



## Obesity prevention: co-framing for intersectoral 'buy-in'

Akram Khayatzadeh-Mahani, Arne Ruckert & Ronald Labonté

To cite this article: Akram Khayatzadeh-Mahani, Arne Ruckert & Ronald Labonté (2018) Obesity prevention: co-framing for intersectoral 'buy-in', *Critical Public Health*, 28:1, 4-11, DOI: [10.1080/09581596.2017.1282604](https://doi.org/10.1080/09581596.2017.1282604)

To link to this article: <https://doi.org/10.1080/09581596.2017.1282604>



Published online: 25 Jan 2017.



Submit your article to this journal [↗](#)



Article views: 400



View related articles [↗](#)



View Crossmark data [↗](#)



Citing articles: 3 View citing articles [↗](#)

COMMENTARY



## Obesity prevention: co-framing for intersectoral ‘buy-in’

Akram Khayat-zadeh-Mahani<sup>a,b,c</sup>, Arne Ruckert<sup>c</sup> and Ronald Labonté<sup>c,d,e</sup>

<sup>a</sup>School of Public Policy, University of Calgary, Calgary, Canada; <sup>b</sup>Health Services Management Research Center, Institute for Futures Studies in Health, Kerman University of Medical Sciences, Kerman, Iran; <sup>c</sup>School of Epidemiology, Public Health and Preventive Medicine, University of Ottawa, Ottawa, Canada; <sup>d</sup>Canada Research Chair, Globalization and Health Equity Research Unit, University of Ottawa, Ottawa, Canada; <sup>e</sup>Faculty of Health Sciences, Flinders University of South Australia, Adelaide, Australia

### ABSTRACT

The multi-factorial causes of obesity demand integrated prevention policies with the collaboration of diverse sectors, although to date, there is little evidence of engagement by non-health sectors in developing obesity prevention policies. In this commentary, we develop a three-step argument for improving intersectoral collaboration. We first note that to encourage non-health sectors in developing and implementing integrated preventive policies, obesity should be reframed as a systemic problem rather than its dominant framing as a matter of individual behavioural change. We then propose a co-framing of obesity, such that it aligns with the policy goals of diverse non-health sectors. Finally, drawing on the network governance literature, we argue that a network-based governance approach with an independent network administrative organization will best facilitate multisectoral collaboration through a successful co-framing strategy.

### ARTICLE HISTORY

Received 3 August 2016  
Accepted 29 December 2016

### KEYWORDS

Obesity; reframing; co-framing; Health in All Policies (HiAP); network governance

## Introduction

The obesity epidemic has been growing steadily over the last three decades in all countries and amongst all segments of society (Gortmaker et al., 2011). Cultural, environmental, genetic and behavioural factors, all contribute to the development of obesity (Huang et al., 2015); most of these lie outside the direct mandate of the health sector. Obesity prevention, therefore, requires a multifaceted integrated approach, often referred to as Whole-of-Government or Health in All Policies (HiAP) approach (Kickbusch & Gleicher, 2012). In this commentary, we draw on the literature about problem framing to assert that a key barrier to integrated action is how obesity continues to be framed predominantly as an individual problem. We first argue that obesity needs to be reframed from an individual to a systemic (or social/commercial determinants of) health problem, highlighting the role of non-health (including corporate food and beverage) sectors in contributing to the obesity pandemic. We then argue that in reframing obesity, it should be ‘co-framed’ to take account of the policy goals, interests and mandates of those non-health sectors not actually implicated in contributing to the obesity pandemic. Co-framing can address a key barrier to obesity prevention, that the problem is often considered to be the primary, if not sole, responsibility of the health sector (Newman, Ludford, Williams, & Herriot, 2014). Finally, drawing on the network governance literature, we suggest that a specific network governance arrangement, the network administrative organization (NAO) model, will best facilitate co-framing and approaching obesity through a HiAP lens.

## HiAP: an integrative approach to obesity prevention

Recent years have seen a fast growing recognition of, and emphasis on, intersectoral collaboration for health at the global level. The UN Political Declaration on Non-Communicable Diseases, the WHO Commission on Ending Childhood Obesity, the UN Sustainable Development Goals, the WHO Global Action Plan on Antimicrobial Resistance and the WHO Commission on Social Determinants of Health (CSDH), to name but a few, are among high level global agendas/commitments that have directly called for such collaboration, most prominently a HiAP approach, to address persisting health and social problems. HiAP is an approach/strategy to operationalize intersectoral collaboration for health. It includes a set of institutional arrangements managed mainly outside the health sector to ensure the positive or neutral impact of other sectors' policies on population health. It is arguably one of the best strategies to coordinate government actions to tackle complex health problems (Leppo, Ollila, Pena, Wismar, & Cook, 2013).

