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# Examining the World Health Organization's governance and response to noncommunicable diseases: A Foucauldian analysis

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Examining the World Health Organization's governance and response to noncommunicable  
diseases: A Foucauldian analysis

by

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A THESIS

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## **Abstract**

The World Health Organization (WHO) is a key actor leading international cooperation to address global health problems. This dissertation focuses on how the WHO mobilizes discourse to construct and inform the international response to global health problems in its guideline and technical documents. The theoretical framework of governmentality is used as a lens to examine the WHO as a global institution that governs while unable to impose policies on sovereign Member States; thus, the WHO's mobilizations of the discourse and evidence in its documents and document review procedures are critical for its governance. This project explores the extent to which the WHO is neoliberal and mobilizes biopolitical techniques of power. Through an in-depth, Foucauldian discourse analysis of 29 WHO guideline and technical documents from 1992-2016 and five WHO key informant interviews, this dissertation more specifically examines the WHO's approach to noncommunicable diseases (NCDs). The dissertation shows that the WHO depicts NCDs as undermining economic and social development throughout the world, threatening the achievement of internationally agreed-upon development goals, and increasing inequalities between countries and populations. In WHO documents, NCDs are attributed to a few behaviours considered modifiable, such as dietary choices and tobacco use, although many scholars argue that this focus is ineffective in decreasing NCDs. At times, the WHO attributes the economic burden of NCDs to irresponsible individual behaviours, suggesting a neoliberal governmentality. To measure this economic burden, the WHO employs a biopolitical technique in service of neoliberalism in the form of epidemiological statistics of premature deaths. The WHO experiences several tensions in this current, neoliberal political climate as it negotiates how to protect global health and attempts to govern the global population; these tensions involve the tobacco and food industries, evidence review, and political and financial support. Furthermore, in the creation of WHO documents, the WHO's epistemology is evidence-informed decision-making which results in systematically favouring medical evidence and excluding social science literature. I question the extent to which WHO documents are useful due to their assumptions and limitations in construction – given the need for the WHO as a global partner, and the tensions experienced by the organization.

## **Preface**

This thesis is original, unpublished, independent work by the author, K. Chaisson. The empirical research was covered by Ethics ID: REB17-0237, issued by the University of Calgary Conjoint Faculties Research Ethics Board for the project “Examining the World Health Organization’s governance and response to noncommunicable diseases” on June 13, 2017.

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Thank you to Dr. Tom Langford, my committee member, for your guidance in the classroom and on the dissertation. Thank you for your compassion and understanding as I finished my coursework at a time that I really needed it. Thank you for sticking it out with me as you retired, and keeping me as your last student and defence. I cannot thank you enough for both your accommodation and pushing me to do better, making this dissertation the great piece that it is today.

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*I want to share my thanks and gratitude to everyone who participated in my defence, over Zoom, during a pandemic.* I doubted that the defence would be possible until I saw all of your faces on my iMac like the ‘The Brady-Bunch’ introduction. It is not lost on me the privilege that made the Zoom defence possible. Thank you for keeping the defence as a priority and, most importantly, making it feel like a celebration rather than just an examination. To Dr. Ross Upshur and Dr. Michael Adorjan, thank you for your time as my examiners and for your thoughtful questions and feedback that made the dissertation round out into a finished piece.

I have asked myself a couple of times throughout the PhD process ‘what keeps academics such as those listed going in this line of work?’ I realized it is for days like the defence and graduation

– the days of celebration. For me, this dissertation and PhD program are a dream come true and you all help make dreams come true every year. *It is a debt I can never repay, but I will do everything I can to pay it forward.*

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*2020 is a year none of us will ever forget. May we continue to lean on each other, grow together, and inspire one another to continue to do the amazing work we are all doing – both in the medical and social science fields. This dissertation taught me that we cannot do our work alone – research is so much better and more rewarding when we work together.*

My job is making windows where there were once walls.  
– Michel Foucault

## **Dedication**

There are still millions of girls and women who have never entered a classroom.  
To every girl and woman dreaming of an education to change the circumstances of your life,  
I dedicate this dissertation to you.  
To all of the women who fought to enter the classroom before me,  
I thank you.

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## **List of abbreviations**

<b>Acronym</b>	<b>Name</b>
BMI	Body Mass Index
DALY	Disability-Adjusted Life Year
FCTC	Framework Convention on Tobacco Control
GBDS	Global Burden of Disease Study
GPG	Global Public Goods
GRADE	Grading of Recommendations, Assessment, Development, and Evaluation
GRC	Guideline Review Committee
IARC	International Agency for Research on Cancer
IRIS	Institutional Repository for Information Sharing
NCD	Noncommunicable Diseases
RCT	Randomized Controlled Trials
SDOH	Social Determinants of Health
SDG	Sustainable Development Goals
TFI	Tobacco Free Initiative
UN	United Nations
WHA	World Health Assembly
WHO	World Health Organization
YLL	Years of Life Lost

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## Chapter 1: Introduction

### 1.1 Overview of dissertation

This dissertation project analyzes the use of discourses by the World Health Organization (WHO) in its guidance guidelines and technical documents, intended to inform international and national policies. Using these documents, I examine in particular how the WHO mobilizes knowledge and evidence and adopts particular governance strategies by focusing on the WHO's presentation of, and policies around, the problem of noncommunicable diseases (NCDs). NCDs are illnesses that are *not contagious* such as cancer and diabetes, unlike 'the big three' infectious diseases of HIV/AIDS, tuberculosis, and malaria (Mgone & Makanga, 2010). This dissertation uses Foucault's approach to discourse, key concepts, and theory of governmentality to understand how the WHO, that is not a policing but a governing of global health organization, governs health problems.

From reviewing the WHO documents, I argue that the WHO positions NCDs as an economic burden caused by individuals and correcting 'modifiable behaviours' as both a necessary and sufficient solution to NCDs. In so doing the WHO at times adopts a neoliberal strategy of governing (detailed below). 'Modifiable behaviours' are behaviours that individuals can ostensibly control. But through a careful comparison of the WHO's approach to obesity and tobacco use in particular, I also illustrate some of the tensions in the WHO's discourse and governance strategies. I find the WHO's governmentality vacillates between a neoliberal focus on an economic burden that is individualized, and, at times, more complex and nuanced recommendations regarding how to protect the health of the global population in its documentation.

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I focused on the WHO because of its position as the global leader of health and its purpose to regulate and monitor health of the global population, and because there is relatively little literature about the role of the WHO as an international leader in the process of health policy creation and translation. There has been some scholarship about how the WHO has had to evolve and adapt to a growing global neoliberal ideology and an increase in the number of countries implementing neoliberal forms governance (Chorev & Babb, 2009; Chorev, 2013; Ding et al., 2016; Gostin & Friedman, 2013; Katz, 2013; Navarro, 2007) and it has separately been argued that “NCD advocacy” was central to revitalizing the WHO as an organization in the 1990s (Weisz & Vignola-Gagné, 2015). However, there has not been consideration of how the WHO’s approach to NCDs – its discourses and strategies – may be related to neoliberalism. Additionally, there is a breadth of social science literature that critically examines how the problem of NCDs is often attributed to individual ‘modifiable behaviours’ and neoliberal forms of ‘responsibilization’ (Bell, McNaughton, & Salmon, 2011; Evans & Colls, 2009; Gard & Wright, 2001; Gostin & Friedman, 2013; Lupton, 2013), but no analysis of how the WHO, as the major global institution of public health, has constructed the problem of NCDs. Overall, I was interested in how the WHO executes its power, as reflected in its guideline and technical documents about the problem of NCDs.

This set of interests and questions is well suited to a Foucauldian analysis. The foundation of Foucault’s work is his focus on authoritative discourses which are forms of knowledge mobilized to inform what we know to be ‘true’ about ourselves and society – constituting ‘regimes of truth.’ In addition, Foucault’s discourse analysis explores the relationship of these discourses to the political and economic conditions of their possibility, by mapping the series of events, often nonlinear, that supports the construction of these discourses

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that inform our truths. Later in his work on governmentality, Foucault's focus changes to explore techniques of power and a new, non-state-centric way of thinking about government, which seeks to understand how individuals govern others and how we govern ourselves (Dean, 2010). For this dissertation, governmentality studies is a particularly apt framework for conceptualizing how the WHO governs as a global institution that cannot impose policy on sovereign Member States; rather it can lead, guide, and recommend knowledge and action for Member States to follow (Dean, 2010). Foucault also explored neoliberalism and liberalism as forms of governmentality in his lectures. He introduced the concept of biopolitical power as the execution of technologies of power over the conditions of life of the population, such as the execution to surveil (understand) and discipline (manage) the individual to prevent poor health of the population (Dean, 2010). This dissertation considers a connection that Foucault only introduced but did not systematically examine: how biopolitical techniques of power are mobilized either under neoliberalism or other forms of governmentality. I use Foucault's theoretical framework of governmentality studies to analyze the WHO's discourse in terms of whether and how neoliberal governance and biopolitical power are mobilized (Foucault, 2003, 2007).

Further, I used Foucault's concepts of *savoir* and *connaissance* to examine how formal knowledge is mobilized through discourse in the WHO documents. *Connaissance* refers to specific bodies of knowledge such as medicine and public health (Scheurich & McKenzie, 2005). *Savoir* includes all types of knowledge and the broad discursive 'conditions' that form the specific bodies of knowledge (i.e. *connaissance*) (Scheurich & McKenzie, 2005). These concepts are part of Foucault's method of archaeology, his mechanism to understand the conditions of discourse and how these conditions are possible to inform thought and action (Power, 2011). But attention to discourses and their conditions of possibility is arguably retained in his method of

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genealogy, which extends archeology to the power-knowledge relationships that explains why discursive strategies may appear, when they appear (Foucault, 1980). These methods are further discussed in Chapter 4.

I conducted a Foucauldian discourse analysis of 29 NCD guideline and technical documents purposefully selected from a database I assembled of 203 WHO documents on NCDs and ‘modifiable behaviour’. Guideline documents are evidence-based documents created using the GRADE method (grading of recommendations, assessment, development, and evaluation) – a proposed systematic and transparent method to rank the ‘best’ evidence to inform ‘gold standard’ guidelines. Technical documents are more common, referring to WHO publications that include global status reports and action plans that inform on a specific health concern and recommendations to address this concern. I also conducted five WHO key informant interviews in Geneva, Switzerland to understand both the formal and informal procedures to create guideline and technical documents.

The research questions for this dissertation projected are as follows:

RQ1. How does the World Health Organization use evidence and discourse to construct and respond to NCDs? To what extent does this evidence and discourse reflect a neoliberal regime, and what biopolitical techniques are mobilized?

RQ1.1. How are ‘modifiable behaviours’ targeted and positioned in the WHO documents?

RQ1.2. How is scientific knowledge about ‘modifiable behaviours’ used to understand how individual behaviours contribute to health concerns?

RQ1.3. In what ways are human rights to health considered in the WHO documents addressing NCDs?

RQ1.4. How does the WHO position the ‘economic burden’ argument to address the problem of NCDs?

RQ2. To what extent does the WHO’s approach to NCDs reflect a process of the internationalization/ standardization of health care policy?

RQ2.1. How does the WHO attempt to inform the internationalization/standardization process through global guidelines and technical documents?

In answering these questions with a Foucauldian discourse analysis, I found that the WHO's epistemology is evidence-informed decision-making which results in systematically favouring medical evidence and excluding social science literature. In addition, I found that the WHO is not consistently neoliberal as it both uses and recommends biopolitical technologies in its documents to present and address the economic burden of NCDs, and such techniques are not necessarily in keeping with neoliberalism. The WHO experiences tension in this current, neoliberal political climate as it negotiates as an institution how to protect global health. Thus, the WHO is a complex institution trying to address global problems for the global population.

### **1.2 Overview of chapters**

The literature reviewed for this dissertation project (Chapter 2) includes research on the WHO as a global health leader and the role of the WHO in grouping NCDs together as a single disease category and why this was significant. I also discuss the literature surrounding the framing of tobacco use and obesity as 'modifiable behaviours', which I later analyze in the WHO documents. It is from this literature review that I recognized that tobacco use and diet and physical activity in relation to obesity are the main 'risk factors' discussed in the social science literature on NCDs, as 'modifiable' behaviours. Thus, as my dissertation project developed, I focused on tobacco use and obesity as important and illustrative examples of NCD discourse. I also review literature on how the idea of 'modifiable behaviour' is embedded in broader understanding of 'risky' human behaviour, to set the stage for my analysis of how the WHO presents correcting 'modifiable behaviours' as the necessary response to NCDs. I then provide



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background on the WHO's only treaty, the Framework Convention on Tobacco Control (FCTC), which will be important for the subsequent analysis.

In Chapter 3, I expand this discussion to broader issues in social theory, by considering the relationship between 'modifiable behaviours' and biopolitics as a mechanism to change behaviours to manage the populations – in response to NCDs and other issues. Further, I highlight the background of global health governance and the role of social actors.

In Chapter 4, I outline Foucault's methods of archaeology and genealogy and how these methods were used at different points in the discourse analysis. I also delineate the process I took to conduct a discourse analysis including coding and analysis, and the WHO key informant interviews.

The dissertation contains three substantive chapters. In Chapter 5 ("Framing the problem: The 'cost' of death and the 'value' of life"), I explore how global burden of disease statistics from the Global Burden of Disease Study (GBDS) are used to construct and situate the problem of NCDs – addressing RQ1, RQ1.3, and RQ1.4. I identify how the WHO relies on premature mortality statistics, a portion of the disability-adjusted life year (DALY) measurement, to frame the burden of NCDs in terms of the number of lives lost. In doing so, the WHO does not deploy a human rights framework and instead situates the NCD problem as an economic burden that causes a significant loss in productivity, which burdens the individual and society, and relies on a normative value of life discourse to be persuasive. The use of premature mortality statistics is also an example of how the evidence (mortality statistics) can be mobilized by what Foucault calls *savoir* – the largely implicit condition of the WHO's discourse that is the value of life. I also discuss how the WHO's discussion of production and economic costs and its use of

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biopolitical techniques, especially the measurement of premature mortality, relate to neoliberalism.

In Chapter 6 (“The discourse of addressing tobacco use and obesity as the solution to NCDs”), I perform a historical discourse mapping of the WHO’s approach to tobacco use and obesity to highlight how the WHO follows, changes, and/or mobilizes knowledge to construct and address the problem of NCDs – addressing RQ1, RQ1.1, and RQ1.2. For tobacco use, I show that because of the FCTC, the WHO is a key leader in furthering the agenda of reducing tobacco sales and use through a more comprehensive approach that incorporates governmental responsibilities and interventions. In the WHO’s discourse about the need for the FCTC, the tobacco industry is deemed the culprit for lying to the population and getting them addicted to a harmful product. Based upon my analysis, I argue that the FCTC offers a unique response first because it is the only health treaty so far created, and second because it is not arguably a neoliberal response as its purpose is to regulate and monitor the tobacco industry. Also, I found that the WHO rejects the tobacco industry’s claim to the freedom of choice discourse that positions humans as having a freedom to choose to use tobacco products, arguing instead there is no freedom in this choice because of the tobacco industry’s purposeful actions to trick individuals into smoking. In this case, the WHO is thus removing the blame and burden from the individual.

For obesity, I found that the WHO’s approach is much different. By presenting obesity through the lens of ‘modifiable behaviours’ such as diet and physical activity, the WHO misses key opportunities to highlight the complex social and environmental factors that contribute to the ‘obesity epidemic.’ Instead, the healthy lifestyle discourse remains the dominant understanding of obesity throughout the timeline of the WHO documents – positioning the individual as

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responsible for the harm caused to themselves and the economic burden on the healthcare system and society. Whereas the tobacco industry was deemed responsible for the uptake and burden of tobacco-related illness in the WHO documents, the WHO has not pursued a similar dialogue about the food industry in the documents I reviewed. When I asked WHO key informants if an obesity treaty would help to manage the obesity epidemic and the food industry, they said there is ‘no appetite’ for a framework convention on obesity from Member States because of the complexity of the problem and trade agreements with the food industry. I also show that over time, tobacco use too has been grouped together with obesity under the healthy lifestyle discourse as a catch all to manage ‘modifiable behaviours’.

In Chapter 7 (“The institutional conditions of WHO guidelines and technical documents for global health governance”), I outline how WHO guideline and technical documents are created – their conditions of possibility. I outline the use of the GRADE method for ranking evidence, considered necessary for the creation of guideline documents. Using the GRADE methods situates the WHO as the leader in using ‘gold standard’ evidence to create ‘gold standard’ guidelines – as argued by the WHO key informants. I argue that evidence-based medicine and evidence-informed decision-making model are the basis of the WHO’s epistemology. The drawback of these frameworks is they exclude the Social Determinants of Health (SDOH) literature and recommendations because social science literature is ranked as ‘weak’ on the GRADE scale and is therefore absent from guideline documents.

For technical documents such as the NCD Action Plans and Global Status Reports, the WHO allows for expanded evidence to include, for instance, randomized controlled trials (RCTs) and observational case studies as evidence. Nevertheless, the WHO technical document limitations, from my review, still embrace the same epistemology of evidence-based medicine

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and evidence-informed decision-making and are limited in using and understanding SDOH and social science literature. Due to the production process involving Member States and the World Health Assembly (WHA) (unlike guidelines and explored in detail in Chapter 7), the WHO is again limited – albeit in a different way than the GRADE process – in what evidence is used in technical documents due to the politics of such evidence such as trade agreements between countries.

Investigating how certain kinds of knowledge and evidence about ‘modifiable behaviours’ are taken up in WHO guideline and technical documents to address NCDs, I conclude that by relying on ‘high quality’ evidence from the GRADE method to create guidelines, and favouring evidence-based medicine in technical documents, the WHO is unable to move past the discourse of individual responsibilities embedded in the perception of ‘modifiable behaviours’ – as presented in Chapter 6. I also discuss the WHO key informants’ perspectives on this, including that there is a lack of funding for the NCD program at the WHO, leading to Member States’ unwillingness to tackle the complex issue of obesity due to geopolitics and trade agreements, and that the WHO is unable to propose politically complicated recommendations due to needing Member States and the WHA to endorse the WHO recommendations. The WHO finds itself in a difficult political position of being the producer and holder of knowledge in the form of documents and statistics, but needing to balance how to best address these problems while responding to their ‘bosses,’ the Member States.

Furthermore, in Chapter 8 (“Conclusions”), I argue that the WHO follows an evidence informed decision-making model epistemology and uses evidence-based medicine with the GRADE method to position its authority as grounded in neutral, transparent, rational, and ‘high quality’ evidence to be able to create recommendations for NCDs. The limitation, however, is

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that the WHO is unable to address the complex problems of NCDs because important evidence is considered ‘weak,’ such as social science evidence and environmental, observational research, or new approaches to interventions which are politically unfavourable. If the WHO is perceived to produce ‘gold standard’ knowledge for the world, how do we understand these limitations when Member States are unwilling to recommend politically difficult approaches to address NCDs? The consequence is the WHO remains in a difficult position of trying to call attention to the problem of, and make recommendations about, NCDs with outdated and ineffective knowledge and a narrow definition of evidence. As such, I identify policy recommendations to propose how the WHO can address its limitations found in this dissertation.

While reviewing the WHO documents and the use of discourses by the WHO I also explored to what extent the WHO is set up to internationalize the response to disease as the major global actor to manage the health of the global population – RQ2 and RQ 2.1. The internationalization of disease policy is a process that standardizes responses to global health issues at international and national levels (Hanson, 2010). The main purpose of internationalization is to plan and implement policies that are suitable for all countries. According to the global social policy literature, discourses and ideas proposed by international organizations can directly influence national policies (Béland & Orenstein, 2013; Dolowitz & Marsh, 1996, 2000; O’Brien, 2002; Stone, 2004). I argue that the WHO perpetuates an internationalization of global health by producing standardized documents, informed by its epistemology, that are meant to inform uniform Member State action.

However, for this dissertation, while I did not explore whether and how the WHO influences the transfer process, I did consider how the goals of internationalization may shape the examined documents, and specifically the politics involved in the production of technical

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documents. Further, the process and politics that goes into drafting these documents are hidden from the reader and the WHO does not explore in its documents how these processes position the document or the institution. This exploration of internationalization led to an analysis of the institutional conditions that makes the production of these documents possible, and the conditions that leave out certain types of evidence and strategies. This thread of analysis is consistent with Foucault's archaeological and genealogical analysis because like Foucault, I examined how the WHO as an institution is situated as a producer and user of knowledge and the power (and political) dynamics influencing this relationship.



## **Chapter 2: Literature review: Global health and managing individual, ‘modifiable behaviours’**

### **2.1 The World Health Organization and noncommunicable diseases**

#### **2.1.1 The World Health Organization**

The WHO was founded in 1948 following the Second World War as a specialized agency of the United Nations (UN) (Fasulo, 2015). The WHO’s work ranges from supplying medication, to sending in health specialists, to monitoring outbreaks (Fasulo, 2015, p. 183). The WHO also takes on the development of international documents to define and recommend global strategies or programs to improve health. The WHO has historically focused on epidemics and is the agency that declares disease outbreaks – traditionally from infectious diseases – an epidemic (Weisz & Vignola-Gagné, 2015), but more recently the WHO included NCDs in this framework – obesity was declared an epidemic in 1997 (Caballero, 2007). Considering how the WHO frames the problem of disease provides insight into how the WHO understands and shapes health issues.

Moreover, from my experience in academia and working in public health for the provincial government, it is common practice for academics and governments to use WHO frameworks to conduct their research or create health care/promotion initiatives and programs. This led me to investigate the WHO and its assumed authority, which appears to be unquestioned by some. The WHO has certainly been critiqued regarding, for example, its leadership (Lerer & Matzopoulos, 2001), finances (Lerer & Matzopoulos, 2001), response rate to outbreaks (such as Ebola in 2015 (Cluzeau, 2015; Gostin, Sridhar, & Hougendobler, 2015)), and construction of knowledge and recommendations (Katz, 2013). Yet it retains what Gostin et al. (2015) identify as ‘normative authority,’ defined as



an organization's power to shape or influence global rules and norms and to monitor compliance. This can be contrasted with, for instance, the organization's technical role (e.g., providing medical or logistical advice on a vaccination campaign or monitoring and reporting on the global spread of an epidemic) (p. 854).

Gostin et al. (2015) argue that the WHO exercises its normative authority through ‘soft power,’ which includes “either constitutionally authorized ‘recommendations’ or more informal action by the [World Health] Assembly, Board, and/or Secretariat” (p. 855). The documents and recommendations reviewed for this dissertation indicate how the WHO exercises its soft power to influence legislation and regulation at the national level. The WHO’s constitution gives it the authority to design treaties which include recommendations for Member States to regulate the tobacco industry for countries that ratify the treaty (Lee, 2005, p. 589). To ratify a treaty means a country signs the treaty and is “consenting to be bound” by the terms of the treaty (Fasulo, 2015, p. 87). The WHO rarely exercises this ‘hard power’ to create treaties (Gostin, et al., 2015, p. 855).

### **2.1.2 The World Health Organization’s Framework Convention on Tobacco Control**

The WHO’s use of its ‘hard power’ to create its first and thus far only treaty, the ‘Framework Convention on Tobacco Control’ (FCTC) was a pivotal moment in the WHO’s institutional history. The FCTC was unique because it was in response to a specific *health concern* that had not been addressed in UN treaties. The FCTC’s development started in 2003 and took effect in 2005, laying out and designing universal standards for how to limit tobacco use (Blouin & Dubé, 2010). The FCTC has been widely accepted, with 180 Parties (179 countries and the European Union) ratifying the Convention, and 80% of the Parties reporting they have used the FCTC recommendations to change tobacco control regulations (WHO, 2015b). One of the reasons the WHO had not drafted a treaty earlier is because historically, the

WHO used its diplomatic position to refer to UN treaties (similarly to FCTC to include recommendations for regulation), such as the Convention on the Rights of the Child, where they had implications for health reform (Blouin & Dubé, 2010).

As a treaty, the FCTC is considered “binding international law” (Wipfli & Huang, 2011, p. 107). However, the WHO is not a policing agency and does not have the authority to ensure conformity or implement sanctions on Member States which do not adopt recommendations from the FCTC. However, there appears to be a sense of legal obligation to “obey international law” without such enforcement measures (Lakin, 1997, p. 42). The WHO and Member States view the FCTC as an opportunity for “international cooperation” to “establish a global regulatory system” to address the tobacco industry (de Seizas Correa, 2002, p. 942). The FCTC can also be seen as a tool to empower Member States to implement national policies, in cooperation and collaboration with other Member States, to address the tobacco industry – cooperation that may not have existed before the collaboration and drafting of the FCTC.

The WHO (2003a) argues that implementing the FCTC protocols to regulate tobacco “reaffirms the right of all people to the highest standard of health” (p. v) and the FCTC “represents a milestone for the promotion of public health and provides new legal dimensions for international health cooperation” (pp. 35-36). I consider key discursive aspects of these protocols in Chapter 6, but note here that the implementation of the treaty protocols is complex. The WHO (2003a) claims that through the ratification of the Convention, developed countries are tasked to “assist developing country Parties and Parties with economies in transition” in implementing the FCTC protocols (p. 19), thus requiring cooperation between Parties in order for tobacco reduction to succeed at the global level. Wipfli, Fujimoto, and Valente (2010), however, argue that different countries may have various reactions to the FCTC and its components depending

Chapter 2: Literature review: Global health and managing individual, ‘modifiable behaviours’ on their relationship with tobacco production. For example, countries whose economic stability relies on tobacco production and exportation may see the FCTC as a threat to financial gains (Wipfli et al., 2010, p. 1261).

At the negotiation stage, the treaty process encouraged policy transfer as Member States increased communication surrounding the treaty (Wipfli, & Huang, 2011, p. 108). From reviewing policies of 193 WHO Member States (including States that did not ratify the FCTC treaty), from 1996 to 2005 (for before, during, and after FCTC negotiations), Wipfli and Huang (2011) found that 83% of the countries adopted at least one smoking-control policy (p. 111). Member States were also more likely to shift their policies from weak, general policies, to stronger, WHO-promoted policies as the treaty negotiations continued. In this respect, the WHO was also deploying its soft power (i.e. negotiations and conversations) to promote change in national policies even before finalizing and signing the FCTC (Gostin et al., 2015). However, lower-income countries were less likely to implement new policies, and the policies that were adopted are considered weaker, non-WHO policies (Wipfli, & Huang, 2011, p. 113).

The FCTC is usually considered a great success in instigating international awareness, uniting countries, and allowing the WHO to pressure countries to cooperate (Blouin, & Dube, 2010). Taylor, Bettcher, and Peck (2003) argue that FCTC is a “global public good for health” due to its significant impact in facilitating domestic tobacco control action (p. 213). Wipfli and colleagues (2010), however, bring into question the extent to which countries can cooperate, how economics may influence Member State actions, and how policy can transfer between levels of governance.

For the purpose of my dissertation, the FCTC allows for an interesting comparison in terms of why the WHO exercised its legal authority (hard power) to draft a treaty in relation to

tobacco use, while so far other ‘modifiable behaviours’ understood as bad for health have not been addressed through a treaty. This response to tobacco use is unusual and comparing tobacco use to obesity in this dissertation helped me understand the ways in which the WHO manages itself, question what it means to govern through a treaty, speculate on the possible governance by the WHO, and see if the same conditions are in place for another NCD treaty as were for the tobacco treaty. Considering the deliberate approach by the WHO to proposed the FCTC as a response to the tobacco industry, in Chapter 7, I highlight the WHO key informant interview responses when asked if there would ever be an obesity treaty to address the food industry and why or why not.

### **2.1.3 Noncommunicable diseases**

NCDs, also commonly known as chronic diseases, are noncontagious and non-infectious diseases such as cancer and diabetes (Hunter & Reddy, 2013). Communicable diseases refer to diseases that are contagious through infections, such as HIV/AIDs, cholera, malaria, and tuberculosis (WHO, 2020a). Before the 1950s, specific NCDs were discussed as separate diseases with distinct treatment and prevention programs (Weisz, & Vignola-Gagne, 2015). However, largely due to the efforts by the United States in the 1970s to 1990s, NCDs came to be addressed as a group (Weisz, & Vignola-Gagne, 2015, p. 508). The NCD grouping is constituted mostly of four disease clusters: cardiovascular diseases, cancers, chronic pulmonary disease (respiratory), and diabetes, which together account for 80% of the NCD death rate (Hunter & Reddy, 2013; WHO, 2013). As claimed by the WHO (2014a), 38 million (68%) of 56 million global deaths in 2012 were attributed to these four disease clusters, with 82% of NCDs occurring in low- and middle- income countries (p. xi). It is these high death rate statistics that identified NCDs as passing the communicable disease rates and led to my interest for this dissertation.

George Weisz (2014) traced the social, political, and economic reasons for how NCDs became constructed as a critical public health issue and thus shaped health care policy – and how the United States, United Kingdom, and France differed in its approach to NCDs in this timeline. In his analysis, Weisz (2014) highlights that the causes of attention to NCDs were complex and not the simple results of the epidemiological shift, in which infectious diseases were diminishing and people were living longer and thus dying of diseases such as cancer.

Although not a central component, Weisz (2014) explores how and why NCDs were created into a new category through efforts largely in the United States, but also in the United Kingdom, and France. He highlights in particular that as NCD rates increased, private insurance companies saw an opportunity to create an NCD category separate from chronic diseases for purposes of health coverage. Similarly, as risk factors emerging rapidly in the 20<sup>th</sup> century, NCDs and behaviours became grouped together under one large category because of its reported correlation to one another and to streamline the administration of insurance for this large group of diseases and behaviours (Weisz, 2014). These behaviours included personal hygiene behaviours and physical examination procedures which supported the development of the individualized responsabilization and the healthy lifestyle discourse (Weisz, 2014).

Due to this increased attention to the rise of chronic diseases, and the aging populations of the UK and France, both countries followed the United States’ leadership in raising awareness about the NCD category (Weisz, 2014), with the WHO responding after the Member States and bringing national awareness to the economic and medical issues of chronic diseases (Weisz & Vignola-Gagne, 2015). This example demonstrates how in the process of international policy making and knowledge translation, a Member State may be the leader in raising awareness and

adapting to new health concerns, while the WHO lags in its response, in this case continuing to focus on chronic diseases long after the second world war, as argued by Weisz (2014).

Further, Weisz and Vignola-Gagne (2015) follow Weisz’s (2014) analysis and also identify the WHO’s use of two competing models in its framing of NCDs: the “equity rhetoric of Alma-Ata” and the “cost-benefit / market views of the World Bank” (p. 517). First, the Declaration of Alma-Ata, which was adopted at the International Conference on Primary Health Care in Almaty (formerly Alma-Ata), Kazakhstan, in September 1978 (WHO, 1978), was a landmark international policy document for its call for a greater role for primary health care – bringing equity and social justice to the forefront for policy reform. Second, the cost-benefit analysis is the estimation of costs as it relates to intervention outcomes and program effectiveness (Felce, 2017). The World Bank is argued to have used the cost-benefit analysis long-before it was taken up by other institutions and organizations and was used to establish its reputation and ensure accountability (Independent Evaluation Group, 2010). According to the Declaration, primary health care should be “based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people’s full participation and at a cost that the community and country can afford” (WHO, 1978, pp. 1-2). The importance of this statement is the acknowledgement of balancing interventions that are equitable *and* affordable, which is undoubtedly the goal to achieve in primary health care but arguably difficult to attain (Rifkin, 2018). Weisz and Vignola-Gagne (2015) found in their analysis of WHO NCD documentation, that both models (Alma Alta and cost benefit analysis) remained in use by the WHO in their response to NCDs and achieved in balancing the importance of equity and social justice, while encouraging a cost-benefit analysis approach.

