, 27.01.2015). Yet, there is a discussion within children's rights discourses between the rights to protection and participation, often seen in a dichotomous relationship, as the one can be seen to delimit the other (Franklin, 1995; Freeman, 1992). First, I will show some of the ways the documents emphasize participation.

6.1.1 Children's rights to participation

Article 12 in the UNCRC about children's right to be heard (United Nations, 1989) is stated in the documents in different ways. There is a focus on hearing children's views and including their interest on many holds, for instance is this emphasized in concerns to areal planning processes. Further, in *Children's Future: National Strategy for children and young people's environment and health* it argues that more has to happen in the municipalities so children generally experience that they are being heard. The documents say:

> *"An overarching principle for children and youth politics is to stimulate to shared responsibility and ensure that children and young people's needs and interests are put in the center when designing offers and services."* (Departementene, 2007a, p. 6).

The focus on children's participation in creation of offers and services emphasizes both their needs and interests. In *The action plan of physical activity: Working together for physical activity*, it is stated:

> *"Experience shows that children's and adolescents' participation have a positive effect on local communities, and that they come with important contributions to local planning and decision making processes."* (Departementene, 2004, p. 50).

Within these quotes, there is a view of children as resources, who come with important contributions and should be heard. Children's participation is valued, and important for the society around them.

Generally, in the documents, there were many references to wanting more patient participation. In relation to article 12 and article 13 in the UNCRC (United Nations, 1989), children should also participate as patients concerning own illness and treatment. It is stated in *The Primary Health Service of the future – closeness and unity* the importance of ensuring that children as patients have real influence in the communication with professionals. Further, it says that children often know best themselves what is needed to better their health and life

condition. Changing lifestyle habits through behavioral therapy is the best tested and most used approach. In *Prevention, assessment and treatment of overweight and obesity in children and young people*: *National Professional Guidelines for the primary health service,* it is stated that:

> *"The child/youth must be involved both in definition of behavioral goal and evaluation of the process along the way. Involvement is a prerequisite for motivation."* (Helsedirektoratet, 2010a, p. 55).

Children's participation in medical encounters is recognized, however it is not frequently mentioned in the documents. The references to children as competent and with valuable contributions, is in line with the thinking in the social studies of children and childhood, see chapter 3.6.2. There are many positive sides with this position, mainly it has and is still helping children out of the negative construction as being incompetent and vulnerable, and on the way to becoming human beings. The negative side of this position is that it puts a great emphasis on the competent child, potentially creating a new powerful discourse on how children are and should be (Seland, 2010). The risk is for over empowering children, which in terms of overweight, leaves them in a position of responsibility, and at fault if they do not succeed.

6.1.2 Protection rights valued over participation?

Contrasting to participation, there were references focusing on children's protection. An important finding in the empirical material was in the document *Prevention, assessment and treatment of overweight and obesity in children and young people: National Professional Guidelines for the primary health service*, which says that when health care personnel find development of overweight with a child, an assessment and counselling conversation need to be conducted with the *parents.* It says:

> *"It will often be natural that the child participates in the conversation, but this needs to be considered individually."* (Helsedirektoratet, 2010a, p. 39).

Here we see that children are viewed as different, but for a reason not exposed in the document, children's participation in consultation about their weight needs to be given consideration. Since the reason is not given, it is difficult to interpret the meaning related to children inherent in this quote. However, it can be seen together with adults preference of not having children present in conversations about body because of a protective standpoint (Jåtun, 2012b).

Conversations around children's body weight is generally considered to be harmful to children's self-image, therefore not involving children could be a way to ensure the best interest of the child (United Nations, 1989). Children's participation as something needing individual consideration, places it as unnecessary in these conversations, and treatment of overweight in children is not dependent on children's involvement. This bears comparison to the cognitive development approach valuing cognitive structures (Horstman & Bradding, 2002). However, later in the document there is a paragraph about how to talk to children about overweight. We see here that conversation with children is considered different from adults, needing other words and language. One can say that maybe children are not cognitively lacking, but just different.