Obesity has been widely referred to as a complex 'wicked' health problem due to the multiple factors that contribute to it (e.g. Australian Public Service Commission, 2012). The obesity map developed by the UK Foresight Institute (Butland et al., 2007) clearly demonstrates such complexity (de Leeuw & Peters, 2015), with frequent calls that obesity prevention should follow an integrated approach like HiAP (e.g. Newman et al., 2014). To date, however, the evidence of tackling obesity using HiAP is limited (Newman et al., 2014). We argue in the next section that one reason for this could be that obesity is predominantly being framed as an individual, rather than a systemic social, problem (Dorfman & Wallack, 2007; Kersh, 2015; Kersh, Stroup, & Taylor, 2011; Klein & Dietz, 2010).

## Systemic framing of obesity: a sine qua non for HiAP

The importance of how a health issue is framed, and how such framing shapes policy interventions (its performative power) is becoming more widely recognized in the public health literature (Aronowitz, 2008). Framing an issue, or how people mentally organize and discuss the central ideas surrounding it, has a strong impact on how the issue is understood, who is responsible for it, and what should be done to address it (Lawrence, 2004). The literature on the social construction of policy problems posits that the way an issue is framed and constructed informs subsequent policy solutions (Gusfield, 1981; Stone, 1989). In the same vein, theories of agenda setting (e.g. Baumgartner & Jones, 2010; Kingdon, 1984) emphasize how an issue is defined and framed as a public problem and its implications for future policy outcomes. Gusfield (1981) argues that frames generally refer to causal links, termed as 'causal stories' by Stone (1989), ownership, responsibility, and policy solutions. Stone (1989) notes that competition to control causal stories does not end when an issue reaches the political agenda but extends to the selection and formulation of policy options/solutions. Attributing causation and assigning responsibility influence how governments, media and the public respond to the issue (Patchett, Yeatman, & Johnson, 2014). Hall (1993) shows how neoliberal financial policy solutions emerged following the shift in ideas about the causes of, and solutions to, the economic crises. He believes policy-makers normally work within a set of ideas that determines not only the policy goals and solutions but also the nature of problems that they try to address (Hall, 1993). Central to all, these discourses around framing is the deliberate use of language and symbols in the policy process, especially in how an issue gets in or off the political agenda (Edelman, 1977, 1985; Elder & Cobb, 1983; Stone, 1989).

In the case of obesity, framing is central to what type of policies or interventions are developed to tackle it (Lawrence, 2004). For example, an obesity prevention policy that used increased health insurance costs to incentivize behaviour change differs fundamentally from a policy to reduce population weights through subsidizing fresh fruits and vegetables among low-income communities (Bergeron, Castel, & Saguy, 2014). The literature on obesity suggests a vigorous frame competition between individual responsibility for health, on the one hand, and social and environmental causes, including corporate influence on food policy, on the other (Jenkin, Signal, & Thomson, 2011; Kim & Anne Willis, 2007; Lawrence, 2004). *Individualized framing* generally results in policies that favour personal behavioural