Weisz and Vignola-Gagne’s (2015) work concerning the balance between the Alma-Ata and cost-benefit analysis helped me frame how I would read and code these WHO document. I am carrying forward this analysis to the present moment of WHO NCD documentation with a different set of documents and a discourse analysis, and I took a closer look at these model (Alma-Ata and cost-benefit analysis) as discourses of human rights and economics. As I will show, I did not have the same findings as Weisz and Vignola-Gagne. Further, Weisz (2014) and Weisz and Vignola-Gagne (2015) do not attempt to link their work with neoliberalism in their analyses as I have for mine.

Further, from this background, I became interested in how these changes in WHO’s approach to thinking about NCDs, and possible contradictions in its approach, would appear in the WHO’s documents and policy recommendations, how they affect the WHO’s conceptualization and use of knowledge, and whether and how these shifts might be related to questions of governmentality and biopolitics.

## **2.2 Modifying behaviours**

### **2.2.1 ‘Modifiable behaviours’ and a healthy lifestyle**

Social science scholars argue that behaviours such as diet, physical activity, tobacco use, and alcohol consumption have become the target for intervention for the ‘new public health’<sup>1</sup> as these behaviours are considered *modifiable*, and are deemed the key to managing NCDs (Bell, 2011, 2013; Bell, Salmon, Bowers, Bell, & McCullough, 2010; Bell et al., 2011; Campos, Saguy,

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<sup>1</sup> The ‘new public health’ is defined by Tulchinsky and Varavikova (2010) as “a contemporary application of a broad range of evidence based scientific, technological, and management systems implementing measures to improve the health of individuals and populations. Its main objectives are the political and practical application of lessons learned from past successes and failures in disease control and the promotion of preventive measures to combat existing, evolving and re-emerging health threats and risks” (p. 25).

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Ernsberger, Oliver, & Gaesser, 2006; Elliott, 2007; Gard, 2010; Glasgow & Schrecker, 2015; Katz, 2013; Oliver & Lee, 2005). These behaviours are considered modifiable because they presumably can be changed through an *individual’s* own decisions – someone can quit smoking, stop drinking alcohol, eat healthier, and exercise more. If you do not change these behaviours, then these actions become ‘risk factors’ that contribute to your risk of ill health and disease (Murray & Lopez, 1997). The ‘old public health’ had a “focus on controlling filth, odour and contagion, [while] the new public health is characterised by an intense concern with the health status of populations” (Bell et al., 2011, p. 1). The wave of the new public health resulted in a review of “the social, environmental and behavioural variables statistically associated with patterns of chronic disease” (Bell et al., 2011, p. 2). Importantly, an NCD due to (or correlated with) a risk factor (modifiable behaviour) is deemed to result from a “failure of individual control, a lack of self-discipline, an intrinsic moral failing” (Brandt, 1997, p. 64).

Following this shift in public health interventions, the discourse of public health focused on the behaviours that make up a ‘healthy lifestyle’ (Bell et al., 2010; LeBesco, 2004; Rogge, Greenwald, & Golden, 2004). The healthy lifestyle discourse constructs life as a series of responsible or ‘rational’ choices versus irresponsible or ‘irrational’ choices (Bell et al., 2011). This responsible pathway leads to a healthy lifestyle of not smoking, limited alcohol consumption, a healthy diet, and sufficient physical activity to prevent disease generally and NCDs specifically. Narratives surrounding behaviours instruct individuals to take on all means possible to be healthy (LeBesco, 2004; Rogge et al., 2004).

Bell et al. (2011) argue that this new public health became linked with a neoliberal ideology where “an increasing concern with individual responsibility, self-control and lifestyle” (p. 1). This ‘individual responsibility’ resulted in a process of responsabilization, which refers to



the process of individuals becoming accountable, judged and sanctioned for their actions taken and decisions made (Gray, 2009, p. 326). As such, under neoliberalism, individuals become understood by their entrepreneurial virtues (i.e., individualized entrepreneurship), where individuals are expected to invest in their types of self and to take on all opportunities where one can advance themselves (Harvey, 2005, pp. 65-66). The individual becomes faced with many choices, and in the neoliberal project, some decisions are considered good versus bad, thus making up what it means to be a responsible individual (Harvey, 2005, p. 69). Thus, the discourse of a ‘responsible citizen’ constructs behaviours as ‘modifiable’ because these behaviours are changeable when a responsible individual ‘does the right thing.’

A number of social science scholars have argued that the ‘healthy lifestyle’ discourse results in the unintended harm of shaming and marginalizing individuals who do not ‘modify’ their behaviour to live healthily. In the case of tobacco use, research has identified that individuals are blamed for increasing their chances of lung cancer (Chapple, Ziebland, & McPherson, 2004; Lobchuk, McClement, McPherson, & Cheang, 2008), and medical research on lung cancer is under-funded due to the perceptions of those who smoke (Tran et al., 2015). For obesity, several social science scholars argue that there is a moral undertone to the medical literature on obesity because it suggests that responsible, moral citizens will regulate their bodies to optimize their health and reduce their chances of illness (Elliott, 2007; Harrison, 2012; LeBesco, 2004; Oliver, 2006a; Rogge et al., 2004). The healthy lifestyle discourse creates two opposing bodies. To achieve a healthy, fit body, one must be disciplined to eat healthy, exercise, and to have a healthy, productive body to contribute to the economy; the obese body is the opposite, a lazy, selfish, gluttonous body that drains health care due to poor, personal decisions (Bell et al., 2011; LeBesco, 2011; Rogge et al., 2004).

The healthy lifestyle discourse is also criticized by social science scholars for ignoring the social context of behaviours that make them difficult to modify, and for missing a broader understanding of the income, gender, mental health, and other SDOH that help us understand risks of poor health (Bell, 2013; Bell et al., 2011; Campos et al., 2006; Gard, 2010). Social science scholars argue that these SDOH factors are as important as understanding the biological factors of what happens when you eat a high sugar diet or smoke cigarettes (Campos et al., 2006; Gard, 2010). In order to understand how to change these ‘modifiable behaviours’, individuals need something other than scare tactics (‘if you smoke you will get lung cancer’), because research has shown that this type of behaviour deterrence is ineffective (Katz, 2013).

While scholars have analyzed how alcohol use became included in the healthy lifestyle discourse (Bacchi, 2015; Bell, McNaughton, & Salmon, 2009; Bell et al., 2011; Pachankis, Hatzenbuehler, & Starks, 2014) and its relationship to NCDs (Limb, 2012; Mendis, Davis, & Norrving, 2015; Mitchell & Voon, 2011; Sridhar, 2012), in the WHO documentation, alcohol use is rarely discussed by itself as a direct cause of NCDs. Instead, alcohol is mentioned when the WHO lists all presumably ‘modifiable behaviours’ together, or it is discussed in separate documents not relating to NCDs. Therefore, alcohol use was only explored in this dissertation to the degree it was mentioned, which was typically as part of a group of ‘modifiable behaviours’/risk factors. As such, a comparison of tobacco use and obesity (as it relates to diet and physical activity) was focused on because of the priority the WHO has placed on them, and because of the different features of these apparent dangers to the population – despite the WHO’s grouping of ‘modifiable behaviours’ so robotically in its documentation.

### 2.2.2 Medicalization of obesity

As the concern about obesity increased and the WHO identified points of medical intervention to prevent and treat obesity, some social scientists argue obesity has been ‘medicalized.’ Medicalization is the process where human conditions and problems are “defined and treated as medical problems, usually in terms of illnesses or disorders” (Conrad, 1992, p. 209). Furthermore, ‘over-medicalization’ is said to occur when human conditions and problems become solely addressed through medical intervention such as the medicalization of ‘sadness’ as ‘clinical depression’ and over prescribing anti-depressant medication (Broer & Besseling, 2017).

Medicalizing obesity has entailed two key things; first, body weight is to be measured and understood in medical terms such as the use of the body mass index (BMI) and poor health outcomes correlated with an increase in BMI (Ulijaszek & Lofink, 2006); and BMI is to be managed with medical interventions such as meeting with a health care professional to monitor your weight and diet, and bariatric surgery (Ulijaszek & Lofink, 2006). BMI is a calculation of weight times height and is used to classify the body into four categories: underweight, normal weight, overweight, and obese (WHO, 1995). These categories were constructed by the WHO (1995), although based upon previous medical research, were widely adopted in medical research and literature, and in personal medical and insurance records (Nuttall, 2015).<sup>2</sup> BMI also functions as a surveillance tool – for health care payers and providers to surveil the patient, for countries to surveil the population, and for international organizations such as the WHO to surveil the globe (Gutin, 2018).

Social science scholars argue that the use of the BMI to measure and assess the body resulted in obesity following the same path of medicalization as “madness into mental illness and

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<sup>2</sup> The 1997 Consultation and the 2000 ‘Obesity: Preventing and managing the global epidemic’ report series used BMI.

drunkenness into alcoholism,” where the behaviour itself is ‘sickness’ (Levenstein, 2003, p. 262). Paul Campos (2004), one of the scholars leading the critique of the obesity literature, highlights that epidemiological research overstates its findings since large-scale observational studies cannot control for enough factors to estimate causation over correlation or probability (p. 2). Also, LeBesco (2011), an activist and social science scholar, states that measurements such as the BMI creates an obese, marginalized category of bodies and people that are perceived to require medical intervention. Scholars have also claimed that using the BMI measurement at the population level aims to “prevent, contain, or eliminate the abnormal” (Guthman & DuPuis, 2006, p. 444) and results in blaming the individual for their poor choices (Rogge et al., 2004). As a result, individuals develop an unhealthy relationship with food, dieting, and binge eating, with extreme weight loss and weight gain (LeBesco, 2011).

In 2013 the American Medical Association officially classified obesity as a disease (Pollack, 2013), giving it a dual status as both an NCD and as a contributing factor to NCDs. This status also gives obesity a mortality rate, allowing the WHO (2014a) to claim, “overweight and obesity... were estimated to account for 3.4 million deaths per year” (p. 79). Scholars have since been critical of calling obesity a disease because one does not ‘die from being overweight,’ therefore epidemiological evidence that suggests obesity *causes* death portrays “body fat [as] pathological” (Oliver, 2006b, p. 612) – fatness is a ‘dangerous, contagious disease’ one should be fearful of catching or being near (LeBesco, 2011). This literature led me to pay close attention to the broader discourse and the word choices used by the WHO around obesity.

### **2.2.3 ‘Modifiable behaviour’ and economic burden**

As the rates of type II diabetes and other NCDs increase, from a neoliberal perspective, the economic burden placed on the health care system makes it the responsibility of every citizen

Chapter 2: Literature review: Global health and managing individual, ‘modifiable behaviours’ to ‘do the right thing’ and live a healthy lifestyle to reduce one's individual, economic burden. This economic framing, examined in the WHO documents in Chapter 5, proposes that thinness decreases the chances of the individual getting sick while obese citizens are an economic burden on the health care system due to the costs to treat obesity related illnesses, such as diabetes (Elliott, 2007; Harrison, 2012; LeBesco, 2004; Oliver, 2006a; Rogge et al., 2004). There is a purported domino effect with obesity and costs: the rise in obesity causes an increase in related health concerns (e.g., coronary heart disease), resulting in more citizens receiving treatment for these health concerns, leading to an increase in annual health service costs, causing an increase in taxes needed to fund healthcare, raising costs of private healthcare, and ultimately making health services unaffordable to all other citizens needing access to health care (Butland et al., 2007). The same domino effect is seen for tobacco use and health concerns. Thus, obese individuals and smokers are represented in medical literature as failed, irresponsible citizens because of the economic costs of their personal choices (Bell et al., 2010; Elliott, 2007). Given the success of the FCTC, scholars are calling for something similar to address obesity (Blouin & Dubé, 2010).

## **2.3 Global health governance**

I explore the governance concept further, from a Foucauldian lens, in Chapter 3, but international relations literature defines ‘governance’ broadly as a need to bring individuals together to “accomplish an agreed end” (Lee & Kamradt-Scott, 2014, p. 2). The concept of global governance is embedded in international relations literature to refer to effective international cooperation. Further, global governance includes the framing of urgent and escalating ‘global problems’ that require international cooperation to manage and prevent. The core dilemma of global governance is state sovereignty – the power for each sovereign state to

independently regulate itself. The question for scholars is, how do global institutions “effectively govern [international concerns] without government” (Lee & Kamradt-Scott, 2014, p. 2)? Global governance is the effort to respond to social and political issues through collaboration and cooperation, whereas global government refers to police/policing powers to enforce implementation and reform by a global institution such as the WHO in a specific country (Lee & Kamradt-Scott, 2014).

As health concerns can escalate to pandemics and cause significant economic burdens, they can jeopardize the security of the individual, population, and state. Therefore, health concerns are one of the leading global governance needs alongside armed conflicts and poverty (Gagnon & Labonté, 2011). Scholars argue, however, that there is no clear vision for global health, as the goals and implementation vary depending on whether the concern is framed as a security threat, foreign policy issue, human security, human rights, or global public good needs (Ng & Ruger, 2014). Security threats and foreign policy approaches focus on infectious disease outbreaks and the needs of surveillance and possible consequences for economic stability (Ng & Ruger, 2014). The global public goods (GPG) perspective understands health goods, like “peace and security, and law and order,” as being outside of any single country’s control and asserts that “individuals cannot be prevented from partaking of them” (Kaul & Faust, 2001, p. 870).

Applying this perspective to global health concerns means surveillance, prevention, and control procedures are themselves GPGs that must be implemented to limit the spread of disease from person to person, and country to country. For example, the West Nile virus cases in the United States highlighted the need to treat communicable diseases control as a GPG to ensure international cooperation to prevent the spread of disease (Kaul & Faust, 2001, p. 870).

In terms of the infrastructure needs of global health governance, scholars have identified “three concentric circles of actors”: (1) WHO and World Bank at the centre; (2) countries, International Monetary Fund, and other UN organizations next; and (3) non-governmental organizations, multi-national corporations, epistemic communities, and individuals in the outermost ring (Ng & Ruger, 2014, p. 2, Stone, 2004). The WHO is considered the authority on global health governance and problems (Koivusalo, 2015; Ng & Ruger, 2014), and is the only global health organization to have treaty powers. As the centre of global health governance actors, the WHO has been examined and criticized extensively, including in relation to corruption allegations and mis-management of operations, staff, and funding (Lerer & Matzopoulos, 2001). Ng and Ruger (2014) argue that current global health governance issues include the lack of coordination between donors and recipient countries (including health plans), international organizations, and non-governmental organizations; and disagreements on norms and activities concerning health rights, and criteria and needs to receive donations and health aid (p. 9).

### **2.3.1 Internationalization**

The WHO promotes the internationalization of health policy. In this context, internationalization refers to the process that standardizes responses to global health issues at national and international levels (Hanson, 2010), for either collaborative or separate state implementation. Further, policy transfer refers to the process whereby ideas, practices, policies, and programs are transferred between States, and national and international levels of governance (Stone, 2004), and is a key element to global governance. For this dissertation, I did not explore the specific transfer process, but I do consider how the goals of internationalization and policy transfer may shape the examined documents. The importance of focusing on the WHO as a

leading international actor is because the discourse, ideas, and evidence supporting its recommendations can directly influence national policies (Béland & Orenstein, 2013; Dolowitz & Marsh, 1996, 2000; Drezner 2001; O’Brien 2002; Stone, 2004). The ability to influence through discourse and ideas is because international actors are ‘open systems’ that can adapt to international demands (Béland & Orenstein, 2013), support social learning between international and national actors (Stone, 2004), and can implement “indirect modes of influence” such as resource leveraging or coercion, norms teaching (can include courses and seminars), or membership conditionality (such as the European Union) (Orenstein, 2008, p. 60).

The WHO has remained at the centre of international actors since its creation in the 1940s, despite its issues concerning corruption, staff shortages, and funding. I argue that the WHO remains the international authority on health due to its ability to engage national health ministries; support these countries through WHO regional offices and officers; collaborate with and hire experts around the world, including universities, to conduct research and provide expert opinion; and enforce rigorous evidence reviewing methods including systematic reviews and meta-analysis, and the GRADE method for guideline creation. The WHO has established itself as the regulator and creator of global health knowledge, exercising its soft power in part through managing knowledge production (Gostin, et al., 2015), which turns into arguably ‘harder’ forms of power in the form of national policies and regulations at the national level.

A part of the process of knowledge translation is indicator surveillance performed by the WHO. The WHO identified nine NCD targets in the WHO (2014a) ‘Global Status Report on Noncommunicable Diseases 2014’ such as ‘Target 5: A 30% relative reduction in prevalence of current tobacco use in persons aged 15+’. To measure this progress, the WHO publishes indicators which are measurable variables, such as number of deaths, that are recorded and



‘surveilled’ at the national level and report to the WHO (WHO, 2017b). Current tracking data that is available to the public includes the WHO (2017b) ‘Noncommunicable Diseases Progress Monitor’ document that lists ten progress indicators for 194 countries. These NCD indicators track mortality data, risk factor surveys, national integrated NCD policy/strategy/action plan, tobacco demand-reduction measures, harmful use of alcohol reduction measures, unhealthy diet reduction measures, public education and awareness campaign on physical activity, evidence-based guidelines for management of major NCDs and drug therapy/counseling to prevent heart attacks and stroke (WHO, 2017b, pp. 8-9). The WHO (2017b) tracking document concludes that progress to meet the NCD indicators that inform the Sustainable Development Goals (SDG) have “been insufficient and highly uneven” and states that

the current rate of decline in premature death from NCDs will not meet the SDG target, leading to the significant GDP losses and impoverishing millions of people through long-term health care costs (WHO, 2017b, p. 5).

Tracking data such as these highlights how the WHO attempts to monitor knowledge<sup>3</sup> and policy translation by setting goals, indicators to track goals, and surveillance monitoring to report progress. They also suggest that there may be significant limitations to the successful transfer and implementation of WHO recommendations. Few studies have examined the operations of international organizations in the knowledge and policy transfer process, with the policy literature often focusing on the state as an influence (Stone, 2004). Moreover, as the limited literature states, we are unsure how WHO recommendations for managing NCDs are being taken up by Member States (Katz, 2013). In this dissertation, I do not explore whether WHO policies

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<sup>3</sup>‘Knowledge translation’ mentioned here is because the WHO NCD indicators are not all policy environment recommendations as some target the social (such as media campaigns), physical (such as images of health warnings), and economic (such as increase taxes and prices) environments.

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are implemented at the national level. Instead, I focus on what – and how - evidence is mobilized to inform WHO to better understand the *knowledge translation process* that then informs policy.

I review how the WHO, as a leading actor, constructs knowledge and discourse, provides ‘best practice’ or ‘best evidence’ recommendations at the global level for the purpose of changing national policies and procedures, and how this evidence is related to the WHO’s governance.



## **Chapter 3: Theoretical framework**

The theoretical framework for this dissertation centers on governmentality theory and its attention to biopolitical techniques and neoliberal forms of governance, in relation to which I position my understanding of WHO discourses. In this section I relate the concepts of governmentality, neoliberalism, and biopolitics to global health governance and how discourses can be mobilized by and for global health governance.

### **3.1 Governmentality**

In Foucauldian social theory, governmentality examines ‘government’ broadly as “the type of governing authority or agency, the forms of knowledge, techniques and other means employed, the entity to be governed and how it is conceived, the ends sought and the outcomes and consequence” (Dean, 2010, p. 18). Governmentality as a theoretical framework also assesses how government makes up a ‘discursive field’ where the control of behaviours is rationalized (Dean, 2010; Lemke, 2002) – this is the distinction of governmentality versus other government analyses. Foucault’s analysis of governmentality complicates the story of the shift of power from monarchs to the state (McKee, 2009). Foucault argues that a condition of this change of governing power were techniques “towards optimizing the well-being of the population” and making citizens both more ‘docile’ and ‘productive’ (McKee, 2009, p. 466). The result was governance in the sense of a ‘conduct of conduct,’ where the behaviours and actions of individuals and populations becomes a focus of regulation and governance (Dean, 2010, p. 17). ‘Governance’ is any action taken to influence and shape our behaviours including changing formal mechanisms such as laws but also changing informal norms and values (Dean, 2010; Klesse, 2007).

### Chapter 3: Theoretical framework

To help clarify, Coomber, Donnermeyer, and McElrath (2014) provide three definitions to distinguish governmentality, governance, and social control.

Social control is defined as the various processes by which groups within a society attempt to regulate the behaviour of its members, thereby reducing deviance and enhancing conformity. Governance is the practice of governing through formal institutions within a society based on political, religious and other forms of authority. Governmentality refers to both external and internal processes by which individuals learn to control their own behaviours through various sanctions and socialisation strategies used by groups and institutions within a society (p. 30).

These three concepts are thus related, while governmentality is premised, to a greater degree than governance, on freedom – meaning that individuals will be governed through their freedom and through processes not centrally controlled by institutions (Coomber, et al., 2015). A key distinction that Coomber et al. (2015) leaves out is Foucault's understanding of power as both oppressive and creative. Lacombe (1996) argues that social control theory only understands power as oppressive, while Foucault's understanding of governmentality adopts the notion of power "as a 'mechanism for life' that includes strategies of self-development that both constrain and enable agency" to "maximize life" (p. 332, 334).

Further, Dean (2010) highlights three components of governmentality that stem from the idea of the 'conduct of conduct.' First, to conduct means "to lead, to direct or to guide"; second, there is a moral sense "to conduct oneself" that implies a meaning of "self-direction appropriate to certain situations"; and third, defining conduct enables a reference to "our behaviours, our actions and even our comportment" and thus refers to the regulation of our behaviours (Dean, 2010, p. 17). These three aspects of governmentality are a "means of calculation" that encourages individuals to be governed and focuses on the conduct of conduct (Dean, 2010, p. 13, 18).

Therefore, a fundamental component of governmentality is that this analysis is not restricted to “the institutions or political power of the state” as the ‘conduct of conduct’ enables an analysis of the “comprehensive meaning of governing” (McKee, 2009, p. 468). This ‘comprehensive’ meaning includes how ‘the governable subject’ can be governed through techniques and practices that may not be specific to the state, such as health care and health practices (McKee, 2009). Therefore, for governmentality studies, government does not necessarily mean one, centralized body; rather, government is “a domain of strategies” that ‘diverse authorities,’ institutions, or state bodies can use to govern (Rose & Miller, 1992, pp. 175, 183), with “mechanisms and procedures” (Foucault, 2007, p. 2).

When considering the ‘conduct of conduct,’ Foucault outlines how subject positions are created through the means of political rationalities<sup>4</sup> – where subjects become governable and are steered towards governing themselves (McKee, 2009). Specific forms of governmentality will also involve specific configurations of power and regimes of truth. For Foucault (1995), power is everywhere and both represses and “produces; it produces reality; it produces domains of objects and rituals of truth” (p. 194). Furthermore, there is a power-knowledge relation, where “power produces knowledge,” and “power and knowledge directly imply one another” (Foucault, 1995, p. 27). Rituals of truth, also known as ‘truth regimes,’ are types of discourses that the power-knowledge relation presents as true. Foucault was interested in the relationship between knowledge, scientific discourse, regimes of truth and power (Weir, 2008), and how truth regimes

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<sup>4</sup>Cornelissen (2018) provides several definitions of political rationalities, for the purpose of this dissertation, Dean’s (2010) work understands political rationality as a “systematic form of knowledge specifically aimed at formulating techniques and objectives of government” (p. 130).

“inform the ‘norms’ against which individuals and populations are measured and encouraged to aspire” (Evans & Colls, 2009, p. 1055).

### 3.1.1 Neoliberalism

Neoliberalism is a “theory of political economic practices” where human well-being is thought to “best be advanced by the maximization of entrepreneurial freedoms within an institutional framework characterized by private property rights, individual liberty, free markets and free trade” (Harvey, 2007, p. 22). Both liberalism and neoliberalism are based on an image of the individual as ‘Homo oeconomicus’— man is “an entrepreneur of himself, being for himself his own capital, being for himself his own producer, being for himself the source of [his] earnings” (Foucault, 2008, p. 226). Under liberalism, the technology of homo oeconomicus requires the individual to be ‘left alone’ (Dilts, 2011) to “pursu[e] his own interest, and whose interest is such that it converges spontaneously with the interest of others” (Foucault, 2008, p. 270). Under neoliberalism however, there is the expectation at the entrepreneurial individual will avail themselves of all opportunities to better themselves and their circumstances, such as individuals doing everything they can to make themselves healthy – quitting smoking once they know smoking is not healthy. This requires the use of ‘behaviour techniques’ to construct how individuals should rationally, economically behave (Foucault, 2008, p. 270). Neoliberalism requires a subject who “accepts reality or who responds systematically to modifications in the variables of the environment, appears precisely as someone manageable, someone who responds systematically to systematic modifications artificially introduced into the environment” – thus someone who is “eminently governable” (Foucault, 2008, p. 270). The difference for Foucault between these two ideologies is how technologies are mobilized to support the market economy, as Foucault (2008) argues

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the problem of neoliberalism is rather how the overall exercise of political power can be modeled on the principles of a market economy. So it is not a question of freeing an empty space, but of taking the formal principles of a market economy and referring and relating them to, of projecting them on to a general art of government (p. 131).

This distinction by Foucault supports Thorsen's (2010) position that neoliberalism is not simply a 'revival' of liberalism; neoliberalism is a "more radical descendant" of liberalism that is a 'sweeping reactionary political program' (p. 208).

"Neoliberal modes of governance" therefore undertake the 'conduct of conduct' by "governing at a distance" (Crawshaw, 2012, p. 200), condoning only forms of regulation that do not entail direct control by the government or the law. This is evident in the case of health as it is not illegal to be unhealthy, but it is irresponsible to be a burden on the health care system, and thus it is our individual responsibility to maintain good health. As such, neoliberalism is often reduced to a basic component of its worldview: individuals are responsible for their own behaviour. Neoliberalism as an institutional reform resulted in an evolution of ideologies surrounding individualism with individuals being responsible for their own and their families' well-being (Harvey, 2007, pp. 32, 34). The individual becomes faced with many choices, and in the neoliberal project, there are decisions that are considered good versus bad, thus making up what it means to be a responsible individual (Harvey, 2005, p. 69). As further emphasized by Benatar, Upshur, and Gill (2018) with the "neoliberal individualist ideology, the economic risks of the least powerful tend to be blamed on those considered to be unworthy individuals who have not provided for themselves in times of need" (p. 159).

The role of the state in neoliberalism is to ensure an institutional framework, including ensuring the integrity of money, but also setting up "military, defence, police, and juridical functions" to "secure private property rights," and markets that may not exist, such as by privatizing state functions like health care (Harvey, 2007, pp. 22-23). In his analysis of the



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neoliberal project, David Harvey (2007) argues neoliberalism emerged in the 1970s. The 1970s in the United States and the United Kingdom experienced an economic recession. This recession led to rising support for communist and socialist parties which threatened the “ruling classes everywhere” as it brought forth a threat to the capitalist structure and the organization of economics (Harvey, 2007, p. 28). The ruling class needed to respond with a new ideological foundation that would support a re-organized capitalist structure. Harvey (2007) states that the ideological foundation of neoliberal political ideas of civilization is individual liberties and freedoms. From this stance, it allowed for governments to argue against anything that threatens individual liberties, including fascism, dictatorships, communism, and extensive state intervention (Harvey, 2007, p. 24). This focus on individual liberties underpinned economic conditions where individuals were responsabilized for their well-being and the withdrawal of state forms of security and assistance. Individuals became responsible for assessing their own “social risk,” with neoliberal discourses enforcing an individual model of negotiating the “burden of risk which he or she imposes on society, by participating, for example, in preventive health-care programs” (Gordon, 1991, p. 45).

Foucault (2008) argues that it is with the emergence of liberalism in the 19<sup>th</sup> century that the regulation of the population developed its “urgency” as a problem. Biopolitics, further discussed in the next section, functions as a technique of power over life that is made use of by forms of governmentality, and these techniques can vary depending on governing rationality (Weir, 2006). These biopolitical techniques of power manifest differently in policy, regulation, and implementation depending on the different governing rationalities (Foucault, 2008). But the goal of achieving power over life may pose some difficulties for modes of governance premised upon governing at a distance. Securing the health of the population without direct state

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intervention can cause a tension since biopolitical techniques may require such intervention, for instance through the collection of individual survey data to understand the population to then manage it. In the following chapters, we will see how WHO mobilizes discourses and knowledge to mediate this tension and justify the need for the biopolitical techniques that secure the health of the population. For example, the healthy lifestyle discourse is so pervasive in public health interventions because it mediates this tension by arguably reconciling neoliberal individualism with the need to surveil risk factors and premature death rates for the purpose of saving lives and preventing NCDs. In this dissertation I explore how the WHO, whose purpose is to regulate the health of populations, governs and manages these tensions.

Chorev (2013) argues that after the 1980s, “some neoliberal prescriptions were successfully transmitted” into WHO programs and policies, “but others were transformed” by the WHO, meaning the WHO adapted this global regime to the culture and purpose of its organization (p. 628). Among the transmitted neoliberal prescriptions, Chorev (2013) includes WHO programs and policies that support “embracing economic reasoning, prioritizing cost-effective programs, and accepting market-driven solutions and business-friendly arrangements” (p. 628). However, the WHO pivoted away from a neoliberal focus in “calling for greater financial investment in health, prioritizing the delivery of high-quality essential care to all while maintaining a focus on infectious diseases affecting the poor, supporting access to generic HIV and AIDS drugs, and regulating the tobacco sector” (Chorev, 2013, pp. 628-629).

Currently, neoliberalism is a global project; neoliberal policy and ideology spread globally, in part through international organizations’ uptake of the neoliberal regime through meetings, conferences, creation of international laws, and provision of loans enforcing neoliberal conditions (Campbell & Pedersen, 1996; Chorev, 2013; Halliday & Carruthers, 2009). Harvey

(2007) argues that this global project caused “institutional reform and discursive adjustment,” so that the “the rules of engagement now established through the World Trade Organization (governing international trade) and by the International Monetary Fund (governing international finance) instantiate neoliberalism as a global set of rules” (p. 23). Neoliberalism has therefore become the international standard of trade and regulation and its political-economic practices arguably “incorporated into the common-sense way we interpret life in and understand the world” (Harvey, 2007, p. 22). Nevertheless, few scholars have focused on how international actors operate in, enforce, or challenge a neoliberal regime (Glasgow & Schrecker, 2015). Of those who have, most scholarship has focused on the World Bank and the International Monetary Fund (Babb & Buira, 2005; Brune, Garrett, & Kogut, 2004; Chorev & Babb, 2009), and less has focused on the WHO (Chorev, 2013; Glasgow & Schrecker, 2015).

### **3.2 Biopolitical and disciplinary power**

For Foucault, the shift in governing from the sovereign to liberal, “governmentalized” states depended on new techniques of power – disciplinary techniques over individual bodies (the topic of *Discipline and Punish* (1995) and disciplinary power), but also biopolitical forms of power. At the onset of this dissertation I did not include disciplinary power in the proposed research because I did not anticipate examples of disciplinary power in the WHO documents and thus it was not included in the research questions. Upon investigation, I found examples of disciplinary power and in this section, I outline these two different forms of power (disciplinary and biopolitical) and how they can be mobilized by a governmentality.

Foucault understands disciplinary power as a power that controls the individual body and biopolitical power as a power of regularization of the population. Foucault outlines the introduction of disciplinary power as follows

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in the seventeenth and eighteenth centuries, we saw the emergence of techniques of power that were essentially centered on the body, on the individual body. They included all devices that were used to ensure the spatial distribution of individual bodies (their separation, their alignment, their serialization, and their surveillance) and the organization, around those individuals, of a whole field of visibility. They were techniques that could be used to take control over bodies (Foucault, 2003, pp. 241-242).

Biopolitical power dovetails with disciplinary power, and uses it “after a first seizure of power over the body in an individualizing mode” to regularize the population based on “general biological processes” (Foucault, 2003, pp. 243, 249).

Biopolitical power is a technique of power with a specific interest in securing and extending life and regulating the population (Foucault, 2003, p. 243). Biopolitical power allows for the regulation of people as a group, therefore, through biopolitical power, humans as a species can be regulated. As such, biopolitical power is executed over the population for the “administration of life itself,” through, for instance, the regulation of “health, sanitation, procreation, and mental and physical capacities” (McKee, 2009, p. 466).

