

GLOBALISATION AND RISING OBESITY IN LOW-MIDDLE INCOME COUNTRIES

ABSTRACT

While globalisation is a complicated term, evidence shows that increasing political and socio-economic connections, which is a hallmark of globalisation, dictate countries' health and economic decisions. These decisions significantly modify individuals' material circumstances and behavioural activities and lead to physical or psychological expression of disease.

In 2017, the WHO reported that over 4million people died from being overweight or obese. In the last four decades, the rates of obesity, especially in children and adolescents, have quadrupled from 4%-18% globally; in 2016, over 340 million children were either overweight or obese.

Non-traditional global health governance actors-whose influence in determining economic and global health decisions has risen in the last decades- have consistently furthered economic interests, which is, in part, fueling the obesity pandemic.

This paper argues that the increasing economic integration from globalisation, with the aid of the current global health governance landscape, drives the current obesity pandemic by worsening the social determinants of health, perpetuating inequality, and promoting unhealthy changes in the population's economic and socio-cultural environment.

Keywords: Obesity, Global Health, Public Health, Global Health Governance

INTRODUCTION

Abnormal and excessive fat deposition characterises obesity, a significant cause of associated ill-health (1). In 2017, the World Health Organisation (WHO) reported that over four million people died from being overweight or obese. In the last four decades, the rates

of obesity, especially in children and adolescents, have quadrupled from 4%-18% globally; in 2016, over 340 million children were either overweight or obese. Childhood Obesity, once thought to be a problem in high-income countries, is now rising in Sub-Saharan Africa and Asia, increasing by 25% in Africa since 2000 and over 50% in Asia by 2019 (1). Adults are not left out. In 2016, 1.9 billion adults were overweight; 650 million were obese (1).

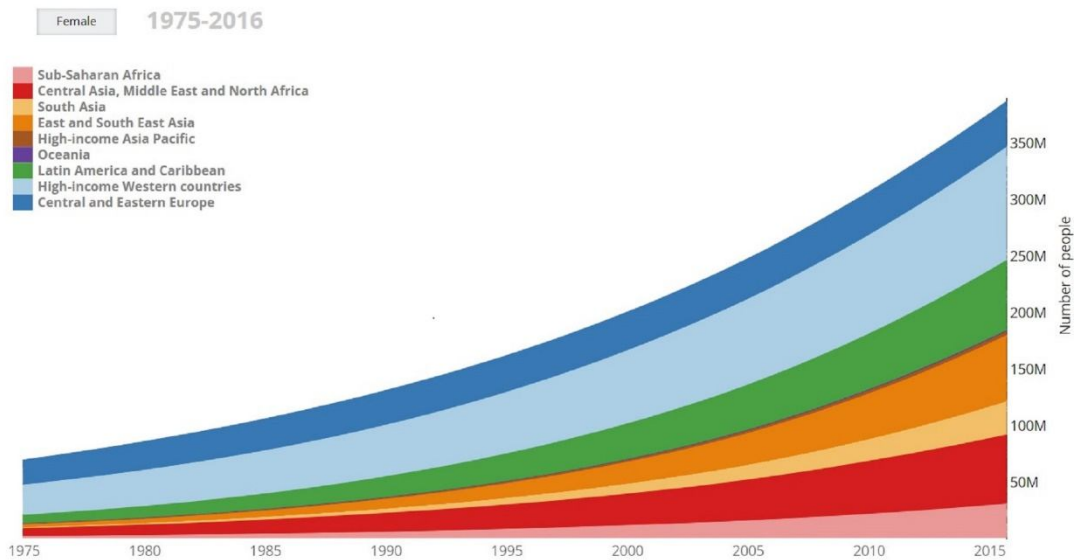


Figure 1: Trends in Global Female obesity patterns by region 1975-2016 (2)

