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The extent to which the public health 'war on obesity' reflects the ethical values and principles of critical health promotion: a multimedia critical discourse analysis

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Abstract

Issue addressed: The discipline of health promotion is responsible for implementing strategies within weight-related public health initiatives (WR-PHI). It is imperative that such initiatives be subjected to critical analysis through a health promotion ethics lens to help ensure ethical health promotion practice.

Methods: Multimedia critical discourse analysis was used to examine the claims, values, assumptions, power relationships and ideologies within Australian WR-PHI. The Health Promotion Values and Principles Continuum was used as a heuristic to evaluate the extent to which the WR-PHI reflected the ethical values of critical health promotion: active participation of people in the initiative; respect for personal autonomy; beneficence; non-maleficence; and strong evidential and theoretical basis for practice.

Results: Ten initiatives were analysed. There was some discourse about the need for participation of people in the WR-PHI, but people were routinely labelled as 'target groups' requiring 'intervention'. Strong evidence of a coercive and paternalistic discourse about choice was identified, with minimal attention to respect for personal autonomy. There was significant emphasis on the beneficiaries of the WR-PHI but minimal attention to the health benefits, and nothing about the potential for harm. Discourse about the evidence of need was objectivist, and there was no discussion about the theoretical foundations of the WR-PHI.

Conclusion: The WR-PHI were not reflective of the ethical values and principles of critical health promotion.

So what? Health promotion researchers and practitioners engaged in WR-PHI should critically reflect on the extent to which they are consistent with the ethical aspects of critical health promotion practice.

Key words: best practice, critical health promotion, critical weight studies, ethics, fat studies.

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Background

Governments in Australia and many countries around the world have responded to what is perceived as an 'epidemic of obesity' with a public health 'war on obesity': policies and programs explicitly focused on reducing and preventing obesity at the population level.[1,2] Many of these weight-related public health initiatives (WR-PHI) utilise health promotion strategies. Various attempts have been made to explore the values and principles of health promotion, some of which have used the discourse of health promotion ethics, with proposals for a health promotion code of ethics,[3,4] an ethical framework or agenda[5,6] and exploration of ethics used in health promotion practice.[7,8] One tool that supports the exploration of ethics in health promotion practice is the Health Promotion Values and Principles Continuum (the Continuum), which was constructed from the literature on the values and principles central to health promotion.[9]

A health promotion value is an idea or concept that is regarded as worthy, desirable or useful to health promotion, and a health promotion principle describes the actions taken to enact the value.[9] The Continuum includes three domains of values and principles related to health promotion: philosophical values and principles; ethical values and principles; and technical values

and principles.[9] Practice at the 'ideal' end of the Continuum can be conceptualised as best health promotion practice[10] and modern[11] or critical health promotion;[12–14] practice at the opposite end of the Continuum can be conceptualised as common health promotion practice[10] or traditional health promotion.[11,14] Health promotion values and principles in the ethical domain of the Continuum focus on participation in the change process of people affected by an issue, personal autonomy, beneficence, non-maleficence and basis for practice. At the best practice or critical health promotion end of the Continuum, the ethical values are active participation in the change process, respect for personal autonomy, maximum beneficence, minimum or non-maleficence, and comprehensive use of evidence and theory as a basis for practice. These ethical values and their related principles together with the ethical values and principles reflective of the traditional health promotion end of the Continuum are described in Table 1.

WR-PHI have been subjected to extensive critique based on ideological, ethical and empirical grounds.[15–17] Critiques using a public health ethics lens have highlighted the potential for WR-PHI to cause unintended harm to individuals through further stigmatisation of fat people.[18] Stigmatising discourses have been identified in WR-PHI[19,20] and such initiatives are perceived as stigmatising by the people at whom they are directed.[21–23] An iatrogenic effect of the public health 'war on obesity' is the stigmatisation of fat people, which potentially contributes to an increase in health inequities. As such, this war has been posited as adipophobicogenic (creating fat hatred and weight stigma),[24] a social determinant of poor health[1] and an impediment to living a flourishing and full life.[1,2]