As biopolitical power is ‘seized over the body,’ the body is then measured and specific phenomena including birth, death, and illness is measured in ‘statistical terms’ (Foucault, 2003).

As Foucault (2003) states

the mechanisms introduced by biopolitics includes forecasts, statistical estimates, and overall measures. And their purpose is not to modify any given phenomenon as such, or to modify a given individual insofar as he is an individual, but, essentially, to intervene at the level at which these general phenomena are determined, to intervene at the level of their generality (p. 246).

The goal of these mechanisms is to first, achieve an equilibrium of mortality and birth rates, and to achieve regularity to take “control of life and the biopolitical processes of man-as-species and of ensuring that they are not disciplined, but regularized” (Foucault, 2003, pp. 246-247). Thus, biopolitical power is a technology centered upon life and needs to be able to control random events and predict these events to protect the population against danger (Foucault, 2003, p. 249).

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As such, disciplinary (over the body) and biopolitical power (over the population with the use of discipline) are exercised at different levels, but they are not mutually exclusive (Foucault, 2003, p. 250).

Furthermore, Foucault (2003) argues that in biopolitical power, “racism is the precondition that makes killing acceptable” and “once the State functions in the biopower mode, racism alone can justify the murderous function of the State” (p. 256). The aim of biopolitical power is to foster life, but sometimes fostering the life of some is seen to require the death of others seen as a biological threat (Foucault, 2003). For Foucault (2003), “racism justifies the death-function in the economy of biopower by appealing to the principle that the death of others makes one biologically stronger” (p. 258). Through racism, biopower can be exercised with the intention of “the death of the bad other” for the purpose of making life “healthier and purer” (Foucault, 2003, p. 255). Understanding racism as a way of “establishing a biological type caesura within a population,” that allows murder, indirect murder, the exposure to death, or increasing the risk of death, enables us to understand that not all groups are afforded the chance to be governed – some may be excluded and left to die (Foucault, 2003, pp. 255-256). If biopower is a technique of power to secure and extend life and regulate the population (Foucault, 2003), then in a form of governmentality operating with biopower, death can be justified only by labelling individuals as “deserving” of death or ill health because they are a threat to the health of others.

Foucault (2003) uses Nazism as an example for his analysis. As such, for Foucault (2003), Nazism represented a distinct and extreme mixture of the sovereign (the State’s central authority) right to kill and the biopolitical power to make live and let die. Sovereign and biopolitical power was transmitted “throughout the entire social body” creating a state that has

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superimposed sovereign and biopolitical power “exposing the entire population to universal death” to protect a “superior race” (Foucault, 2003, p. 260). This example of Nazism demonstrates how a State’s policies can execute sovereign and biopolitical power where the “‘population’ [is] an object of political intervention” (Rasmussen, 2011, p. 41).

In the contemporary neoliberal context, biopolitical power is mobilized to “minimise social risks” (Padovan, 2003, p. 473). An example of a health problem managed by biopolitical techniques is obesity. As critical health scholars have identified, obesity is often framed as an ‘epidemic’ due to a ‘dramatic’ increase in overweight bodies, causing alarming predictions of increased mortality rates, and reversing the rising human life expectancy (Campos et al., 2006). For example, social scientists have begun identifying obesity prevention programs and policies as biopolitical strategies to govern the individual body for the purpose of regulating and managing the health of the population, and the costs of health care (Evans & Colls, 2009; Gibson & Dempsey, 2013; Goodman, Johnston, & Cairns, 2017). The measurement of BMI in particular is seen as an epidemiological, biopolitical mechanism that quantifies the body to enable the individual to be governed at the population level (Evans & Colls, 2009), as “to count a problem is to define it amenable to government. To govern a problem requires that it be counted” (Rose, 1991, p. 686). This BMI measurement measures bodies for the purpose of ‘minimalizing risk’ (Padovan, 2003) as bodies have been established as a site for political intervention to manage the population (Legg, 2005).

Larsen (2011) argues that typically, governmentality and biopolitics are not talked about together, as biopolitics is the “descriptive term for policies and technologies aiming to optimize the biological life of the population, whereas governmentality takes aim not at the population as such but at the modes of governing” (p. 202). While Larsen says biopolitics and governmentality

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are “distinct theoretical perspectives” (Larsen, 2011, p. 203), Foucault made a link between the two suggesting that modes of governing use biopolitics as a mode of power. As outlined with the definitions in this section, I argue that biopolitics is not a form of governmentality, but rather, a set of techniques of power; neoliberalism is a type of governmentality that can mobilize biopolitical power to support managing the population. In this dissertation, specifically Chapters 5 and 6, I consider the WHO’s governmentality as neoliberal and the biopolitical and disciplinary technologies the WHO uses to address NCDs.

## **Chapter 4: Methodology**

This dissertation project uses qualitative methods to answer exploratory research questions about why and how the WHO presents NCDs as a problem and ‘modifiable behaviours’ as their cause, and whether and how the WHO adopts an internationalized/standardized approach to health care policy. I analyzed WHO guideline and technical documents and conducted WHO key informant interviews to answer the research questions. In this chapter, I discuss the research questions, data sources, and methods of analysis and evolution of the project. For data sources, I describe how I first compiled a database of 203 WHO documents from which I then drew a purposeful sample of 29 documents to be analyzed with a Foucauldian discourse analysis. I outline the components of a Foucauldian discourse analysis by defining discourse and delineating Foucault’s methods of archaeology and genealogy. I describe how I approached qualitative coding (using NVivo) to identify discourses, both present and absent, in the WHO documents. I also discuss the process for carrying out analyzing the key informant interviews.

### **4.1 Research questions, data sources and methods, and justification**

This dissertation focused on two main research questions and five sub research questions as follows:

RQ1. How does the World Health Organization use evidence and discourse to construct and respond to NCDs? To what extent does this evidence and discourse reflect a neoliberal regime, and what biopolitical techniques are mobilized?

RQ1.1. How are ‘modifiable behaviours’ targeted and positioned in the WHO documents?

RQ1.2. How is scientific knowledge about ‘modifiable behaviours’ used to understand how individual behaviours contribute to health concerns?

RQ1.3. In what ways are human rights to health considered in the WHO documents addressing NCDs?



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RQ1.4. How does the WHO position the ‘economic burden’ argument to address the problem of NCDs?

RQ2. To what extent does the WHO’s approach to NCDs reflect a process of the internationalization/ standardization of health care policy?

RQ2.1. How does the WHO attempt to inform the internationalization/standardization process through global guidelines and technical documents?

Through RQ1 and RQ2 this project sought to

- Begin to explain how neoliberal governmentality is or is not used by the WHO and how biopolitics is or is not used by the WHO as a power to regulate populations;
- Describe how NCDs are understood in WHO discourses and policy recommendations over time;
- Identify how modifiable behaviours are positioned in the WHO documents as part of the NCD response;
- Consider, during the period of 1990-2015, how discourses presented by the WHO have or have not changed, and how different knowledge has been mobilized;
- Examine the degree to which the WHO’s discourse of health knowledge related to NCDs has been internationalized.

Data sources for RQs 1-2.1 included WHO guideline and technical documents on topics about NCDs and modifiable behaviours (i.e. documents about smoking). WHO documents are the appropriate medium for analysis because WHO documents are a record of arguments, justifications, recommendations and evidence WHO uses to position NCDs as a problem. Further, WHO documents provide documentation of whether and how the arguments and recommendations in the documents reflect a process of internationalization/standardization. WHO key informant interviews were conducted primarily to understand the process of how WHO documents are created, which informed all of the research questions.

Data analysis for RQs 1-2.1 included a Foucauldian discourse analysis of WHO guideline and technical documents which included specifically reviewing the core themes in each of the research questions such as when and where the WHO discusses costs or an economic concern, whether and how human rights is used and so forth. Foucauldian discourse analysis provides a

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framework to consider both the WHO's discourse on NCDs, the WHO's governance model (if it is neoliberal or not and whether the WHO manages global health using biopolitical techniques), and to analyze the discourse(s) that situate behaviours as 'modifiable,' evidence that informs the problem, and the forms of justification (i.e., human rights versus an economic burden).

The prospectus for this dissertation project included a third research question:

RQ3: To what extent have national policies on NCDs in the Global North adopted the discourses and rationales of the WHO recommendations?

RQ3.1: To what extent do the countries in the Global North demonstrate different or similar governance regimes, and what can this tell us about governance, biopolitics, and the internationalization of policy?

These research questions (3 and 3.1) were identified in the prospectus as optional depending on the findings for research questions 1-2.1. The findings from the WHO key informant interviews showed that there was enough to explore the political processes of the WHO for questions 1-2.1. I concluded research questions 3-3.1 would be best answered in a separate project on the policy translation process by Member States and WHO regional officers (as identified by the WHO key informant interviews), that would include additional types of evidence.

### **4.2 Foucauldian discourse analysis**

I conducted a Foucauldian discourse analysis of the documents to identify the embedded conventions of thought and knowledge in WHO guidelines and technical documents on tobacco use and obesity, including how those conventions changed over time. Following Michel Foucault, discourses refer to ideas or patterned thinking in textual and verbal communication (Springer & Clinton, 2015; Walton & Lazzaro-Salazar, 2016). Discourses are executed through "language and discursive strategies" and are "situated in local and wider social structures" (Walton & Lazzaro-Salazar, 2016, p. 461). The function of discourses is to create our "social

reality” through means of knowledge about social practices (Walton & Lazzaro-Salazar, 2016, p. 461). Foucault’s discourse analysis examines how a story is told using discursive strategies that include assumptions about what constitutes knowledge and persuasive techniques (Starks & Trinidad, 2007). Examining this story is done by coding for themes and uses of language to identify how the language is used to present a specific message (Starks & Trinidad, 2007).

A Foucauldian discourse analysis also examines the *what* and *why* of language and knowledge used in discursive practices (Springer & Clinton, 2015). For example, the discourse of smoking constructs smoking as dangerous, unhealthy, and invasive by putting others at risk from second-hand smoke (Bell, 2011). This discourse has been extended and embedded in other discourses, such as responsible mothering, where mothers are told not to smoke while pregnant due to an increased risk of miscarriage and Sudden Infant Death Syndrome (commonly known as SIDS) (CDC, 2017). Simultaneously, a smoking, pregnant woman is constructed as a ‘site’ that should be shamed and understood as ‘bad parenting’ because of the *potential* risk brought to the child. In this example, the *what* of the language and knowledge is made up of evidence-based research that identifies *risks* or *harms* to the child, and the *why* is to prevent ill-health outcomes to children.

The reason I conducted a specifically Foucauldian discourse analysis is that his approach emphasizes how discourses produce and manage power (Johnson, Moffat, & Malchy, 2010). Johnson, et al. (2010) highlight this analysis well in the following passage

discourses both enable and constrain the production of knowledge, they allow for certain ways of thinking about reality while excluding others... Our approach was informed by a Foucauldian perspective in that we sought to understand how discourses operate in ways that privilege certain positions and marginalize or even exclude others. A central concern of Foucault’s work is how discourses are shaped and become forms of power that enable particular understandings (p. 3).

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Foucault's analysis is unique in its review of ways that *discourse* privileges some while marginalizing/excluding others. For example, through Foucault's discourse analysis, we see how the healthy lifestyle discourse discussed in Chapter 2 positions thin bodies as privileged in terms of both health and a perception of 'beauty,' and simultaneously marginalizes obese bodies (Gracia-Arnaiz, 2010).

Analyzing language and knowledge, from Foucault's perspective, enables an examination of the relationship between power and knowledge to *produce reality*. Foucault understands power as a web that may dominate but it is also *productive* in that "power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production" (Foucault, 1995, p. 194). Foucault clarifies his understanding of 'rituals of truth' or 'truth regimes' in the following passage

each society has its regime of truth, its 'general politics' of truth: that is, the types of discourses which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true (Foucault, 1980, p. 131).

Thus, a Foucauldian discourse analysis is a method to understand, while considering power as productive, how knowledge or 'truths' construct our reality. As recommended by Erik Mykhalovskiy and Lorna Weir (2004), a Foucauldian analysis would therefore require the deconstruction of a truth regime of 'best evidence' to identify the relationship between understandings of evidence and contemporary forms of governance.

Discourse analysis is occasionally confused with linguistic analysis. Linguistic analysis focuses on language and patterns of language use such as pronouns, verbs, and specific word choice (Li, Jiao, & Zhu, 2018). Discourse analysis generally focuses on patterned ways of thinking such as the popular rhetoric concerning child safety for example and the relationship between power and knowledge (Walton & Lazzaro-Salazar, 2016). Discourse analysis considers

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social and cultural influences of dominant thought presented in speak and text, while linguistic analysis is more specific to the use and meaning of words – which may too consider social and cultural influences, but also may not.

Similar to Foucauldian discourse analysis is critical discourse analysis, often associated with the work of Teun van Dijk (1993, 1999) and Norman Fairclough (1989, 1992). Critical discourse analysis considers the use of word choice and language, and is also interested in the relationship between power and knowledge. Critical discourse analysis generally draws upon a Marxist perspective of power, which tends to view power as something that can be held in a *dominating, repressive* way by certain groups and organizations (Fairclough & Graham, 2002). For example, critical feminist work uses critical discourse analysis to deconstruct how patriarchal power produces discourses and knowledge that subject women to the male gaze (van Dijk, 1995). Comparing critical discourse analysis to Foucault's discourse analysis highlights that discourse analysis is generally interested in the relationship between power and knowledge, however, how one understands power and the production of knowledge varies depending on the theorist one follows. In contrast to critical discourse analysis, Foucault sees power also as *productive* – for instance disciplinary power produces docile bodies (bodies that are regulated) (Foucault, 1995) and biopolitical power produces bio-political subjects (that self-govern for the benefit of the population) (Foucault, 2003).

I selected Foucault's discourse analysis compared to critical discourse analysis because I see Foucault's understanding of power as more amenable to an in-depth analysis of the WHO as an open system that is adaptable to the demands of international actors, Member States, and global problems (Béland & Orenstein, 2013). Further, a discourse analysis compared to qualitative content analysis to answer my research questions allowed me to analyze the complex

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nuances of the text in the documents and the process to create them. A qualitative content analysis limits the analysis to focusing on frequency of themes making this analysis too descriptive for the purpose of diving deeper into the context and nuances in the documents and the procedures to create these documents.

For this dissertation, it is useful to consider the value both of Foucault's earlier approach of archaeology and his later work of genealogy, in that the first examines how discourse mobilizes knowledge (archaeology) while the second (genealogy) considers the relationship of discourse to institutions and techniques of power, in this case the relations of the WHO, WHA, and Member States.

### 4.2.1 Archaeology and genealogy

A key element of Foucault's archaeology, the methodology that was the basis for his first five books, is the distinction between *savoir* and *connaissance*, which I used to examine the WHO documents. Scheurich and McKenzie (2005) nicely summarize Foucault's distinction between these terms as

*savoir* includes formal knowledge such as philosophical ideas but also institutions, commercial practices, and police activity [discursive conditions], whereas *connaissance* includes only formal bodies of knowledge such as scientific books, philosophical theories, and religious justification (p. 846).

Foucault provides more details of the difference between *savoir* and *connaissance* and how it relates to discourse:

by "archaeology," I would like to designate not exactly a discipline but a domain of research, which would be the following: in a society, different bodies of learning, philosophical ideas, everyday opinions, but also institutions, commercial practices and police activities... refer to a certain implicit knowledge [*savoir*] special to this society. This knowledge is profoundly different from the [formal] bodies of learning [*des connaissances*] that one can find in scientific books, philosophical theories, and religious justifications, but it [*savoir*] is what makes possible at a given moment the appearance of a theory, an opinion, a practice (as quoted in Scheurich & McKenzie, 2005, p. 846).

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Essentially, Foucault argued that *savoir* includes the broad discursive ‘conditions’ that are required for the formation of specific bodies of knowledge (*connaissance*) such as disciplines (like sociology, public health, epidemiology) (Scheurich & McKenzie, 2005, p. 846). *Savoir* is the ground on which specific knowledge is mobilized, from which statements are given power, and where the rules are established for what defines true and false and how information is to be presented to make it persuasive. *Savoir* also captures what is said and what is unsaid, what is visible and what is invisible, and through the method of archaeology, we can analyze the implicit thought, actions, and motives that informs the discourse. *Connaissance* refers to more specific bodies of knowledge and evidence.

Scholars Dean (2010), Dreyfus and Rabinow (1983), Gordon (1991), and Lemke (2019) highlight that Foucault’s work always included analyzing the institutional, social, and political conditions of the discourses that he is examining, such as his archaeological works of *Madness and Civilization* and *the Birth of the Clinic*. For example, in *Madness and Civilization*, Foucault (1988) analyzed how madness was respected during the Renaissance and then became stigmatized by society during the Enlightenment. With the Enlightenment came asylums; an institution to hide madness along with other social deviants from society (Foucault, 1988). Madness was positioned as the opposite of reason and the ‘unreasonable’ were excluded from the regime of truth and from society (Foucault, 1988). Following the Enlightenment, Foucault (1988) argues that the mad were not ‘liberated’ from the asylum, but were transitioned to the medical institution to be assessed, understood, and ultimately cured. These shifts in the discourse of reason and madness were sometimes overt with the social and political movements of the Renaissance and the Enlightenment, and sometimes more subtle as they became embedded in practices and rules of these institutions and confinement houses (asylums to hospitals). In the

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*Birth of the Clinic*, Foucault (2003) analyzed how the conditions of possibility, or the *savoir*, of medicine changed and their complex relationship to the French Revolution.

Foucault's methodology of genealogy, developed in his books *Discipline and Punish* and *The History of Sexuality, Vol. 1*, investigates the historical emergence and positioning of *savoir* and *connaissance*, by adding an explicit analysis of techniques of power that makes it possible to examine why discursive strategies may appear, when they appear (i.e. the power-knowledge relationship) (Scheurich & McKenzie, 2005, pp. 854-856). With the method of genealogy, we can analyze the history of knowledge and practices, how discourses are positioned, and specific techniques of power and their relation to discourse. For example, in Foucault's (1995) *Discipline and Punish*, he argued that Jeremy Bentham's panopticon— a prison designed with a guard tower in the middle and the prison cells circling the tower so the guard could observe the prisoners at any time – was a technology of power to discipline prisoners to regulate their behaviours. For Foucault (1995), the panopticon was an example of how power could be deployed over a population through a single technology. In Foucault's (1995) analysis, he explored how disciplinary power (Chapter 3) was mobilized in a specific time period (especially over the course of the 18<sup>th</sup> century) and was a condition for the rise of liberalism. Bentham's panopticism was a technology that made governing at a distance possible and was mobilized by the State in other sites such as hospitals, schools, and factories and eventually throughout society.

Foucault's genealogical methodology was influenced by Friedrich Nietzsche's *Human, all too Human* (1878), *The Dawn* (1881), and *On the Genealogy of Morality: A Polemic* (1887). The focus on techniques of power in Nietzsche's work led Foucault to focus on how the body became an important object for these techniques. Foucault (1977) highlights an example from Nietzsche about the positioning of the body and then clarifies the objective of genealogy.



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The body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated Self (adopting the illusion of a substantial unity), and a volume in perpetual disintegration. Genealogy, as an analysis of descent, is thus situated within the articulation of the body and history. Its task is to expose a body totally imprinted by history and the process of history's destruction of the body (p. 148).

In Foucault's genealogical work, discourse is now one element in a broader analysis. In the *History of Sexuality* for example, Foucault (1990) explores not just the discourse that sexuality has been repressed, but the evolution of how and why such a discourse exists. In this analysis, Foucault (1990) discusses biopolitics for the first time to distinguish different techniques of power that are exerted on the body, and how sexuality is a means to do so. Foucault (1990) argues that rather than being repressed, a host of new discourses and techniques emerged in the 19<sup>th</sup> century in regard to sexuality, especially scientific and therapeutic. Individuals were then assigned to categories of sexuality for the purpose of examination and regulation. In doing so, Foucault (1990) argues that biopolitical power is a technology of power where the discourse of sexuality is mobilized "for achieving the subjugation [to be brought under control] of bodies and the control of populations" (p. 140). The genealogical method thus begins to include the theory of power and how it is exercised as a technology for institutional, political, and social purposes. It is through Foucault's (1990) analysis of the discourse of sexuality that he first explores the institutional, political, and social requirements for how the body becomes a regulatory site to manage biological processes such as birth and death rate.

There is a debate on whether genealogy is a more advanced methodological analysis and whether Foucault left archaeology behind when he undertook genealogy (Scheurich, & McKenzie, 2005, p. 849). Along with Scheurich and McKenzie (2005), I take the position that there is a connection between the two for Foucault. Through archaeology, we can assess how problems are shaped by discourse, how notions of truth and evidence are circulated through

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discourse, and how particular *epistemes* contour the limits of knowledge/discourse. By complementing archaeology with genealogy, we can analyze the deployment of discourse such as the translation of policies to programs. Importantly, while conducting my analysis I found that the lines between archaeology and genealogy are not always clear I see discourse as central to both methodologies and because Foucault examines the relations between politics and institutions of knowledge in both his archeological and genealogical studies.

In this dissertation, I used Foucault's methodology of archaeology to understand how the WHO discourse (informed by *savoir* and *connaissance*) constructs the NCD problem and the causal role of 'modifiable behaviour', which then informs the strategies to address NCDs and how individuals can manage their behaviours. In Chapters 5 and 6, I rely on Foucault's method of archaeology, specifically the concept *connaissance*, to analyze the knowledge that constructs NCDs as a problem and 'modifiable behaviours' as the target of intervention in the creation of guideline and technical documents. I explore how WHO key informants identify the political and financial conditions that produce the WHO documents analyzed and thus the institutional conditions that supports the evidence used and the discourses discussed in Chapters 5 and 6. In Chapter 7, I use the concept *savoir* to examine the conditions of possibility that allow for guideline and technical documents to be created – I attempt to situate the discourses of the WHO in their institutional, political, and historical conditions, as Foucault would. While I do not examine in this dissertation whether and how the guideline and technical documents are acted upon, the method of genealogy calls attention to techniques of power, which, within the WHO documents, I explore to some degree as techniques for managing global health.

### **4.3 Procedures for the purposeful sample**

#### **4.3.1 Selecting World Health Organization documents for analysis**

I compiled a WHO document database of 203 documents from which to sample a smaller number of documents for analysis. The selection process for assembling the WHO documents database first included reviewing the “WHO programmes” – known now on the WHO website as ‘health topics’ – listed on the WHO website (<https://www.who.int/entity/en/>). From the programmes list, ten different programs were identified and included: noncommunicable diseases and mental health, chronic health and health promotion, cardiovascular disease, cancer, chronic respiratory diseases, diabetes, global alliance against chronic respiratory diseases, global strategy on diet, physical activity and health, tobacco free initiative, and nutrition. From the list of programmes, I included the documents relating to NCDs and ‘modifiable behaviours’ presented as contributing to NCDs, such as diet, physical activity, tobacco use, and alcohol consumption. To narrow the focus, mental health documents were excluded to focus on the four ‘modifiable behaviours’ and NCD diseases. Further, documents specific to children such as breastfeeding, marketing for children, and childhood obesity were excluded to narrow the focus further. After the inclusions and exclusion criteria, I compiled a data base of 203 documents that included all document types (programmes, guidelines, policy suggestions, meeting reports) and included all publishing years of 1990 to 2016. Duplicate documents were removed.

This database of documents allowed me to broadly understand the nature and range of WHO documents related to my dissertation topic, and thereby make a more informed decision about choosing a smaller, purposive sample of global guideline and technical documents to undergo ‘full discourse analysis review.’ This selection took place after and was informed by the WHO key informant interviews, as outlined below. In addition, it also became important to

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purposefully select a second set of supplementary documents to review, that were important to the development of the documents I was analyzing and/or to understanding the WHO's context and its operations.

From the database of 203 WHO documents that I assembled, I selected a purposeful sample of 29 guideline and technical documents. These are the documents most likely used by Member States and WHO staff/officers when consulting with national Ministries of Health. These documents are therefore the 'guidance' documents of the WHO. Guideline documents are the second highest level of guidance documents produced by the WHO, only after WHO treaties, but above technical documents. WHO technical documents are produced in response to mandates from the WHA of the UN. It is worth noting, however, that while selecting the guideline and technical documents, I found that the hierarchy of technical and guideline documents is more fluid than presented by my WHO informants. I found that because some topics have several global guideline documents, while other topics have more technical documents, there is no rule about how or when one type of document would be used by Member States or WHO staff/officers over another.

This means there are a number of other types of documents that I, as a rule, excluded from full discourse review, including: meeting reports; 'technical report series'; research publications; systematic reviews; cost effectiveness analysis documents; surveillance publications; brochures; and a few documents I was unable to save. I excluded these documents to narrow the discourse analysis to the guidance documents that are used by the WHO officers implementing guidelines and recommendations. However, as discussed below, I did select a few of these 'non-guidance' documents to analyze when it became clear they were essential to the production, context, or meaning of the guidance documents.

### *Technical documents*

Technical documents are documents such as Global Action Plans and Global Status Reports that include some kind of guidance and/or recommendations in the document and/or in the appendix. The WHO key informants helped me define these technical documents and informed me that Action Plans and Global Status Reports are technical documents because they provide guidance and planning to address diseases. Specifically, in selecting the WHO technical documents from the 203 WHO document database, I used the following criteria. The documents had to

1. Be specific to NCDs and ‘modifiable behaviour’ topics.
2. Include guidance recommendations, either in the text or in the appendices. These recommendations may not be ‘Guidelines,’ (discussed in the next section) but are recommendations meant to guide the response to global health problems.
3. Be for an international audience and not specific to one country. (Documents specific to countries are composed by the regional branches of the WHO.)
4. Not be a publication of a systematic review of previous research, but a combination of data, research, and recommendations.

As I learned from the WHO key informant interviews and reviewing the documents, WHO technical documents are produced in response to mandates from the WHA. The WHA is the governance, decision-making body of the WHO (WHA, 2019). The WHA meets annually and is attended by WHO Member State delegates to discuss a health agenda prepared by the Executive Board of the WHO (WHO, 2019l). The Executive board is “composed of 34 technically qualified members elected for three-year terms,” composed of representatives from each WHO region (WHO, 2019c), and its main function is to ensure that the decisions made at the WHA are carried out by the WHO (WHO, 2019l). There is no clear description of how an agenda is set by the Executive Board. However, based on my WHO key informant interviews, it appears that the WHO and Member States propose agenda items based on the events of the year and then the Executive Board agrees on the agenda for the year, where some proposed items may

be declined for that year. By reviewing previous WHA documentation, the WHA will often request the WHO to follow up and present on a topic.

The WHA serves the important purpose of writing ‘resolutions.’ Resolutions are written motions for various needs; among them are requests for new documentation for new knowledge, practices, or policies (WHO, 2006c). WHA resolutions are *global* resolutions, and all WHO technical documents are also written from a global perspective – to be used and adapted by all countries. In the technical document production, the documents undergo WHA review. During this final review, the WHA will either endorse or not the technical document. When the WHA ‘endorses’ a document produced in response to a resolution, the document acts as guidance for Member State practices and policies to address the problem (WHO key informant interview 5). For example, the WHA71.6 WHO global action plan on physical activity 2018-2030 is listed as ‘endorsed’ by the WHA (WHA, 2018, p. 2). Once published, the physical activity action plan is the document that Member States are expected to consult and follow when addressing physical activity. These documents are called ‘technical documents’ as they are the documents guiding the technical work/implementation of recommended actions to address the problem identified. Global status reports are technical documents produced by the WHO to report back to the WHA on the global status of health topics, such as diabetes.

Technical documents that are not endorsed are *not guidance documents*. The difference is these not endorsed documents are not ‘supported’ by the Member States to guide action (WHO key informant interview 5), and are not referred to in subsequent WHA resolutions or follow-up reports. An example of when a document from the WHO was not endorsed is the WHO (2016b) ‘Commission on Ending Childhood obesity’ report (WHO key informant interview 5). The Commission was mandated by the WHO Director General (WHO key informant interview 5).

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The WHA ‘welcomed’ Member States to read and use the Commission’s report and wrote a resolution for the Commission to create an implementation plan so Member States could use the report (WHA, 2016a, pp. 68-69, WHA, 2017, p. 47), but the report itself was not endorsed. Oddly, the technical documents themselves do not mention if they were endorsed or not. The only source I could find that identifies which documents are endorsed are the WHA meeting records, and based on these it appears only three documents from my technical document list were endorsed – presented in table 1.

### *Guideline documents*

Guidelines are specific documents that compile and analyze the ‘best’ evidence to date on a specific topic. Further, guidelines are developed in response to “a new public health problem or emergency; the uncovering of new evidence; an absence of good-quality evidence (or any evidence at all); or a change in resource availability or access to services” (WHO, 2014d, p. 1). The WHO (2014d) guideline handbook identifies that a guideline document is any document “containing recommendations for clinical practice or public health policy,” to achieve the “best health outcomes possible” (p. 1). While this sounds broad and could pertain to technical documents as well, after 2007 the WHO narrowed its definition of guideline documents to refer only to those documents using the GRADE method and approved by the WHO Guideline Review Committee (GRC). WHO key informant interviews revealed that guideline documents could take approximately three-years to create, given that the GRC process includes a time-consuming review and approval of all evidence and recommendations. A key element to the guideline development with the GRADE method is a recording of the ‘strength’ of the recommendations in the guideline as per the evidence available. As table 1 below shows, six

documents analyzed are guidelines, four of which are post-2007 and went through the GRC process.

#### 4.3.2 Documents selected for supplementary review

Additional ‘supplementary’ documents that are not technical or guideline documents were selected to complete the archaeological and genealogical review to better position the WHO guideline and technical documents in the historical context and better understand what informed the guideline and technical documents I reviewed. These documents were selected purposefully from the 203 WHO document database I created, following the interviews and full discourse analysis review. An example of a supplementary document is the WHO (2011b) ‘Waist Circumference and Waist-hip Ratio: Report of WHO Expert consultation, Geneva 8-11 December 2009,’ which highlights the need for a different obesity measurement than the BMI. The documents selected for the genealogical review included reports on expert consultation, historical epidemiological documents, WHA agenda and resolution documents, research documents published in partnership with the WHO, and “technical report series” which are research publications initiated by the WHO (and not technical documents initiated by the WHA).