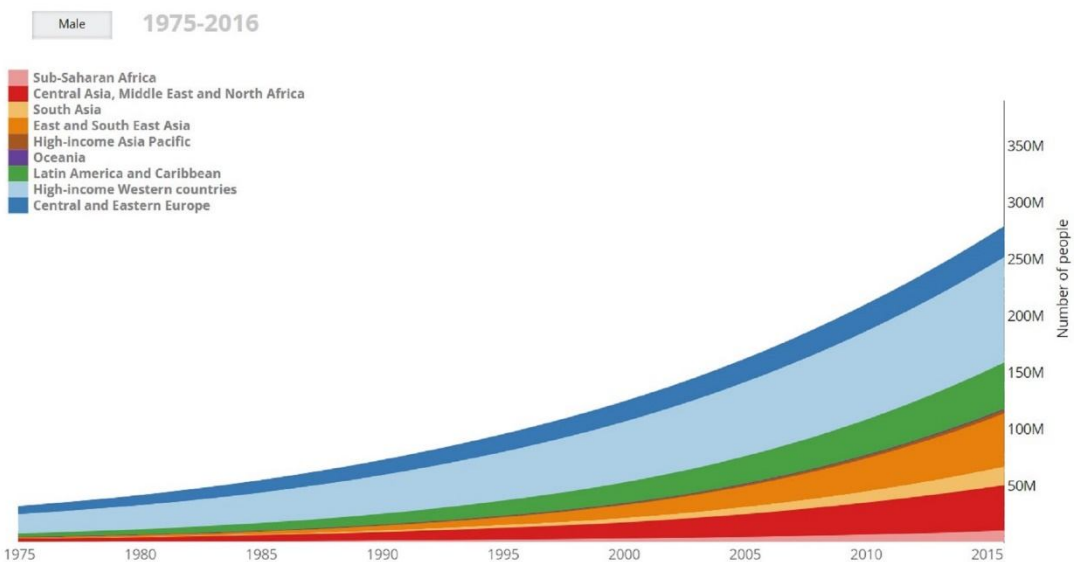


Figure 2: Trends in Global Male obesity patterns by region 1975-2016 (2)

Obesity is due to an imbalance between calorie consumption and energy expenditure, and policies initially targeted obesity by focusing on individual choices. However, evidence shows that obesity is not wholly dependent on individual choices but is an interaction between health's social determinants and individuals' choices (3). Factors like poor sleep, high-stress levels, and sedentary behaviour with weight gain are now known to be associated with the aetiology of obesity (4-6). These "obesogenic" factors are closely related to an individual's socio-political and socio-economic environments, e.g., race, ethnicity, social class, income, education, and gender (7-9).

This paper will argue that the increasing economic integration from globalisation drives the current obesity pandemic by worsening the social determinants of health, perpetuating inequality, and promoting unhealthy changes in the population's economic and socio-cultural environment. The paper will also show how current global health governance systems aid the increasing prevalence of obesity and proffer ways to strengthen global health governance to arrest the growing obesity pandemic.

WHAT IS GLOBALISATION?

Globalisation is a complicated term to define. Many scholars argue about what the term connotes and how it frames research and policy regarding Global health (10). However, all scholars on globalisation agree that it is characterised by deepening and widening connections worldwide.

Scholte uses words like internationalisation, liberalisation, westernisation and universalisation to describe globalisation (11). However, he argues that these words limit globalisation research because it does not "*generate new understanding that is not attainable with other concepts*" (11). Scholte proposes using Globality instead and argues that this is more appropriate for discussions regarding globalisation. He based his assertion on the fact that Globality better serves to relate globalisation to its effect on the social space where humans live and operate. However, as Sparke argues, globalisation has two forms-

Political/Economic and Ideational- framing its influence on global public health (12). Hence, in Sparke's view, globalisation may be described as:

1. A broader economic integration aiming to extend trade values or economic policies between nations (12)-Political/Economic form of globalisation

OR

2. A form of solidarity when tackling a pandemic or when there is a need to improve drug access among the poor (12) -Ideational form of globalisation

This paper will adopt Sparke's argument of globalisation as a political/economic form because, irrespective of the term used to describe globalisation, global health governance and outcomes do not lie outside the influence of politico-economic decisions or activities but are driven by it.