In *The Primary Health Service of the future – closeness and unity* it is stated:

> *"The health and care service of the future should be the patient and users service where the main rule is that no decisions about me as a patient, should be taken without me."* (Helse- og omsorgsdepartementet, 2015, p. 45).

As seen previous children's participation in health encounters are stated in the documents as something wanted and important. Further, we see here in this quote that patients are wanted to participate in decisions and treatment, it is even a main rule for the future health service. However, we have also seen participation is not always wanted in terms of overweight children. Also here there are some ambiguities, and it seems like the subordination of children as a minority group and adult agendas, limits their participation as patients (Mayall, 1998).

Citizenship is intertwined with rights here, under the pretext that rights are linked with responsibility. Looking at the Law of Patient Rights, under article § 3-4 "Information when the patient is a minor", it is stated: "If the patient is under 16 years, both the patient and parents or other with parental responsibilities should be informed." (Sosial- og helsedirektoratet, 07/2004)[8]. Under article § 4-4 "Consent on behalf of children" it is stated: "Parents or others with parental responsibilities have the right to consent to health help for patients under 16 years.". However, it is also stated later in the same article:

[8] All quotes from Law of Patient Rights are translated to English by the author.

> "As the child develops and matures, the child's parents, and others with parental responsibility (…) shall listen to what the child has to say before consent is given. When the child reaches 12 years, it shall be allowed to say it's opinion in all questions regarding own health. It shall be given increasing weight on the child's opinions due to age and maturity." (Sosial- og helsedirektoratet, 07/2004).

When children's involvement in conversations about own overweight is recommended to be considered individually, children's rights as patients are unrecognized. Children are positioned more as passive objects concerning own overweight when the personal responsibility is put on parents, more so since it is optional to include children in conversations about own body weight. The age limit when children are given opportunity say their opinion within the Law of Patient Rights are higher than in the Child Welfare and Children's Act (United Nations, 2008). Meaning more children are excluded from their rights to article 12 in the UNCRC (see chapter 3.7) while being patients within the health care system. We also see that in the justice system children are considered of sound mind ("tilregnelig") by the age of 15 (Justis- og beredskapsdepartementet, 20.05.2005), while in medical concerns not considered liable until the age of 16. Thus, it can seem like there are some ambiguities surrounding the view of children's competencies within the Norwegian society. Furthermore, we see the western societies' construction of people based on age (James & James, 2004), where age works as a determinant for discrimination. Generally, it seems like ideas from the protectionist approach, see chapter 3.7.1, is at work within the Norwegian construction of children. Child patients are potentially excluded from participation rights, as protection often is accompanied by exclusion (Qvortrup, 1990). However, from another point of view this can be a way for the Government to protect the vulnerable child, and acting in its best interest.

6.2 Beings and/or becomings

The fundamental thinking about human beings, often places children in a separate group from adults, thereby showing adult ideas about children and childhood. The concept *human becomings* refers to a person in development into becoming a human being. This main theme falls under a great discussion in the social studies of children and childhood, with controversies within this theoretical position about what one gives most weight to (James et al., 1998), see chapter 3.6. Adults are recognized as human beings, whereas children often are seen as becomings, not yet fully mature and competent.

6.2.1 Children as human becomings

In my analysis, I found many references in the documents which were categorized under the umbrella human becomings. I think it is an important aspect to include about children's position. While saying something about how children are viewed, it also adds to an emphasis on the future and an understanding of children in terms of what they will become. Some of the ways children are conceptualized in the documents, compare in thinking with ideas within the psychological position towards children, see chapter 3.6.1. Thereby giving an indication of the Norwegian Government and health authorities viewpoint being influenced by this position. There are four concepts used in the documents, which I have emphasized in referring to children's status as human becomings; these are *development*, *needs*, *dependency* and *vulnerability*.