**Table 1: WHO documents selected for full discourse review**

Tobacco documents	Type of document
WHO. (1998). Guidelines for controlling and monitoring the tobacco epidemic.	<b>guideline</b>
WHO. (2003). WHO Framework Convention on Tobacco Control	<b>treaty</b>
WHO. (2004). Tools for advancing tobacco control in the 21st century: Tobacco control legislation: An introductory guide	technical
WHO. (2009). Report on the global tobacco epidemic 2009: Implementing smoke free environments	technical



WHO. (2012). Technical resource for country implementation of the WHO framework convention on tobacco control article 5.3	technical
WHO. (2013). FCTC guidelines for implementation: Article 5.3, Article 8, Articles 9 and 10, Article 11, Article 12, Article 13, Article 14	technical
WHO. (2015). Report on the global tobacco epidemic, 2015: Raising taxes on tobacco	technical
Diet, nutrition, and physical activity documents	Type of document
WHO. (1992). World declaration and plan of action for nutrition	technical
WHO. (2004). Global strategy on diet, physical activity and health	technical - WHA endorsed
WHO. (2009). Interventions on diet and physical activity: What works, summary report	technical
WHO. (2010). Global recommendations on physical activity for health	technical
WHO. (2012). Guideline: Potassium intake for adults and children	<b>guideline</b>
WHO. (2015). Guideline: Sugars intake for adult and children	<b>guideline</b>
NCD documents	Type of document
WHO. (2002). National cancer control programmes: Policies and managerial guidelines: Second edition	technical
WHO. (2006). Cancer control: Knowledge into action: Planning	technical
WHO. (2006). Cancer control: Knowledge into action: Prevention	technical
WHO. (2006). Cancer control: Knowledge into action: Early Detection	technical
WHO. (2006). Cancer control: Knowledge into action: Diagnosis and treatment	technical
WHO. (2006). Cancer control: Knowledge into action: Palliative care	technical
WHO. (2006). Cancer control: Knowledge into action: Policy and advocacy	technical
WHO. (2007). Prevention of cardiovascular disease: Guidelines for assessment and management of cardiovascular risk	<b>guideline</b>
WHO. (2008). Action plan for the global strategy for the prevention and control of noncommunicable diseases 2008-2013	technical – WHA endorsed
WHO. (2011). Collaborative framework for care and control of tuberculosis and diabetes	<b>guideline</b>
WHO. (2011). Use of glycated haemoglobin in the diagnosis of diabetes mellitus	<b>guideline</b>

WHO. (2011). Global atlas on cardiovascular disease prevention and control	technical
WHO. (2011). Global status report on noncommunicable diseases 2010	technical
WHO. (2013). Global action plan for the prevention and control of noncommunicable diseases 2013-2020	technical – WHA endorsed
WHO. (2014). Global status report on noncommunicable diseases 2014	technical
WHO. (2016). Global report on diabetes	technical

**Table 2: Supplementary WHO documents selected for review**

NCD documents	Type of document
WHA. (1980). WHA33.35 WHO's programme on smoking and health. Retrieved from <a href="https://www.who.int/tobacco/framework/wha_eb/wha33_35/en/">https://www.who.int/tobacco/framework/wha_eb/wha33_35/en/</a>	WHA resolution
Jayant, K. (1986). Cancers of the cervix uteri and breast: Changes in incidence rates in Bombay over the last two decades. <i>Bulletin of the World Health Organization</i> , 64(3), 431-435. Retrieved from <a href="https://apps.who.int/iris/handle/10665/264352">https://apps.who.int/iris/handle/10665/264352</a>	Research report
WHO. (1990). Lung cancer incidence, 1973-1986. <i>Weekly Epidemiological Record</i> , 65(27), 210-212. Retrieved from <a href="https://apps.who.int/iris/handle/10665/227668">https://apps.who.int/iris/handle/10665/227668</a>	WHO report
WHO. (1998). Obesity: preventing and managing the global epidemic: report of a WHO consultation on obesity, Geneva, 3-5 June 1997. Retrieved from <a href="https://apps.who.int/iris/handle/10665/63854">https://apps.who.int/iris/handle/10665/63854</a>	Consultation report
WHO. (2000). Obesity: Preventing and managing the global epidemic: Report of a WHO Consultation. Retrieved from <a href="https://www.who.int/nutrition/publications/obesity/WHO_TRS_894/en/">https://www.who.int/nutrition/publications/obesity/WHO_TRS_894/en/</a>	WHO Technical Report Series 894
WHA. (2000). Fifty-third World Health Assembly: Global strategy for the prevention and control of noncommunicable diseases. Provisional agenda item 12.11. March 22, 2000. Retrieved from <a href="http://apps.who.int/gb/archive/pdf_files/WHA53/ea14.pdf">http://apps.who.int/gb/archive/pdf_files/WHA53/ea14.pdf</a>	WHA agenda item
WHO. (2003). Diet, nutrition and the prevention of chronic diseases: Report of a joint WHO/FAO Expert Consultation. Retrieved from <a href="https://www.who.int/dietphysicalactivity/publications/trs916/en/">https://www.who.int/dietphysicalactivity/publications/trs916/en/</a>	WHO Technical Report Series 916
WHO. (2004). Diet, nutrition and the prevention of chronic diseases: Special issue in separate publications <a href="https://www.who.int/nutrition/publications/obesity/PHNvol7no1afeb2004/en/">https://www.who.int/nutrition/publications/obesity/PHNvol7no1afeb2004/en/</a> Nishida, C., Shetty, P., and Uauy, R. (2004). Introduction (pp. 99-100). Darnton-Hill, I., Nishida, C., and James, W. (2004). A life course	Special issue

<p>approach to diet, nutrition and the prevention of chronic diseases (pp. 101-121).</p> <p>Swinburn, B., Caterson, I., Seidell, J.C., and James, W. (2004). Diet, nutrition and the prevention of excess weight gain and obesity (pp. 123-146).</p> <p>Steyn, N., Mann, J., Bennett, P., Temple, N., Zimmet, P., Tuomilehto, J., Lindstrom, J., and Louheranta, A. (2004). Diet, nutrition and the prevention of type 2 diabetes (pp. 147-165).</p> <p>Srinath Reddy, K., and Katan, M. (2004). Diet, nutrition and the prevention of hypertension and cardiovascular diseases (pp. 167-186).</p> <p>Key, T.J., and Schatzkin, A., Willett, W.C., Allen, N.E., Spencer, E.A., and Travis, R.C. (2004). Diet, nutrition and the prevention of cancer (pp. 187-200).</p> <p>Moynihan, P., and Petersen, P.E. (2004). Diet, nutrition and the prevention of dental diseases (pp. 201-226).</p> <p>Prentice, A. (2004). Diet, nutrition and the prevention of osteoporosis (pp. 227-243).</p> <p>Nishida, C., Uauy, R., Kumanyika, S., and Shetty, P. (2004). The Joint WHO/FAO Expert Consultation on diet, nutrition and the prevention of chronic diseases: process, product and policy implications (pp. 245-250).</p>	
<p>WHO. (2011). Waist Circumference and Waist–Hip Ratio: Report of a WHO expert consultation. Retrieved from <a href="https://doi.org/10.1038/ejcn.2009.139">https://doi.org/10.1038/ejcn.2009.139</a></p>	<p>Consultation report</p>
<p>Bouvard, V., Loomis, D., Guyton, K. Z., Grosse, Y., Ghissassi, F. El, Benbrahim-Tallaa, L., Straif, K. (2015). Carcinogenicity of consumption of red and processed meat. <i>The Lancet Oncology</i>, 16(16), 1599–1600. <a href="https://doi.org/10.1016/S1470-2045(15)00444-1">https://doi.org/10.1016/S1470-2045(15)00444-1</a></p>	<p>International Agency for Research on Cancer (IARC), the cancer agency of the WHO</p>
<p>WHO. (2016). Report on the commission on ending childhood obesity. <i>World Health Organization</i>. Retrieved from <a href="https://apps.who.int/iris/bitstream/handle/10665/204176/9789241510066_eng.pdf?sequence=1">https://apps.who.int/iris/bitstream/handle/10665/204176/9789241510066_eng.pdf?sequence=1</a></p>	<p>Commission report</p>
<p>WHA. (2018). Seventy-first World Health Assembly: WHO global action plan on physical activity 2018-2030, WHA 71.6. May 26, 2018. Retrieved from <a href="http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_R6-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_R6-en.pdf</a></p>	<p>WHA resolution</p>

## 4.4 Data collection and organization procedures

### 4.4.1 Coding for discourse analysis

The qualitative data analysis and organization software NVivo was used to code the WHO documents. Based on Foucault's approach to discourse analysis, my coding was organized around the following issues:

- who the targets/subjects of discourses are,
- who the audience is for the discourses, documents, and recommendations,
- how the subjects of the documents are constructed (for instance as people who are unhealthy and should be healthier),
- which knowledge is used by the WHO (*connaissance*),
- tactics and strategies used by the WHO to persuade readers (*savoir*) that these recommendations are appropriate and needed (such as addressing 'modifiable behaviours'),
- what language (such as normative language) is used to mobilize ideas around who is responsible for the health of the population (i.e., the State or individuals).

### 4.4.2 How to read and code a discourse

I used discourse mapping as a template to identify arguments and positions in the WHO documents and reviewed the story these arguments were telling, focusing on moral language, the evidence referenced, and formal claims such as statistics of disease and death. I identified strategies to mobilize knowledge by coding specific words or phrases such as the word epidemic and by searching for arguments and assumptions, such as that humans are *suffering* when experiencing illness or that a 'healthy lifestyle' is a responsibility of the individual. This search also included thinking about what was missing or made absent – such as unintended harms – in these discourses. In reviewing assumptions and acknowledging missing discussions, I considered how the WHO justifies its arguments and position on global health problems and solutions. I examined the evidence used in WHO documents by reviewing references and claims made in the WHO documents. For example, as I will show, by not using social science literature and not

considering unintended harms, the WHO provides a narrow view, supported with evidence-based medicine, of complex, social problems.

I also attended to the presence of dominant, competing, and opposing discourses about NCDs and ‘modifiable behaviours’. For example, the discourse concerning second-hand smoke is constructed from opposing discourses of *freedom of choice* and *invasiveness*. Individuals are free to *choose to smoke*, however, smoke is *invasive*, and floats through the air affecting everyone around whether if they choose to smoke or not. Therefore, some individuals’ freedom of choice is incompatible with others’ freedom of choice. A single passage may reflect one discourse or multiple competing or complementary discourses.

The first round of coding included a descriptive, exploratory analysis where codes represent specific examples and themes. The second round of coding included reviewing the codes through the lens of my analytical and theoretical framework and identifying themes, anomalies, and unique examples. Unlike traditional qualitative content analysis, discourse analysis does not rely on identifying themes of the highest frequency. Instead, discourse analysis focuses on the story of what and why in relation to arguments and positions, which may or may not be the most frequent across the documents.

### **4.5 World Health Organization key informant interviews**

In the summer of 2017, I interviewed five key informants/WHO experts to give me insights into how technical and guideline documents are prepared. These WHO key informants are currently employed at the WHO, work on and with NCD technical and global guideline documents, and were senior employees, ranging in work tenure of 15-25 years. Potential interviewees were identified by reviewing the WHO website for program directors, and from the lists of authors and contributors in the publicly available WHO documents. From these sources, I

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purposefully selected a list of 20 potential participants all of whom were invited to participate. For my purposes, representativeness is not a concern as these key informants have an expert vantage point on the context of how these documents are created.

Key informant interviews were conducted to understand the workings and politics of WHO document production. To enhance my discourse analysis, I needed to understand how and why WHO documents, and the recommendations within, are created, the purpose the documents serve for managing global health, and the perceived influence of the documents from the perception of WHO employees. Interviews were important for the WHO document review and the discourse analysis because interviews may “fill in blank spots in the facts already assembled,” and may be aimed to highlight “interpretations or clarifications unlikely to appear in published accounts” (Spector, 1980, p. 101).

At the time of the interviews, I had assembled my database of 203 documents but had not yet selected the smaller group of documents for full document analysis. The interview respondents are not representative of the range of WHO employees and programs; however, they are senior employees of the WHO and have been involved in producing various NCD documents (and corresponding programs). The five WHO key informant interviews revealed the global politics of drafting WHO technical and guideline documents, such as the influence of the WHA, the need and use of the GBD statistics, the perception of expert knowledge and best evidence, and the knowledge translation process of these documents to national implementation.

Semi-structured interviews were conducted for all five WHO experts. Semi-structured interviews include an interview guide to structure the interview with specific questions and topics, while leaving the questions open-ended for the interviewee to answer (Bryman, Bell, & Teevan, 2012, p. 16). The benefit of semi-structured interviews is it enables a conversation-style

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interview, where the interviewer can adapt based on the participants' expertise and knowledge. The flexibility to adapt the questions is important because the WHO experts' specific area of work was not known before the interview. However, my questions remained on the same topics with the goal of asking for expert opinion depending on their experience and work at the WHO. Further, it is anticipated that semi-structured interviews will be different each time to serve the purpose of exploring the topic as opposed to testing specific hypotheses (Bryman et al., 2012). The respondents were provided with the semi-structured interview questions beforehand to allow them to prepare to prevent risks or employment consequences from participating in an interview. One respondent revealed that because of their role, they had to provide the questions to their legal and media departments. The semi-structured interview guide is available in Appendix A.

The analysis of the interviews was a reflective process in which the respondents' accounts were compared to the documents. The interview review process was divergent rather than convergent – meaning the coding “involved carefully opening up associations that strengthen understanding of the topic rather than focusing in on a single governing theme” (Moules, McCaffrey, Field, & Laing, 2015, p. 117)<sup>5</sup>. This reflective process was supported through what Moules, et al., (2015) call a ‘multifaceted engagement’ with the literature, re-listening/re-reading the interviews, and writing the interpretations and continuing to reflect on the writing (p. 120). The interviews were completed first which changed the document selection. Then I completed the discourse analysis coding. After the discourse coding was completed, I went back to the interview recordings and listened to the interviews without any transcription to reflect on what stood out in comparison to the discourse analysis. I listened to the interview

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<sup>5</sup> Although I am referencing interview analysis from hermeneutic research, the interview process was not hermeneutic due to the use of a semi-structured interviews. However, the analysis and interpretation of the interviews included reflective components truer to hermeneutic analysis rather than coding simply based on themes.

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recordings several times and transcribed the portions of the conversation relevant to the dissertation, organized the transcribed passages according to themes.

The passages were continuously reviewed as the analysis and writing of the discourse analysis was incorporated into the dissertation and organized into chapters. This reflective process helped me see what is not present or visible in the discourse of the documents, and the respondents' discussions of institutional practices shed light on why certain discourses are present and others are not. This reflective comparison between the discourses of the interviews and the documents continued throughout the entire writing process.





## Chapter 5: Framing the problem: The ‘cost’ of death and the ‘value’ of life

### 5.1 Introduction

In this chapter, I outline how the WHO discourse frames NCDs as an escalating problem. In this and the proceeding chapter, I understand ‘frames’ as how a topic is problematized in the context of society at the time, how it is measured to be understood, and how solutions are proposed based on this context and measurement (see Epstein, 2007). The evidence used by the WHO to show that NCDs are an escalating problem is ‘premature death’ statistics and the predicted economic burden of disease and death. The WHO calculates premature death from the ‘years of life lost’ (YLL) portion of the DALY, a popular metric to calculate the burden of diseases (Anand & Hanson, 1997; Ashmore, Mulkay, & Pinch, 1989) that also quantifies ‘quality of life’ due to a disability (Rock, 2000) and the improvement of this ‘quality’ from an intervention (Moreira, 2012). As the WHO presents it, the problem with dying ‘prematurely’ is the foregone economic contributions to society, and the waste, or deficit, of losing individuals to a disease that are preventable.

I then explore how and why the WHO focuses on NCDs as an economic problem, how the premature death statistics support this and are used as a persuasion technique, and the extent to which governing assumptions associated with a neoliberal ideology and biopolitical mechanisms are embedded in the WHO’s discourse on the costs of death and value of life. I also highlight the relative absence of what was once a more prominent part of the WHO’s discourse – a human rights framework for understanding and responding to disease. This chapter also shows that tobacco use and obesity are presented as unnecessary actions and thereby make NCDs an unnecessary problem. The WHO uses alarming language such as *human suffering* when discussing NCDs, tobacco use, and obesity to set a normative tone to *value life* and prevent

death. In the next chapter, I examine more closely the WHO discourse on ‘modifiable behaviours’ as a key target for preventing NCDs.

## **5.2 Background**

### **5.2.1 When noncommunicable diseases became a problem to the World Health Organization**

Only guideline and technical documents starting in 1990 were available electronically for this dissertation. To better understand when NCDs became discussed by the WHO, I also examined other types of documents from pre-1990 available electronically in the WHO archive<sup>6</sup> and WHA agendas and resolutions using the WHO Institutional Repository for Information Sharing (IRIS). Before 1990, the WHO archives focus on communicable diseases ranging from yellow fever, to mumps, to influenza and vaccinations and then to AIDs in the 1980s. NCDs are discussed too, to a lesser extent, throughout the 1970s and into the 1980s through surveillance<sup>7</sup> updates with tracking data for cancer such as the ‘Lung Cancer Incidence, 1973-1986’ (WHO, 1990a) and ‘Cancers of the Cervix, Uteri and Breast: Changes in Incidence Rates in Bombay Over the Last two Decades’ (Jayant, 1986) reports. NCDs escalate as a problem for the WHO following the first report of the GBDS in 1992<sup>8</sup>, which estimated that NCDs account for 60% of the global burden of disease (WHA, 2000).

In 1991, the GBDS was launched by Dr. Murray and Dr. Lopez at Harvard University with the World Bank, in collaboration with the WHO, to design a “comprehensive and internally consistent source of information” to capture global rates of diseases, injuries, and major disease

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<sup>6</sup> These WHO documents were not guideline or technical documents but were often memos or surveillance updates.

<sup>7</sup> Surveillance data refers to the systematic collection of health-related data to inform health problems and public health actions (WHO, 2019h).

<sup>8</sup> Dr. Chris Murray and Dr. Allan Lopez from Harvard University, in partnership with the WHO, developed the GBDS in 1992.

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risk factors (Murray & Lopez, 2013, p. 448). The GBDS is currently housed at Institute for Health Metrics and Evaluation at the University of Washington, led by Dr. Murray in collaboration with the WHO and hundreds of other collaborators (Institute for Health Metrics and Evaluation, 2019). Murray et al., (2012) define the GBDS as “a systematic, scientific effort to quantify the comparative magnitude of health loss due to diseases, injuries and risk factors by age, sex and geographies for specific points in time” (p. 2063).

The advantage of the GBD approach is that consistent methods are applied to critically appraise available information on each condition, make this information comparable and systematic, estimate results from countries with incomplete data, and report on the burden of disease with the use of standardized metrics (Murray and Lopez, 2013, p. 448).

As the GBDS evolved, and became more accurate with higher quality surveillance instruments and included further evidence to support validation, these statistics became the ‘best in the world’ to measure the ‘global’ burden of disease. The development of the GBDS, with its creation in 1991 and first major publication in 1996 (Prüss-Üstün, Mathers, Corvalán, & Woodward, 2003), aligns with the WHO’s increased publications about NCDs, suggesting that as the data became more readily available, NCDs as a problem emerged. By 2000, the GBDS had generated over seven major publications that seemed to have an influence at the WHO. Following the release of GBDS findings, the WHO published its first two major NCD publications: the WHO (1998) ‘Guidelines for Controlling and Monitoring the Tobacco Epidemic,’ addressing one of the leading risk factors contributing to NCDs, and the WHO (2002) ‘National Cancer Control Programmes: Policies and Managerial Guidelines’ addressing one of the greatest disease burdens among NCDs.

At the Fifty-third World Health Assembly in May 2000, the WHA requested “the Director-General [of the WHO] to develop a global strategy for the prevention and control of

noncommunicable diseases” (WHA, 2000).<sup>9</sup> This request was in part because NCD prevention was not included in the UN (2000) Millennium Development Goals<sup>10</sup> (WHO, 2008), deemed by many members of the WHA as a serious oversight by the UN (Fehling, Nelson, & Venkatapuram, 2013). The result of this request was one of the key documents in the trajectory of NCD publications by the WHO, the 2008 ‘Action Plan for the Global Strategy for the Prevention and Control of NCDs 2008-2013’ technical document. The WHO (2008) NCD global action plan is the first document that includes a broad discussion of all NCDs and delineates together the four ‘modifiable behaviours’ understood as primary risk factors. Before the 2008 document, the WHO also mentioned infectious diseases (such as Hepatitis B) as contributing factors to NCDs, but after 2008, infectious diseases are dropped from NCD documents, and only ‘modifiable behaviours’ are listed as contributing factors to NCDs (WHO, 2006a).

### 5.2.2 The noncommunicable disease burden

In its documents, the WHO frames NCDs primarily as an economic problem for the individual and society due to health care costs and loss in productivity and uses the ‘premature death’ portion of the DALY metric to do so. In this section, I provide a description of the DALY and consider why the WHO uses only a portion of this metric in its documents.

#### *Disability-adjusted life year (DALY)*

Dr. Murray and Dr. Lopez created the DALY measure to quantify disability for the GBDS (Murray & Lopez, 1994). DALYs then became a surveillance metric used by the WHO to

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<sup>9</sup> The WHO (2008) ‘Action Plan for the Global Strategy for the Prevention and Control of NCDs’ technical document was presented at the Sixty-first WHA, resulting in the endorsement of WHA resolution WHA61.14 (WHO, 2008, p. 21).

<sup>10</sup> These goals were revised in 2015 by the UN to be the ‘2030 Sustainable Development Goals’ which again, do not identify NCDs as a specific goal, but it does request to strengthen the WHO FCTC implementation (UN, 2015). The WHO (2019g) stated that NCDs are a ‘major challenge for sustainability development’ to achieve these goals.

produce the yearly GBDS reports. The DALY combines the YLLs due to premature death and the ‘years lived with disability’ (YLDs) to quantify the productivity, well-being, and mortality of individuals (Grosse, Lollar, Campbell, & Chamie, 2009, Parks, 2014). DALY is defined as follows:

DALY for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences:  $DALY = YLL + YLD$  (WHO, 2019f, p. 1).

The YLL operationalizes premature death, early death, and premature mortality as an individual dying before the age of 70<sup>11</sup> (WHO, 2019a, WHO, 2014a). By this measure, globally, premature death caused by cancer accounts for 8.2 million deaths and 196.3 million years of life lost in 2013 (Murray & Global Burden of Disease Cancer Collaboration 2015). The YLL can serve to calculate the foregone financial contribution of working individuals. For example, Carter, Schofield, and Shrestha (2016) calculated that in 2003, 88,000 working years were lost due to the premature deaths caused by cancer in Australia, accounting for \$4.2 billion dollars forgone. The WHO does not provide specific dollar estimates foregone productivity as Carter et al. (2016) have done – the WHO just includes the YLL.

The DALY is used as measurements for studies and organizations world-wide and Christopher Murray, co-founder of the GBDS, stated that the purpose for quantifying disability and death burdens was to provide policymakers with the statistics needed to plan and prioritize how to save lives (Parks, 2014, p. 2). The DALY is said to provide a cost and benefit analysis to support said planning and prioritization (Ashmore et al., 1989).

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<sup>11</sup> Seventy-years old is the standard age calculated for life expectancy – i.e. the average life expectancy world wide (WHO, 2019a). Of the documents reviewed for this dissertation, the WHO does not mention an adjustment to the calculation based on location.

### **5.3 World Health Organization documents findings: Reasons to be concerned about noncommunicable diseases**

The overall and consistent theme throughout the 14 years of WHO documents analyzed is that NCDs are an economic burden attributable to ‘avoidable,’ ‘preventable,’ or ‘modifiable’ ‘risk factors’ or behaviours<sup>12</sup>. The WHO’s discourse on the problem of NCDs has four characteristics. First, the WHO presents premature death statistics to map the scale and spread of the NCD problem. Second, the WHO uses premature death statistics to identify the economic burden on the individual and society. Third, the WHO delineates the burden of unnecessary human suffering and how tobacco use and obesity contribute to this suffering. Finally, the WHO sparingly discusses how NCDs hinder a human right to health, in WHO technical documents. In this section, I outline how the WHO uses these four approaches to convince its audience that NCDs are a problem. In the subsequent discussion section, I argue that the WHO relies on normative assumptions to persuade readers that life is ‘valuable,’ both to live a productive life and live without suffering. Through these assumptions the WHO seems to take a position that is consistent with a neoliberal ideology and uses premature death statistics as a biopolitical technology of governance by economizing the self-entrepreneurial individual.

The WHO prefers ‘premature death’ statistics over the DALYs to quantify the risk of dying of an NCD - with premature death/YLLs appearing in 16 of 29 documents, and six of 29 referring to DALYs<sup>13</sup>. In the 16 documents that mention premature death statistics, these statistics are included in the summary, introduction, and background sections to frame the NCD

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<sup>12</sup> Tobacco use, alcohol consumption, physical inactivity, and healthy eating are identified as key contributing factors to NCDs throughout the 14-year timeline; however, the specific phrasing of ‘risk factors’ or ‘behaviours’ for example varies between documents.

<sup>13</sup> Only one out of 16 documents that mentioned premature death/YLLs was a guideline document; WHO (1998a) ‘Guidelines for Controlling and Monitoring the Tobacco Epidemic.’ The six documents referring to DALYs also referred to premature death/YLLs. Zero of these six documents that mention DALYs were guideline documents.

problem. For example, in the background of the WHO (2014a) NCD global status report document,<sup>14</sup> the WHO states that 40% (16 million) of 38 million deaths attributed to NCDs were ‘premature’ (WHO, 2014a, p. xi). In NCD technical documents on specific diseases, such as diabetes, the WHO uses the same method of presenting mortality data to frame the problem.

Diabetes caused 1.5 million deaths in 2012. Higher-than-optimal blood glucose caused an additional 2.2 million deaths, by increasing the risks of cardiovascular and other diseases. Forty-three percent of these 3.7 million deaths occur before the age of 70 years (WHO, 2016a, p. 6).

The WHO then uses alarming language to interpret these statistics.

The *epidemic* of tobacco use is one of the greatest threats to global health today. About one-third of the world’s adults use tobacco. Half of them will die from it. To take one vivid example, China is home to some 331 million males under the age of 30. Some 100 million of them are likely to die prematurely from tobacco use (WHO, 2004a, p. 15). [emphasis added]

Already the single most preventable cause of death and disease in many countries, tobacco products kill nearly 5 million people each year. *Sadly, the future looks even worse.* Because of the long-time lag between the onset of smoking and the *inevitable wave of deaths that follows*, the full effects of today’s globalization of tobacco marketing and increasing rates of usage in the developing world will be felt for decades to come (WHO, 2004a, p. 45). [emphasis added]

Together, the WHO presents premature statistics with alarming language to hook the reader and frame the problem of NCDs as an aggressive threat with high rates of death. Further, the *rate of death* is positioned as something that can be controlled because death itself, cannot.

Also, the WHO uses the premature death statistics to identify the economic burden on the individual and society. The economic concerns around NCDs begin in WHO technical documents in terms of their effect on efforts to reduce poverty and malnutrition (WHO, 1992), but then evolve to centre on health care budgets and the costs of NCDs for economic development. For instance, in 1992 the WHO states:

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<sup>14</sup> Note that the publishing year is 2014, but the premature mortality statistics are from 2012.



We are especially distressed by the high prevalence and increasing numbers of malnourished children under five years of age in parts of Africa, Asia and Latin America and the Caribbean. Moreover, more than 2 million people, mostly women and children, are deficient in one or more micronutrients: babies continue to be born mentally retarded as a result of iodine deficiency; children go blind and die of vitamin A deficiency; and enormous numbers of women and children are adversely affected by iron deficiency. Hundreds of millions of people also suffer from communicable and non-communicable diseases caused by contaminated food and water (WHO, 1992, p. 1).

However, after this, poverty and malnutrition, and their relation to one another and NCDs, are not foregrounded in the discussion. Instead, a decade later, the cost of healthcare as a burden for society and the individual due to health care costs is emphasized as a threat to economic and social development:

Nor is tobacco use a private matter, when its consequences extend far beyond the user. *When smokers... receive medical treatment, society bears the burden* (WHO, 2004a, p. 140).

The objective of this guideline is to provide recommendations on the intake of free sugars to reduce the risk of NCDs in adults and children, with a particular focus on the prevention and control of unhealthy weight gain and dental caries. This is in recognition of the rapidly growing *epidemic* of overweight and obesity around the globe and its role as a risk factor for several NCDs. In addition, dental caries is the most common NCD, and *the cost of treatment places a heavy burden on healthcare budgets in many countries*. The recommendations in this guideline can be used by policy-makers and programme managers to assess current levels of free sugars intake in their countries relative to a benchmark (WHO, 2015a, p. 6) [emphasis added]

In addition to the traditional burden of communicable diseases, developing countries today are faced with a huge increase in noncommunicable diseases. Tobacco is a major contributor to these diseases, which now account for more than half the disease burden in those countries. *This alarming increase threatens to undermine developing countries' economic and social development*. Countries and development agencies are increasingly recognizing that tobacco use *has negative implications for development that go beyond the damage done to health outcomes and life expectancy of tobacco users* and people exposed to second-hand smoke. These include a heavy household financial burden due to significant expenditures on tobacco products and health care expenditures, as well as an environmental degradation caused by tobacco farming (WHO, 2004a, p. 51). [emphasis added]

The third listed passage above notes that the negative impacts of tobacco use go ‘beyond’ health impacts and death rates, to create burdens such as those to household finances and environmental

degradation from tobacco farming; none of the other WHO documents expand on these two ‘beyond’ health impacts. These passages reveal a tension as the WHO adopts a neoliberal framing of the problem of NCDs, but in the case of tobacco it uses this to promote an intervention that is not neoliberal and will use other discourses as well (as per the next chapter).

The economic discourse of the WHO also includes the loss of income - an economic consequence for the individual in terms of forgone income and for society in terms of the loss of income gained and productivity. This discussion of foregone income/productivity is consistent throughout the 14-year timeline of the WHO documents reviewed – as seen in the passages below from 1998, 2002, and 2014. The WHO is using death statistics framed as an economic burden for society and individuals, arguably because this neoliberal framing is expected and will be persuasive.

These costs include direct medical care for tobacco-related illnesses, absenteeism from work, fire losses, *reduced productivity and foregone income due to early mortality* (WHO, 1998a, p. 3). [emphasis added]

The economic burden of cancer is most obvious in health care costs, such as those for hospitals, other health services, and drugs. *Indirect costs arise from loss of productivity as a result of the illness and premature death of those affected.* Direct costs may be estimated fairly readily in situations where the nature and extent of services provided to cancer patients are known (WHO, 2002, p. 22). [emphasis added]

Noncommunicable diseases act as key barriers to poverty alleviation and sustainable development. The data presented in this report demonstrate that NCDs affect all countries and that the burden of death and disease is heavily concentrated in low- and middle-income countries. *Loss of productivity due to premature deaths, and the individual and national costs of addressing NCDs,* act as important barriers to poverty reduction and sustainable development (WHO, 2014a, pp. xv-xvi). [emphasis added]

Tobacco use increases the risk of cardiovascular disease, cancer, chronic respiratory disease, diabetes and premature death. Six million people are currently estimated to die annually from tobacco use ... Tobacco use also imposes an *economic burden in the form of increased medical costs and from lost productivity.* In most economies, the health cost burden from tobacco also exceeds the total tax revenue(s) collected by the governments from tobacco product (WHO, 2014a, p. 53). [emphasis added]

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In addition, the WHO uses alarming language again to escalate the concern about the economic burden, such as NCDs are “robbing societies.”

The NCD epidemic exacts a *massive socioeconomic toll* throughout the world. It is rising rapidly in lower-income countries and among the poor in the middle- and high-income countries. Each year, NCDs are estimated to cause more than 9 million deaths before the age of 60 years with concomitant negative impacts on productivity and development. The increasing burden of NCDs also imposes *severe economic consequences* that range from impoverishment of families to high health system costs and the weakening of country economies. The NCD epidemic is *thwarting poverty reduction efforts and robbing societies* of funds that could otherwise be devoted to social and economic development (WHO, 2010a, p. 37).

Unless the NCD epidemic is *aggressively confronted* in the most heavily affected countries and communities, the mounting impact of NCDs will continue and the global goal of reducing poverty will be undermined (WHO, 2010a, p. vii). [emphasis added]

As seen here, and a page above, the WHO does sometimes link NCDs to the goals of reducing poverty. Unlike malnutrition, poverty is mentioned throughout the 14-year timeline of WHO documents reviewed. However, the WHO does not explore how poverty contributes to NCDs other than the example statements provided, nor suggest responses to NCDs that would increase incomes at the individual level thus leaving the *loss of productivity* as the responsibility of the individual.

Third, the WHO also identifies the consequences for individuals who have an NCD as including unnecessary suffering – which is inseparable from its discussion of NCDs as caused by behaviours framed as modifiable, including obesity and tobacco use, explored further in Chapter 6. The passages below are adopting techniques of persuasion that are not exactly neoliberal.