Jenkins' definition of globalisation sums up the politico-economic nature of globalisation.

"... a process of greater integration within the world economy through movements of goods and services, capital, technology and (to a lesser extent) labour, which lead increasingly to economic (and health) decisions being influenced by global conditions... (13)."

HOW GLOBALISATION DRIVES THE OBESITY PANDEMIC

Socio-economic and political environments play a huge role in modifying individuals' material circumstances and behavioural activities. These modifications, in turn, lead to the disease's physical or psychological expression (14, 15). These inequalities result from government policies (actions and inactions) which, as the world grows more interconnected, become more dependent on external factors rather than driven by local contexts.

Reduction in trade boundaries and increasing interdependence of economies have been hallmarks of globalisation exemplified by the 2008 economic crisis. However, relating the effects of globalisation to population health only recently became mainstream, and while an argument that globalisation has brought about wealth and improvement in the lives and economies of many countries exists(16, 17), it is also known to increase inequalities within

and amongst countries, especially among the socio-economically vulnerable population. Globalisation directly influences the distal/structural determinants of health and indirectly influences the proximal/intermediate determinants of health (14, 18), producing the observed population health characteristics, or in this case, obesity.

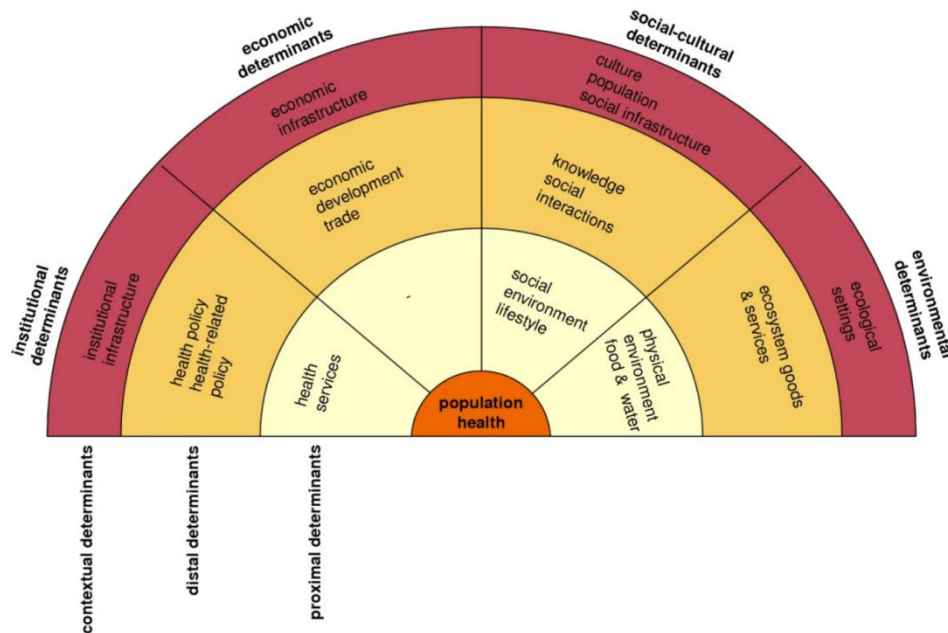


Figure 3: Conceptual framework for the effect of globalisation on population health (18)

Firstly, multilateral and bilateral agreements, e.g., the Trans-Pacific Partnership agreement, facilitate globalisation. However, these agreements thinly veil power imbalances that favour the more developed party, leading to an influx of foreign trade and goods at lower prices that put local businesses and local food producers in danger by weakening their bargaining powers (19, 20). This translates to reduced income for these small business owners and an inability to afford healthy food choices for their families.