One way the focus from the psychological position is visible in the document is through the emphasis on *development*. This corresponds with psychologists, who position development and socialization into adulthood and good citizens as the inherent goal of childhood (Hill & Tisdall, 1997). There are references in the documents to children's level of development, and development process. One document where this is particularly present was in *The Government's Strategy for prevention: Community – safety – equalization.* The document emphasizes the importance of a good and safe childhood for children, and of good development opportunities. Development is viewed in different ways, one way is the focus on learning:

> *"Children are born with a great potential for learning and constructive development."* (Departementene, 2009, p. 13).

This quote is interesting because it inhabits many meanings on a conceptual level. The term children is used particularly, instead of humans or people. Additionally, the term constructive is used, meaning helping to improve or encourage something, and is commonly employed as a synonym to positive. In this quote, learning and development is used together placing the focus on future outcomes. Further, the document again refers to development, however, the emphasis is on normality of development.

> *"Recent research shows that early intervention is crucial for ensuring children at risk get a normal cognitive and emotional development and behavioral development."* (Departementene, 2009, p. 38. Emphasis added.).

The focus on development within this quote is a way the idea of children as *becoming* is evident. There is especially one word here I find interesting; the use of the word *normal*. In the previous chapter, I discussed normality in relation to body weight. Normality comes back here in terms of children's development. By relating something to normality, one is saying that deviation from this standard is abnormal. The normality and universality of development is also evident in the psychological position towards children (Prout & James, 1990), and it may seem like this position has established itself within the Norwegian society as 'regimes of truth' (Foucault, 1977 in Prout & James, 1990). Development is believed to be a biological given status inside the child body without outside influence. Seeing the discussion of normality here, and in relation to overweight, we can see that children's mind and body are both supposed to form in a special preconceived 'normal' way. A normality which is constructed by society, and it is an aspect we see is relied on in modern day society. For instance with the measuring and weighing of children, where measurements are marked against a chart of normalcy according to age, and courses are mapped out as conforming or deviant. Projects of weighing and measuring reflects a traditional Norwegian emphasis on close state regulation (Tingstad, 2009).

Development is emphasized in other documents as well, as seen in *The action plan of physical activity: Working together for physical activity*, where the focus is not surprisingly on the importance of physical activity for children's growth and development. Also in *Assessment and treatment of obesity in specialist health services – children and youth* development was focused on in terms of the need for children to reach a certain point of development to make decisions about surgery. For obese adolescents to be considered for bariatric surgery they need to fulfil different criteria. Some of them are to show ability to make decisions, have a supportive family and most importantly give informed consent. Being able to give informed consent requires the skill to do so, which:

> *"...requires a preoperative assessment of cognitive, social and emotional development."* (Helseforetakene, 2007, p. 20).

There is a reliance here on a level or status of development, similar ideas that have become popular through the thinking of the psychological position. It seems as the Government and health authorities put a lot of weight on development level, thereby suspending a belief in development happening through different levels, or stages, rather than seeing it as a dynamic and social process.

Talk about *needs* was also a way children's becoming status was evident in the documents. Children's needs are often put in a dichotomous position to children's rights, because it gives priority to the protection of children and promotion of their welfare, rather than to their entitlements (Woodhead, 1997). The concept of needs signalize an element of judgement, about what is good for children and how this is achieved (Ibid.). The following quote from *Recipe for a healthier diet: Action plan for a better diet in the population,* was stated in reference to meals in school:

> *"Children need to have pleasant surroundings and some fixed structures around the meal to ingest what they need of food and drink, but also to learn to take time to eat and to experience the pleasure of eating with others."* (Departementene, 2007b, p. 44. Emphasis added).

We see again, by using the concept of needs, the psychological position towards children. I found it interesting the many references in the documents about parents' need for guidance and information, as discussed in the previous chapter. This was in contrast to the references about children needing guidance and information, which was next to none. Under the heading "Information to children and guardians", about measuring and weighing in the school health service the following was stated in the document *National professional guidelines for weighing and measuring in health stations and school health services*:

> *"It is the parents/guardians that has responsibility for monitoring children and young people's weight and development, and that therefore should have good information. Children shall have factual information in accordance with their needs and level of development."* (Helsedirektoratet, 2010b, p. 9).