changes that address the proximal causes of obesity. This framing, critics argue, offers cover to food and beverage industries that seek to downplay their own responsibility in terms of production and marketing of obesogenic products (Robbins & Nestle, 2011). *Systemic framing* locates the root, or more distal, causes of obesity in an expanding obesogenic environment, with a resulting emphasis on government, industry and civil society responsibilities for action to transform this environment (Lawrence, 2004; Patchett et al., 2014). Despite the work of the CSDH and increased public health reference to social determinants of health, individualized framing still predominates in much of the health literature (Jenkin et al., 2011; Kim & Anne Willis, 2007). An abundant literature on public health (e.g. Baum et al., 2013; Hilton, Patterson, & Teyhan, 2012; Roberto & Kawachi, 2015; Tesh, 1988) reveals how individual framing of alcohol, tobacco and junk food consumption has led to adoption of policies that disregard the underlying structural and social determinants. Some suggest this is linked to the influence of the food and other relevant industries over obesity framing (Klein & Dietz, 2010; Williams & Nestle, 2015). Although not ignored, especially within the critical public health community, much less attention is given to more systemic political, cultural and socio-economic determinants of obesity, for example, the expansion of multinational food and beverage industries in the context of the globalization of food production and consumption (Baum & Fisher, 2014; Williams & Nestle, 2015). Some locate the root cause of the current situation in the dominant neoliberal paradigm that is sweeping the world (Baum & Fisher, 2014; Glasgow, 2012; Labonté, 2016; Labonté & Stuckler, 2016). Glasgow (2012) argues that a neoliberal political rationality is pervasive through 'constructing the healthy, active participant whose primary aim is to return to an economically productive life'. Framing obesity from a neoliberal stance leads to 'solutions to burden individuals' (Atanasova & Koteyko, 2016). This neoliberal extension of market values to all aspects of life in order to change personal behaviour rests on the assumptions that individuals can simply be educated to make better choices (e.g. Atanasova & Koteyko, 2016).

We argue for developing a systemic understanding of obesity at a higher policy level to (re)shape the environment within which obesity is created (Newman et al., 2014). To prevent governments from succumbing to what has been termed 'lifestyle drift' wherein they shift from approaching obesity as a social problem to an individual one, obesity should be consistently framed as a whole of society concern (Carey, Malbon, Crammond, Pescud, & Baker, 2016). Somewhat paradoxically, we further contend that the two competing frames (individual and system) could and should be merged to acknowledge the reciprocal relationship between individual behavioural choices and the social environment which conditions and constrains such choices (Roberto et al., 2015). That is, the (market) environment not only shapes the demand and preference for unhealthy products (choice), such choices also incentivize environmental changes (markets) that encourage more consumption of unhealthy products.

Nathanson (1999) introduces four key methods of framing public health risks that are relevant to any obesity reframing effort. Risks can be conceived as (1) acquired deliberately or involuntarily, (2) created knowingly or unintentionally, (3) universal or particular, and (4) arising from within the individual or from the environment. Framing health issues as involuntary, environmental, universal, and knowingly created risks represents a systemic framing (Lawrence, 2004). Such a framing for complex public health problems is not new. It is most evident in the long history of tobacco control programs which saw a shift in the 1980s from a singular behavioural change approach to one that emphasized the use of policy levers such as taxation (cost disincentives), availability (for purchase and consumption), and product advertising and labelling restrictions. More recently, Shiffman and colleagues (2015) note that when HIV/AIDS was framed as a problem affecting only certain people it had difficulty attracting resources, but this changed when the problem was reframed more universally as an exceptional disease posing systemic and almost existential threat to humanity. Although there is some evidence of a similar shift regarding obesity (e.g. the introduction of sugar taxes on carbonated beverages), there is not yet the same framing consensus around obesogenic products as exists for tobacco or HIV prevention and treatment programmes. Rather, as Klein and Dietz (2010) argue, the persisting pejorative connotation of the term, obesity, has led to 'its application only to the severely or morbidly obese' (the 'particular' end of the universal/particular framing), reducing its perception as an immediate and more systemic public health risk.

Although Nathanson's four public health risk frames are stated as binary opposites, they are best regarded as ideal types with movement between them, since it is unlikely that an obesity health risk is never (or at best rarely) *only* involuntarily or deliberately chosen, knowingly or intentionally created, and universal or particular in effect. Fully excluding individual behaviour from systemic framing of obesity removes human agency (with disempowering implications) just as individual framing that ignores systemic influences obscures corporate culpability. In developing a problem framing that instantiates both, with the concomitant intent of increasing the likelihood of intersectoral 'buy-in' in prevention planning, the critical public health task becomes one of nuancing which of the two competing frames receives the greater emphasis.

Thus, public health advocates and policy entrepreneurs when reframing obesity in systemic terms should also acknowledge some individualized features, i.e. obesity is a risk that originates in the environment, that individuals do not necessarily assume voluntarily, that affects everyone albeit disproportionately some individuals or groups and that is knowingly created by others. By emphasizing systemic forces, the agency of people to make choices is tempered, but not negated. This framing, we believe, could better foster a consensus around both the urgency of the problem, and the integrated preventive actions required to mitigate it. Yet, this might not be enough to encourage participation of a wide range of non-health sectoral actors. This is why we propose the idea of co-framing, as a relatively new concept in intersectoral collaboration in general and HiAP actions in particular.