Every year, millions of cancer patients could be saved from premature death and *suffering* if they had timely access to early detection and treatment (WHO, 2006b, p. 2). [emphasis added]

Regardless of resource level, every country can take steps to curb the cancer epidemic by undertaking primary prevention actions and thereby avoid *unnecessary suffering* and premature death (WHO, 2006b, p. 2). [emphasis added]

Noncommunicable diseases (NCDs) are one of the major health and development challenges of the 21st century, in terms of both the *human suffering* they cause and the *harm they inflict* on the socioeconomic fabric of countries, particularly low- and middle-income countries. No government can afford to ignore the rising burden of NCDs. In the absence of evidence-based actions, *the human, social and economic costs* of NCDs will continue to grow and overwhelm the capacity of countries to address them (WHO, 2014a, p. X). [emphasis added]

In these documents, curbing tobacco use emerges as one of the key methods to prevent cancer and the suffering of cancer. Obesity is also specifically framed as a way of living that entails suffering – and is still framed this way after being categorized as a disease itself in 2013. For example, the WHO (2000) document presented obesity as something individuals dread and would avoid or trade for a different illness if given the option.

A dramatic example of how extremely overweight individuals perceive their disorder has been provided by studies of a group of severely obese patients before and after losing weight as a result of gastric surgery. Before surgery, all the patients felt unattractive and the great majority felt that people talked about them behind their backs at work. They also felt that they had been discriminated against when applying for jobs and treated disrespectfully by the medical profession. *After having achieved a weight loss of 50kg, all the patients said that they would prefer to be deaf, dyslexic or diabetic or to suffer from severe heart disease or acne than to return to their previous weight.* Given a hypothetical choice, they all preferred to be of normal weight than have “a couple of million dollars” - a choice that they made in less than a second (WHO, 2000, p. 73). [emphasis added]

Further, the WHO special issue on obesity outlines the ‘costs’ of obesity, one of which is an ‘impaired quality of life.’ In the passage below, impaired quality of life is considered an ‘intangible cost’ (social and psychological marginalization), whereas diabetes and DALYs are a direct cost (illness and economic).

The direct costs of obesity are predominantly from diabetes, cardiovascular diseases and hypertension. Indirect costs, which are far greater than direct costs, include workdays lost, physician visits, disability pensions and premature mortality which all increase as BMI increases. *Intangible costs (impaired quality of life)* have not been estimated, but given the social and psychological consequences of obesity, they are likely to be enormous (Swinburn, Caterson, Seidell, & James, 2004, p. 125). [emphasis added]

Fourth, the WHO sparingly discusses how NCDs hinder a human right to health, and does so only in its technical documents, not guidelines. At the outset of this project, I hypothesized that a human rights frame would be important to the WHO’s discourse around NCDs as a normative, persuasion technique to highlight the importance of NCDs. Instead, when human rights are mentioned, the WHO writes sweeping statements about protecting rights.

Of all the rights cherished by human beings and enshrined in international law, none is more fundamental *than the right to health* (WHO, 2004a, p. 45). [emphasis added]

The WHO FCTC is an evidence-based treaty that reaffirms *the right of all people to the highest standard of health* (WHO, 2003a, p. V). [emphasis added]

Further, the WHO’s ‘Global action plan for the prevention and control of NCDs from 2013-2020’ claims to incorporate a “human rights approach” for the action plan, claiming that

it should be recognized that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, as enshrined in the Universal Declaration of Human Rights (WHO, 2013, p. 12).

However, the WHO does not identify, nor follow up with in later documents, specific human rights measures or indicators to surveil the progress of human rights in countries. From my review, the WHO only mentions human rights a few times in the reviewed documents, to remind the reader of its importance and relevance, but nothing further. The WHO also does not provide strategies relating to protecting human rights.

## 5.4 Discussion

The WHO’s framing of NCDs in some respects displays a neoliberal ideology and governmentality, insofar as it constructs NCDs not only as an economic problem, but as it links increasing areas of “life” to economic value and increasingly makes economic problems matters of individual responsibility. The use of premature death statistics is a biopolitical technique to

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measure and surveil the population that is useful in neoliberal forms of governance. But I will also discuss tensions in this discourse. First, there is a tension around DALYs as a basis for interventions to ‘make live’, apparent in the WHO’s focus on premature death (or YLLs) instead of the DALYs, perhaps as a response to social scientists’ extensive criticism of DALYs and a sign of struggles around neoliberalism as allowing some (those who are irresponsible) to die. Second, I discuss how the absence of the human rights discourse is another example of tension as the WHO ‘values life’ and thereby positions itself as governing in a biopolitical mode, but through the discussion of ‘modifiable behaviours’ the WHO also implicitly restricts whose lives are valuable, reinforcing neoliberalism.

To show that NCDs are an economic burden, the WHO does two things. First, the WHO uses a capitalist argument to frame ‘years of life lost’ as lost ‘productivity.’ This ‘productive body’ is thus a ‘good body’ that contributes to the economy and is not a drain on it such as through the use of health care services. From a capitalist perspective a good body is one that participates in the workforce to sell their labour to the employer. In order to provide for yourself and your family, you need to be able to sell your labour and work (Harvey, 2007). But the linking of YLLs to productivity is arguably neoliberal in form – it expands the domains of life that are made economically relevant. Under neoliberalism, if you cannot work long enough, you and your body are a drain on welfare as the state has to pay to provide for you, therefore, you cannot contribute to society or the employer (Harvey, 2007). This ‘drain’ is measured formally as a ‘loss of productivity’ which includes the YLL multiplied by “monetary terms” of gender and average wages (Bolin, Bjo, & Lindgren, 2007). While the WHO does not calculate the ‘monetary terms,’ the WHO expresses its concern for the ‘loss of productivity’ when framing the NCD

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problem by explicitly stating that NCDs cause a loss in productivity and burdens social and economic development.

As I will discuss in Chapter 6, this neoliberal tactic of positioning this lost productivity as “preventable” and “unnecessary,” is in keeping with another strand of the WHO discourse around NCDs, which links them to ‘modifiable behaviours’ and makes NCDs problems of individual responsibility. With the support of alarming language to say NCDs are causing *human suffering*, the WHO asks the reader of its documents to be concerned for the individual while also positioning the individual as burden on society. Further, the presentation of obese individuals in the passages above already suggests how the WHO will frames these individuals as governable, by for instance, suggesting that since an intervention is available (bariatric surgery) it is irresponsible to be obese. The WHO does not tie the fact that individuals are suffering to the issue of their human rights, which are being violated if they do not have access to health care or income to prevent such suffering. Instead, as shown further in the next chapter, the WHO connects individual suffering to individual responsibility.

The WHO uses the YLLs, and broadly the DALYs, as a biopolitical technology to quantify the individual (a disciplinary power) and surveil the population (biopolitical power). Biopolitical mechanisms mobilize purposeful counting, and organizations can use the knowledge gained from counting to problematize, recommend, and govern (Legg, 2005). Further, as Rose (1991) states, “to count a problem is to define it and make it amenable to government. To govern a problem requires that it be counted” (p. 686). The need to count at the individual level to manage the life of the population is presented in these documents. Through the use of YLLs, this counting can lead to supporting a cost-benefit analysis of resources and intervention. The WHO further uses the YLL as a mechanism to understand the loss of productivity, to predict disease

burden, and leverage this surveillance statistic globally, such as the GBDS, to quantify *the value of life* and persuade leaders to manage the population.

The YLLs and premature death statistics are an example of what Wahlberg and Rose (2015) call ‘human technologies’ that collect knowledge for the ‘governmentalization of living’ – which is defined by Wahlberg and Rose (2015) as when rates of ‘birth, sickness and health in a national population... come to be regarded as objects of political concern, and made knowable, calculable and thereby amendable to various strategies of intervention that aim to improve the ‘quality of life’ or ‘wellbeing’ of individuals and populations” (p. 2). The YLLs come to be used more readily in understanding the impact of disease to understand the ‘seriousness of a disease’ (Wahlberg & Rose, 2015). This seriousness is understood in the WHO documents as an economic burden on the individual and society due to the loss of productivity, and the burden on social and economic development (Wahlberg & Rose, 2015).

Finally, from a governmentality perspective, this YLL as indicator data is an example of a biopolitical technique of how national indicators can be used to surveil the global and national populations. While the WHO presents a global YLL indicator, the measurement (by risk factor) is at the individual level to predict and later prevent premature death (Murray & Institute for Health Metrics, 2018), thus making the body a site of intervention and surveillance (Ajana, 2013). Since death cannot be controlled, the WHO focuses on the mortality *rate*, that can be controlled and managed. These YLL indicators serve as a biopolitical mechanism to carry out a governance strategy to surveil the population to measure premature deaths for the purpose of gaining knowledge of the individual (e.g., their behaviours) so these individuals can be managed at the population level (e.g., through modifying behaviours – see Chapter 6).



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In using the YLL measure and linking it to productivity, the WHO is arguably using a biopolitical technique in service of neoliberalism. But the WHO’s use of YLL rather than DALY suggests some tension between neoliberalism, biopolitics and the WHO’s purpose of improving health. Critical social science scholars have challenged the use of the DALY because of the concern that in the process of understanding ‘how’ to save lives, the DALY may be used to determine ‘which lives to save’ and ‘which lives are more valuable to save’ (Anand & Hanson, 1997, Parks, 2014, Solberg, Norheim, & Barra, 2017). Originally, the DALY included age and disability weights, where young and older ages, and certain disabilities were weighted less heavily based on the lower expectations of productivity (WHO, 2014b). These weights were considered discriminatory as they categorize groups of individuals as lesser contributors to society, and thus could affect the amount of resources that goes towards supporting their lives (Anand & Hanson, 1997, Parks, 2014, Solberg, et al., 2017). The weights were removed in 2004 from the DALY and the GBDS (WHO, 2014b); however, the DALY still do not include any measure to capture the social, cultural, or environmental context of disability that affects individuals and regions (Murray & GBD 2017 Risk Factor Collaborators, 2018; Rock, 2000). For example, the DALY do not capture any qualitative aspects relating to cultural differences in behaviour that contribute to health outcomes.

DALY have been criticized for the normative assumptions shaping the ‘problem’ of disability. Rock (2000) highlights that by quantifying the body in the terms of disability, it assumes that there is a ‘normal’ body and living with a disability is a “socially devalued state subject to medical treatment” (p. 407). By situating the disabled body as abnormal, the framing of the problem equates “disability with pathology” with the goal of eliminating the disease (Rock, 2000 pp. 407-408). As the cost-benefit analysis of “scaling people according to their

degree of disability,” Rock (2000) argues that this logic “implies that fewer resources should flow to people with disabilities than people without disabilities” (p. 412). The example Rock (2000) uses from Anand and Hanson (1997) explains this well:

A treatment which enables a person in a wheelchair to live another year (without altering the person’s existing disability) prevents fewer DALYs than the same treatment given to a perfectly healthy person. This is because, given his existing disability (weighted, say, at a value of 1/2), he is permanently suffering half a DALY per year. Extending his life by a year thus only averts half a DALY (assuming an age weight of unity and no discounting), whereas extending the life of a perfectly able-bodied person averts a whole DALY (Anand & Hanson, 1997, p. 700).

Therefore, quantifying the abnormal, disabled body determines who receives treatment from a cost-benefit analysis instead of one of human rights and equality (Rock, 2000).

Moreover, I propose that perhaps the reason the WHO favours the YLLs over the DALYs is because the WHO supports (although not directly) the social science literature that critiques the DALYs for supporting discrimination against disabilities. In doing so, the WHO perhaps recognizes the danger of biopolitics – that it can be used to create biological caesura – or Foucault’s concept of racism (Foucault, 2003) – that creates a binary of opposing bodies, one that is disabled and one that is not (Lemke, 2011). Instead, the WHO focuses on the YLLs, or premature death statistics, to render lives equally valuable via the single measure of age of death. That being said, YLLs still serve the purpose of measuring and counting individuals for the purpose of preventing diseases by managing the population. A question stemming from this analysis is if neoliberalism values individual entrepreneurship, and it is a response to the NCD burden, then does neoliberalism increase the chances that biopolitical techniques will include a biological caesura?

Yet, in downplaying the framing of human rights, the WHO arguably also participates in the production of biological caesuras. While designing the proposal for this dissertation, I sought

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to explore whether and how the WHO, as a branch from the UN with a mission to promote and protect human rights, incorporates a human rights rhetoric in its documents and anticipated the WHO might present NCDs as caused by a lack of equal access to health care and promote a mandate to protect the right to life and limit diseases. However, I found that the WHO only discusses human rights in sweeping statements to remind the reader that fundamental human rights are important when discussing NCDs, instead of pinpointing specific violations of human rights that increases the likelihood of NCDs.

Benjamin Meier (2009), a scholar focusing on human rights and international organizations, argues that the reason for the WHO’s absence from the human rights debate is because it was never included in the WHO’s infrastructure following its conception in the 1940s. Due to the favouring of bilateral aid from developed countries, which dictates where aid goes such as the current Bill and Melinda Gate’s Foundation focus on vaccines and immunization (WHO, 2019b), developed countries were able to weaken the WHO’s infrastructure by donating money strategically, and politically, away from a human rights focus (Meier, 2009). Meier (2009) argues that the WHO’s failure to solidify a rights-based approach “stemmed from not engaging consistently in political advocacy to meet its political health goals through human rights norms” (p. 233). Meaning, the WHO arrived too late to political negotiations, lost its infrastructure to do so, and has been unable to gain traction ever since to incorporate a rights-based approach into its policies and programming. Simultaneously, neoliberal development policy spread globally (Fox & Meier, 2009), and without the proper infrastructure, the WHO was susceptible to dominant neoliberal thinking throughout its development (Meier, 2009).

Another reason for the absence of human rights and its accompanying discourse, may be due to the fact that the ‘risk factors’ included in the WHO and GBS surveillance data are

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‘modifiable behaviours’ measures, such as weight – variables that support healthy lives (Gruskin, Ferguson, Tarantola, & Beaglehole, 2014). Thus, the WHO is unable to discuss linkages between human rights and NCDs because it does not have the measures for its indicators (Gruskin et al., 2014). As such, the human rights discourse and evidence is absent from the WHO documents selected for this dissertation.

The passages included in this chapter were the only passages mentioning human rights, quality of life, and broader environmental concerns ‘beyond’ health outcomes (such as the passaged relating to tobacco) in the analyzed documents. The WHO is signalling for its reader ‘reminder, human rights and other factors are important too.’ Nevertheless, the WHO limits the framing of the NCD problem to economic terms because it seems those are the terms that matter to the most influential members (states) of its audience. This absence of human rights, where its presence could include a deeper discussion of how it relates to NCDs, or include measures in the WHO indicators, highlights a tension in the moral tone of preserving life in neoliberal conditions.

### **5.5 Chapter conclusion**

In this chapter, I explored how the WHO frames NCDs as a problem. From my review I found that NCDs are discursively constructed as an economic problem that inhibits economic development. The YLLs measures the rate of premature mortality to estimate the magnitude of the NCD problem and puts the ‘loss of productivity’ into perspective. By positioning NCDs as a rational, economic concern, the WHO mobilizes a neoliberal ideology and uses the biopolitical technique of metrics to ‘economize’ (Kenny, 2015) the ‘cost’ of death and the ‘value’ of life. The GBD study, QALYs, DALYs, and mortality statistics are biopolitical techniques and metrics as each quantifies the individual to support making decisions for intervention and regulation (Evans

& Colls, 2009, Kenny, 2015). As such, these biometrics serve as a governing mechanism to make the body ‘amenable’ and to govern the population (Ajana, 2013). In these WHO documents, biometrics are biopolitical mechanisms used to understand the global ‘burden’ and justify intervention. Finally, the justification of an economic analysis is to present the NCD problem in ‘objectively true’ terms to support the ‘rational’ perception (Ajana, 2013; Anand & Hanson, 1997; Ashmore et al., 1989; Rock, 2000) that we must act now to prevent and treat NCDs.

## **Chapter 6: The discourse of addressing tobacco use and obesity as the solution to noncommunicable diseases**

### **6.1 Introduction**

According to the WHO, tobacco use and obesity are serious health concerns, threats to global health, and leading factors in death world-wide. In this chapter, I explore how the WHO differently positions tobacco use and behaviours seen as linked to obesity (such as eating and physical activity) as modifiable, and therefore differently positions individual behaviour change as a solution to NCDs. Until about 2008, the WHO largely presents tobacco users as victims of the tobacco industry, who are not blamed for their use of tobacco products, and who have difficulty quitting smoking. The WHO simultaneously rejects the tobacco industry's claim of the 'freedom of choice' discourse, according to which the tobacco industry is free to sell its product and the user as free to purchase the product (consistent with a classical form of liberalism), but supports the discourse that the clean-air movement mobilizes that smoking is an infringement on others' choice (more of a neoliberal form). The WHO argues that there is no freedom to choose to smoke because, it alleges, the tobacco industry has lied and distorted evidence: those who smoke want to quit anyway, and clean air is a benefit for the whole population. The WHO thus reconfigures the meaning of 'freedom of choice' in neoliberal terms.

Obese citizens, on the other hand, are positioned as individuals who have not upheld a 'healthy lifestyle' and the WHO discourse focuses on blaming the individual for their poor decisions and suggests that to be healthy is to *live healthily* and manage your diet and exercise. This healthy lifestyle discourse makes use of medical measures, including the BMI – an obesity measure that is argued to be a mechanism to medicalize the body (Conrad, 1992; LeBesco, 2011; Nuttall, 2015; Rogge et al., 2004; Ulijaszek & Lofink, 2006). Unlike tobacco use, the WHO does

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not challenge, or recommend regulations of, the food industry and narrows its view to individual behaviours. The WHO key informants highlight that this topic is complex for the WHO because of the political interests at stake with the food industry. Also, despite the social science literature extensively highlighting the complexities of obesity, including the experience of obese individuals with marginalization and stigmatization (Elliott, 2007; Tomiyama et al., 2018), the WHO fails to engage in a more complex discourse for a complex topic.

As mentioned in Chapter 5, a pivotal point in time for ‘modifiable behaviours’ in the WHO’s discourse was the WHO (2008) ‘Action Plan for the Global Strategy for the Prevention and Control of NCDs 2008-2013,’ as the first-time ‘modifiable behaviours’ were grouped together in relation to NCDs. As tobacco use became talked about more generally with ‘modifiable behaviours’, I will show that tobacco use was incorporated into the ‘healthy lifestyle discourse’ according to which individuals are expected to quit smoking because, it is implied, everyone knows smoking is harmful, and the resources and products available to quit are more readily available than before 2008 (Bell, 2011, 2013; Bell et al., 2010, 2011).

Similarly, to Chapter 5, I continue the argument that the WHO employs a neoliberal governmentality by recommending interventions that responsabilize individuals – which is popular among Member States and affordable – no matter the likelihood of success. Further, in the discussion of this chapter, I argue that ‘modifiable behaviours’ are constructed as problems for individuals, who need to regulate their bodies for the purpose of benefiting the population. As such, the WHO does two things. First, the WHO frames the solution to the NCD problem as needing to free individuals from their habits, addictions, and misleading advertising to live better. This framing denies the possibility that we may not live only for health (Bell, 2013) – as biopolitical power would mandate. Second, the WHO positions the body as a disciplinary site

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and uses biopolitical techniques to regulate social life (such as mass media campaigns to change behaviours norms) and train the individual to self-discipline and reduce risk (Gibson & Dempsey, 2013; Welch, McMahon, & Wright, 2012) in the “name of public good” (Gibson & Dempsey, 2013, p. 45).

## **6.2 World Health Organization documents findings: Comparing tobacco use and obesity**

### **6.2.1 Tobacco use**

#### *World Health Organization tobacco timeline*

Before NCDs were identified as a problem in the 2000s (as discussed in Chapter 5), tobacco use was on the WHO’s radar since the 1970s as a behaviour concern related to cancer<sup>15</sup>. The earliest documentation I could find was from the twenty-third WHA in 1970 which highlights “serious effects of smoking” and tasks the Director-General of the WHO to “consider convening an expert group to recommend further action that might be taken to discourage smoking” (WHO, 2019i). In 1976, the Director-General was tasked “to continue, and intensify, WHO’s antismoking activities” (WHA, 1976, p. 2) and in 1980 the Director-General presented the ‘WHO Expert committee on smoking control’ which argued tobacco use is “now a major public health problem” (WHO, 2019k). In 1998, the WHO published guidelines<sup>16</sup> for tobacco titled, ‘Guidelines for controlling and monitoring the tobacco epidemic,’ which recommended tobacco control measures such as increased prices and taxation and media campaigns.

As the evidence of the relationship between tobacco use and poor-health continued to be researched by academics and the WHO in the 1980s and into the 1990s (Waterstone, 2010), there

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<sup>15</sup> I searched archived WHO documents and WHA agendas and resolutions using the WHO IRIS.

<sup>16</sup> The WHO (1998a) tobacco guideline is the earliest guideline on tobacco that I could locate online.



was additional support to take on the tobacco industry in the form of litigation in the United States. The 1998 Minnesota litigation settlement<sup>17</sup> changed the course of tobacco knowledge and discourse leading into the 2000s as the tobacco companies were caught lying to Congress about their knowledge of the addictive nature of tobacco (Hurt et al., 2009, p. 447). The lawsuit and the release of documents exposed the tobacco industry for paying researchers to contradict evidence-based research against tobacco use and poor health correlations and involving third parties to support political lobbying for big tobacco agendas (Bero, 2003, p. 268). Importantly, the documents put the ‘is tobacco bad for you’ debate to rest. Following the Minnesota settlement, the WHO created the Tobacco Free Initiative (TFI) (1998) (WHO, 2019j) and FCTC (2003) to inform Member States about tobacco control and to take on the tobacco industry (Mamudu & Glantz, 2009; WHA, 1999). The guidelines, TFI, and FCTC made the WHO the global leader in tobacco control, as claimed by the World Bank (1999). In this section, I outline the WHO’s position on the tobacco industry and the use of the *freedom of choice* discourse in its argument.

### *The tobacco industry*

As mentioned, the WHO blamed the tobacco industry for the intentional uptake of tobacco. The WHO identified that the tobacco industry was untrustworthy starting in the 1990s. After the Minnesota settlement, however, the WHO’s language escalated to be more aggressive against the tobacco industry for being schemers and liars:

Many countries have undertaken health promotion programmes and health education programmes to inform people of the hazards of tobacco. *However, these efforts are continually undermined by the tobacco industry.* Over 40 years of experience with health education and health promotion measures show that these measures alone are insufficient to combat the tobacco problem. If smoking is still perceived as socially acceptable,

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<sup>17</sup> The 1998 Minnesota settlement was the “Minnesota tobacco trial and the signing of the Master Settlement Agreement by 46 US State Attorneys General and the US tobacco industry” (Hurt et al., 2009, p. 446). The United States were seeking “public health relief” and received a settlement of \$206 billion dollars through to 2025 (Hurt et al., 2009, p. 447).

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educational campaigns focused on the health hazards of tobacco use will have but modest results in getting large numbers of adults to stop smoking, or in preventing teenagers from starting. The net effect will be a well-informed population of continuing smokers. For better results, education and health promotion must be accompanied by other actions, particularly legislation and tobacco tax measures, that will reduce the social acceptability of tobacco use (WHO, 1998a, p. 6). [emphasis added]

Similarly, in FCTC technical documents of 2004, the WHO writes:

The tobacco industry actively lobbied prominent political figures, scientific standards officials, and the media. In addition, they planted pro-tobacco articles in newspapers and *manipulated* third-party organizations to lobby on behalf of tobacco industry interests. The companies spied on and infiltrated potential foes, such as the WHO and the Arab Gulf States Health Ministers' Council, and were therefore eminently prepared to react *forcefully* against every tobacco control policy proposed. Despite the best efforts of committed public health officials, politicians, and public health groups in the [Eastern Mediterranean Region], the multinational tobacco industry continues to wield enormous power over the policy-making process in the region (WHO, 2004a, p. 138). [emphasis added]

Opposition to tobacco control legislation is unusually ferocious because of the role of the tobacco industry. Once-secret tobacco company documents offer insights into the ways this industry mobilizes every resource at its disposal when threatened. *The industry's web of influence runs through the fabric of society*, and enables it to fight tobacco control in both overt and covert ways. Much of this is done through surrogates, including third-party allies, front groups and "independent" sources secretly paid by tobacco companies. Through all these channels, tobacco companies put forth several recurring arguments, minimizing the importance of the tobacco epidemic, insisting that tobacco use is a matter of personal freedom, denying that legislative measures will work, and suggesting that tobacco control will cause economic injury (WHO, 2004a, p. 18). [emphasis added]

Following the WHO (2008) 'Action Plan for the Global Strategy for the Prevention and Control of NCDs 2008-2013' tobacco use was grouped with other 'modifiable behaviours' as part of unhealthy lifestyles, that individuals are encouraged to change. Tobacco use is mentioned alongside obesity (diet and physical activity) as lifestyle patterns for individuals to change.

Reducing the level of exposure of individuals and populations to the common modifiable risk factors for noncommunicable diseases – namely, tobacco use, unhealthy diet and physical inactivity, and the harmful use of alcohol – and their determinants, while at the same time strengthening the capacity of individuals and populations to make healthier choices and follow lifestyle patterns that foster good health (WHO, 2008, p. V).

The vast majority of the world's diabetes cases are type 2 (1). Some risk factors for type 2 diabetes – such as genetics, ethnicity and age – are not modifiable. Others, such as being overweight or obese, unhealthy diet, insufficient physical activity and smoking are modifiable through behavioural and environmental changes (WHO, 2016a, p. 35).

However, the WHO does not stop targeting the tobacco industry during this period. The WHO continues to identify how the tobacco industry influences science and individual choice by interfering with research studies and legislation.

The tobacco industry has a history of creating the appearance of scientific controversy in an attempt to counter initiatives intended to restrict tobacco use. However, the ultimate goal of these types of industry-backed initiatives is to maintain the social acceptability of smoking and prevent adoption of meaningful smoke-free policies in public places and in workplaces (WHO, 2009a, p. 32).

Tobacco industry interference is one of the key challenges to the creation and implementation of tobacco-reduction measures. It continues to undermine control efforts globally, and more needs to be done to counter its negative influence. In fact, during the reporting cycle of the WHO FCTC, which ended at the beginning of 2014, the challenge mentioned most frequently by Parties to the convention was tobacco industry interference. The tobacco industry continues to use legal challenges (often employed without success) to national tobacco-control measures, including litigation or support for litigation under multilateral and bilateral trade and investment agreements, to prevent, delay or weaken implementation of tobacco-control measures (WHO, 2014a, p. 62).

'Modifiable behaviours' are considered *modifiable* because there are choices/options for individuals to change these behaviours. The WHO does two things when discussing choice. First, the tobacco industry targets federal legislation based on what the WHO dubs as a *freedom of choice* discourse – that individuals are free to smoke as they so choose. Second, the WHO promotes media campaigns as a strategy *to change behaviours* and promote *healthier choices*. However, the potential tensions created by the WHO's inclusion of tobacco use among the behaviours deemed modifiable become apparent in the WHO documents in the discourse around freedom and choice, and the WHO's approach to interventions.

*Tobacco use and the 'freedom of choice'*

The 'freedom of choice' discourse positions the individual as having the freedom to choose to smoke and the tobacco industry the freedom to sell its products. The WHO addresses this position in the technical documents, and argues that the tobacco industry mobilizes the 'freedom to choose' as the liberty "to pursue profits through private property sanctity," claiming that selling a product is not an issue as individuals have the choice to consume them (Waterstone, 2010, p. 888). The passage below highlights how the WHO critiques the position of the tobacco industry.

"Tobacco use is a personal choice." Opponents' second theme characterizes tobacco use as an issue of "freedom," "rights," or "choice." This argument insists that tobacco control measures interfere with individual decisions and the autonomy of the individual tobacco user. This view is especially attractive to lawmakers who favour a limited role for government, who are likely to see the use of tobacco products as a private matter... In reality, arguments about "choices" and "decisions" have little meaning in the case of tobacco products. Most users begin before they are old enough to make informed decisions, and are fully addicted before they become adults. Furthermore, surveys show that the preferred "choice" of most adult tobacco users is to quit, but that they are unable to break their addictions (WHO, 2004a, p. 139).

As shown in the passage above and the passage to follow, the WHO highlights that smokers are not able to make informed decisions, and are not fully aware of the dangers of tobacco use.

Despite conclusive evidence regarding the dangers of tobacco, relatively few tobacco users worldwide understand the full extent of the risk to their health (138). Smokers tend to underestimate the risks of tobacco use to themselves and others. Article 11 (Packaging and labelling of tobacco products) of the WHO FCTC establishes an obligation for Parties to meet global standards for warning labels that clearly communicate the dangers of tobacco use in the principal national language, comprise not less than 30% of the principal display areas on all tobacco products, and rotate periodically (WHO, 2009a, p. 48).

The passage also implies that users want to quit, and would not have started, *if only they had known* that tobacco use was harmful for their health and addictive. Also, while after 2008

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tobacco use becomes grouped with ‘modifiable behaviours’, the document from 2009 shows that the WHO still also sees tobacco use as a problem perpetuated by the tobacco industry.

Next, the WHO tries to discredit this ‘pursuit of profits’ position by discrediting the tobacco industry as a legitimate industry that should obtain profits.

The powerful commercial interests involved in production and distribution of tobacco products exploit people’s dependence on tobacco in order to maintain sales. Their arguments include the preservation of “free” trade and of individual “freedom” to enjoy tobacco, as well as the need to avoid economic problems in the form of loss of jobs and material investment in the tobacco industry (WHO, 2002, p. 29). [emphasis added]

Effective tobacco control legislation is likely to encounter stiff opposition in most countries, even apart from the opposition of the tobacco industry. Where the truth about tobacco and health is not well understood, parliamentarians who mistakenly perceive tobacco use as a matter of “freedom” and “choice” or who are philosophically disposed toward a minimal role for government regulation, will often be sceptical, at least initially, as will some elements of the general public (WHO, 2004a, p. 53). [emphasis added]

Similarly, if the public is not fully aware of the medical facts, tobacco use may be falsely associated with “freedom” and “rights,” whether in the form of “freedom” to smoke in public places, “freedom” to advertise or “freedom” to promote international trade in tobacco products, even though “freedom” has little meaningful application to the use of products that addict their users, most of whom become addicted before they reach adulthood, and that endanger innocent bystanders exposed involuntarily to smoke (WHO, 2004a, p. 52). [emphasis added]

All WHO passages above discredit the ‘pro-tobacco,’ or ‘pro-choice,’ argument by stating that the harm of tobacco outweighs any argument to have access to tobacco. Overall, the WHO blames the tobacco industry for influencing individual choice and created the FCTC to take on the industry because of its power and influence over health.

The arguments of ‘autonomy’ are further opposed by the WHO because of the harm of second-hand smoke. Second-hand smoke is a concern because of the harm it imposes on the general population, the risk of health to children, and increasing the chances of children becoming smokers:

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Tobacco use is currently one of the leading causes of preventable deaths in the world. Risks to health result not only from direct consumption of tobacco but also from exposure to second-hand smoke. Tobacco use increases the risk of cardiovascular disease, cancer, chronic respiratory disease, diabetes and premature death. Six million people are currently estimated to die annually from tobacco use, with over 600 000 deaths due to exposure to second-hand smoke (with 170 000 of these deaths among children) (WHO, 2014a, p. 53).

Strictly from a standpoint of health protection of non-smokers, there is a strong case for implementing smoke-free environments in every possible sector. The case is especially strong for protecting workers and others *who are not free* to leave a smoky setting (WHO, 2004a, p. 102). [emphasis added]

Non-smokers who breathe in the smoke of others (also called second-hand smoke or environmental tobacco smoke) are at increased risk for lung cancer. A non-smoker who is married to a smoker has a 20–30% greater risk of developing lung cancer than the non-smoking spouse of a non-smoker. Workers who have been exposed to tobacco smoke in the workplace are also more likely to get lung cancer (WHO, 2002, p. 27).

The WHO uses references to second-hand smoke for two things. First, the WHO uses it to discredit the ‘freedom of choice’ discourse by highlighting the *consequences* of these choices on the entire population and children. Second, the WHO uses second-hand smoke statistics, similarly to NCD statistics in Chapter 5, to escalate the problem of tobacco.

### *Tobacco strategies: Media campaigns*

While exploring the ‘freedom of choice’ discourse, I found a contradiction in the WHO’s approach in its strategy recommendations. The WHO highlights that a strategy to change smoking behaviours is to change the social norms encouraging smoking. One strategy is taxation and pricing as the passages previous and below highlight how taxes can discourage tobacco use and change the social acceptability of tobacco in the long-term.