This quote underlines again the parental responsibility, but the focus here is for monitoring. This can be linked with the previous chapter and society's emphasis on measuring and surveillance. We can see from this quote that it is something the Government and health authorities want parents to do, on top of the measuring by the primary health service. They emphasize parents' need for information, and when talking about children, the document emphasizes need and level of development. The linking of age with competence is apparent (Mayall, 2015). Use of the term level of developmental, as has been presented previous, holding meanings of universality, and development as solely biological and individual. The

psychological position has been strongly criticized on the grounds of universality, viewing all children the same, and the failure to recognize children's competences.

Children's becoming status were often shown through references to their *dependency*. Their dependency on parents was discussed previously in terms of responsibility for health. Children's dependence on their surrounding environment was emphasized in the documents. This was often stated in terms of the importance of children centered areal planning, and in location of spare time activities. The following quote from *The action plan of physical activity: Working together for physical activity*, show children's biological becoming status as not yet adults, in terms of children's decreased freedom in choice of environment.

> *"Children are to a greater extent than adults dependent on facilitation for play and activity in the local community."* (Departementene, 2004, p. 15).

Children's common inability to choose their environment is true for many children, especially young ones. However, the quotes here make stronger claims about dependency. Not only on closeness to areas, but also on facilitation. Children's dependency on the food they are offered was also mentioned in the documents. Finally, in terms of dependency, children were referred to together with elderly and people with impaired functioning, suggesting similarity between the groups.

The last way the concept of children as becomings became apparent in the documents, was through referring to children's *vulnerability*. Children were often referred to as a group that needs special consideration, who are vulnerable and cannot handle as much as adults can. There were different ways these references were made. One way was to position children as different from adults. When talking about wanting more participation from children in planning processes, children and young people are mentioned by the Ministries as a group that *"requires special facilitation"*. Why they require special facilitation is not mentioned, nor what facilitation they need. Children are said to not be able to meet certain challenges, or should not handle some challenges because of their young age. The documents also spoke directly about vulnerability, both concerning children and childhood. In *Children's Future: National Strategy for children and young people's environment and health* it is stated that childhood is a vulnerable period in life. Further, it is stated:

> *"(Children)… are more vulnerable than adults, and have less possibility to influence their own life situation."* (Helsedepartementet, 2003, p. 45).

Children's vulnerability is conceptualized as a fact, something that children have in common simply by being children. This is shown also with statements about children having a different way of expressing themselves, and needing health professionals to use a different language when talking about weight. We have seen there are different views on children, what they are and should be. How children are conceptualized give indications on the citizenship of children, which can be seen within a wider societal theory of the modern welfare state, and the maintenance of the social order.

6.3 Social investment: interdependency between children and society

An important finding in my empirical material was the importance of children's meaning for the sustainability of society, in line with the theory of social investment (Esping-Andersen, 2002). This idea came out from one main theme from the analysis of my data, the idea that children are the future, which is an idea with different meanings. On one hand it is an incontestable biological fact, the human race has a limited lifespan and the younger are bound to take over. On the other hand, it holds a certain attitude towards what children are and what they mean to society. Within this outlook is also a notion of children in the present as less important. A typical way this is presented in the documents is to focus on the future consequences of children's actions in the present, their diet, level of physical activity or other weight related behavior.

Children's importance for the future can be seen with the use of other words, as we see in *The Primary Health Service of the future – closeness and unity,* with the quote about services and measures towards children and young people:

> *"To invest in children and young people's health is crucial in a societal economic perspective; a sustainable societal development requires a rising ("oppvoksende") generation with good health."* (Helse- og omsorgsdepartementet, 2015, p. 95).

> *"Good childhood and living conditions for children and young people is an investment in the future."* (Helse- og omsorgsdepartementet, 2015, p. 102).