### **Co-framing: a solution to encourage collaboration of non-health sectors?**

Co-framing obesity (in systemic terms) with other issues of importance to non-health sectors (e.g. agriculture, transportation, education, finance, urban planning) could encourage these sectors to participate in developing and implementing integrated obesity prevention policies. One way to do co-framing is to translate research evidence on obesity into practical and politically feasible policy actions for non-health sectors (Newman et al., 2014). Policy actions/recommendations should be aligned with the policy goals and interests of diverse non-health sectors (apart from those responsible for the continued production and marketing of obesogenic products), clearly articulating how these sectors can benefit from obesity-related policy and programme interventions. Working directly with diverse sectors, looking for areas of alignment and tailoring policy recommendations to their goals can also enhance cross-cultural understanding and mutual respect leading to further commitment of non-health sectors to sustained policy implementation (Newman et al., 2014). The key to success here, we believe, is the ongoing interactions and negotiations among diverse sectors/actors using scientific evidence, referred to by Jenkins-Smith (1988) as 'strategic interactions' or 'analytical debates'. This co-framing process, we argue, will lead to collective learning (Heikkila & Gerlak, 2013), also known as policy learning (Jenkins-Smith, 1988; Sabatier & Jenkins-Smith, 1993) and diffusion of ideas (Berry & Berry, 2014; Chapter 9), both considered as key explanations of policy change (Weible & Carter, 2015). Belief systems (including values and causal links) are subject to revision on the basis of feedback, experimentation and evidence (Brewer, 1973) during strategic interactions/analytical debates. Change in value systems and causal assumptions would change actors' understanding of, and policy prescription for, the policy issue (Jenkins-Smith, 1988), here obesity, and ultimately policy solutions. The important role of policy entrepreneurs (Kingdon, 1984; Mintrom & Norman, 2009) in the process of co-framing should not be underestimated. They are thought to play a crucial role in fostering policy learning in networks (e.g. HiAP networks) through mediating between members/actors, raising awareness of the network goals and developing interactions and dialogues among diverse members/actors (Borzel, 1998; Sabatier & Weible, 2014). This raises the question of how co-framing might best be achieved.

In a consultancy project undertaken by one of the authors over a decade ago, the normative goals and core mandates of most of government departments were found to align with those of public health initiatives to reduce health inequities. The wording of these goals and mandates varied slightly, but there was far more similarity than difference – a co-framing that became a starting point for strengthening HiAP efforts. But, there are also more recent experiences of successful co-framing between various

health and non-health sectors directly related to obesity. The South Australia (SA) HiAP Healthy Weight Project (Newman et al., 2014) provides such an example. It co-framed obesity goals, such as achieving a healthy weight with core policy goals of the SA housing department through constant interactions and use of evidence. The project proposed an environmentally sustainable infrastructure design for home food production and neighbourhood gardening which would simultaneously address key goals of both sectors. In terms of health goals, community gardening enables access to locally grown, affordable and healthy food, while the physical activity associated with community gardening provides opportunity for healthy exercise. Community gardening also contributes to enhancing social cohesion and reducing vandalism and crime, core goals of the SA housing department which can be fostered through neighbourly support and contact among the population involved in community gardening. Similarly, Conk and Porter (2016) documented the role of neighbourhood gardening and sharing homemade products in increasing social capital, with positive implications for both health and social cohesion.

Assuming public health's capacities to identify multiple other co-framing opportunities (e.g. increased infrastructure supporting safe bicycle commuting to reduce fossil fuel use – an environmental sector goal – while improving 'active living' to increase physical activity), the question arises as how to operationalize co-framing, in particular under what form of governance it can best be achieved? In what follows, drawing on the network governance literature and empirical evidence from a case study of HiAP in Iran, we propose a form of governance that may be effective in promoting a co-framing of obesity.

### **Which governance mode could facilitate a co-framing of obesity?**

Governance of HiAP networks has been the subject of limited research to date (Kickbusch & Gleicher, 2012). In a recent study, we drew on network governance theory to investigate which governance mode best fits HiAP networks (authors, under review). The three most commonly cited network governance modes include: (1) *Shared governance* where all member organizations interact with each other. This governance mode results in a highly decentralized network in which decisions are made by all members collectively and power is symmetrical irrespective of member organizations' differences in terms of size, performance and resource capabilities. (2) *Lead organization governance* where the network is governed mainly by a single organization that acts as a highly centralized network broker or lead organization. (3) *Network administrative organization (NAO) governance* where a separate legal administrative entity is formed for the sole purpose of network governance and administration (Provan & Kenis, 2008).