Ethical concerns or issues that may have ethical significance have been highlighted in a small number of studies of Australian WR-PHI. Thomas and colleagues found that 'obese' people in the community had a range of ethical concerns and issues about WR-PHI including: limitations to personal freedom; coercion; increased moral judgements about food choices; focus on biological or physical health rather than holistic well being; prioritisation of single physical health outcome (weight) over people's dignity; lack of understanding of lived experiences; stigmatisation, blame and

Table 1. Health promotion values and principles in the ethical domain of the Health Promotion Values and Principles Continuum[9]

Focus	Critical health promotion value	Critical health promotion principle	Traditional health promotion value	Traditional health promotion principle
Participation in change process	Active participation	Ensuring that the people most impacted by an issue are an integral part of all components of a health promotion change process that addresses the issue	Passive recipients	Making decisions for people most impacted by an issue
Personal autonomy	Respect personal autonomy	Ensuring that all relevant parties consent to health promotion change processes and acknowledging and respecting that not all people will choose the same actions	Restrict personal autonomy	Expecting all people to adopt the same actions, irrespective of their own preferences
Beneficence	Maximum beneficence	Actively considering what the benefits of any health promotion change process may be to the full range of beneficiaries	Limited beneficence	Considering what the benefits of any health promotion change process may be to a limited range of beneficiaries
Non-maleficence	Non-maleficence is a priority consideration	Actively considering what the potential harms of any health promotion change process may be; who may be harmed by the change processes and in what way; taking steps to minimise or avoid this harm; communicating risks involved in a truthful and open manner	Scope of maleficence not fully considered	Considering only a limited range of potential harms (due to a belief that health promotion processes will result in positive health outcomes)
Basis for practice	Comprehensive use of evidence and theory	Ensuring that needs assessment processes incorporate the perspectives of all stakeholders, and that health promotion practice is based on sound evidence of need, evidence of effectiveness, and appropriate theoretical foundations	Limited or selective use of evidence and theory	Basing health promotion practice on selective use of evidence of need and/or effectiveness; not applying appropriate theory to practice

depression; and potential for creating eating disorders.[25] Carter and colleagues critiqued *Measure Up*, the Australian Government 'obesity prevention' social marketing campaign, and identified a range of ethical concerns and issues including: individual change was prioritised over community or structural change; biological health was prioritised over positive self-image or general well being; preserving dignity was not a priority; assumptions about individual freedom to choose healthy behaviours were forefronted rather than recognition of structural constraints; reducing waist measurements were more important than avoiding unreasonable coercion; and permitting stigmatisation was more important than preserving dignity and avoiding stigmatisation of fat people.[26] Although these studies identified a range of ethical issues and concerns, WR-PHI in Australia or elsewhere have not been subjected to critique with respect to the full set of values and principles of critical health promotion.[27] Given the responsibility of the health promotion discipline to implement most WR-PHI, it is imperative that such initiatives are subjected to critical investigation through a health promotion ethics lens in order to ensure ethical health promotion practice.

Methods

The aim of this study was to analyse the discourses within Australian weight-related public health initiatives, and to use the results of the discourse analysis to evaluate the extent to which these initiatives reflect the ethical values and principles of critical health promotion. The epistemological position in this study was constructivist,[28] and the theoretical perspective was critical theory.[28] The study sits within the critical fields of critical weight studies and fat studies. Multimedia critical discourse analysis (MCDA)[29] was used to examine the text of WR-PHI commissioned or produced by the Australian Government or parliament. MCDA uses a broad definition of text to include words, pictures and symbols.[29] MCDA has a nested methodological approach involving three layers of analysis: textual practice analysis is at the core, within the context of discursive practice analysis (for claims-making strategies), all within the context of social practice analysis, which explores the role played by power and ideology in supporting or disturbing the discourse.[29] Analysis of textual practices included, for example, examination of word connotations (choice of words that place the events into a particular framework of reference or discourse), over-lexicalisation (surfeit of repetitious, quasi-synonymous terms, over-persuasion, excessive description), presupposition (used to imply meaning or present things as taken for granted and uncontested; can also enter into common usage and come to appear as self-evident, with their ideological origins backgrounded or completely forgotten), verb modality (verbs or adverbs used to convey certainty, authority and power over others and over knowledge) and genre (style of text: formal, informal, scientific, conversational, fictional).[30] Analysis of the way people and other subjects were represented in images included, for example, examination for gaze, interaction, poses, distance, angle, number, generic versus specific depictions, and exclusion.[29] Analysis of discursive practices included, for example, examination of claims-making (an attempt to persuasively define a situation in a particular way and to have that definition become widely accepted as a basis for ameliorative action) and hedging (lack of specifics, can create ambiguity or sound more authoritative and persuasive).[30]