High tobacco taxes and prices help reinforce messaging in graphic warning labels, media campaigns and other interventions that warn users about the health and economic damage caused by tobacco, and similarly reinforce strengthened social norms against tobacco use that result from comprehensive smoke free air policies (WHO, 2015b, p. 29).

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Another strategy to change the social norms of smoking is through media campaigns, as shown in the passages below – presented in the FCTC and WHO technical documents. The WHO (2003a) FCTC Article 13 has a specific recommendation regulating ‘tobacco advertising, promotion and sponsorship.’ WHO guidelines and technical documents highlight how mass media campaigns are critical to addressing tobacco use messages. Taxes can also be a way to fund these media campaigns.

Where tobacco advertising is permitted, the tobacco industry typically devotes substantial resources to advertising and promoting tobacco products. In the United States in 1993 tobacco companies spent US\$ 6200 million on tobacco advertising and promotion, nearly 5000 times the entire WHO budget for activities related to the health effects of tobacco in the same year. While spending on tobacco advertising may be more modest in other countries, it no doubt vastly exceeds the total amount that public health interests could spend to discourage tobacco use. Health interests can never hope to match the spending by tobacco interests on paid media advertising, and *probably should not try*. Nevertheless, paid media advertising, when used with precision, can be an effective tool in a comprehensive effort to *discourage tobacco consumption*. One way of funding this would be to earmark a portion of tobacco taxes for this purpose (WHO, 1998a, p. 15) [emphasis added].

In the passage above, the WHO warns that public health media advertising cannot match in spending that of the tobacco industry, and then in the next sentence recommends media advertisements anyhow. In the passage below, this hesitation is absent.

Anti-tobacco advertising in all forms of media can help publicize the full extent of tobacco’s dangers and can counter tobacco use as a social norm. When exposed to effective television anti-tobacco messages, teenagers are half as likely to become established smokers and adult smokers are more likely to quit. Hard-hitting campaigns using graphic images that demonstrate the physical harm caused by tobacco use are especially effective in convincing users to quit. The tobacco industry has created its own anti-tobacco advertising, but its advertisements are ineffective in reducing smoking and may even increase smoking, especially among the young (WHO, 2009a, p. 49).

The WHO (2009b), claims that mass media campaigns are effective interventions to change attitude and behaviour by increasing knowledge. The passage below is a document from 2015, showing mass media campaigns were recommended throughout the WHO document timeline

selected for this dissertation.

Well-designed, sustained anti-tobacco mass media campaigns reduce tobacco use. By increasing awareness of the harms of tobacco use, hard-hitting anti-tobacco mass media campaigns reduce tobacco use, increase quitting attempts and reduce second-hand smoke exposure. Campaigns should ideally be sustained over long periods to have a lasting effect, although more limited campaigns can have some impact if they are run for at least a few weeks. Despite the expense involved, mass media campaigns can quickly and efficiently reach large populations. Television advertising with graphic imagery is especially effective in convincing tobacco users to quit (WHO, 2015b, p. 73).

As noted above, a major perceived benefit of mass media campaigns is that it reaches large populations. Changing social norms and thus behaviours is a challenging task, especially if you have the tobacco industry also using the media to reach large populations to fight against anti-smoking campaigns. Further, mass media campaigns against tobacco are necessary to challenge the tobacco industry media campaigns. However, only half of the countries that ratified the FCTC have implemented a mass media campaign.

Around half of all countries have not run any kind of sustained mass media campaign in the past 2 years – one quarter of the world's population has not been exposed to an anti-tobacco campaign during that time. People in low-income countries are the least likely to be exposed to anti-tobacco mass media: 65% of low-income countries, with 60% of the total low-income country population, have not had any kind of campaign in the past 2 years to inform people about the harms of tobacco use or to encourage them to quit (WHO, 2015b, p. 72).

The WHO appears to continue to recommend mass media campaigns – while identifying that media campaigns are not sustained by Member States. The passages in this section also highlight that if WHO believes tobacco use can be discouraged, then WHO must also see tobacco use as a choice that individuals make. Other passages in this section highlight how tobacco users are also presented as duped by the tactics of the tobacco industry – so the WHO takes a not entirely consistent two-pronged approach to combating tobacco use, one being that the tobacco industry cannot be trusted and therefore must be regulated to prevent the misguidance of the potential



tobacco user, and another that targets the tobacco user (or potential user) to not smoke as they may very well decide to continue smoking even while knowing the health risks.

### 6.2.2 Obesity

#### *World Health Organization obesity timeline*

Obesity appeared in WHO documents starting in the 1990s with its annual World Health Statistics or other epidemiological reports (WHO, 1990b, p. 108). As the concern over obesity increased in the 1990s, into the 2000s, as outlined in the literature review, obesity became more prominent in WHO documents. In 1997, the WHO hosted an expert consultation on obesity to “review current epidemiological information on obesity” and write “recommendations for developing public health policies and programmes for improving the prevention and management of obesity which is emerging as a global public health problem” (WHO, 1998b, p. xv). The GBDS publications between 1994 and 1997 also provided data for the expert consultation on obesity. The obesity expert consultation concluded two things: first, obesity should be recognized as a disease, and second, the WHO should recognize obesity as an “epidemic” caused by “sedentary lifestyles and high-fat, energy-dense diets” (WHO, 1998b, p. xvi). These two conclusions are present throughout the WHO documents since the 1998 publication.

The WHO has published few documents specifically on ‘obesity’ as a topic, instead, either obesity, diet, or physical activity appears in more general NCD documents from 2000 to 2019. As outlined in the methodology chapter, other WHO documents were selected purposefully to fill gaps from the original document list for full review. In this section, I outline the discourses around *who is to blame for obesity* – (un)healthy lifestyles and the food industry –

and *medicalizing obesity* as presented in the WHO documents. From my review, the WHO blames an unhealthy lifestyle for causing obesity. Unlike its discourse around tobacco, the WHO guideline and technical documents do not discuss how the food industry influences individual behaviour. Second, the WHO aligns with the medicalization of obesity literature by using the BMI to highlight obesity as a problem and as a means to measure obesity.

### *(Un)healthy lifestyles*

As the problem of obesity increased, so did the literature on (un)healthy lifestyles as a leading cause of obesity (Campos et al., 2006; Elliott, 2007; Kleinert & Horton, 2015; Rogge et al., 2004), as discussed in the literature review. The WHO adopts the ‘healthy lifestyle’ discourse throughout the timeline of the technical documents selected for this dissertation. According to this discourse, one of the ways to change behaviour that leads to obesity is to change the social norms of ‘accepting’ unhealthy lifestyles. The WHO explicitly advocates for a change in norms to accept healthier behaviours to reduce obesity and to quit smoking. The passages below demonstrate how the WHO rejects ‘unhealthy lifestyles’ and simultaneously argues there is a need to change the social norms that sanction this behaviour.

Human existence is characterized by behaviour patterns—what people do to meet their biological, psychological, and social needs. These patterns may include certain ways of preparing and consuming food, physical inactivity, and the development of dependence on tobacco products, alcohol, and drugs. Many of these patterns have an impact on cancer, as well as on other diseases. *Adopting a healthy lifestyle that includes a healthy diet, physical exercise, appropriate body weight, and avoidance of risk-associated behaviours* can lead to a long active life (WHO, 2002, p. 7). [emphasis added]

No country has yet been able to slow down or *stop the epidemic* of overweight and obesity. Evidence to date supports preventive interventions encouraging physical activity and a healthy diet while restricting sedentary activities and offering behavioural support. These interventions should involve the whole family, schools and the wider community (WHO, 2006b, p. 21).

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To halt the rise in obesity and type II diabetes it is imperative to scale-up population-level prevention. Policy measures are needed to increase access to affordable, healthy foods and beverages; to promote physical activity; and to reduce exposure to tobacco (WHO, 2016a, p. 15).

The last quote above also highlights how, especially after 2009, tobacco use is lumped together as a ‘behaviour pattern’ that individuals can modify through a ‘healthy lifestyle.’ However, the WHO also discusses how individuals are ‘exposed to tobacco,’ while it does not, in these documents, consider something like “exposure to unhealthy food.” The message for obesity does not change over time. Also, the final quote listed above demonstrates how the WHO alludes to possible changes to the food industry without calling them out as liars and schemers as it does with the tobacco industry. This demonstrates that the WHO explicitly chooses to take on the tobacco *industry* and not just *tobacco users* or *second-hand smoke* but fails to attack the food *industry* in the same way. The word choices in the three passages above demonstrate how the WHO uses specific words to convey its messages to persuade the reader and challenge health concerns.

In the passages above, the WHO appears to be unclear in its understanding of individual agency as it requests a change in social norms as in some cases the individual is ‘duped’ by the tobacco industry for taking up smoking (low agency) but is responsible for their weight gain (high agency). In this contradiction, it seems the WHO is aware that individual behaviours are not simply a matter of choice but are influenced by culture and social norms but then holds the individual accountable for making the wrong choices that leads to weight gain assuming individuals have the agency to make these choices. In addition, the WHO fails to acknowledge that changes in social norms can lead to the stigmatization of irresponsible choices as has been argued by social science scholars (Bell et al., 2011; Gard & Wright, 2005).

Further, as the WHO does for tobacco use, it recommends mass media campaigns to change the norms and thus behaviours that cause obesity.

Mass media campaigns use paid and non-paid forms of media to increase knowledge and change attitudes and behaviours towards diet and physical activity. These interventions commonly employ television and radio, as well as print media, and are often associated with community-based activities that run in parallel. Twenty-four interventions were summarized, including two targeting disadvantaged communities and three in low- or middle-income countries (WHO, 2009b, p. 13).

Mass media campaigns and social marketing can influence positive change and make *healthy behaviours more the norm*. These strategies have the potential to reduce the occurrence of type 2 diabetes and may also reduce complications associated with diabetes (WHO, 2016a, p. 15). [emphasis added]

There is a research literature on how environments can encourage unhealthy behaviours and result in weight gain and obesity, referred to as ‘obesogenic environments,’ which refers to a set of environmental conditions with high access to unhealthy food options and limited access to physical activity (Ulijaszek & Lofink, 2006). For example, areas with over development of restaurants (such as fast food chains providing access to high calorie food) and limited green and working space are considered obesogenic. The WHO does not discuss obesogenic environments in the guideline or technical documents selected for this dissertation, but does in the additional documents that were purposefully sampled for the supplementary review to fill the gaps of the documents selected for full review.<sup>18</sup> Obesogenic environments entered the WHO documents with the WHO ‘Diet, Nutrition and the Prevention of Chronic Diseases’ technical report series in 2004, following the expert consultation of 1997. The report walks through each micro environment, while identifying limitations of data and possibilities for intervention.

Much of the evidence of the impact of environments on dietary intake and obesity comes from cross-sectional associations and some intervention studies, although it is generally

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<sup>18</sup> This supplementary, purposeful sample list is outlined in the Chapter 4: Methodology, page 61. Note that the WHO technical report series from 2004 has separate authors per chapter, as noted on pages 63-64 in the methodology.

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very difficult to tease out the impacts of specific environmental elements (Swinburn, et al., 2004, p. 133).

Collectively, [school food and nutrition policies] probably influence dietary intake and, coupled with the physical activity environment, probably affect obesity prevalence but definitive evidence is still lacking around which elements are most important [in schools] (Swinburn, et al., 2004, p. 133).

However, diversity is a concern in these micro environments, making a settings approach – places where environmental, organizational, and personal contexts influence the individuals in them such as schools, homes, and workplaces (WHO, 2019e) – difficult but optimal to manage health.

As a [home] setting, however, it is difficult to influence because of the sheer numbers and heterogeneity of homes and the limited options for access (with television advertising campaigns being the most effective but very expensive access option) (Swinburn, et al., 2004, p. 134).

In the WHO technical documents selected for review, the WHO describes different settings (workplace, schools, etc.) as sites for intervention to change behaviours, rather than as obesogenic environments more broadly, for example that schools are often environments with limited healthy food options. The WHO's approach results in smaller, focused interventions that may benefit some, but do not tackle the broader, obesogenic environments where people live and play.

The workplace is an ideal venue to offer employees structured and planned activities to improve their health. Since many workplaces provide meals, snacks and/or beverages, these can be optimized by providing healthy options at lowest prices in vending machines or in the available food service facilities. Additionally, physical activity programmes that are accessible and sustainable can be introduced at low cost to the organization to provide maximum health benefits for employees. Evidence consistently indicates that including workers in programme planning and implementation brings positive outcomes (WHO, 2009b, p. 18).

Effective interventions [for schools]: High-intensity school-based interventions that focus on diet and/or physical activity, are comprehensive, multi-component and include: curriculum on diet and/or physical activity taught by trained teachers; supportive school environment/policies; a physical activity programme; a parental/family component;

healthy food options available through school food services: cafeteria, vending machines, etc. (WHO, 2009b, p. 15).

The WHO blames the rise of obesity on unhealthy behaviours but is limited in its discussion of what causes unhealthy behaviours outside of identifying overconsumption of unhealthy foods and beverages and insufficient physical activity.

*Missing from the obesity discussion*

Additionally, the WHO has not targeted the food industry as it has targeted the tobacco industry. The WHO on occasion references access to healthy food, however, this is not a critique of the food industry. A notable partial exception occurred in 2015, when 22 scientists met at the International Agency for Research on Cancer (IARC), the cancer agency of the WHO, to “evaluate the carcinogenicity of the consumption of red meat and processed meat” (Bouvard et al., 2015, p. 1559). After reviewing 800 epidemiological studies on different types of cancer and the association with red and processed meat, the expert group identified that processed meat is “carcinogenic<sup>19</sup> to humans” (Group 1 classification<sup>20</sup>) (Bouvard et al., 2015, p. 1560). Red meat was determined as “probably carcinogenic to humans” (Group A2 classification) (Bouvard et al., 2015, p. 1560). The WHO responded to the carcinogenic report with a question and answer series, stating the reason for such an expert consultation was to “to provide authoritative scientific evidence” of red and processed meat cancer risks (WHO, 2015c, p. 1).

An international advisory committee that met in 2014 recommended red meat and processed meat as high priorities for evaluation by the IARC Monographs Programme. This recommendation was based on epidemiological studies suggesting that small *increases in the risk* of several cancers may be associated with high consumption of red meat or processed meat. Although these risks are small, they could be important for public health because many people worldwide eat meat and meat consumption is increasing in low- and middle-income countries. Although some health agencies already

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<sup>19</sup> Carcinogenic means to be have the potential to cause cancer.

<sup>20</sup> The WHO (2015c) clarified that the Group 1 carcinogenic of processed meat is the same as tobacco use because of the “strength of evidence” and to not say that they are “equally dangerous.”

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recommend limiting intake of meat, *these recommendations are aimed mostly at reducing the risk of other diseases*. With this in mind, it was important for IARC to provide *authoritative scientific evidence* on the cancer risks associated with eating red meat and processed meat (WHO, 2015c, p. 1). [emphasis added]

The IARC has continued to publish research/manuscripts regarding the relation between diet and cancer, however, the WHA has not written resolutions for follow-up work for the WHO to investigate the food industry. From the WHO technical document list, the WHO (2002) ‘National Cancer Control Programmes: Policies and Managerial Guidelines Second Edition’ is the only report that mentions high intake of red meat increases the chance of cancer such as colorectal and breast cancer (p. 13).

For obesity, the only situation in which regulations of the food industry are discussed is in relation to children; the WHO recommends restricting advertisement of high sugary meals, such as in the WHO (2004b) ‘Global Strategy on Diet, Physical Activity and Health.’ The quote below however asks Member States to work together with industry, instead of targeting the food industry directly in its recommendations and language as it does for the tobacco industry.

Marketing, advertising, sponsorship and promotion. Food advertising affects food choices and influences dietary habits. Food and beverage advertisements should not exploit children’s inexperience or credulity. Messages that encourage unhealthy dietary practices or physical inactivity should be discouraged, and positive, healthy messages encouraged. Governments should work with consumer groups and the private sector (including advertising) to develop appropriate multisectoral approaches to deal with the marketing of food to children, and to deal with such issues as sponsorship, promotion and advertising (WHO, 2004b, p. 7).

However, Member States have not implemented such restrictions on the food industry, which was brought to the WHA’s attention in 2016, with the presentation of the WHO (2016b) ‘Report of the Commission on Ending Childhood Obesity’ (WHA, 2016b).

Moreover, the WHO once took an approach to issues of food consumption centered around nutrition and linked nutrition to issues of social justice and human rights—for example,

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the WHO (1992) published a ‘World Declaration and Plan for Nutrition’ to address the problem of malnutrition and poverty leading to malnutrition. In later nutrition documents (such as 2017) the language of social determinants and social justice are absent and obesity is discussed only as a ‘risk factor’ for other diseases and not as an outcome of inequalities and environments. For example, in the 1992 passage below, the WHO is concerned about poverty, discrimination, and education and access to safe food and clean water – all factors relating to SDOH and equal access to the conditions for health.

Development strategies to reduce poverty and ensure better nutrition for all should be oriented towards achieving economic growth with equity, ensuring social justice and protecting and promoting the well-being of all, particularly of vulnerable groups. Policies that discriminate against people on the basis of gender, age, ethnic, tribal, religion, political affiliation or other grounds militate against social justice. All people in all societies must have equitable access to economic resources and opportunities, adequate and safe food, healthy living conditions and health services, clean water, sanitation and education and related services since these are basic requirements for nutritional well-being (WHO, 1992, p. 4).

Since this publication, the WHO has addressed obesity and NCDs in documents separate from malnutrition documents. None of the obesity and NCD documents in my WHO document database discussed malnutrition in relation to obesity. However, under the ‘malnutrition’ health topic on the WHO website (WHO, 2019d), the WHO mentions that obesity and being overweight cause malnutrition, as does being underweight, but then specifically mentions the association between obesity/overweight to NCDs.

Malnutrition, in all its forms, includes undernutrition (wasting, stunting, underweight), inadequate vitamins or minerals, overweight, obesity, and resulting diet-related noncommunicable diseases (WHO, 2018, p. 1).

To explore further, I reviewed a WHO (2017a) document titled ‘Global Nutrition Monitoring Framework: Operational Guidance for Tracking Progress in Meeting Targets for 2025’ to see whether and how obesity is discussed in relation to malnutrition in recent publications. This



document only discusses obesity in relation to illness and mortality and does not discuss the role of malnutrition and obesity specifically.

Maternal overweight and obesity result in increased maternal morbidity and infant mortality. Maternal overweight is also associated with overweight and metabolic syndrome in children. In some developed country settings, maternal obesity is also associated with delayed lactogenesis and short breastfeeding duration. Obesity in women can increase health risks for both the mother and child during and after pregnancy (WHO, 2017a, p. 10).

Overweight in children is reaching alarming proportions in many countries and poses an urgent and serious challenge. The prevalence of overweight among children is rapidly increasing even in many low- and middle-income countries. In 2016, at least 40.6 million children less than 5 years of age were overweight or obese, and most of them live in low- and middle-income countries. Progress in tackling childhood obesity has been slow and inconsistent (WHO, 2017a, p. 23).

Instead of discussing the association with malnutrition, the WHO technical documents selected for this dissertation argue that it is over-consumption of ‘bad food’ and insufficient physical activity that are to blame for the increase of obesity.

### *Medicalizing obesity*

Medicalizing obesity refers to the process whereby obesity became understood, measured, and treated in/by medical terms (Hofmann, 2016). In the WHO technical documents, this medicalization is present through the use of the BMI measurement. The BMI is used to introduce the obesity problem to the reader. In doing so, the WHO also identifies that an overweight or obese category is not the ‘optimal’ health category, and individuals should be aiming for a lower BMI. The passages below are from guideline (WHO, 2002) and technical documents (WHO, 2006b, 2014a) and demonstrate that BMI has been the WHO’s indicator throughout the 14-year timeline of this dissertation.

Obesity is epidemic in many developed countries, and is increasingly becoming a concern in many developing countries. Obesity is defined by WHO as a body mass index (BMI) of  $>30 \text{ kg/m}^2$ , while people with BMI in the range  $>25 - <30 \text{ kg/m}^2$  are classified as overweight (WHO, 2002, p. 40).

Body mass index (BMI) is defined as weight in kilograms divided by the square of the height in metres ( $\text{kg/m}^2$ ). It provides the most useful population-level measure of overweight and obesity as it is the same for both sexes and for all ages of adults. However, it should be considered as a rough guide because it may not correspond to the same degree of fatness in different individuals. WHO defines “overweight” as a BMI equal to or more than 25, and “obesity” as a BMI equal to or more than 30. These cut-off points provide a benchmark for individual assessment, but there is evidence that risk of chronic disease in populations increases progressively from a BMI of 21 (WHO, 2006b, p. 20).

Overweight and obesity – i.e.  $\text{BMI} \geq 25 \text{ kg/m}^2$  and  $\geq 30 \text{ kg/m}^2$  respectively – were estimated to account for 3.4 million deaths per year and 93.6 million DALYs<sup>21</sup> in 2010. To achieve optimal health, the median BMI for adult populations should be in the range 21–23  $\text{kg/m}^2$ , while the goal for individuals should be to maintain a BMI in the range 18.5–24.9  $\text{kg/m}^2$ . The risk of comorbidities increases with a BMI in the range 25.0–29.9  $\text{kg/m}^2$ , and the risk is moderate to severe with a BMI greater than 30  $\text{kg/m}^2$  (WHO, 2014a, p. 79).

As outlined in the literature review, the BMI has been criticized for inaccurately measuring obesity and creating a categorical system to measure and manage bodies (Gutin, 2018). Oliver (2006a) reports that academic publications critiquing BMI increased following 2004, the year obesity articles reached its peak in the media. Responding to the criticism of the BMI measurement, the WHO proposed a new, additional measurement called the ‘waist circumference and waist-hip ratio,’ defined as “the waist circumference divided by the hip circumference” (WHO, 2011b, p. 1). One of the justifications for a second measurement of weight is because “waist–hip ratio appeared to be a stronger independent risk factor than BMI” and to use the waist-hip ratio to “further define risks” (WHO, 2011b, p. 1). The WHO (2011b) waist circumference report identifies that the ‘Expert Consultation on Waist Circumference’ working group was formed in 2002 to “start examining data on the relation between waist circumference and morbidity, and on any association between BMI, waist circumference and

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<sup>21</sup> This is one of the three times the WHO mentions DALYs specifically.

health risk” (p. 1). The WHO does not, however, use the waist circumference measurement in any of the documents reviewed for this dissertation, despite the WHO (2011b) waist circumference report indicating that the waist circumference measurement is an effective measurement and “practical considerations appeared to favour the use of waist circumference as an alternative to BMI” (p. 19).

### 6.3 Discussion

‘Modifiable behaviours’ are positioned as the response to treat and prevent NCDs. The WHO discusses tobacco and obesity separately and differently. In this discussion, I speculate about the reasons for differences and specifically, especially the WHO’s willingness to blame the tobacco industry for deceiving the public, while failing to present or understand the food industry as contributors to obesity. For example, the WHO is willing to critique the *freedom of choice* argument in relation to tobacco use, but has not made a similar claim against the food industry. Instead, for obesity, the WHO largely limits itself to a healthy lifestyle discourse and ignores the SDOH literature – explored further in Chapter 7. Next, I discuss the limitations of the narrow focus of the guidelines and the implications of the limited discussion of SDOH. Finally, I argue that the WHO employs a neoliberal governmentality through its emphasis on mass media campaigns – although it is unclear if the WHO is intervening in culture and norms or individual behaviours.

The timeline for tobacco evidence, legislation, and legal proceedings shows that the WHO mobilized this momentum to target the tobacco industry and create the FCTC. As the WHO key informants argued, the FCTC was created at the ‘right time’ with the support from Member States. As highlighted above, the WHO began targeting the tobacco industry before the

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legal proceedings; implying that the WHO supported the medical research from the 1970s stating that there was a correlation between tobacco use (and second-hand smoke) and poor health and then started blaming the tobacco industry for deceiving the public that smoking was safe. The WHO tobacco documents are consistent in blaming the tobacco industry for deceiving the public and discussing the correlation between smoke (and second-hand smoke) and NCDs. Following the Minnesota settlement, the WHO had new leverage to escalate the concern about tobacco. Arguably, the WHO was not able to create the FCTC without the Minnesota settlement, which provided the legal argument to create a treaty such as the FCTC.

The food industry has not had the same place in the WHO discourse as the tobacco industry, despite the rise of vegetarianism, veganism, and plant-based diet research (Kim, Caulfield, & Rebholz, 2018; Marsh & Saunders, 2012; Tilmans & Clark, 2014; Yokoyama et al., 2014). Food, as the WHO key informants highlighted, is a more complicated problem because everyone needs to eat, Member States require international trade agreements to trade food, and there are no defined unsafe limits for consumption as there is for tobacco use (WHO Key informant interview 1,2,5). For example, following the IARC publication on red and processed meat causing cancer, the WHO's (2015c) question and answer page identified that IARC expert consultation did not clarify what is a 'safe' level of consumption and the WHO did not proceed to do so, nor publish any follow-up work. Furthermore, when WHO key informants were asked about the possibility of an obesity treaty, all respondents said it is not possible and there would not be an obesity treaty because the development would be too complicated and there is no demand for one.

Should we have one? Probably. Will we get one? I doubt it because it's so complicated. Is there an appetite for Member States? Not at the moment (WHO key informant interview 5).

No to all of them, it's not the same kind of enemy. Because the interventions, you know the tobacco industry is still quite strong and that stops every country from signing the treaty. The industry is strong so the country gets revenue. So, it's not easy to give up on that. But many countries do not use tobacco so it is easier for them to sign up. For food it's a trickier issue, there is I think, much bigger money in food than in tobacco. And you will immediately have countries object to that, to a treaty. Because a treaty is sort of binding. I don't know what sort of punishment countries get in the FCTC, but it's more binding when you sign a treaty than saying ok, WHO has written this here, we might try to do that but maybe we won't (WHO key informant interview 4).

Tobacco was a bit more black and white. You had this product that any use causes harm, that's been promoted by a billion dollar industry, whose only purpose is to do health harm and to promote a product that is in no way shape or form for any one at any dose is not harmful. So, it's very black and white around that. And then you had the whole history of an industry lied and manipulated, done everything they possibly could to make sure people were addicted to this product that was going to harm them. So, from a public health perspective, and because it's a multi-billion-dollar industry, it was really seen as this is beyond the borders for countries to control. So, the whole idea for the framework convention is to make sense in that context. Now, there's not another product particularly that's the same as that. So, alcohol is probably the closest parallel. Ok so it's also harmful, but it's also nuanced, is there some small level of cardiovascular benefit? So, you may have some cardiovascular health benefit but you're increasing your risk of breast cancer at the same dose. It's not as straight forward that any dose is going to kill you and so forth (WHO key informant interview 2).

The responses above highlight how, unlike tobacco use, there is no 'black and white' threshold, perspective, or product for the WHO to target for the food industry despite the IARC publication (WHO key informant interview 1,2,4,5). Arguably, as the WHO informants acknowledge too, the food industry has much greater power in relation to international trade and is supported by more lobbyists than the tobacco industry. Challenging the food system itself is *literally unthinkable given the discursive horizons of neoliberalism*.

One of the barriers to an obesity treaty is the lack of Member State buy-in. The need for such buy-in prevents the WHO from over-extending its power to create treaties that will not be used, but on the other hand, it prevents the WHO from moving the agenda forward for how to tackle obesity. If the WHO were to take a stand against the food industry, similarly to how it has against the tobacco industry, then perhaps the WHO would include strategies in these types of

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WHO documents (endorsed technical and guidelines) to regulate processed foods, high calorie meals in restaurants, and fast-food restaurants. If an obesity treaty limited access to unhealthy food, and promoted policy and economic changes to make healthy food more affordable as legal scholars have called for (Blouin & Dube, 2010), then perhaps we would see a new era in addressing obesity.

The WHA report following the presentation of the Commission on childhood obesity highlights some potential that the food industry may be targeted in the future due to the concern for marketing food and beverages to children.

The Commission notes with concern the failure of Member States to give significant attention to Resolution WHA63.14 endorsed by the World Health Assembly in 2010 and requests that they address this issue. Parents and caregivers are increasingly the target of marketing for foods and beverages high in fats and sugar, aimed at their children (WHA, 2016b, p. 16).

This concern for advertising food and beverages to children has been established in the literature as an influence in child decision making for food and beverages (Boles, Adams, Gredler, & Manhas, 2014; Harrison, 2012; Heart and Stroke Foundation, 2017; Lupton, 2004). As a response to the WHA63.14, the WHO produced a set of recommendations in 2010 that were endorsed by the WHA and suggests that regulations can be industry-led or exist within a governmental framework (WHO, 2010b).

The defined policy may be implemented through a variety of approaches. Statutory regulation is one approach through which implementation and compliance are a legal requirement. Another approach is industry-led self-regulation, which covers whole industry sectors, for example the advertising sector, and can be independent of government regulation. This approach may still be mandated by government in some form such as the setting of targets and monitoring implementation using key indicators. Other approaches include various co-regulatory mechanisms, comprising statutory, self-regulation and/or voluntary industry initiatives which either exist within the framework of a government mandate or are not formally linked. Governments or mandated bodies can also issue or implement guidelines (WHO, 2010b, p. 10).

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However, the WHO (2016b) commission on childhood obesity report identified that industries and governments are not regulating the food industry – thus highlighting two things. First, since the WHO recommendations are endorsed but are not binding obligations, Member States are not required to follow them – and in this case, chose not to. Second, the food industry despite knowing the evidence and concern, has not been self-regulating itself to support children in making healthier choices.

The passages from the technical documents presented in this chapter, overall, show an absence of SDOH discussion, recommendations, and evidence around issues such as individual income, employment, social support systems, and gender. Social science scholars have criticized the healthy lifestyle discourse for ignoring the social context of behaviours, and why behaviours are difficult to modify (Bell et al., 2011; Caballero, 2007; Campos et al., 2006; Chopra, Galbraith, & Darnton-Hill, 2002; Elliott, 2007; Evans & Colls, 2009; Flint et al., 2016; Goldberg, 2016; Kirk, Penney, & McHugh, 2010; Oliver & Lee, 2005). Social science scholars argue that these SDOH factors are as important as understanding the biological factors of what happens when you eat a high sugar diet or smoke cigarettes (Campos et al., 2006; Evans & Colls, 2009; Oliver & Lee, 2005). The WHO has focused on culture, but this is arguably a vague term that references some of the social context relating to tobacco use but still avoids specifics of social context that are not about ‘culture’ such as inequality, poverty, age, and gender.

Ultimately, the goal of capacity-building and, indeed, of all tobacco control, is to change the society’s culture. Legislation is important, but, in the final analysis, it is the norms and values of a society that determine whether tobacco use is accepted. The underlying goal of the effort to build national capacity is to begin to transform the society’s culture—from one that tolerates tobacco as a legal product used by people exercising supposedly free “choice,” to one that rejects tobacco as a deadly and highly addictive product that injures not only tobacco users, but also their families, innocent bystanders and society as a whole (WHO, 2004a, p. 85).

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In order to understand how to change ‘modifiable behaviours’, individuals need more than the scare tactics from media campaigns of ‘if you smoke you will get lung cancer’ because research has shown that this type of behaviour deterrence is ineffective (Chapple et al., 2004; Lobchuk et al., 2008; Tran et al., 2015). After the FCTC, the WHO focused again on the importance of media campaigns in relation to obesity and smoking. Further, telling people that something is bad for them is not effective to convince people to change their behaviour (Allen et al., 2015; Atusingwize, Lewis, & Langley, 2015; Silver, 2001; Terry-McElrath et al., 2013). The WHO technical documents are therefore limited at confronting the social context for tobacco use and obesity.