Returning to the obesity case, a shared governance mode to govern the HiAP obesity network is not suitable given the complex causation of the problem which leads to high heterogeneity of institutions, backgrounds, ideas, and interests and where members may be unwilling to allocate a great deal of time to coordinate across a large number of diverse organizations. The lead organization governance mode, in which the health sector would lead the HiAP obesity network, would be less effective compared to an NAO mode for a number of reasons, including the feeling of health imperialism and resentment towards the health sector among non-health members (Breton, 2016; Collins & Hayes, 2007). Such resentment is thought to reinforce ideological resistance to collaboration among diverse sectors, especially from the powerful finance sectors (Collins & Hayes, 2007). Further, the health sector is frequently argued to have low capacity in the areas of intersectoral coalition or partnership building (Breton, 2016; Lin & Carter, 2013), as well as in negotiation, diplomacy and policy coordination (Newman et al., 2014). To better govern a HiAP obesity network and to facilitate an effective co-framing strategy, we believe, an NAO governance mode, which is a centralized network governance form, established exclusively for the purpose of network coordination, would best serve that purpose. Here, the network broker or the NAO, which is established either through mandate or by the network members themselves, coordinates and sustains the network. The NAO may be a nonprofit or a government entity. In terms of scale, it may have only one single individual (i.e. network broker or facilitator) or a formal organization including an executive director, staff and a board (Provan, Isett, & Milward, 2004; Provan & Kenis, 2008). Given the diversity of actors/sectors involved in the obesity HiAP network, we believe, the latter form, or a more formalized NAO, works better as it has a board structure that includes all or a subset of network

members and is argued to enhance network legitimacy and to reduce the complexity of shared governance (Provan et al., 2004). Further, a successful NAO requires trust development amongst network members (Provan & Kenis, 2008). Given the crucial role of policy entrepreneurs in network effectiveness, including trust-building, we suggest that the NAO should be a platform for systematically training and institutionalizing policy entrepreneurs. We do caution, however, that the results of our single case study may not be transferable to others contexts; rather we encourage other obesity HiAP initiatives to consider more deliberately and explicitly what network governance models might work best within their particular context.

To better govern the obesity HiAP network, one important aspect to consider, which we believe will engender a successful co-framing strategy and subsequent policy change (towards integrated preventive obesity policies), is to capitalize on new resources (Weible et al., 2011), most importantly social movements (McAdam, McCarthy, & Zald, 1996; Williams, 1995). Social movements can help link certain aspects of obesity to shared cultural symbols, values and beliefs (Entman, 1993) and help to accelerate collective actions that reframe or co-frame endeavours. Such a collective environment helps all actors/sectors involved in the network to transform through reflection, dialogue, critique and relationship-building (Ryan & Gamson, 2006), or as we discussed above, collective policy learning.

## Conclusion

It is clear that the obesity epidemic requires new approaches to tackling its root causes, as obesity rates continue to rise in both the developed and the developing world. At the heart of such a rethinking process is the need to reframe obesity as a systemic, and not primarily individual, problem which requires intersectoral collaboration. Co-framing of policy goals, best achieved through a dedicated obesity governance network with an independent lead organization (NAO), can encourage non-health sectors to become involved in obesity prevention, while also ensuring more effective outcomes. In an effective obesity HiAP network with a co-framing strategy, both network goals (e.g. obesity reduction) and each member organization's individual goals guide network performance. Such a co-framing strategy can help non-health members of the network to relate their organizational goals to those of the larger network. Although we have proposed a co-framing strategy embedded within an NAO governance mode as the most effective coordination tool for a HiAP obesity network, we conclude by acknowledging that the precise means and phrasing by which this might occur will be driven by local contexts – the very political landscapes with which all member organizations involved in the HiAP obesity network must increasingly seek to engage.