The Health Promotion Values and Principles Continuum[9] was used as a tool to evaluate the extent to which the discourses identified within the WR-PHI reflected the ethical values and principles of critical health promotion. The Continuum has been used extensively by two of the authors (LOH and JT) over the past 8 years in health promotion professional development programs, community-based health promotion projects and tertiary health promotion curricula in Australia. In addition the Continuum has been included in tertiary health promotion and health education curricula in the USA and the UK.

Initiatives were sought for inclusion in the study that met following six criteria:

1. be a report, policy, program, strategy or action plan
2. be commissioned or produced by the Australian federal government or parliament
3. be published between 2003 (when Health Ministers first named obesity as a public health problem)[31] and February 2013
4. focus on body weight as the primary or major issue of the document's name, description or rationale
5. have a population level focus
6. be freely available on the internet.

These criteria ensured that all freely available WR-PHI from the previous decade were included in the analysis. Documents analysed included written documents as well as online, print, television and radio advertisements and other materials. Documents reporting on the progress or evaluation of a public health policy or program were excluded. All documents were entered into NVivo data analysis software (QSR International Pty Ltd Version 10, 2012). Documents available as pdf files from the internet were imported directly into NVivo. Other web-based documents were converted to Microsoft Word documents and imported into NVivo. Radio and television advertisements were transcribed, saved as Microsoft Word documents and imported into NVivo.

Results and discussion

Ten initiatives met the inclusion criteria and were included in the analysis (Table 2). Except the Technical Report on Obesity, all of the Australia: The Healthiest Country by 2020 documents addressed three issues: obesity, tobacco use and alcohol use. The sections specifically related to tobacco and alcohol use were not included in the present study. All other sections were included.

Table 2. Weight-related public health initiatives included in analysis

Document	Year	Document modalities
Healthy weight 2008 – Australia's future: the national action agenda for children and young people and their families[31]	2003	26-page written policy
'Measure up' social marketing campaign[32]	2006	Brochures, booklet, posters, tape measure, 12-week planner, community guide, print, radio, television, outdoor and online advertisements, websites
Australia: the healthiest country by 2020 – a discussion paper[33]	2008	80-page written discussion paper
Australia: the healthiest country by 2020. Technical report 1 – Obesity in Australia: a need for urgent action[34]	2009	138-page written technical report
Australia: the healthiest country by 2020 – National Preventative Health Strategy – overview[35]	2009	60-page written report
Australia: the healthiest country by 2020 – National Preventative Health Strategy – the roadmap for action[36]	2009	316-page written report
Weighing it up: obesity in Australia report[37]	2009	223-page written report
Taking preventative action – a response to Australia: the healthiest country by 2020 – The report of the National Preventative Health Taskforce[38]	2010	125-page written report
'Swap it, don't stop it' (Measure Up phase 2) social marketing campaign[39]	2011	Brochures, posters, cards, fact sheets, recipe collections, print, radio, television, outdoor and online advertisements, website
Australian Government Response to Weighing it up: obesity in Australia report[40]	2013	22-page written report

Participation in change process

Ensuring the active participation of people most impacted by health issues in public health strategies designed to address those issues is an ethical value of critical health promotion.[9,14,27] One of the actions in the National Preventative Health Strategy implementation plan focused on the participation of Aboriginal and Torres Strait Islander communities. This section of text suggested that Aboriginal and Torres Strait Islander communities would be given the power to control every stage of the health promotion process, from needs assessment to planning, implementation and evaluation. This was the strongest and clearest reference to the expectation of a high level of active participation in the WR-PHI. However, the use of the terms 'target group' and 'intervention' in the document simultaneously implied that Aboriginal and Torres Strait Islander people may not be active participants in such initiatives after all.