Next, the resulting trade liberalisation leads to an influx of imported foods and the technology to set up manufacturing hubs in the host countries, leading to a broader range of food options (21). However, in Low Middle-Income countries (LMICs), which are majorly net importers, there is a net increase in the availability of processed food compared to local produce. Furthermore, the rapid change in diet to highly processed fast foods provides

business opportunities, especially in fast-growing populations like Sub-Saharan Africa. This "gold mine" (a McKinsey report put the food processing and handling sector at 100 billion USD in 2018 (22)) is exploited through the various trade agreements to set up wholesale and retail manufacturing hubs of highly processed food all over the region.

With the rapid influx of highly processed foods and big food companies' set-up of manufacturing hubs locally, the food ecosystem and the resultant goods provided are irreversibly altered. Also, the services provided by these companies and the allure of western-styled jobs cause the migration of farmers previously involved in the farming of whole foods to these companies, leading to a net reduction in the availability and a resultant increase in the prices of healthy food options. **This price increase further puts the reach of healthy food options out of the poor and forces them to consume the cheaper unhealthy options.**

Furthermore, with increasing globalisation and the possibility of an untapped market, especially in sub-Saharan Africa, big food companies successfully lobby governments to pass legislation favouring the continued dominance of their products. For example, despite anti-advertising laws in South Africa, lobbyists succeeded in watering down the regulation, allowing direct T.V. advertisements to children (23, 24). Other LMICs are not left out. In Mexico, **food and beverage companies tailored 75% of advertisements watched by children toward influencing the consumption of unhealthy foods and beverages.** These companies can also influence health policy by providing industry-sponsored research as a basis for making policies. In China, for example, Coca-Cola shaped health policy for obesity by shifting focus from a population health approach to an individual-based approach (25).

Trade liberalisations and economic globalisation may provide the background for the proliferation of unhealthy food and even directly influence policies. However, an indirect modification of population habits and lifestyles, like the participation of these companies in corporate social responsibilities in an attempt to clean up their image before the public, makes the final piece of the puzzle come together. These companies embark on providing

their products to school children under the guise of nutrition or even sponsoring sports activities known to be good for health (26, 27). Therefore, this indirect modification promotes the idea that the consumption of ultra-processed foods is timesaving, cheaper, and connotes a particular classist appearance. They target the working class with how easy it is to make a meal using these products, children by how palatable and sweet the food is, and adolescents and teens by how "hip" consumption of these meals makes them (28, 29). The "westernisation" of these meals feeds into the class anxiety already present and further shapes the lifestyle of the targeted population leading to the view that locally produced healthy meals are inferior.

Finally, with increasing economic integration, knowledge and technology transfer options between nations become easy and flow alongside trade. However, this flow of technology does not come without its dangers (30, 31). Technological advances have provided the means to prepare meals from stores easily. Microwaves and ultra-fast ovens mean that pre-packaged meals can be ready in a few minutes. Technology has provided ways to get any meal or grocery delivered to your doorstep at the click or touch of a screen. Companies advocate that we put our feet up and let them bring our meals to us. Technology also means that little labour is needed to produce outputs that would have taken one hundred people in the past to produce. In addition, with the growth of technology, population growth, and migration towards urban areas associated with globalisation, housing has sprung up without designing areas necessary for physical activity or recreation. Therefore, the increasing "economic boom" comes at the cost of physical activities leading to more sedentary lifestyles.

CURRENT GLOBAL HEALTH GOVERNANCE RESPONSE TO OBESITY

Like globalisation, global health governance (GHG) has varying definitions. With the explosion of interest in the role of governance in global health in determining global population health (32), the change in recent decades from terms like international health governance and the involvement of non-traditional actors like **the World Trade Organisation**

(WTO), International Monetary Fund (IMF) and World Bank in the global health space, the boundaries of GHG have become blurred(32, 33). Lee attempts to discuss this by providing three conceptual forms used to discuss GHG in academic literature (34). Frenk and Moon also argue that GHG's meaning depends on the lens with which it is viewed (35). Despite the several ways used to describe GHG, it is clear that governance in the global health space affects population health.