What does our co-framing argument imply for the field of critical public health? With existing knowledge about the idea of co-framing still being very limited, we call for additional research using mixed-method research designs to collect evidence on what type of network governance for obesity HiAP networks works best in different political contexts. More research is also required to explore what an effective structure of a NAO guiding a HiAP obesity network would look like, in terms of its scale, degree of formality and membership. More empirical evidence is also needed on how to capitalize on the participation of social movements in HiAP obesity networks for the purpose of co-framing. Finally, we call for more empirical research to better understand how policy learning can contribute to an effective co-framing strategy within a HiAP obesity network, for example how to use evidence to achieve policy learning, what type of evidence to rely on, and what mechanisms of conflict resolution and trust-building among diverse members can facilitate co-framing.

## Disclosure statement

No potential conflict of interest was reported by the authors.

## References

- Aronowitz, R. (2008). Framing disease: An underappreciated mechanism for the social patterning of health. *Social Science & Medicine*, 67(1), 1–9. doi:10.1016/j.socscimed.2008.02.017
- Atanasova, D., & Kotevko, N. (2016). Obesity frames and counter-frames in British and German online newspapers. *Health*. doi:10.1177/1363459316649764
- Australian Public Service Commission. (2012). *Tackling wicked problems: A public policy perspective*. Canberra: Author. Retrieved from <http://www.apsc.gov.au/publications-and-media/archive/publications-archive/tackling-wicked-problems>
- Baum, F., & Fisher, M. (2014). Why behavioural health promotion endures despite its failure to reduce health inequities. *Sociology of Health & Illness*, 36, 213–225. doi:10.1111/1467-9566.12112
- Baum, F. E., Legge, D. G., Freeman, T., Lawless, A., Labonté, R., & Jolley, G. M. (2013). The potential for multi-disciplinary primary health care services to take action on the social determinants of health: Actions and constraints. *BMC Public Health*, 13, 460. doi:10.1186/1471-2458-13-460
- Baumgartner, F. R., & Jones, B. D. (2010). *Agendas and instability in American politics*. Chicago,: University of Chicago Press.
- Bergeron, H., Castel, P., & Saguy, A. (2014). When frames (don't) matter: Querying the relationship between ideas and policy (Vol. 18, pp. 1–44). *LIEPP Working Paper*. Paris: Sciences Po.
- Berry, F. S. & Berry, W. D. (2014). Innovation and diffusion models in policy research. In P. A. Sabatier & C. M. Weible (Eds.), *Theories of the policy process* (3rd ed., pp. 307–363). Boulder, CO: Westview Press.
- Borzel, T. A. (1998). Organizing Babylon – On the different conceptions of policy networks. *Public Administration*, 76, 253–273.
- Breton, E. (2016). A sophisticated architecture is indeed necessary for the implementation of health in all policies but not enough comment on “Understanding the role of public administration in implementing action on the social determinants of health and health inequities”. *International Journal of Health Policy and Management*, 5, 383–385. doi:10.15171/ijhpm.2016.28
- Brewer, G. (1973). *Politicians, bureaucrats, and the consultant*. New York, NY: Basic Books.