I found in my analysis that intervention of ‘mass media campaigns’ was recommended the most frequently to change behaviours. The purpose of mass media campaigns is to change the norms of healthy behaviours and potentially – and eventually – persuade the audience to make healthier choices. However, social science literature has identified that these types of superficial interventions that do not address the environment or equity are unsuccessful in changing behaviours (Bell et al., 2011; Campos et al., 2006; Gibson & Dempsey, 2013; Oliver & Lee, 2005). This recommendation highlights that the WHO does not partake in a more nuanced discussion of SDOH and modifying behaviours. The WHO key informants agree with this critique and state that Member States choose media campaigns as an easy check box to say that it has implemented an intervention, and generally, the approach is popular among Member States.

So, mass media campaign... every review shows that it's not effective, but if you ask a country what it's doing, that's often the response “we're educating young people at school.” Well, everybody knows that doesn't really work and yet what would work is price increases, restrictions on availability, and restrictions on advertising. But they're politically unpopular (WHO key informant interview 2).



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Arguably, the WHO recommends implementing mass media campaigns because media campaigns are *affordable* (Atusingwize et al., 2015) and are often discussed in the context of a ‘cost benefit analysis’ assuming the logic that media campaigns change health norms and thus individuals change their behaviours. This logic however relies on individuals being *able* to change behaviours and ignores the social and environmental factors that prevent this change – despite limited evidence showing a change in behaviour (Allen et al., 2015; Silver, 2001; Terry-McElrath et al., 2013).

In relation to obesity, scholars have highlighted the potential stigmatizing nature of healthy lifestyle media campaigns (improving lifestyle behaviours) to combat obesity (Boles et al., 2014; Dixon, Murphy, Scully, Rose, & Cotter, 2016; Puhl, Luedicke, & Peterson, 2013). But interestingly, this stigmatizing effect is not discussed in relation to anti-smoking or obesity media campaigns. Literature I found reviewing tobacco media campaigns focused on effectiveness across different populations, cost of campaigns, and the use of graphic images (such as Allen et al., 2015; Atusingwize et al., 2015; Silver, 2001; Terry-McElrath et al., 2013). This highlights that media campaigns for the two ‘risk factors’ differ: tobacco campaigns use personal narratives and graphics to scare individuals to prevent or quit smoking, whereas obesity media campaigns focuses on changing ‘lifestyle behaviours’ to make healthier choices and easy ways to incorporate exercise into your daily routine (such as Boles, Adams, Gredler, & Manhas, 2014; Dixon, Murphy, Scully, Rose, & Cotter, 2016; Puhl, Luedicke, & Peterson, 2013; Walls, Peeters, Proietto, & Mcneil, 2011). While the WHO may group tobacco use and obesity together under the ‘modifiable behaviour’/risk factor umbrella, obesity appears to be more commonly discussed in the literature in relation to the health lifestyle discourse – in alignment with the WHO passages presented in this chapter.

A likely reason the WHO relies on the healthy lifestyle discourse is that there is a dominant medical literature supporting it. The healthy lifestyle discourse is supported with medical evidence that states that there is a relationship between over-consumption of unhealthy food and insufficient activity leading to obesity (Ferris & Crowther, 2011; Kuehl, Kirk, Dumas, & Rph, 2017; Ortiz, Kawachi, & Boyce, 2017). The discussion that supports this discourse is from the neoliberal, individual entrepreneurial ideology that individuals *should* (and want to) better themselves (Guthman & DuPuis, 2006; Reubi, 2016). Together, this discourse is constructed with medical evidence and a dominant ideology of how individuals should behave. Even in the case of BMI, the WHO proposes an alternative measurement, such as the waist-hip ratio, but fails to use it in its own documents and perpetuates the medical categories of obesity. Perpetuating a measurement that scholars have deemed ineffective, the WHO is ignoring the social science literature that argues against such a measurement to categorize and monitor individuals (Evans & Colls, 2009; Gutin, 2018; Nuttall, 2015). Favouring medical literature is also seen when the WHO ignores the literature on obesogenic environments, a prominent argument in the social and contextual understandings influencing obesity (Kirk et al., 2010; Tomiyama et al., 2018; Ulijaszek & Lofink, 2006).

Similarly, to the technical documents, the guideline documents are limited in relation to the SDOH. Because the WHO produces fewer guideline documents (discussed in the next chapter) only six guidelines were reviewed for this dissertation. These guidelines included regulation of potassium and sugars, the control of tuberculosis as related to diabetes, glycated haemoglobin to diagnose diabetes mellitus, prevention of cardiovascular disease, and controlling and monitoring tobacco use. Outside of the tobacco document from 1998, the other 5 guidelines are between the years of 2007 to 2015 and these guidelines are specific recommendations on a

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particular topic, whereas technical documents are broader, with various recommendations. As I explore the creation of technical and guideline documents more closely in Chapter 7, I will show that limitations of how evidence is collected is a key contributor to why SDOH evidence is missing from both sets of documents – but especially, the guidelines.

The discussion of the absence of SDOH, a focus on healthy lifestyles, and an intervention that is ineffective and supports this absence and focus is therefore, an intervention that will undoubtedly fail. Mass media campaigns are nonthreatening to neoliberalism as it is cost-effective, easy, and do not require government regulations or interventions. Mass media campaigns are also an example of a method to *govern at a distance* as media campaigns can reach the whole population, or at least the most ‘relevant’ populations, for the purpose of regulating social life. The intention of this governing at a distance method of media campaigns, and similar interventions, is to encourage the individual to self-discipline to reduce their risk of NCDs. The FCTC on the other hand, is inconsistent with neoliberalism as it is meant to empower Member States to regulate the tobacco industry.

Further, the passages concerning tobacco use present the individual as someone who is both the victim of the tobacco industry and as someone who may choose to smoke. This complex understanding of the tobacco user leaves the WHO with a difficult task of challenging a tobacco industry that requires smokers and new smokers to make a profit and will by any means try to persuade individuals to smoke. Simultaneously, even while managing the tobacco industry to the extent the WHO recommends, individuals may still choose to smoke knowing the health risks and is thus a more difficult behaviour to modify. The WHO also acknowledges the difficulties of quitting smoking, but still recommends taxation and mass media campaigns to change social norms and behaviours which focuses on the individual to change their behaviour. This

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complexity highlights that there is a need to understand *why individuals smoke in the first place* – even after the tobacco industry is regulated – which I argue, requires SDOH literature to understand the context and mental health of the smoker to understand smoking as a vice.

To successfully govern at a distance, the body is viewed as something that can be disciplined and managed at the individual level to regulate the population. Further, framing ‘modifiable behaviours’ as the solution to the NCD problem implies that individuals need freeing from their habits, addictions, and misleading advertising to live better. This framing denies the possibility that we may not live only for health – as biopolitical power would intend – and supports governing at a distance based on biopolitics such as the GBDS and premature death statistics. To prevent NCDs and decrease premature death rates, the WHO implements neoliberal interventions to govern at a distance, with the support of biopolitical techniques and measures to gain knowledge of the population to be governed.

### 6.4 Chapter conclusion

In this chapter I explored how tobacco use and obesity are constructed in the WHO documents as ‘modifiable behaviours’ as a solution to NCDs. I outlined each problem’s trajectory with the WHO and highlighted that because of both scientific evidence and political agreement, tobacco use was addressed rapidly and widely through the FCTC, while obesity has not been similarly addressed. I agree with the medical evidence that tobacco use and obesity are a problem, but I agree with the social science literature that our overall understanding of the problem is too narrow due to medicalization and the absence of the SDOH literature. In this absence, the social context of ‘modifiable behaviours’ and possibilities for intervention in the interests of public health are missed.

## Chapter 6: The discourse of addressing tobacco use and obesity as the solution to noncommunicable diseases

Moreover, as I have demonstrated in this dissertation, the techniques to regulate tobacco for example through the FCTC, are biopolitical as the FCTC mobilizes surveilling and regulating the individual to manage and benefit the population in the name of health. Therefore, the process to achieve ‘diverse’ neoliberal policies and implementation may incorporate biopolitical techniques that are still grounded in a neoliberal regime.

In Chapter 7, I explore the process and politics of producing WHO technical and guideline documents. The discussion of the absence of SDOH literature is continued and related to how evidence is ranked by the WHO procedures. Chapter 6 also began the discussion of the conflict of interest of the Member States being involved in the WHO decision making. In Chapter 7, I further analyze the implications of the Member States’ politics and conflicts of interest in their roles on the WHO executive board as it relates to WHO technical officers’ work.

## Chapter 7: The political and institutional conditions of World Health Organization documents

### 7.1 Introduction

The WHO produces several types of documents including guidelines, technical documents, academic manuscripts, reports, brochures, and fact sheets, for example. For the purpose of this dissertation I focused on guideline and technical documents because these are the WHO's guidance documents for global action. To understand the production of these documents, I conducted key informant interviews at the WHO in Geneva. In this chapter, I present the findings from the WHO informants as they describe how the construction of these guideline and technical documents are related to evidence-based medicine and political and financial support. For this dissertation, I understand evidence-based medicine as formal, institutional knowledge that relates to the area of medicine and public health and is thus a *connaissance* as defined by Foucault. The political and financial conditions in which this knowledge is created, assessed and used is *savoir*.

Exploring the process of how evidence is used in the WHO documents complements my discourse analysis. In Chapters 5 and 6 I outlined the *connaissance*, the formal bodies of knowledge as it relates to NCDs as a problem and 'modifiable behaviours' as the solution. Chapters 5 and 6 also explored to some degree the *savoir* or conditions that support the *connaissance*. Here, I analyze how the WHO sets up procedures so that usually only a particular *connaissance* – the evidence from clinical medicine and epidemiology – informs its documents. These procedures are part of the *savoir* – the assumptions, biases, and politics – that influence the creation and content of the documents. I discuss that because of the WHO's use of the evidence informed decision-making model (Liang, Howard, Leggat, & Murphy, 2012; Poot et al., 2018; Yost et al., 2014), science literature generally, and SDOH literature specifically, is

Chapter 7: The political and institutional conditions of World Health Organization documents

absent from these documents as it is perceived as not strong enough (Mercuri & Baigrie, 2018; Mercuri, Baigrie, & Upshur, 2018). As the WHO key informants mentioned, the political conflicts and financial support from Member States creates tensions in the creation of the documents. For instance, in using the GRADE method for evidence ranking, guideline documents are seen as produced in a process separate from the politics of the WHO and WHA. As such, the guideline documents are so few and narrow in scope that their relevance to policy seems negligible. Technical documents require political support throughout – the need for them is determined by the WHA, member states review their evidence and recommendations, and the WHA can endorse them (making them more likely to become acted upon). This involvement with the WHA/Member States means the evidence in technical documents is ‘diluted’ (or weakened) or some evidence is excluded, as the WHO respondents discuss, and in my view the resulting recommendations will undoubtedly fail (as identified in Chapter 6).

## 7.2 Background

As outlined in Chapter 4, guideline documents are approved by the GRC and technical documents are requested through WHA resolutions and may be endorsed (reviewed and supported) by the WHA. My understanding from my review of documents and WHO key informant interviews is that all documents endorsed by the WHA or written and approved as formal guidelines by the GRC, are *endorsed guidance for Member States*. Research and technical report series documents (that are not from a WHA resolution or not endorsed) may have recommendations in them but are not *endorsed guidance*. There are two key differences between guideline and technical documents: the type of evidence used and the approval/review process.

To evaluate evidence for guideline documents, the WHO uses the GRADE method to assess and rank existing research and identify the ‘best’ or ‘gold standard’ evidence (WHO,

2014c). The WHO adopted the GRADE method in 2007, following its creation at McMaster University (Davoli et al., 2015; WHO, 2014d). The GRADE method is a product of an ‘evidence informed decision making’ model that emphasizes that decisions and policies should be *informed* by best evidence and practice to limit the influence of political and financial biases (Messac, Ciccarone, Draine, & Bourgois, 2013). For this dissertation, guidelines that were identified as such prior to 2007 were included for review, but in fact the only guideline document identified prior to 2007 is the WHO (1998a) ‘Guidelines for Controlling and Monitoring the Tobacco Epidemic.’ Guidelines are less frequently produced by the WHO and tend to be about specific topics (WHO key informant interviews 3, 4) such as potassium intake, and thus, I only have six in my review.

The GRADE method uses a 4-point scale to rank evidence as very low, low, moderate, and high (WHO, 2014c). In the majority of cases, evidence from RCTs is ranked at the top (ranked high quality) and single, observational studies at the bottom (ranked low or very low quality). This traditional hierarchy of evidence (Upshur, Vandenberg, & Goel, 2001) means social science evidence, which is often categorized as single, observational studies, is ranked as lower quality and not ‘recommended’ as ‘good enough’ evidence to construct guidelines (WHO key informant interview 4). The GRADE method is only used for guidelines, and not technical documents due to the time commitment (approximately 2-3 years) and resources needed to construct guidelines (WHO key informant interviews 3,4).

Due to the GRADE method and GRC process, guidelines are exempted from the process of Member State view or approval. Guidelines are initiated by the WHO or requested by “Member States, WHO country offices, external experts or other stakeholders” when there is “uncertainty” about evidence



uncertainty can be triggered by a new public health problem or emergency; the uncovering of new evidence; an absence of good-quality evidence (or of any evidence at all); or a change in resource availability or access to services (WHO, 2014a, p. 1).

However, due to the time and resource commitment to produce guidelines (as discussed below), certain topics are more likely to be approved for guideline development because there is a greater demand for them – the example provided from the interview was there is a greater demand for HIV guidelines than for diabetes because funders are not interested in diabetes (WHO key informant interview 4). For example, when funding is limited, WHO officers sometimes engage in advocacy for them by reaching out to philanthropists for example (WHO key informant interview 4).

Technical documents may draw upon relevant guidelines in their recommendations (WHO key informant interview 3) but they are not required to use the GRADE methods and can be more flexible in their use of evidence. However, evidence-based medicine research is still prioritized, from my review of the references. The results of this flexibility are also affected by the fact that technical documents are only ‘endorsed’ by the WHO if the Member States agree on the information presented. This ‘endorsement’ opportunity occurs at the WHA each year and gives the WHO ‘stamp of approval’ to be a technical document with endorsed guidance. The purpose of technical documents can be to, for instance, produce guidance recommendations with a fast turnaround, fulfill a pressing need, outline global burdens (global status reports), and identify how to take action (global action reports). Some technical documents focus on synthesizing the broader NCD problem and how to address it (such as the NCD global action plan). From my review, technical documents are the ‘what is the status,’ ‘what is the problem,’ or ‘how to tackle the problem’ documents.

## 7.3 World Health Organization document evidence

### 7.3.1 Guideline documents and process

The WHO key informants highlighted that guidelines are difficult to produce because of several obstacles. First, the WHO key informant interviews revealed that it typically takes 2-3 years to produce a guideline due to the rigorous review process. The production process was described as expensive and time consuming.

We are very, very cautious to prepare guidelines because it takes a long time and a lot of money (WHO key informant interview 3).

NCDs are chronically underfunded... HIV and malaria and TB have many more resources and much more money that they can spend on guideline development. We have to be very frugal so it depends on how much money we can raise for a particular guideline. It doesn't come from the regular budget, you have to seek elsewhere (WHO key informant interview 4).

“Elsewhere” means philanthropies and Member States.

By talking to philanthropies and most of it ends up being from Member States. WHO has a regular budget that every country has to contribute to based on their GDP. So rich countries contribute more than poor countries but that regular budget is only enough for electricity and general services so most of the activities are funded from extra budgetary funding which is from various donors. Mostly philanthropies, foundations, development agencies, and governments of richer countries often give more than they need to give just for the regular budget so they give more. That is typically earmarked (WHO key informant interview 4).

The respondent also identified that fundraising is difficult due to NCDs being a low priority topic for countries.

They will give their dues that they have to as the membership fee but then they will give 2 million dollars for HIV work. Or for reproductive health. And NCDs are not very attractive to governments... [because] it's not a sexy topic. Most of the NCDs which are a priority for WHO, which is diabetes, CVD, asthma, chronic respiratory diseases, and cancer, *many of them are perceived as questions of personal responsibility rather than something that the government should do something about.* However, *that is not in reality the case because if a healthy diet is not affordable then the government should be doing something.* It's not just a matter of people being gluttons, it's also a matter of not being able to afford physical activity or a healthy diet. You can say you have to eat more

vegetables but fresh vegetables and fruit are typically more expensive than anything else, any healthy food (WHO key informant interview 4). [emphasis added]

The informant notes that governments tend to perceive NCDs as *individual responsibilities*, making it appear as if there is little uncertainty about the NCD problem, and a lesser need for funding, for guidelines or government action. And it is noteworthy that this WHO key informant mentions the SDOH factor of affordability in relation to diet and physical activity – despite the SDOH being ignored in these documents, as highlighted in Chapter 6.

Following the discussion of funding, I asked what is required to update or change an existing guideline and this respondent revealed that only when new, ground breaking evidence that will save lives emerges will a new guideline be created. The example provided by the WHO informant was if a new drug is available to manage diabetes (WHO key informant interview 4), and if new medication management is required to be revised from previous policies (WHO key informant interview 1).

They are sort of updated every 5-10 years unless there's some revolution or a very important movement in any particular item. Like if there's a new medicine that now saves life and nothing was available before, then you want to update your guidelines as soon as possible. It depends on the speed of the evolution in the field (WHO key informant interview 4).

I asked specifically whether there is concern about this 5-10-year timeline, noting that the WHO (2007) cardiovascular guidelines are still used in 2013 documents, as an example. The respondent highlighted that a date of a guideline is not relevant unless there is a new breakthrough in the field.

It doesn't matter, things don't get updated simply by the passage of time. There might be something new but unless it invalidates because [new guidelines] will also say don't smoke or reduce this and hasn't been contradicted by anything newer. So, this sort of update it does depend on resources but it depends on the dynamics in the field. So, for some things, for example hepatitis C, relatively recently there is a bunch of new medicines which make a difference between life and death. Well, they need to be quickly incorporated into guidelines and quickly incorporated into this list because they make

such a difference. So, that's how it works. There are probably documents that are 20 years old but don't have much wrong with them. Probably most need to be updated every 10 years at least to say there's nothing new or no need to change it. But it depends on rather you have the money to do it. We are a very poor agency. There is a lot of money to do certain things in certain fields but for others there is a lot of looking for funding almost begging around to use the word (WHO key informant interview 4).

WHO key informants identified that the guideline process is “very, very strict” and referred to the GRC as the “guideline police” because of how extensive the process is regulated. A WHO key informant highlighted that the GRC does not usually review the content of guidelines as the GRC is made up of a variety of experts and may not be aware of the evidence in a specific area, but the GRC ensures the evidence assessment process was followed correctly by the WHO working group and expert consultation. And sometimes the GRC may step in to review evidence if there is a member who is an expert in the field.

The GRADE method is considered a rigorous, transparent review of evidence because the technique requires a summary of the methods and conclusions to determine the accuracy of the data (Davoli et al., 2015). The WHO (2014c) guideline handbook provides the following table (table 3) to summarize the four levels to rank evidence. In the ranking hierarchy of evidence, RCTs are considered the ‘gold standard’ and ‘high quality’ evidence (Grossman & Mackenzie, 2005). The quality of evidence determines the ‘strength’ of the recommendation with ‘high quality’ evidence equating to ‘strong’ evidence (WHO, 2014c). Thus, by using ‘gold standard’ evidence such as RCTs, the WHO claims to produce ‘gold standard’ guidelines.

WHO scans the best knowledge in the world. WHO brings together the best brains in the world. We are a major convincing agency... We get the best experts in the world we get people who have done this already from other countries, and we also get the ministries of health to come... It's not that we are all waiting here saying ‘what is the best knowledge’ it is not like that (WHO informant interview 1).

**Table 3: Four levels of evidence in GRADE (WHO, 2014c, p. 113)**

Quality	Definition
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.
Very low	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

The overall quality of assessed evidence determines the ‘strength’ of the guideline, with the WHO (2014c) dividing the evidence as ‘RCTs’ in one category and ‘non RCTs and observational studies’ in another (p. 112). There are also several factors that can increase (such as large effect) or decrease (such as bias) the confidence in both categories (table 4).

**Table 4: Factors that increase and decrease the confidence in evidence by the GRADE method (WHO, 2014c, p. 114)**

Decreases if:	Increases if:
<ul style="list-style-type: none"> <li>• Risk of bias</li> <li>• Inconsistency</li> <li>• Indirectness</li> <li>• Imprecision</li> <li>• Publication bias</li> </ul>	<ul style="list-style-type: none"> <li>• Large effect</li> <li>• Dose-response</li> <li>• All plausible confounding and bias                             <ul style="list-style-type: none"> <li>• Would reduce a demonstrated effect or,</li> <li>• Would suggest a spurious effect if no effect was observed.</li> </ul> </li> </ul>

When I asked a WHO key informant, who works on global guidelines, whether and how low-quality evidence is used in guidelines, they said there has to be a great demand for it that justifies using it.

You can justify [using low quality evidence] by a great demand for the guidance and no resources to do any other review... You wouldn't use [low quality evidence], but... you could use something that scores good/[low], or very good/[moderate], or excellent/[high] (WHO key informant interview 4).<sup>22</sup>

When asked to highlight a scenario where low-quality evidence is 'strongly recommended' for a guideline, the WHO key informant highlighted that there would have to be a justification based on experience.

It gets discussed with the group. To have a strong recommendation on very low-quality evidence is becoming a rarer thing. Then you have to acknowledge it is your expert opinion or best practice, or something like that. For insulin for example in diabetes, there's – for type 1 evidence – there's no RCTs that people with type 1 diabetes should receive insulin, but you still strongly recommend it because you know they will die if they don't get it although there are no RCTs. So, there are situations like that. We are discouraged by the guidelines police to strongly recommend something on very low-quality evidence. And if we do it has to be explained. It is very low-quality evidence but this is the best practice, we don't know, until we know more about it, is it worth to do it, the intervention is not harmful for example [sic] (WHO key informant interview 4).

The WHO key informant highlighted that by following a rigorous process the guidelines have 'a lot of value.'

Value in the fact that there is neutrality [and] it is completely evidence-based, it is decided by a group of experts, ministry representatives, and all stakeholders, who are vetted for their conflict of interest, they have to be upfront...so if there is a conflict of interest then ideally, they will be asked to be removed away from the meeting... So, that is why WHO guideline when it comes out, it has a lot of value attached to it. Because it is in a way the most neutral thing that we can get. And those are the values of the WHO, see. One of the main values of WHO is its neutrality. So, we are not like any government or any agency which can be heavily funded by a food company or a private company for that matter (WHO informant interview 1).

But the value may be limited in terms of the breadth or substance of the guidelines: the six guidelines from the years 1998-2015 reviewed for this dissertation were on narrow topics such as the 'Use of Glycated Haemoglobin in the Diagnosis of Diabetes Mellitus' (WHO, 2011a).

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<sup>22</sup> In this conversation the WHO key informant referred to a four-level ranking but did not use the proper terminology for the rankings from the WHO (2014) Guideline handbook. I assume that they are referring to the same four-level ranking as in the WHO (2014) Guideline handbook.

### 7.3.2 Technical documents and World Health Assembly politics

The majority of technical documents result from WHA resolutions, but no matter if a document is requested from a WHA resolution, once completed all technical documents, unlike guidelines, are presented to the WHA for endorsement. All the technical documents included in my sample for full discourse review resulted from a WHA resolution. The production of technical documents includes experts, working groups, and committees but they can be created faster and updated more often than guidelines because they do not go through the GRC process. From my review, I found that this ‘quicker process’ means that the evidence used in WHO technical documents includes more single, primary original research studies than found in guideline documents. Technical documents are therefore created with ‘weaker’ evidence than that used in guidelines. Further, technical documents serve a different need than guidelines as these documents are responding to WHA mandates requested by Member States and are meant to highlight ‘best practice’ but are not limited by the GRADE method and the evidence hierarchy.

Nevertheless, when I asked how much social science literature is typically included in technical documents, I was told that there is very little. However, the intention is not to directly leave it out; “robust” data to support the importance of SDOH is viewed as difficult to obtain:

Very little, very little. Primarily we don’t have the data... It’s very difficult to get robust data on a lot of variables particularly in developing countries so really, we try to prioritize what are the main things we need to know. There’s a cost element to get that many variables you’d really want and really need. You’d have to have huge samples sizes and that’s really resource intensive. So, at a global level we just try to pick up things, and also inform, in this document we also have the targets, the NCD targets<sup>23</sup>, so we need the data to inform those targets (WHO key informant interview 5).

The passage above demonstrates that SDOH indicators are a lower priority because it is too difficult to track and measure the variables and data required to report on individual behaviours

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<sup>23</sup> NCD targets from the WHO (2014a) ‘Global Status Report on Noncommunicable Diseases 2014’ document – and this is the document referred to in the quote as “in this document”.

such as eating and exercise behaviours. The resources available for data collection and management thus go to indicators of higher priority.

Well yes and no... It's not that it [SDOH literature] gets left out but there are definitely things that are like the least, there are some interventions although highly effective or cost effective, they're not as *palatable politically*. So, things like looking at the alcohol example, restricting availability of outlets, price, policy to make it more expensive etc. If you presented this range of strategies, it's very often the weaker ones that the governments embrace (WHO key informant interview 2). [emphasis added]

While technical documents have more options for evidence than guidelines, there are still limitations on the evidence included because of costs and politics. Further, the WHO informant highlights that the difficulties in including SDOH literature is less about the difficulty in tracking variables (although still difficult) than willingness to engage with forms of knowledge that are less 'palatable' or sellable to WHO's audiences, including member states.

A second important difference between technical and guideline documents is technical documents are reviewed by Member States, because technical documents are meant to be relevant for all countries, with differing capacities. Thus, technical documents and recommendations are reviewed for feasibility to see if all countries can implement the recommendations<sup>24</sup>, or if additional recommendations need to be added to support different countries.

It is [really difficult], and especially when you have to meet the needs of the whole world. Where everyone has got different places where they're starting from, where they are, their needs are different, their capacities are different, so there is no one size fits for all (WHO key informant interview 1).

A concern raised by a WHO key informant is that the Member State involvement allows for a "geopolitical review," where Member States will either ask for something to be removed, or will not take a position on a topic due to trade agreements. When asked specifically about the WHO

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<sup>24</sup> Global status reports may not include recommendations; however, these documents will advise Member States which targets have not successfully been met to encourage Member States to act on those targets.



(2013) ‘Global Action Plan for the Prevention and Control of Noncommunicable diseases,’ in appendix 3, which outlines the tools and resources to implement the NCD global action plan, one WHO key informant highlighted the issue with Member State involvement:

It was a negotiated document so it went through governing bodies. What happens then is the best evidence for example that’s been developed by the WHO secretariat (WHO staff), which is one of our jobs, as technical specialists, *then becomes politicized* because it goes through a governing bodies meeting. So, typically what can happen there is, and I’ll just use a hypothetical example, if we have for example a recommendation on sugar consumption and which we can do as a technical agency and put it on our website and Member States can implement it or not. But, when we then take that kind of guidance actually through a governing bodies process and this is presented to our governing bodies and they say ‘oh’ and if you happen to be a sugar producing country *then maybe you don’t necessarily politically agree with that rather than scientifically agree with that*. And potentially the level of evidence or *the evidence can be diluted because of politic[s]...* So that’s why you know in my view... that the role of the material coming through governing bodies should be high level policy and reducing sodium intake or sugar intake or whatever it might be and the technical advice on how do you get there... really should be a piece of technical work that we the secretariat provide and help Member States implement. But when your technical advice goes through a governing body it gets diluted and it’s not very helpful ultimately, I think, or it can get diluted (WHO key informant interview 5). [emphasis added]

As informant 5 says, “Member States can implement it or not” – technical documents are nonbinding, as is the case for guidelines. The FCTC is the only treaty reviewed for this dissertation. WHO appears to prefer technical documents to be endorsed by the WHA so Member States will take the information and recommendations more seriously.

When asked to elaborate further on the effects of the geopolitics of Member States on technical documents, a WHO key informant highlighted that in trying to address health, Member States are also trying to address security or ‘health security.’

In this context, mostly but not always, the health of the population, global or domestic populations of what Member States are trying to protect and promote health through governing bodies. But it’s also about health security. Primarily, a lot about health security about ensuring that epidemics are contained or don’t happen in the first place or are contained if they do happen and that’s about global security that’s not about health. That’s actually about global security so that’s one of the big things that it’s about trade, I

mean trade relationships you'll see very strongly coming out on the assembly floor (WHO key informant interview 5).

Further, the WHO key informant highlighted that the science can sometimes be challenged, but the reason may be because of politics.

It's not quite as rigorous a process which then lends ourselves to debate or discussion by the Member States. But this then becomes a Member State government... So, the secretariat put our best stuff in there but the Member States can come back and say well *our scientists, we don't believe that, we believe this*. And that's what I was saying before that's the place that the science can be challenged because of domestic or other issues which were often trade related (WHO key informant interview 5).

For instance, the United States criticized the WHO, (2004b) 'Global Strategy on Diet, Physical Activity and Health,' because it relied on the WHO (2003b) 'Diet, Nutrition and the Prevention of Chronic Diseases' technical report series (Norum, 2005). In a letter, the United States accused the WHO and Food and Agriculture Organization of the United Nations (FAO) of not using 'sound science' in the WHO (2003b) report and provided different evidence that the WHO and FAO should consider (Steiger & Department of Health and Human Services, 2004). One of the key objections by the United States was the conclusion that certain foods are associated with NCDs and obesity (Steiger & Department of Health and Human Services, 2004). The United States also disagreed that marketing of energy-dense foods or fast food outlets increases the risk of obesity (Steiger & Department of Health and Human Services, 2004).

The WHO's senior scientist Dr. Kaare Norum criticized the United States (and wrote a manuscript about it, 2005) for siding with the food industry and highlighting the country's rise in obesity rates in doing so. Dyer (2004) reported that following Dr. Norum's criticism, the United States Health Secretary of the time, Tommy Thompson, "encouraged Grocery Manufacturers of America members to 'go on the offensive' against critics blaming the food industry for obesity" (p. 245). I was unable to find the previous version of the WHO (2004b) 'Global Strategy on Diet,

Physical Activity and Health’ to make any comparisons. Nevertheless, the dialogue between the United States and the WHO supports the WHO key informant statements – recommendations in technical documents can be influenced through politicized debates over evidence and recommendations.

I asked the WHO informants how health concerns are escalated to understand how topics become important to the WHO and WHA and thus what documents are created. When asked if the WHO persuades Member States to escalate health concerns, the key informants identified that the surveillance data<sup>25</sup> WHO collects is something Member States rarely argue with. The WHO then can use this data to persuade Member States to act upon certain health issues, however, Member States can decline anything the WHO proposes and the conversation ends there.

Yes, but you do the best you can to manage it. The data is one thing where we’re pretty ok... We tend to [use the data], there’s no real hiding if you’re a country. I mean, the way it works there is we explain the data and then we go back to each Member State with the estimate and give them their comments. And we have had from time to time where countries come back and say no we don’t agree with that estimate and we have a dialogue with them. Rarely, I don’t think to my knowledge, we’ve ever had to comply with their wishes, but there’s been some interesting ones... I still think overall, we perform a needed function. It’s like anywhere, one has to make compromises, and we the secretariat (WHO staff) just try to do the best that we can (WHO key informant interview 5).

It’s a negotiation. Of course, it’s the case that sometimes [the data] needs to be brought to the Member State attention that something is an issue. So, it’s never like all one way... Our role is to produce guidance and advice and support so we can also generate that stuff and we do... It’s actually not always from here or always from here, it’s somewhere in the middle to work alongside each other. And you would expect that because our role has to be, you know, we’re looking at the data we’re looking at the issues and problems and we’re talking to the countries and we’re seeing that... Now we might be able to raise it as an issue but if the Member States then don’t support us working on it for whatever reason it might go away. It might not become a resolution, it might not become a global report, it won’t become a framework convention, but it doesn’t stop us from raising things as issues or anything... In reality of course it’s a two-way street (WHO key informant interview 2).

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<sup>25</sup> Surveillance data refers to the systematic collection of health-related data to inform health problems and public health actions (WHO, 2019h).