The first quote focuses on economy and sustainability of the society. A healthy new generation is important for society, and therefore investment into their health is crucial. The second focuses on good childhood and living conditions rather than health, but both quotes have an economical focus, referring to investment. Investment means time, energy, or money spent in the hope of

future benefits. The last two words here are important to note: *future benefits*. Investment in children do not entail a benefit in the present, but in the future.

One way to view the focus on the future of children is in the focus on children's learning. A common way to convince the readers of the documents about the measures taken by the Government, is showing positive outcomes on learning and concentration. Concerning trials with offering school meals, and fruits and vegetables in school, the investment is supported by stating that the pupils will have better learning outcome, and it will have positive effects on their concentration. The following quote, in the document *The Cooperation Reform: The right treatment – at the right place – at the right time,* was stated together with argumentation for more physical activity in schools:

> *(...) one sees a positive correlation between increased physical activity and school performances, and that increased physical activity improves cognitive function. Increased physical activity acts positively on concentration, memory, behavior in the classroom and psychosocial learning environment."* (Helse- og omsorgsdepartementet, 2009, p. 81).

We see the same tendency concerning children's living environment and community. The following quote, from the document *Children's Future: National Strategy for children and young people's environment and health*, concerns children being affected by traffic and neighbor noise:

> *"Chronic exposure to noise affects children negatively in teaching situations by leading to lower motivation and concentration to solve problems, worse memory and reduced reading skills."* (Departementene, 2007a, p. 13).

Viewing children's life in whole this is, in my view, a very narrow focus strictly on children as learners. The focus here is clearly on learning and school performances, as opposed to other aspects of children's life, such as their health or well-being. I view emphasis on children's learning as a future oriented focus because it positions children as apprentices, to learn and acquire the knowledge needed to be an adult. By the references in the documents to children's performance, function and behavior, it seems that adult society's needs are prioritized over children's needs (Fauske & Øia, 2003).

The future oriented focus is presented, however, it is not the only view point present. In *Children's Future: National Strategy for children and young people's environment and health* the document begins with:

> *"Children and young people are the future, but they are also the present."* (Departementene, 2007a, p. 2).

These quotes illustrate children's dual status in time, both as the present and the future, see chapter 3.8. Similar references were made in other parts of the documents, yet not as straight forward. Children's dual status is recognized, however viewing the latent meanings in the documents, as presented here with the focus on protection, human becomings and the future benefits of children, it seems the focus on children in terms of the future is more emphasized in the documents. Either way, present or the future, society is dependent on children for sustainability. However, one can also see in the documents that this dependency goes both ways.

6.3.1 Ensuring children good childhood – a societal duty

One focus in the documents was about society's responsibility in ensuring good living condition and help for children. This was one of the most frequent categories from my analysis on children. We can see this in connection with the societal responsibility for ensuring good health and 'normal' weight as discussed in chapter 5. In relation to social investment, we see here how society invests in children's upbringing, and the ways children are dependent on this investment. Therefore, there is an interdependency between children and society in order to make the welfare state function. Following is a quote from *The Government's Strategy for prevention: Community – safety – equalization* about health and social differences:

> *"Children's living conditions and surroundings in childhood affects educational pathway and career opportunities later in life, which again affects health in adult age. Healthy diet, fresh air and physical activity in childhood has a direct significance for health later in life."* (Departementene, 2009, p. 19).

This quote illustrates the effect children's living conditions are believed to have. The effects here are only expressed with focus on the future, not the present. Society have the possibility to affects individuals future health in adult life, and are therefore responsible for creating good

upbringing environments. This societal responsibility goes together with the societal obligation towards the health of the population, as shown in the previous chapter. Within societal responsibility there is a great focus in the documents about the responsibility society have for children. This is in line with the Schwartz and Puhl (2003) who say threats to children are considered societal problems. The societal responsibility for health is expected from many different sectors in society, the health care sector, kindergarten, school and volunteer organizations are encouraged or mandated to do their part. Kindergarten is seen as a good place for prevention.

> *"By being able to offer all children a kindergarten offer of good quality one can early discover and prevent future social and health related problems. This will save the society for big social and economic consequences in the long term."* (Helsedepartementet, 2003, p. 97).