- Butland, B., Jebb, S. A., Kopelman, P., McPherson, K., Thomas, S., Mardell, J., & Parry, V. (2007). *Foresight. Tackling obesity: Future choices – Project report*. London: Government Office for Science.
- Carey, G., Malbon, E., Crammond, B., Pescud, M., & Baker, P. (2016). Can the sociology of social problems help us to understand and manage ‘lifestyle drift’? *Health Promotion International*. doi:10.1093/heapro/dav116
- Collins, P. A. & Hayes, M. V. (2007). Twenty years since Ottawa and Epp: Researchers’ reflections on challenges, gains and future prospects for reducing health inequities in Canada. *Health Promotion International*, 22, 337–345. doi:10.1093/heapro/dam031
- Conk, S. J., & Porter, C. M. (2016). Food gardeners’ productivity in Laramie, Wyoming: More than a hobby. *American Journal of Public Health*, 106, 854–856. doi:10.2105/AJPH.2016.303108
- de Leeuw, E., & Peters, D. (2015). Nine questions to guide development and implementation of health in all policies. *Health Promotion International*, 30, 987–997. doi:10.1093/heapro/dau034
- Dorfman, L., & Wallack, L. (2007). Moving nutrition upstream: The case for reframing obesity. *Journal of Nutrition Education and Behavior*, 39(Suppl. 2), S45–S50. doi:10.1016/j.jneb.2006.08.018
- Edelman, M. (1977). *Political language*. New York, NY: Academic Press.
- Edelman, M. (1985). *The symbolic uses of politics*. Urbana: University of Illinois Press.
- Elder, C. D., & Cobb, R. W. (1983). *The political uses of symbols*. New York, NY: Longman.
- Entman, R. M. (1993). Framing: Toward clarification of a fractured paradigm. *Journal of Communication*, 43, 51–58. doi:10.1111/j.1460-2466.1993.tb01304.x
- Glasgow, S. M. (2012). The politics of self-craft. *SAGE Open*, 2(3), 1–11. doi:10.1177/2158244012452575
- Gortmaker, S. L., Swinburn, B. A., Levy, D., Carter, R., Mabry, P. L., Finegood, D. T., ... Moodie, M. L. (2011). Changing the future of obesity: Science, policy, and action. *The Lancet*, 378, 838–847. doi:10.1016/S0140-6736(11)60815-5
- Gusfield, J. R. (1981). *The culture of public problems: Drinking-driving and the symbolic order*. Chicago: University of Chicago Press.
- Hall, P. A. (1993). Policy paradigms, social learning, and the state: The case of economic policymaking in Britain. *Comparative Politics*, 25, 275–296. doi:10.2307/422246
- Heikkilä, T., & Gerlak, A. K. (2013). Building a conceptual approach to collective learning: Lessons for public policy scholars. *Policy Studies Journal*, 41, 484–512. doi:10.1111/psj.12026
- Hilton, S., Patterson, C., & Teyhan, A. (2012). Escalating coverage of obesity in UK newspapers: The evolution and framing of the “obesity epidemic” from 1996 to 2010. *Obesity*, 20, 1688–1695. doi:10.1038/oby.2012.27
- Huang, T. T., Cawley, J. H., Ashe, M., Costa, S. A., Frerichs, L. M., Zwicker, L., ... Kumanyika, S. K. (2015). Mobilisation of public support for policy actions to prevent obesity. *The Lancet*, 385, 2422–2431. doi:10.1016/S0140-6736(14)61743-8
- Jenkin, G. L., Signal, L., & Thomson, G. (2011). Framing obesity: The framing contest between industry and public health at the New Zealand inquiry into obesity. *Obesity Reviews*, 12, 1022–1030. doi:10.1111/j.1467-789X.2011.00918.x
- Jenkins-Smith, H. C. (1988). Analytical debates and policy learning: Analysis and change in the federal bureaucracy. *Policy Sciences*, 21, 169–211. doi:10.1007/BF00136407