The escalation of health concerns is a negotiation between the WHO and Member States. When the WHO sees fit, it will raise concerns to the Member States and WHA with the support of surveillance data, however, the Member States and WHA declare what is a priority.

#### **7.4 Discussion**

The passages from the WHO key informant interviews highlight the complexities and difficulties of guideline and technical documents' production and use. Following an evidence informed decision-making model, which is the WHO's epistemology, positions the WHO to experience several tensions. First, while the guidelines use 'gold standard of evidence,' and are therefore considered to be free from political influence in their creation, what is ranked as 'best evidence' enables a systematic low ranking of SDOH and broader social science evidence due to limitations in validity and reliability. Second, this systematic ranking of social science evidence as inferior to medical evidence is seen in the technical documents as well, with technical documents limited in using social science research and the WHO informants confirming that this evidence is often not consulted for drafting documents. Third, political and financial support determines which guidelines are drafted, as the WHO informants highlighted that certain topics are more likely to get funding over others. Fourth, while technical document production may be faster and more flexible compared to the guideline process, the politics of Member States influences which documents are endorsed and the evidence included. These four tensions produce guideline documents that may be too narrow for translation to Member States, making them unusable; and technical documents that are influenced by political opinion despite the evidence informed decision-making epistemology of the WHO. These technical and guideline documents may also be less useful because of the omission of SDOH.

WHO key informants argue guidelines ‘have a lot of value’ because of the transparent process of reviewing evidence and writing recommendations. This process helps the WHO position itself as a neutral, legitimate, and trustworthy agency to produce guidelines and claim ownership over the ‘best’ guidelines. However, what is assumed as ‘best’ follows the medical model of robust data that is valid and reliable (Holman, Bernecker, & Garbayo, 2018; Mercuri & Baigrie, 2018; Mercuri & Gafni, 2018a, 2018b). The issue is research that is high in validity and reliability, such as RCTs and replicated RCTs, are not flexible enough to take into account the *context* evidence is applied to (Messac et al., 2013) – this is often when in-depth, qualitative social science and expert opinion is necessary.

For guideline documents, the WHO values consensus of what counts as ‘best evidence’ and the appearance of being neutral and institutionally assuring collective agreement *more* than it values understanding the SDOH of the individual context and health. This consensus to regulate practice has been called ‘regulatory objectivity’ – see Cambrosio, Keating, Schlich, and Weisz (2006, 2009). Regulatory objectivity in this case means the WHO seeks to be objective for the purpose of successful governance and regulation. In doing so, the WHO ignores the SDOH and does so because of the consensus that SDOH evidence is not the agreed upon ‘best evidence’ – medical evidence is. Perhaps a neoliberal, governmentality ideology favours regulatory objectivity; that is conventions that allow for regulation. In the WHO’s case guidelines are a technology to enforce regulation.

My concern is that prioritizing procedures that allow for consensus can come at the expense of improving health. For example, when you have a consensus that a high BMI number represents obesity, that number in practice may have little connection to the real determinants of

poor health, but it is the collective number that is agreed upon to represent obesity and narrows the view of how to address obesity.

For technical documents however, the consensus is not based on ‘best evidence’; rather, it is based on the opinion of the WHA and whether or not the document is needed and if it should be endorsed. The WHO key informants highlight that this process of technical documents going through the WHO is awkward because although the WHA requests them, the review process results in a political process that the respondents view as arbitrary.

As such, while technical documents may be presented as being more flexible and a better representation of the needs and capacity of the Member States, it is apparent that the *quality* of evidence is still regarded as an important site of discursive struggle. In the example discussed, the United States accused the WHO and FAO of *not* developing recommendations based on *sound science*. The United States also challenged whether certain foods and the advertisement of such foods lead to poor health outcomes (Steiger & Department of Health and Human Services, 2004). Thus, while technical documents are more *flexible*, with the evidence still assessed, reviewed, and debated, “good evidence” is still the discursive focus of the debate. However, what was shown from the WHO key informant interviews and reviewing the United States’ objection to the WHO and FAO’s evidence review, is that the opinions of what Member States think is ‘best evidence’ can stem from political motivation but is also *important* to whether the documents will receive ‘endorsement’ by the WHA. This endorsement by the WHA also creates documents with a lot of value (although less than guidelines) since these documents are approved by the Member States – making them publications that Member States support. This support has authority because it comes from those in power and making the decision to say *this is what the*

*WHO says we should do, Member States agree that this is what we should do, and these documents tell Member States how to do it.*

As all WHO key informants highlighted, the WHO works for the Member States, and thus their ‘bosses’ are the countries themselves, towards which the WHO staff act accordingly. While each WHO respondent highlighted the significance of reducing the conflict of interest of experts for all document production, I asked a WHO key informant their opinion about the potential conflict of interest because the Member States are the WHO’s source of revenue and reviewers of evidence. The WHO key informant highlighted that this relationship can be difficult, but the surveillance data gives the WHO the authoritative backing to hold its position on the evidence. That being said, Member States will openly reject and debate the ‘best evidence’ included in the documents, leaving one WHO informant to claim that this WHA endorsement process ‘dilutes,’ or weakens, the evidence used in the documents. Further, the United States example demonstrates the politics of the food industry and highlights how evidence can be excluded or weakened due to Member State contributions. While I cannot show specifics of whether evidence was excluded or weakened following the United States’ recommendations, the WHO key informant interviews have acknowledged reports ignore SDOH evidence relating to affordability of healthy food and physical activity. Despite the WHO key informants acknowledging this concern, and being experts in their own fields relating to NCDs, SDOH evidence still does not make its way into the endorsed technical documents.

Moreover, social science literature on confounding factors of poverty, stress, and other SDOH that influence behaviours and correlate with NCDs is absent in both guideline and technical documents. This absence is due to first, the lower ranking of social science evidence in guidelines because SDOH research is often qualitative or observational studies that are often

‘ungeneralizable’ and not replicable. SDOH was not identified as an advancement of science that would warrant a new guideline or revisions to previous guidelines if guidelines were to change the consideration of such evidence. Second, technical documents are expected to be ‘international,’ in that any country could pick up a technical document, translate it to its national context, and then implement. SDOH are deemed as incompatible with an “international” discursive frame due to the differences between countries in the configuration of social determinants. I agree with the second point, as each country is unique in capacity, resources, and infrastructure and the context of each country influences the relevance of the evidence (Upshur et al., 2001). However, if the WHO is the global leader of health, and it is unable to publish documents highlighting SDOH, then can we expect Member States to take on such topics if they are not ‘guided’ to? Even when Member States are guided by authoritative power of the WHO, such as with the FCTC/treaty power, Member States may ratify but not act on it, may sign it but not ratify it (such as the United States, a key tobacco lobbying country), and may neither sign nor ratify it (such as Indonesia, the second global leader in tobacco production<sup>26</sup>) (Framework Convention Alliance, 2017). How can we expect Member States to act on other issues, if they will not even do so when faced with a treaty?

Further, what are the consequences for internationalizing global health policy, when context and politics vary between countries? One consequence of the WHO limiting its review of social science literature, as explicated in Chapter 6, is that ‘modifiable behaviours’ are not understood in their broader context. This was also apparent with the WHO key informants in this chapter highlighting that NCDs are not a priority for guideline development because Member States ‘have NCDs figured out’ as an *individual responsibility* and thus guidelines for change are

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<sup>26</sup> Indonesia has the second largest (below China) tobacco industry in the world (Campaign for Tobacco-Free Kids, 2018).



Chapter 7: The political and institutional conditions of World Health Organization documents deemed as not required to direct future action. WHO key informants flag that this individual responsibility requires social science literature to understand these behaviours – and claim so knowing that SDOH is not discussed in WHO guideline or technical documents. Similarly, in Chapter 5, I outlined how the discussion of NCDs did not change over the timeline of review for this dissertation, despite advancement in social science and environmental research concerning the social determinants of weight gain and tobacco use (Evans-Polce, Castaldelli-Maia, Schomerus, & Evans-Lacko, 2015; Ferris & Crowther, 2011; Swinburn et al., 2011).

Finally, in the WHO documents reviewed for this dissertation, the WHO fails to reflect on its limitations in its document production process. The WHO does not identify the extent to which technical documents are reviewed by the Member States, nor does the WHO question its use of the GRADE method and discuss which evidence is excluded or why. By ignoring its publication process in its document, the WHO fails to acknowledge its own assumptions in how the documents are produced, and the potential consequences of such assumptions – such as recommendations being narrow and politically motivated. The assumptions about what can and cannot be subjected to question are indicators of the *savoir* (informal knowledge/discursive conditions) that is present, and the effects of the politics and institutions that inform what knowledge is included or excluded. This *savoir* is the basis of evidence-informed decision making and aligns with specific bodies of knowledge, specifically medical knowledge (*connaissance*). Also, by exploring the GRADE, GRC, and WHA, Foucault's genealogical method informs how I have situated the WHO's operations and its power relationships with the WHA and Member States in knowledge production and use.

## 7.5 Chapter conclusion

In this chapter I outline three issues that shape what the WHO can do, what its discourse can be, in creating guidance documents: relying on evidence-based medicine and political and financial support. Relying on evidence-based medicine that requires political and financial support for guideline and technical document production produces documents that exclude SDOH evidence. Further, WHA procedures results in ‘diluting’ scientific evidence to fulfill the international obligations of the documents. By exploring the WHO’s epistemology of evidence informed decision-making model, we can see the *savoir* of how the WHO’s document construction includes various layers of conditions of possibility. In summary, both types of documents, guidelines and technical, require specific kinds of political conditions.

Further, guidelines are a mechanism through which the WHO maintains its status as the global leader of health. The WHO positions itself as the authority because its guidelines are of ‘great value’ to the global community. By using the GRADE method, the WHO claims to be neutral, transparent, rational, and of valuing ‘high quality’ evidence. As such, the WHO relies on formal evidence to not just produce ‘gold standard guidelines,’ but to demonstrate that they are the ones capable of producing and managing formal knowledge.

For technical documents, the WHA endorsement adds a layer of complication. If these documents are meant to be as applicable to every country as possible, then evidence in documents gets ‘diluted,’ or weakened, both through disagreements based on politics and in terms of the likelihood that resulting recommendations will be implemented. WHO technical documents therefore include a wide range of recommendations from guidelines to ‘best practices’ that may have a lesser impact such as media campaigns (WHO key informant interview 2) to support variation in implementation capacity. However, what are the

## Chapter 7: The political and institutional conditions of World Health Organization documents

consequences of including ‘weaker best practices’ that Member States can implement, but which yield little impact? Is the assumption that ‘something is better than nothing’ geared to get the ball rolling to implement recommendations and changes that better address NCDs down the road?

The WHO key informant interviews did not touch on the implications of making and implementing weaker recommendations. These politics of evidence and political and financial support arguably puts the WHO in an ambiguous position as the leader in global health.

## **Chapter 8: Conclusions**

### **8.1 Introduction**

This project brings together interviews with WHO key informants in Geneva and a discourse analysis of WHO documents to assess what has constituted evidence for the WHO and the consequences of this for the shape and substance of WHO's role as an agent of governance and global health. While certain WHO documents are considered the gold standard of evidence-driven policy for combating global health threats, my analysis of those documents and interviews with WHO informants have shown that social science literature, including the SDOH and critical health research, does not count as evidence for use in the technical documents and guidelines.

In this concluding chapter, I summarize my answers to the two sets of research questions that guided this research and notable contributions to the literature concerning evidence-informed decision-making, healthy lifestyle discourse and how discourses are mobilized, and the use of biopolitical power at the global level. I also outline the limitations of this dissertation research and propose policy recommendations and future research on the topics of policy translation and document production.

### **8.2 Research questions**

This dissertation had two main research questions and five sub-questions to tease out some of the details of the main questions as they relate to the literature. First, research questions 1-1.4 queried how evidence and discourse are used and operationalized in the WHO documents.

RQ1. How does the World Health Organization use evidence and discourse to construct and respond to NCDs? To what extent does this evidence and discourse reflect a neoliberal regime, and what biopolitical techniques are mobilized?

RQ1.1. How are 'modifiable behaviours' targeted and positioned in the WHO documents

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RQ1.2. How is scientific knowledge about modifiable behaviours used to understand how individual behaviours contribute to health concerns?

RQ1.3. In what ways are human rights to health considered in the WHO documents addressing NCDs?

RQ1.4. How does the WHO position the ‘economic burden’ argument to address the problem of NCDs?

In summary, while answering these questions, I discovered that the WHO uses medical evidence to construct the problem of NCDs and positions modifying behaviours as the treatment and response to NCDs. A specific form of evidence that the WHO uses is the YLLs, or premature death statistics, to present NCDs as a simple problem of *people are dying* and modifying behaviours an obvious, logical solution *to an unnecessary problem* due to irresponsible behaviour. The measurement of premature death was used to demonstrate NCDs are an economic burden on society and the individual. Focusing on the economic burden suggests that the WHO is taking a position of neoliberal governmentality with an entrepreneurial view of individuals as valuable in their contributions to economic growth, and focusing on ‘modifiable behaviours’ as the cause of NCDs, responsabilizes individuals for the NCD problem. In the documents reviewed, the WHO does not include a human rights framework as a way to understand, and persuade the reader about, the NCD problem. The WHO relies on the affordable intervention of mass media campaigns to modify behaviours. Media campaigns do not challenge neoliberalism since they require little state intervention and are often preferred by Member States because of the limited state action (WHO key informant interviews). In addition, previous research identified that media campaigns are insufficient in modifying behaviours (Allen et al., 2015; Atusingwize et al., 2015; Boles et al., 2014; Silver, 2001). Reflecting on Weisz’s (2014) and Weisz and Vignola-Gagne’s (2015) work, I conclude that the WHO prioritizes interventions

that are presented as ‘cost-effective,’ but are instead affordable, noncontroversial, and ineffective.

At times, the WHO takes actions and uses discourses arguably in tension with neoliberalism, and its governance cannot be reduced as simply neoliberal. The FCTC is an example of the WHO employing a non-neoliberal agenda. Instead the WHO used its ‘hard power’ to challenge the tobacco industry and regulate Member State responses to tobacco use. However, I have not concluded that the WHO becomes less neoliberal over time because that does not appear to be the case. NCDs are consistently defined in WHO documents as a problem because of economic burdens and individual irresponsibility. Thus, this discussion is complex, with shifts occurring in the discourse based on the politics of evidence and of member states. I argue similarly to Chorev (2013) that the WHO has “survived the neoliberal turn in spite of internal contradictions”; meaning, the WHO has ‘survived’ as an entity with some capacity to address population health. In some cases, this is done with a neoliberal agenda such as obesity, while for tobacco, the WHO resisted neoliberalism when it was politically supported. Arguably, the WHO set up the tobacco issue as an economic burden of paramount concern and then strategically deployed the FCTC while resisting neoliberalism (p. 655).

Despite capitalizing on this opportunity to create the FCTC, the recommendations in the FCTC regarding tobacco use are neither new nor innovative. Still, the FCTC is a treaty and enables the WHO to enforce its soft power (recommendations) with its hard power (treaty) to persuade the Member States. In this case, we see an example of a biopolitical power that is not consistent with neoliberal governmentality; identifying that while neoliberalism may employ biopolitical power, biopolitics is arguably more of a challenge to exercise under liberalism and neoliberalism.

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The purpose of research questions 2-2.1 was to investigate whether WHO documents, written for a global audience, reflect and inform a process of internationalization/ standardization in health care policy.

RQ2. To what extent does the WHO's approach to NCDs reflect a process of the internationalization/standardization of health care policy?

RQ2.1. How does the WHO attempt to inform the internationalization/standardization process through global guidelines and technical documents?

The technical and guideline documents reviewed were one-size-fits-all and did not differentiate between countries. My investigation of research question 2.1 revealed that the WHO attempts to inform an internationalized/standardized process through the guideline and technical documents by perpetuating an evidence-informed decision-making epistemology at the global level of policy and knowledge translation. In doing so, this narrow epistemology systematically neglects the relevance of SDOH and social science literature to global health knowledge, policy, and translation, limiting the WHO's ability to respond to the *context in which individuals engage in behaviours linked to NCDs*. This narrow view and use of evidence is concerning because the WHO has both hard power with the ability to create treaties, and soft power by creating documents and providing 'technical support' (consultation to the Member States, most often in developing countries) to guide the health assemblies in health care reform (Gostin et al., 2015).

### 8.3 Contributions to the literature

This research contributes to the literature on international organizations' governance structure, global health, and health care by showing that the WHO's epistemology of evidence-informed decision making in effect positions evidence-based medicine as the *only* evidence that can inform decision making. This reinforcement thus excludes social science and SDOH evidence that could aid understanding of NCDs and 'modifiable behaviour'. This limitation in

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WHO's epistemology results in guidelines that are too narrow and technical documents that are too broad – questioning their usability and potential for translation to the Member State's context. Instead of advancing global knowledge of NCDs and 'modifiable behaviours' by including social science and SDOH literature in its documents, the WHO is limited to focusing on medical knowledge. Despite what WHO informants claim is possible, SDOH literature still does not end up in these documents.

The WHO's epistemology, inadvertently or not, supports the assumptions of the healthy lifestyle discourse. The healthy lifestyle discourse is presented in Chapters 5 and 6 as the formal medical knowledge of how poor lifestyle leads to poor health, whereby individuals are responsible for their health. This discourse presumes we only live for the management of our health, and health is to be valued over illness (Bell, 2013). These assumptions posit that behaviours are *modifiable* and that individuals have the freedom to make healthier choices. This *freedom of choice* assumption, that underlies the idea of 'modifiable behaviours', is both supported and denied by the WHO. The WHO denies the existence and relevance of freedom of choice when discussing tobacco use and exposure to second hand smoke. Simultaneously the WHO supports the idea of freedom of choice by promoting interventions such as media campaigns to change the norms of health behaviours, so individuals choose to make healthier choices. There is also an assumption that individuals *want* to mediate their risk, and thus changing behaviour is possible if individuals were only properly informed (Boles et al., 2014). This tension is present in the WHO documents as the WHO chooses to assume that, with access to 'best evidence' available, individuals will make healthier choices on their own accord (having the freedom to choose). In comparison, the WHO is also responsible for regularizing behaviours to compel these healthier choices.



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Further, the social science literature has critiqued the use of BMI as a measurement for health, similar to my critique of the YLLs and premature death statistics as a measurement for the value of life. Scholars argue that measurement of BMI allows for the population to be reduced to individual subjects to be surveilled and trained (Evans & Colls, 2009), while simultaneously ‘massifying’ power over the individual to manage the population (Legg, 2005). Foucault argued that individualizing and ‘massifying’ are “two techniques of governance” that “are not mutually exclusive” (Evans & Colls, 2009, p. 1055). Using BMI as a tool enables governance and allows for a biopolitical understanding, by quantifying the body, recording/surveilling the body, positioning the body in a category (such as normal or obese), and targeting the categorized body for interventions to regulate abnormal bodies. Also, this BMI measurement is positioned in ‘scientific’ knowledge such that to be overweight means to be less healthy, which becomes embedded into a ‘common sense’ of or “social and cultural understandings” to be obese bodies (Evans & Colls, 2009, p. 1060). While the WHO does not explicitly acknowledge its purpose in how it uses BMI, by using it to measure and map the obesity epidemic, I argue that the WHO does mobilize BMI as a measurement to gain knowledge about the NCD burden to then manage the population.

This study contributes to the methodological literature by employing a Foucauldian analysis of discourse to decipher how the WHO’s epistemology informs its document creation and perpetuates discourses that are ineffective in both advancing public health and modifying behaviours. A qualitative content analysis does not necessarily direct a researcher’s attention to matters of *connaissance* and *savoir* as does a Foucauldian analysis. This Foucauldian analysis enabled me to examine the discursive political and economic conditions of their possibility, by mapping the trajectory of discourse over the time period of the WHO documents reviewed, often

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nonlinear, that supports the construction of these discourses that inform our truths. Further, the discursive mapping that informed the coding and outlined the trajectory of the discourses enabled an analysis of the tensions the WHO experiences.

By using Foucault's work on governmentality and biopolitics, I explored how the WHO's governance structure attempts to extend the life of the population. The case of NCDs and their association with 'modifiable behaviours' makes deaths from NCDs into 'premature deaths,' which is 'bad deaths' or 'wasteful deaths.' The WHO exercises biopolitical power to make life "healthier and purer" (Foucault, 2003, p. 255) by quantifying the value of individuals through death rates and proposing interventions to regulate the population and secure and extend life. This purpose of trying to extend life, purify life, and reach equilibrium for the population (Foucault, 2003) also denies that individuals may not want to live only for health.

Foucault argued that the logic of racism under biopolitical power is that the 'death of the bad other' makes life 'healthier and purer.' When the WHO emphasizes the economic burdens of lost productivity (individual and society) and increased costs of health care (individual and society), it argues that the extension of life is the priority. By using YLLs rather than DALYs, the WHO arguably recognizes and avoids this form of racism. YLLs assume the need to extend life for the entire population instead of narrowing to the focus to those living with disability. Thus, in some ways, the WHO broadens its definition of 'population' from those living with a disability (DALY) to those who die prematurely (YLL, which can include those living with a disability and those who do not). In doing so, the WHO in a way is protecting those living with a disability from experiencing the racism that comes with biopolitical power. Despite this, the WHO's use of the YLLs as a measurement for productivity enables a discourse of an enabled

body as a ‘good body;’ a body that is self-regulating and disciplined. From this view, the WHO’s use of the YLLs can be interpreted as being marginalizing and discriminatory.

### **8.4 Limitations and future research**

There are several limitations to this study. First, due to the purposeful sampling procedures, I may have missed information and documents that others would consider relevant to the discursive strategies of the WHO. However, using the discourse mapping and because of the information from the key informant interviews, there is high confidence that the documents reviewed include all guidelines and recommendations to address NCDs as a global health problem.

Second, my key informant interviews revealed that technical documents are the operational documents for WHO regional officers. Therefore, WHO regional officers work directly with governments to draft new policies and practices by adapting and contextualizing the global guidelines and technical documents. This dissertation did not explore in-depth the decision-making process that goes into making these WHO guideline and technical documents, for instance, to comment on how different versions changed following working group meetings, Member State recommendations (such as by posting drafts online for feedback), and WHAs. And without talking to regional officers, I am unable to make claims concerning the impact guideline and technical documents have on national health care reform. More research is needed to investigate the ‘on the ground procedures’ of how these documents are used by WHO officers when working with Member States, specifically with developing countries, which is missing in the global health literature. By exploring the operations of the WHO regional offices, future research can further explore governance operations and instruments of the WHO and the implications for the position of social science research in the global health context.

Finally, my dissertation did not include a comprehensive review of the WHO's use of DALYs. Future research exploring the WHO's preference for YLLs to define a population rather than DALYs can answer my hypothesis that the WHO prefers YLLs to prevent a binary of opposing bodies (disabled versus one that is not). Further analysis and interviews can explore the WHO's intent for preferring the YLLs and the impact this has had on global health measurement and interpretation since the GBDS still reports the DALYs.

### **8.5 Implications for policy and practice**

All institutions and governments have an institutional memory that makes up their internal 'ways of working' that can be deemed as common procedures for that institution. It is possible that there is documentation of institutional practices concerning the creation of the WHO documents reviewed that I have missed. However, final versions of the WHO technical documents I reviewed did not include descriptions of the decision making that informed the documents. One policy recommendation for the WHO is to be more transparent when creating each guideline and technical document. This transparency could include either a foreword or appendix of details on the decision-making process behind each document. For example, public access to documentation of reviews and feedback provided by Member States would inform readers who are translating documents to their national or local context of the political limitations of the documents. Although guidelines are less influenced by these politics than technical documents, the WHO neither questions nor provides a summary of the limitations of guidelines created using GRADE.

For technical documents, the WHO needs to be able to have such documentation better reflect the professional knowledge of technical officers and experts in the field by reducing the political influence by the Member States/WHA. While I am critical of the procedures creating

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the WHO guidelines and technical documents, WHO's capacity is limited when Member States elect to exercise their political power to revise documents as it serves their trade and lobbying efforts – sometimes meaning the WHO or WHO officials may disagree with aspects of the documents they have created. The consequences of this conflict between the WHO and Member States is a 'dilution' or weakening of evidence and thus changes the recommendations. Even though I argue that the ranking of evidence is problematic, it is better than the political and international agreements informing WHO documents.

Further, changes can be made to the procedures that exclude social science evidence in the creation of recommendations for the Member States as suggested in this dissertation. Since the technical documents are neither progressive nor innovative for addressing NCDs and modifying behaviours, perhaps the WHO needs to spend more time creating documents that are unique to specific regions. The WHO could then spend the time required to incorporate social science and SDOH evidence to support the Member States in making a more comprehensive change in public health, rather than repeating recommendations (such as media campaigns) that are ineffective. For both types of documents, more transparency and information concerning the creation and expected use of these documents is recommended.

Finally, the WHO is an important global partner that monitors and provides technical support to address global health problems. Without the WHO, we would lack guidance, collaboration, and coordination for Member States to come together to address health concerns that affect populations as we move towards a global economy in our current, globalized world. That this guidance is required was clear on March 11<sup>th</sup>, 2020, as the WHO declared the novel coronavirus (COVID-19) a pandemic due to its spread around the world within three months (WHO, 2020d). By April 30<sup>th</sup>, 2020 (the time of the submission of this dissertation) over 2.5

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million people were infected with COVID-19 and over 175,000 deaths were reported from 210 countries (WHO, 2020b).

The WHO requested global solidarity in the fight against COVID-19, which requires individuals to ‘band together’ and ‘do the right thing’ by social distancing (by staying at home and remaining six feet apart while in public) and closing business that are not essential (such as shops and restaurants) (WHO, 2020c). The WHO has been criticized for its response to COVID-19 as in some places the general public (United States protest COVID-19 lockdown - National Post, 2020b, Alberta planning to protest to restart the economy - Short, 2020) and world leaders (such as Brazil - CTV News, 2020; and the United States - Global News, 2020) chose not to follow the WHO’s recommendations to prevent the spread of COVID-19, depicting the recommendations as a violation of their rights and freedoms and too great a blow to the economy (National Post, 2020b). Canada, among others, is taking legal action in the form of fines against citizens for failing to close businesses (or implement social distancing if remaining open) or failing to follow medical mandates to stay at home and self-isolate if diagnosed with COVID-19, awaiting diagnosis, or returning home from travelling abroad (National Post, 2020a). Enforcement in the present situation includes legal action and is not just of social norms to ‘stay home’ and ‘social distance.’

It may be the WHO’s way of understanding evidence may hamper its ability to respond to COVID-19 as it is not strongly positioned to organize a response to the SDOH that will be apparent in the distribution of costs and suffering from COVID-19. As the WHO publishes documents to guide the response to and coordination of COVID-19 without going through WHA review, due to the need of rapid response from the institution, perhaps the nature of the evidence WHO mobilizes will change. Perhaps the lack of WHA review will improve the WHO’s ability

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to create effective policies and guideline, or, perhaps it will diminish the likelihood that Member States will communicate and collaborate about their COVID-19 responses.

To remain the global partner that we need, the WHO must continue to coordinate the medical response to COVID-19 and begin to tackle the SDOH. The response to COVID-19 will make abundantly clear the limitations of policies and practices for global health that are rooted in a neoliberal framework. The WHO must be transparent in its decision making for how it responded to COVID-19 should more criticism mount in the months to come.

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## Appendix A: Semi-structured interview guide

The semi-structure interviewed guide supported a conversation with WHO key informants, and thus, was not followed exactly. This conversation varied per interview as I gained more knowledge about the WHO and the WHO technical officers (the informants) roles and tasks.

### Interview guide

The goal of this research is to understand how the WHO addresses international health concerns through the means of publishing documents with policy recommendations, how the WHO manages its relationships with Member States regarding these policy recommendations, and how the WHO encourages national health care reform. Your views would be invaluable to the success of this project.

While you may have prepared answers when you were provided with the interview guide, much of the interview will be handled as a conversation, which moves back and forth between topics. Prompts will be used to elicit examples and stories (such as: “can you give an example?” “How did that happen?”) about the process of creating WHO documents and recommendations in the WHO programs you have been involved in.

Participants should answer questions based on their personal role and experiences with the WHO programs and documents mentioned in this interview guide.

#### *Background: Role and circumstances*

The respondent is asked to describe their job at the WHO:

- Can you tell me about your position and the setting of your work and the WHO programs in which you have been involved?
- Can you tell me about your role in the creation of documents and policy recommendations for the programs mentioned?
- How long have you worked at the WHO?

#### *Noncommunicable disease documents:*

The respondent will be asked specific questions about the documents published on noncommunicable diseases, which includes single document publications on cancer for example, or grouped document publications on the topic of noncommunicable diseases, as relevant to each respondent’s professional role and experience:

- In your opinion, what are your views on global public health?
  - What does global public health look like to you?
  - What are the goals of global public health?
- In your opinion, can you tell me the significance of noncommunicable diseases for managing global public health?
  - In your opinion, which policies and procedures are most important for noncommunicable diseases for global public health?
  -

## Appendix A: Semi-structured interview guide

- In the recent publications about noncommunicable diseases, such as “the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020,” the
- modifiable behaviours of tobacco use, alcohol consumption, diet, and physical activity have been grouped together into one document.
  - In your opinion, what is the benefit of having all of these different behaviours grouped into one document?
  - In your opinion, what are the disadvantages of having all of these different behaviours grouped into one document?
- Concerning the management of global public health and noncommunicable diseases, in your opinion what is the benefit of going from cancer programs, such as the 2006 “Cancer control – knowledge into action” “ to “the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020” that includes cancer prevention within one program?
  - In your opinion, what are the disadvantages to having cancer prevention go from a single strategy to a noncommunicable disease program?

### *Tobacco documents and Framework Convention on Tobacco Control*

The respondent will be asked specific questions about the documents published on tobacco and the FCTC:

- In your opinion, what is the importance of tobacco control for global public health?
- Can you tell me the reasoning for the need of a treaty addressing tobacco specifically?
- In your opinion, can you tell me why tobacco was the concern selected for the first treaty created by the WHO?
- In your opinion, what is the WHO’s most effective strategy for encouraging the FCTC strategies and procedures?
  - In your opinion, how could the WHO enhance its efforts to monitor how Member States incorporate the FCTC strategies and procedures?
- In your opinion, has the noncommunicable disease adoption of tobacco control policies and recommendations encouraged Member States to incorporate FCTC strategies and procedures?
  - Has the noncommunicable disease adoption of tobacco control policies and recommendations discouraged Member States from incorporating FCTC strategies and procedures?

### *Diet, physical activity, and obesity documents:*

The respondent will be asked specific questions about the documents published on diet, physical activity, and obesity:

- In your opinion, should there be a treaty similar to the FCTC for obesity?
  - What aspects should be similar to the FCTC?
  - What aspects should be different from the FCTC?
- Obesity knowledge:
  - In your opinion, are certain facts about obesity considered more important? Such as scientific research, the body mass index, or family income?
  - In your opinion, are certain facts about obesity considered least important? Such as chronic conditions preventing physical activity?

## Appendix A: Semi-structured interview guide

- In your opinion, how does the WHO consider social determinants of obesity, such as environment and poverty?
- In your opinion, should the Global South have different policies and procedures to address obesity compared to the Global North?
  - What policies and procedures should be different for the Global South compared to the Global North?

### *Member State expectations:*

The respondent will be asked to discuss the expectations of Member States about recommendations in WHO documents:

- From your experience, what is the relationship between the WHO and Member States?
- From your experience, how does the WHO work with Member States concerning health care reform?
- From your experience, do Member States adopt the recommendations from the WHO documents?
- Can you tell me how the WHO tracks if Member States are following the recommendations from the WHO documents?
- In your opinion, what can the WHO do more for encouraging Member States to take on the recommendations from the WHO documents?

Thank you for your participation.

You can decline to participate at any time. You can decline to answer any of the questions. You can withdraw from the study within three months of the original interview. Should you wish to clarify or amend any of your statements from the original interview, you have three months from the time of the original interview to request a follow-up interview.