The WHO acting as the leader in global health, has repeatedly called for a response to the obesity pandemic (1). It commissioned the "*WHO Global Strategy on Diet, Physical Activity and Health*" in 2004 and restated its commitment to this goal in 2011, recognising and endorsing the role of personal choice in an environment conducive to making these choices and recognising the private sector as an ally in its drive to control obesity (36).

The "*Global action plan on physical activity 2018–2030: more active people for a healthier world*" advocates for the provision of functional spaces via the deliberate creation of enabling laws. The plan calls for purposeful attempts at creating active societies by changing the prevailing socio-cultural norms regarding processed foods (37).

Also, it developed "*The 2030 Agenda for Sustainable Development*", an ambitious project to cut the mortality from Non-Communicable Diseases (NCDs) by 30% by 2030. It aimed to get national governments committed to Sustainable Development Goals (SDG) 3.4 by setting up policies to improve food choices and environments(38). Despite these actions, obesity is still on the rise.

In the period the WHO commissioned various projects to combat obesity, free trade agreements (FTAs) which the WTO oversees, increased to 270 in 2017 in less than 30 years, and obesity rose from 4% to over 18% in the corresponding period(39). Evidence shows that the proliferation of FTAs is associated with increased sugar and calorie consumption(39, 40), demonstrating the global north's heavy influence in the governance and set up of WTO. This governance set-up pushes capitalist ideas and policies that further the global north's goals without concern for the health of the global south(39, 40). While the

WHO's policy actions against obesity may have called for inter/multi-sectoral cooperation, the reality is that cooperation among the major players in the GHG space has been anything but that (39, 40).

The WTO may not be a traditional actor in GHG. However, its policies and activities indirectly affect global health. Its organisation and set-up put it outside the influence of the WHO while allowing it to wield power and influence over population health through the various trade agreements. Furthermore, the increasing relevance of the private sector aided by the trade agreements overseen by the WTO and other non-traditional actors in the current GHG landscape and the continued recognition of their role by the WHO has seen their influence and ability to sway public policy indirectly or directly increase in recent times.

HOW CAN GLOBAL HEALTH GOVERNANCE BE IMPROVED TO TACKLE OBESITY?

GHG in obesity is mainly affected by intersectoral challenges(35). The crisscrossing of the WTO, IMF, and World Bank policies and agendas creates a confusing atmosphere for GHG and obesity. The trade agreements and economic policies of these actors in GHG have consistently reflected the influence of the global north without consideration for local contextual factors in LMICs that may make these policies ineffective or harmful. To tackle this, the WHO must become a key player in the governance of these bodies. Currently, the WHO has only an observer role in these bodies and does not have the power to vote. In order for policies to align, this needs to change. The WHO must be able to have its say on policies affecting population health overall, and its policies regarding health should serve as foundations for policies driving trade or economic discussions. Furthermore, there is a need to restructure the global north's role in the governance and constitution of these increasingly critical non-traditional actors.

Finally, to effectively champion GHG in tackling obesity, the WHO must ramp up its efforts in advocacy and calls for change to deliver the four goods of global health(35)-providing knowledge, mitigating externalities, marshalling global solidarity, and providing stewardship.

While it unarguably provides knowledge for global health, it has been unsuccessful in mitigating externalities and marshalling global solidarity. This has been due to a lack of enforcement powers and the current governance set up in the U.N. and other non-traditional global health actors. The WHO should be given the powers necessary to enforce adherence to its guidance and regulations in matters adjudged to pose a severe danger to population health. The success of the FCTC treaty lends credence to the fact that the WHO can function as the leader in GHG.

CONCLUSION

The continued power of the global north in shaping the decisions of actors in GHG will continue to fuel the current intersectoral challenges unless traditional GHG actors overhaul their governance structures. The current governance structures and increasing economic integration and trade liberalisations favour the creation of inequalities and a widening of economic classes, which fuel the present rise in obesity numbers globally by reducing financial ability and replacing locally available healthy food options. Restructuring the current GHG by empowering the WHO to make its policies a basis for future trade or economic policies is one of the ways the current GHG can better combat the rising obesity pandemic

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