The term 'intervention' is a noun that comes from the Latin 'intervenire', meaning to come between or interrupt. In modern English it is defined as the action or process of intervening or coming between so as to prevent or alter a result or course of events; or any interference in the affairs of others.[41] Synonyms for intervene include interfere, interpose and meddle. The term 'target' is used as both a noun and a verb and comes from the Middle English word 'targe' or shield, and originally meant object to be aimed at in shooting. In modern English, as a noun, a target is defined as a person, object or place selected as the aim of an attack; a mark or point at which one fires or aims; an objective or result towards which efforts are directed; a person or thing against whom criticism or abuse is directed. As a verb, to target is defined as to select as an object of attention or attack; or to aim or direct something.[42] Both target and intervention terms were used repeatedly throughout all of the documents analysed, except for the social marketing campaign materials designed for the public. For example, in the Obesity Technical Report, the term target was used 102 times in the 128-page document, or an average of 0.8 times per page, and the term intervention was used 147 times, an average of 1.1 times per page. In the Roadmap, the term target was used 190 times, and the term intervention was used 172 times. Although some of the uses of the term target referred to normative targets for change, most of them referred to targeting people and behaviours. These terms were characteristic of a militaristic discourse evident in the documents, and their high degree of repetition served as a constant reinforcement of this discourse. The health promotion strategies in the documents were explicitly described as interventions that targeted people, particularly people considered 'high risk' who were usually characterised as 'disadvantaged'. For example: 'Tailoring key campaign messages and interventions to specific target audiences will enhance campaign effectiveness' (Obesity Technical Report, p. 32). The militaristic discourse characterised by the over-lexicalisation of the terms target and intervention to refer to people and processes suggested the very opposite of active participation by people in the change process. To be targeted with an intervention is at best to be a passive recipient, or at worst is disabling and disempowering.

The value of active participation was also evident in discourse related to community ownership. For example, the Weighing it up report included submissions to the Parliamentary Inquiry related to community ownership. Many of these submissions reflected the active participation discourse. However, despite the broad range of submissions on this issue, the Weighing it up report included no recommendations addressing community ownership, thereby completely omitting the requirement for active participation. Throughout the documents the participation discourse was

concentrated at a lower level of participation, characterised by lexical choices such as 'working together', 'working with' and 'engaging' participants in specific settings or activities, rather than active participation of people. In addition, by including strategies that do not entail active participation, such as social marketing campaigns and policy and regulation, the documents implied that people would be passive recipients of initiatives. The significant emphasis on these strategies across the documents resulted in a strongly implied passive recipient discourse.

Participation of the community in all aspects of health promotion, from identifying needs, to setting priorities, and planning, implementing and evaluating health promotion solutions to address needs, is one of the core values of health promotion.[43] It is included in the Galway Consensus Statement on domains of core competency, standards and quality assurance for building global capacity in health promotion.[44] In the documents analysed, there was a wide range of discourses relating to participation but the majority related to relatively low levels of active participation through mechanisms such as engaging, involving, working with and in partnership with people and communities. Additionally the strong presence of militaristic language of target group and intervention also implied a low level of active participation. Overall, there was evidence of discourse supporting moderately active participation in the change process, and the WR-PHI were therefore evaluated as being somewhat consistent with this ethical principle of critical health promotion (Table 3).