- Kersh, R. (2015). Of nannies and nudges: The current state of U.S. obesity policymaking. *Public Health*, 129, 1083–1091. doi:10.1016/j.puhe.2015.05.018
- Kersh, R., Stroup, D. F., & Taylor, W. C. (2011). Childhood obesity: A framework for policy approaches and ethical considerations. *Preventing Chronic Disease*, 8(5), A93.
- Kickbusch, I., & Gleicher, D. (2012). *Governance for health in the 21st century*. Copenhagen: World Health Organization.
- Kim, S. H., & Anne Willis, L. (2007). Talking about obesity: News framing of who is responsible for causing and fixing the problem. *Journal of Health Communication*, 12, 359–376. doi:10.1080/10810730701326051
- Kingdon, J. W. (1984). *Agendas, alternatives, and public policies*. Boston, MA: Little, Brown.
- Klein, J. D., & Dietz, W. (2010). Childhood obesity: The new tobacco. *Health Affairs*, 29, 388–392. doi:10.1377/hlthaff.2009.0736
- Labonté, R. (2016). Health promotion in an age of normative equity and rampant inequality. *International Journal of Health Policy and Management*, 5, 675–682. doi:10.15171/ijhpm.2016.95
- Labonté, R., & Stuckler, D. (2016). The rise of neoliberalism: How bad economics imperils health and what to do about it. *Journal of Epidemiology and Community Health*, 70, 312–318. doi:10.1136/jech-2015-206295
- Lawrence, R. G. (2004). Framing obesity: The evolution of news discourse on a public health issue. *The Harvard International Journal of Press/Politics*, 9, 56–75. doi:10.1177/1081180X04266581
- Leppo, K., Ollila, E., Pena, S., Wismar, M., & Cook, S. (2013). *Health in all policies. Seizing opportunities, implementing policies*. Helsinki: Ministry of Social Affairs and Health.
- Lin, V., & Carter, B. (2013). From healthy public policy to intersectoral action and health-in-all policies. In D. V. McQueen (Ed.), *Global handbook on noncommunicable diseases and health promotion* (pp. 189–201). New York, NY: Springer.
- McAdam, D., McCarthy, J. D., & Zald, M. N. (Eds.). (1996). *Comparative perspectives on social movements*. Cambridge: Cambridge University Press.
- Mintrom, M., & Norman, P. (2009). Policy entrepreneurship and policy change. *Policy Studies Journal*, 37, 649–667. doi:10.1111/j.1541-0072.2009.00329.x
- Nathanson, C. A. (1999). Social movements as catalysts for policy change: The case of smoking and guns. *Journal of Health Politics, Policy and Law*, 24, 421–488. doi:10.1215/03616878-24-3-421
- Newman, L., Ludford, I., Williams, C., & Herriot, M. (2014). Applying health in all policies to obesity in South Australia. *Health Promotion International*, 31, 44–58. doi:10.1093/heapro/dau064
- Patchett, A. D., Yeatman, H. R., & Johnson, K. M. (2014). Obesity framing for health policy development in Australia, France and Switzerland. *Health Promotion International*, 31, 83–92. doi:10.1093/heapro/dau066
- Provan, K. G., Isett, K. R., & Milward, H. B. (2004). Cooperation and compromise: A network response to conflicting institutional pressures in community mental health. *Nonprofit and Voluntary Sector Quarterly*, 33, 489–514. doi:10.1177/0899764004265718
- Provan, K. G., & Kenis, P. (2008). Modes of network governance: Structure, management, and effectiveness. *Journal of Public Administration Research and Theory*, 18, 229–252. doi:10.1093/jopart/mum015
- Robbins, A., & Nestle, M. (2011). Obesity as collateral damage: A call for papers on the Obesity Epidemic. *Journal of Public Health Policy*, 32, 143–145. doi:10.1057/jphp.2011.14
- Roberto, C. A., & Kawachi, I. (Eds.). (2015). *Behavioral economics and public health*. New York, NY: Oxford University Press.
- Roberto, C. A., Swinburn, B., Hawkes, C., Huang, T. T., Costa, S. A., Ashe, M., ... Brownell, K. D. (2015). Patchy progress on obesity prevention: Emerging examples, entrenched barriers, and new thinking. *The Lancet*, 385, 2400–2409. doi:10.1016/S0140-6736(14)61744-X
- Ryan, C., & Gamson, W. A. (2006). The art of reframing political debates. *Contexts*, 5, 13–18.
- Sabatier, P. A., & Jenkins-Smith, H. C. (1993). *Policy change and learning: An advocacy coalition approach*. New York, NY: Westview Press.
- Sabatier, P. A., & Weible, C. (Eds.). (2014). *Theories of the policy process*. New York, NY: Westview Press.
- Shiffman, J., Quissell, K., Schmitz, H. P., Pelletier, D. L., Smith, S. L., Berlan, D., ... Walt, G. (2015). A framework on the emergence and effectiveness of global health networks. *Health Policy and Planning*, 31(Suppl. 1), i3–i16. doi:10.1093/heapol/czu046
- Stone, D. A. (1989). Causal stories and the formation of policy agendas. *Political Science Quarterly*, 104, 281–300.
- Tesh, S. N. (1988). *Hidden arguments: Political ideology and disease prevention policy*. New Brunswick, NJ: Rutgers University Press.
- Weible, C. M., & Carter, D. P. (2015). The composition of policy change: Comparing Colorado's 1977 and 2006 smoking bans. *Policy Sciences*, 48, 207–231. doi:10.1007/s11077-015-9217-x
- Weible, C. M., Sabatier, P. A., Jenkins-Smith, H. C., Nohrstedt, D., Henry, A. D., & DeLeon, P. (2011). A quarter century of the advocacy coalition framework: An introduction to the special issue. *Policy Studies Journal*, 39, 349–360. doi:10.1111/j.1541-0072.2011.00412.x
- Williams, R. H. (1995). Constructing the public good: Social movements and cultural resources. *Social Problems*, 42, 124–144. doi:10.2307/3097008
- Williams, S. N., & Nestle, M. (2015). 'Big Food': Taking a critical perspective on a global public health problem. *Critical Public Health*, 25, 245–247. doi:10.1080/09581596.2015.1021298