Focus here is laid on prevention of health problems, and their costs on society. Rather than the benefits children get from being in kindergarten on their well-being in the present, and rather than on the strains on individuals which health problems lead to. It is both a future focused and societal emphasis on children.

Under political guidelines for children and young people in *Children's Future: National Strategy for children and young people's environment and health,* it is stated that the overarching goal is that children are ensured good and safe childhood and living conditions. Further, *The Government's Strategy for prevention: Community – safety – equalization,* says that efforts are important towards all children in Norway so they are ensured a good childhood, good caregivers and the opportunity for self-expression. As shown previously in this thesis, the Norwegian culture values childhood as a time of happiness, and healthy and active outdoor activity (Nilsen, 2008). The strong focus on prevention and repair of overweight and obesity, as presented in the first chapter, might be such a strong emphasis from the Government because childhood obesity seems to conflict with the romantic idea of childhood in Norway.

A good childhood is seen as important for adult life, as can be seen with the following quote:

> *"Children and young people's childhood and living conditions constitute therefore the very foundation in preventive work."* (Departementene, 2009, p. 17).

Again, we see a reoccurring theme as the previous chapter, because also when concerning children, prevention is a great focus. It was repeating pattern within my analysis. Whereas concerning obesity the topic was prevention of bad health and overweight. Here, on the other hand, the emphasis is on children as a special group advantageous for prevention and health promoting work. Half of the documents mentions prevention towards children as an important step towards better health and less overweight.

> *"Preventive effort towards children and young people has a great potential for improvement and stands as one of the most important welfare political area of priority today. At the same time is preventive efforts towards children and young people a field where both the possibilities and the potential rewards are greatest. Early intervention increases the chances for success in laying the foundation for positive development."* (Departementene, 2009, p. 13).

The reason given in *National professional guidelines for weighing and measuring in health stations and school health services* for health promoting and preventive measures in home, school and local environment, is that the potential for success in preventing overweight in adult age presumable is biggest in child age. Children are targeted by preventive measures, to prevent the future adult population from being overweight. Society gives great emphasis on children's upbringing to ensure they will become good societal actors as adults, an emphasis which is very important for childhood conditions. Thus, the investment towards children is something they benefit from and can be said to a degree to depend upon. Let us take a closer look at this dependency.

6.3.2 Why are children so important for society?

Prevention has been pointed out as an important focus from the Government. Ensuring good habits from early in the life course, was one of the most common reasons expressed as to why prevention towards children is important. It was a reoccurring finding in my analysis. The habits talked about are all related to lifestyle, the main thought presented here is that by establishing good living habits early in life, the risk for disease later is reduced. When taking about diseases later, it is common to find the societal focus in the statements, saying that habits in child years are important in terms of preventing diseases *in the population* in the future. Further, there is a view of childhood as a time period where patterns are laid, which can be determining for adult life, and where the foundation is laid for later public health and health habits.

"In childhood patterns are laid which often can be determinative for adult life. The personality is shaped, social skills are developed and knowledge is appropriated. Many problems amongst adults can be traced back to childhood." (Departementene, 2009, p. 12).

"Successful measures in childhood can also contribute on the entire life course with significance both for individual's life quality and for the ability to contribute to the community instead of needing aid." (Departementene, 2009, p. 13).

"Children and youth are in a phase of life where basic knowledge, skills and attitudes are laid, and potential for promoting good health and prevention of future disease is great. All experience shows that it is difficult to change already established habits. It is therefore of great importance to facilitate so children and youth establishes good health habits, which they can continue in adult age." (Departementene, 2007b, p. 16).

These quotes illustrate a construction of children as future beings. The focus is mostly on the future consequences of actions in child age, both individually and societal. The construction of the recreation of generations as the inherent goal for the lifecycle is visible (Fauske & Øia, 2003). Childhood is seen as a period of life important for securing good habits for healthy adults. It is most likely true that many habits are laid in child years, and that it is a tendency for many to continue these habits into adult life. What concerns me with this category are two things; one the emphasis on the future consequences, second, the deterministic connotation. The way children are conceptualized in the documents, as both competent and dependent is comparable with the way children are seen in Norway in general, see chapter 2.5. Similar to what James and James (2004) report about health policies, my empirical material seem to focus mostly on the futurity of children as the next generation.