Personal autonomy

Respecting people's right to autonomy is an ethical principle of critical health promotion.[9,27] In the WR-PHI analysed there was a strong discourse about 'choice' related to personal autonomy as well as a 'coercive, paternalist' discourse where respect for personal autonomy was effectively restricted. The textual practices of word connotations, over-lexicalisation, and presupposition, together with the discursive practices of claims-making and hedging, created discourses that simultaneously conveyed respect for the right to autonomy and the restriction of autonomy. Throughout all of the documents there was a vast number of references to 'healthy choices'. These 'choices' however were confined to specific behaviours – healthy eating and physical activity – which were positioned as the 'right' choice for people to make. For example, in Swap It, Don't Stop It, Eric was seemingly ignorant about his 'unhealthy' choices, including eating large meals or 'junk' food and being sedentary. Eric's facial expression and body language showed that he was perplexed, unhappy and fearful when he was told that his poor 'choices' led to his increased weight and risk of disease. In the next phase of the campaign, Eric was depicted as making some small changes in his behaviours – swapping 'unhealthy' for 'healthy choices'. The simple deflation of a balloon was the visual practice used to represent the ease with which one can make the 'healthy choice' (for example, riding a bicycle rather than driving a car) and consequently the ease with which Eric could 'lose his belly'. Subsequent images showed a slimmer Eric practising his new 'healthy choices'.

Making the 'healthy choice' the easy or only choice was part of an explicit discourse that implied autonomy to choose, but in fact dictated that the only choices that could be made were those defined by the WR-PHI. As such, these 'healthy choices' were not really choices at all. The textual practice of presupposition created a taken for granted assumption that these are the only behaviours that anyone would want to practise, given the right amount of motivation, incentive, enabling and environmental support. Nowhere in the documents was there any discussion about the right NOT to choose these behaviours, to be autonomous, to make one's own decisions or to make a different choice. This discourse was paternalistic and the strategies used to ensure such healthy choices were made were coercive.

There has been considerable discussion about the ethical issues of autonomy, paternalism and unreasonable coercion in WR-PHI[26,45] and in public health more broadly.[46] Despite these concerns, the concept of libertarian paternalism or 'nudging' people to make the 'right' choice[47] has been proposed as a reasonable strategy for WR-PHI.[48,49] However ethical concerns about this approach are that it is neither libertarian nor paternalist, nor is it as benign as its proponents maintain.[50] Overall, the discourse about making the 'healthy choice'

Table 3. Discourses and position on Health Promotion Values and Principles Continuum for values in the ethical domain
SC = strongly reflective of critical health promotion; SWC = somewhat reflective of critical health promotion; SWT = somewhat reflective of traditional health promotion; ST = strongly reflective of traditional health promotion

Focus of value	Discourses related to value	SC	SWC	SWT	ST
Participation in change process	Active participation Militaristic Community ownership		x		
Personal autonomy	Choice Coercive, paternalist				x
Beneficence	Beneficiaries but not benefits			x	
Non-maleficence	No harm Potential for harm				x
Basis for practice	Evidence of need Need for evidence				x

created the illusion of personal autonomy or freedom to make such choices. However, there was also strong evidence of coercive, paternalist discourse involving 'nudging' or perhaps even demanding people to make the 'right' choice, which resulted in respect for personal autonomy effectively being restricted. The WR-PHI were therefore evaluated as being strongly consistent with this principle of traditional health promotion (Table 3).

Beneficence

Beneficence refers to actions that promote the well being of others – the core purpose of health promotion. Beneficence in health promotion encompasses both who benefits (beneficiaries) and to what extent (benefits). Actively considering ways to maximise beneficence is an ethical principle of critical health promotion.[9,27] Discourses identified in the WR-PHI analysed focused on maximising the reach (beneficiaries) of the initiatives and articulating their benefits. General beneficiaries of the WR-PHI were described as the 'whole population', 'whole community' and 'all Australians'. Specific population groups of beneficiaries were described as those 'most in need', 'in poorest health', 'at risk', 'vulnerable' and 'disadvantaged'. The proposed benefits of the social marketing campaigns were articulated through their messages: reduced waist circumference, decreased unhealthy eating and physical inactivity, decreased rates of chronic disease and longer lives. The major proposed benefit of Healthy Weight was articulated through its subtitle Australia's Future. Healthy Weight aimed to create the highest levels of health in the world. A similar target of the National Preventative Health Strategy was articulated through the title Australia: the Healthiest Country by 2020. Further benefits of the Healthiest Country were framed as avoidance or reduction of economic costs, individual costs, social costs, costs of co-morbidities and hospital costs. Framing benefits as the avoidance of costs, particularly economic costs was consistent with the shifting discourse in health promotion from a new social movement to a new capitalist movement aligned with neoliberal political ideology, whereby capitalism and free markets are privileged over people.[51]

Overall, the analysis revealed that consideration had been given to maximising the range of beneficiaries of the WR-PHI. Aside from the macro-level social and economic benefits of securing Australia's future through having the healthiest country in the world, the benefits of the WR-PHI were more biomedically focused on prevalence rates of overweight, obesity, healthy eating and physical activity. The opportunity costs of the WR-PHI were not considered. Although a broad range of beneficiaries were considered, the limited range of benefits meant that overall the initiatives were evaluated as being somewhat consistent with this principle of traditional health promotion (Table 3).