7 Summary and conclusion

In this thesis, I have aimed to understand the Norwegian Government and health authorities' position towards overweight and obesity, and the notions of children they build on. By situating them into different discourses and debates around the topics, I have looked at how the constructions in the documents relate to wider understandings. This final chapter will draw upon the research questions, the previous chapters, and the results from the study, to say something about what it means. First, I will summarize the main findings, before I conclude the thesis with some implications and suggestions for future research.

The description in the documents of the phenomenon of overweight and obesity is linked to general obesity discourses. Rather than being a neutral voice, it is quite evident that the dominant alarmist discourse underlies the Norwegian health care service. The Government and health authorities presents overweight and obesity as a great problem, a threat to personal and public health, and something that needs 'fixing'. This is done through a language emphasizing disease, deviance, contagion and warfare. The reasoning concerning the increase in average body weight relies on a simple cause-and-effect logic, where the answer is to eat healthier and be more physically active, in a society facilitating healthy lifestyles. This is interesting, seen together with the contrasting opinion in the documents that overweight and obesity are a complex condition. In regards to responsibility, and the proposed solutions, there are clear messages in the documents that the responsibility lies mainly with the society. The individual is positioned as responsible for own health, however confined by societal structures. It is a paradox where structures limit individual agency in terms of personal responsibility, and because of this, individuals are not given direct blame. However, indirectly responsibility is put on individuals with the documents strong focus on individual lifestyle, and parents are indirectly positioned as responsible for children's overweight. Societal responses proposed are changing personal behavior, regulating societal structures to facilitate for healthy lifestyles and prevention efforts towards weight gain in the population.

Within a social constructive model of the child, I have looked at how children are conceptualized. Children's rights are recognized, while in some areas protection seems to be valued over children's participation. Children are conceptualized in terms of their becoming status, through an emphasis on development, needs, dependency and vulnerability. At the same time, they are positioned within broader political and societal concerns, in terms of social sustainability and economic investment. I have aimed to show an interdependency, meaning that while society are dependent on children for maintenance of the welfare state, children are

also dependent on society and the emphasis given to them. The theoretical assumptions the positioning of children are based on, comes from opposing or debated ideas from different academic fields, as such giving various meanings about the positioning towards children. However, there seem to be an underlying emphasis on the future importance of children.

An important finding in my data, surrounding and intertwined in the results presented, are ambiguities, paradoxes, contradictions and dilemmas surrounding both the topics of obesity and the ways in which children are positioned. Interestingly, even though there are clear opinions about overweight and obesity being a problem, we can see there are a number of ambiguities around the phenomenon. As many of the documents do not provide evidence of their claims, it might seem, similar to the findings of Tingstad (2009), that the rational for political argumentation stems from the wider international discourse on obesity. There are ambiguities in the thinking about children, about what importance, qualities and entitlements children have. As a result of these ambiguities in the empirical material, the thesis cannot provide a clear answer about child obesity. Instead, the ambiguities must be seen as part of the answer. This is suggested in the title of the thesis, which gives a dual meaning. First, it informs about the alarming messages in the documents about the phenomenon of obesity, second, that there are ambiguities in the documents, which are in themselves quite alarming in terms of their implications.

7.1 Potential implications and the way forward

With the social responsibility and biopedagogies, people are given certain ways to think about themselves, and how to live their lives (Wright, 2012). The body, particularly in this sense, body weight, is used as a political *space* in which the Government and health authorities hold a power to teach. At the same time, the medium of public documents and health policies are used as pedagogical *sites* to teach correct maintenance of the body (Ibid.). In regards to children, they may internalize and interpret these messages into their own bodily maintenance. Experiences of the body, particularly bodily difference, are for children important signifiers for social identity (James et al., 1998). These messages can have a positive effect, but they also send signals about what is expected of a good citizen, and can constitute a normal standard, which can be difficult for people to adhere to. This is not helped with the simple logic given in the documents behind reasons and remedy for excess body weight.