Non-maleficence

Actively avoiding or minimising harm, and communicating risks and potential harms in a truthful and open manner is an ethical principle of critical health promotion.[9,27] There was a very weak discourse relating to the ethical concept of 'do no harm' in the WR-PHI analysed. Public health initiatives are often considered to be automatically good for people, and their potential to create harm, even inadvertently, is rarely considered.[52] Across the documents, there were few references to the potential harms arising directly from the WR-PHI. One submission to Weighing it up warned of the primary importance of the WR-PHI doing no harm, especially to children, and the Obesity Technical Report acknowledged the potentially harmful outcome of increasing child body dissatisfaction. The Obesity Technical Report acknowledged the disproportional impact that the strategy of taxing 'unhealthy' food may have on people and families on lower incomes, resulting in greater inequities in health status. This was the only acknowledgement in any of the documents of the direct role that the WR-PHI may play in worsening inequity.

Ethical concerns regarding safety and efficacy were raised in the documents, but they were not attributed to the WR-PHI directly. Concerns related to commercial weight loss products and programs were raised in Weighing it up, the Obesity Technical Report and the Roadmap. Weight loss strategies are ineffective in achieving sustained weight loss over 2–5 years for all but ~5% of people,[53] and attempted weight loss strongly predicts weight gain.[54,55] This raises important questions about the ethics of WR-PHI recommending ineffective pursuits such as intentional weight loss,[56] particularly for middle aged or older people, as is the explicit focus of Measure Up and Swap It, Don't Stop It. Discussion about the ineffectiveness and harm arising from weight loss strategies was completely absent from the documents.

Stigma and related concepts of bias, prejudice, harassment, bullying and discrimination were explored in Weighing it up. Although the House of Representatives Committee heard many stories about stigma, stereotyping, discrimination and their effects, these were directly attributed to the body weight of the person rather than the social stigmatisation of fatness. The central characters in Measure Up and Swap It, Don't Stop It assumed full responsibility for their fatness and looked very sad about it. In some images, the Measure Up characters were looking down at the tape measure around their waist, and this position, together with the dejected looks on their faces, suggested hanging their heads in shame. As previously identified by Carter *et al.* the characters' appearance in white underwear also contributed to the portrayal of self-blame and shame.[26] These visual strategies and the overall messages of the campaigns conveyed a strong, consistent message that the characters feel ashamed and indeed are deserving of such shame for their 'poor' behaviours and their subsequent weight gain. The WR-PHI reinforced the 'anachronistic preconceptions'[57(p563)] that weight is 'easily' controlled by 'choosing' a healthy lifestyle. WR-PHI that present fat bodies as problematic and shameful, and the alleged causes and cures as simple and within an individual's control, are perceived by people in the community as inherently

stigmatising.[22,23,25,58] Weight-based stigma is now well recognised as a pervasive and insidious form of stigma.[59] Rather than inadvertently contributing to greater stigmatisation, WR-PHI should be deliberately and proactively designing strategies that avoid stigmatising people in any way.[22,25,26,59]

Overall, there was a very weak explicit non-maleficence discourse with a small number of potential harms noted. The weakness of this discourse was not reflective of the strength of evidence in the literature relating to potential harms. The scope of potential maleficence from the WR-PHI was only minimally considered, and the initiatives were therefore evaluated as being strongly consistent with this principle of traditional health promotion (Table 3).

Basis for practice

Public health strategies that are based on evidence of need and effectiveness and sound theoretical foundations are consistent with critical health promotion.[9,14,27] In the WR-PHI analysed, there was a strong, objectivist 'evidence of need' discourse, a strong 'need for evidence' discourse, and the absence of discourse on theoretical foundations related to the basis for practice. The discursive practice of claims-making was used to present a significant body of evidence in the documents about the prevalence, trends and implications of the current state of obesity. These claims were presented as solid, incontestable and uncontested facts. The genre of the text describing these 'facts' was predominantly scientifically formal. Presenting 'facts' in a very formal style using scientific language served to reinforce the authority of the claims being made.

However, when the documents turned to the evidence of effectiveness of WR-PHI, the level of certainty of the discourse diminished substantially. There was a strong reliance on the discursive practice of using experts and scientific sources for authoritative claims-making. However the discursive practice of hedging using lower modality verbs was also evident across the documents. Rather than evidence 'showing' or 'demonstrating' (terms used when discussing the evidence of need), evidence of effectiveness was framed as 'suggested' or 'still developing', there was acknowledgement of 'gaps in the evidence jigsaw', and 'further debate, research, evaluation and evidence are required' in order to 'learn by doing'. For example: 'there is much evidence about the effectiveness of interventions that is yet to be gathered',[34(p51)] and:

> The Taskforce recognised that in proposing measures to tackle obesity, the evidence for intervention was more variable than in other public health issues such as tobacco control. Therefore, there is a strong emphasis on 'learning by doing' – taking promising approaches, and closely monitoring their results.[38(p34)]

There was an almost universal absence of references to theoretical foundations for the WR-PHI. The sole exception was in the Obesity Technical Report, which acknowledged the evidence that successful workplace health promotion programs were based on theory.

The language of evidence-based health practice has spread from its origins in evidence-based medicine to evidence-based public health and health promotion.[60] There is an ethical imperative for health promotion to be informed by evidence.[5,26] However, the evidence of need and evidence of effectiveness of WR-PHI are both weak and do not justify many of the strategies being implemented in the name of obesity reduction and prevention.[15,17,56]

Overall, there was a strongly objectivist discourse on the evidence of need for public health strategies to address obesity. Large tracts of text were devoted to making the case for obesity as a major public health issue, but there were no alternative perspectives or evidence presented that challenged or questioned this discourse, and therefore the evidence presented was selective. There was a strong discourse on the need for evidence of effectiveness of public health strategies; however, in this case the discourse acknowledged that the evidence base was limited, immature and weak, and as such there was a requirement to learn by doing. There was a complete absence of discourse about the theoretical base for the proposed and currently implemented public health strategies. The initiatives were therefore evaluated as being strongly consistent with this principle of traditional health promotion (Table 3).

Summary

Across the values and principles included in the ethical domain of the Health Promotion Values and Principles Continuum, the WR-PHI analysed in this study were predominantly reflective of traditional health promotion values and principles (Table 3). Some discourses were somewhat reflective of critical health promotion values and principles, but these were largely subordinated by the hegemonic discourses consistent with traditional health promotion. The WR-PHI were therefore not consistent with the ethical values and principles of critical health promotion.

A strength of the study is that it responds to the call to make explicit the values and principles underpinning existing health promotion programs. The study used a practical theoretical framework and well-defined methodology that enabled the discourses in the WR-PHI to be identified and the results to be used to evaluate the extent to which the initiatives are consistent with ethical health promotion values and principles. One of the limitations of the study was that it did not include other government documents such as program evaluation reports or submissions to the consultative processes, or weight-related public health initiatives developed by non-government organisations or the private sector. Future research could focus on such initiatives to determine if the discourses are reflective of those identified in this study. Furthermore, as the study did not involve health promotion and public health practitioners, policy makers or members of the community, it is not known what

their views and experiences are of these weight-related public health initiatives. Future research is needed to explore these important perspectives.

Conclusion

Health promotion practitioners developing, implementing and evaluating weight-related public health initiatives need to critically reflect on the ethical values and principles inherent in these initiatives. Critically examining the extent to which such initiatives reflect the ethical values and principles of health promotion is an essential foundation for mobilising discussion, driving change towards critical or best practice health promotion, and thereby contributing to reorienting and changing public health responses to body weight towards a more ethical approach.

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