The Norwegian Government's reliance on the alarmist approach centers attention towards an issue with great impact on people's lives, and on society. However, the deterministic link

between weight and health within this approach is problematic. First, on an individual level it might allow for harmful societal attitudes towards excess body weight, and in extension overweight and obese people, as people's weight is taken as a socially acceptable measure of health and lifestyle. Overweight people are not necessarily unhealthy or sick, and health is not something to determine based on body shape or a BMI-chart. The documents send out highly normative messages about body and weight, potentially spreading fear of this 'epidemic'. This is evident in the Norwegian society, as reported by Malterud and Ulriksen (2010), in their article titled: "Norwegians fear fatness more than anything else". Secondly, it may undermine the diversity in human bodies. Excess weight can be a manifestation of bad health and unhealthy lifestyle, but it is not necessarily so. The visibility of it makes it a target. The strong focus on body weight as a measurement of health might need some reconsideration, and there is a potential for it leading to unwarranted targeting. A focus on health rather than weight might be a way forward. When we see recent research indicating that mortality risk due to loneliness is higher than that of obesity (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015), it might be time to step back from the narrow focus on body weight.

With the ambiguities found in my empirical material, what I am left to ask is: Maybe we just do not know enough about overweight and obesity? If so, how does it affect governmental and political actions? The documents make many normative statements, sometimes without providing sources of the information, or considering alternative understandings. Because of the power and position of the authors many of these statements comes out as truths, and sometimes as moralist judgements. Thus, the statements can have great influence on people's subjectivities, as they judge their own and others behavior against the expectations that are set (Bacchi, 2009). Because of the power of authority and the biopedagogies used towards the population, it is especially important that the education put forward is trustworthy. The ambiguous construction of children in society, and of overweight and obesity may lead to difficulties in implementing appropriate measures in handling the situation.

Childhood obesity is an important health issue to address. Using the figure of the child in social movement, where the social problem of childhood obesity is seen as a threat, builds on pre-existing anxieties and provides a powerful means in order to command public attention and support (Buckingham, 2000). It is important to ask the question of what the lack of knowledge based information and the landscape of ambiguities means for overweight and obese children in their daily life, and in their meeting with the medical field. Further, what implication do constructions of normality and obesity as non-health have for children?

To bring the focus back to the genre of public documents. Buckingham (2009) questions evidence based policy, and state that its making can never be as simple as rationally responding to available data, but it is unavoidably subject to politics. The topic of excess body weight is a highly political field of interests, where different stakeholders have their own agendas. The political processes of policymaking is important to notice in terms of my study, because of the political space in which I have conducted research. It is also important to question whether all the messages that comes out from the documents are direct opinions and political standpoints. The topic of obesity, and the wider issue of public health, is a highly political field, and the Government do have a political mandate to fulfil. It is important for the state and state authorities to show they are taking action and doing something.

So what it the way forward? An interesting topic to explore further will be the measures proposed by the Government on handling the 'problem of obesity', in light of the insights presented in this thesis. It would be an important contribution to investigate the relationship between problem formulation and implemented measures. Additionally, studying the understandings of health care professionals working with obesity or of children themselves, in the context of Norway, could give a deeper understanding of the phenomenon. Albert Einstein believed that we cannot solve our problems with the same thinking we used when creating them (Calaprise, 2010). Apply his logic to this thesis, where the problem is largely created by the medical field, perhaps there is a need for other fields to come in with a new thinking. In this thesis, I have aimed at 'problem-*questioning'* rather than 'problem-*solving*', meaning I have put the problem itself, what it is represented to be, into question (Bacchi, 2009, p. 271). A potential way forward might be for social scientists to shift the thinking in these terms, in order to fully understand the problem, before trying to create solutions to it.

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