The Fox Building the Henhouse:
Corporate influence on global health governance and the risks to the World Health Organization

by

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Author's declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

Like global governance more generally, global health governance and the global health architecture are changing and, in the process, creating new kinds of openings for non-state actors (NSAs) such as non-governmental organizations (NGOs), the private sector, and philanthropic organizations. This growing role for NSAs in global health governance has occurred at the same time as the World Health Organization (WHO) has turned to the private sector and philanthropic organizations for multistakeholder partnerships and voluntary contributions to bridge its budgetary gap due to some states capping their annual contributions. But without adequate safeguards, there is a risk that the increased influence of the private sector on global health policy-making, norm-setting and governance at the WHO can result in substantive policy shaped to prioritize profits over public interest and health outcomes. There are also risks for the WHO, as the global lead body on health, including the potential for conflicts of interest, damage to institutional reputation, and deeper reliance on private funding in ways that undermine the WHO's mandate.

This dissertation seeks to answer the following questions: 1) In what ways have profit-oriented NSAs engaged with the WHO as a site of global health governance on substantive policies and paradigms that shape policy-making? 2) What are the implications for the WHO of the agency's enhanced engagement with the private sector? This dissertation examines these questions broadly as well as through in-depth analyses of the specific cases of the baby food and soda industries.

The analysis in this dissertation finds that, despite their self-representation as trustworthy partners in addressing health issues, private sector actors have worked to influence substantive initiatives by the WHO related to the sale and consumption of their products. Private sector actors have also engaged in a long-game to shape paradigms that determine which policies are pursued and what role private actors are able to play in developing them. These paradigms create an environment conducive to companies and their associations, for example, arguing against regulation and in favour of voluntary measures and representing themselves as legitimate partners in developing health-related policy. Like other industries, the baby food and soda industries have pursued their substantive and long-term interests by drawing on a so-called "corporate playbook" of strategies and tactics to access and impact upon global health policy-making at the WHO. These strategies and tactics are iterative and mutually reinforcing.

Furthermore, in its efforts to bridge its budgetary gap, the WHO has potentially set itself up for even more in-depth influence by opening itself to fuller engagement through multistakeholder arrangements and PPPs. This fuller engagement has been formalized by the WHO's Framework of

engagement with non-state actors (FENSA). Analysis of the contested development of FENSA serves to highlight the types of issues against which the WHO must guard itself if it is not to undermine the agency's independence, integrity, credibility and mandate. Although FENSA is ostensibly intended to safeguard against potential conflicts of interest, conflating "conflict of interest" with the different but related notion of "conflicting interests" leaves the WHO vulnerable to those very conflicts of interest and can lead the agency to greater, not less, influence from profit-based actor. As it continues to adopt a multistakeholder approach and widen its engagement with NSAs in order to address its financial challenges, the WHO is potentially setting itself up for greater dependence on for-profit entities, which can lead to further conflicts of interest and erosion of the WHO's role as lead global health body.

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Table of contents

List of abbreviations

ABA	American Beverage Association
AFRO	The World Health Organization's Regional Office for Africa
AMRO	The World Health Organization's Regional Office for the Americas
CI	Consumers International
CSI	Civil Society Initiative
CSO	Civil Society Organizations
DPAH	Diet, Physical Activity and Health
EBSS	Executive Board Special Session
EPTA	Expanded Programme for Technical Assistance
EMRO	The World Health Organization's Regional Office for the Eastern Mediterranean
EURO	The World Health Organization's Regional Office for Europe
FCTC	Framework Convention on Tobacco Control
FENSA	Framework of Engagement with Non-State Actors
FSW	Foundation for a Smoke-Free World
GAIN	Global Alliance for Improved Nutrition
GCM/NCD	Global Coordination Mechanism on Non-Communicable Diseases
GEBN	Global Energy Balance Network
HAI	Health Action International
IBFAN	International Baby Food Action Network
ICIFI	International Council of Infant Food Industries
IFBA	International Food and Beverage Alliance
IFM	International Association of Infant Food Manufacturers
IFPMA	International Federation of Pharmaceutical Manufacturers' Associations
ILSI	International Life Sciences Institute
IOCU	International Organization of Consumers Unions
ISDI	International Special Dietary Foods Industries Federation
LNHO	League of Nations Health Organization
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NSA	Non-State Actor

OIHP	Office International d'Hygiène Publique
PAHO	Pan American Health Organization
PASB	Pan American Sanitary Bureau
PASO	Pan American Sanitary Organization
PINGO	Public-Interest Non-Governmental Organization
PPP	Public-Private Partnership
SBN	SUN Business Network
SEARO	The World Health Organization's Regional Office for South-East Asia
SUN	Scaling-Up Nutrition
TRS916	Technical Report Series 916, Diet, Nutrition, and the Prevention of Chronic Diseases
UNICEF	United Nations Children's Fund
UNRRA	UN Relief and Rehabilitation Administration
WHA	World Health Assembly
WHO	World Health Organization
WPRO	The World Health Organization's Regional Office for the Western Pacific
WSRO	World Sugar Research Organisation

Chapter 1 – Introduction

"The new distribution of power raises an absolutely critical question for health in the sustainable development era. Who really governs the policies that shape our health? Is it democratically elected officials acting in the public interest? Is it multinational corporations acting in their own interest? Or is it both? That is, governments making policies that are heavily influenced by corporate lobbies."

Dr. Margaret Chan, Former Director-General of the World Health Organization[1]

1.0 Introduction

Like global governance more generally, global health governance and the global health architecture are changing and in the process creating new kinds of openings for non-state actors (NSAs) such as non-governmental organizations (NGOs), the private sector, and philanthropic organizations (Fidler, 2009; K. Lee & Smith, 2020; McInnes, 2020; O. D. Williams & Rushton, 2011; Youde, 2020). The state remains an important actor in global health governance, and in governance more broadly: States have a duty to protect and fulfil the rights of their populations and they are responsible for representing the public interest in decision-making, including as part of intergovernmental organizations such as the World Health Organization (the WHO). Yet, as this dissertation suggests, states are relinquishing – or delegating (Moloney & Stone, 2019) – some of this role to NSAs, such as corporations, and to multistakeholder initiatives[2].

This growing role for NSAs in global health governance has occurred at the same time as the WHO, the United Nations specialized agency for health created in 1948, has become resource-constrained and found its role as lead global health body undermined as some states capped their annual contributions to the agency and other international organizations. To bridge its budgetary

[1] Address at the Regional Committee of Europe on 15 September 2015. (http://www.who.int/dg/speeches/2015/europe-regional-committee/en/)

[2] Interactions between the public and the private sectors are described in UN, academic and corporate literature by a number of terms, including PPPs; "collaboration or alliances with the business sector; public-private joint initiatives; voluntary initiatives; multistakeholder initiatives or dialogues; corporate social responsibility- or corporate citizenship initiatives; cause-related marketing; corporate sponsorship; venture philanthropy; and reputation- and issues-management" (Richter, 2004b, p. 5). "Multistakeholder" is spelled in this dissertation (except in direct quotations) as one word (without a hyphen) to emphasize the extent to which the model has been regularized and normalized, and the term "multistakeholderism" to describe the dominant approach "in which everyone enters the room on the same footing, ignoring differences in interests, roles, and responsibilities among the parties, and negating power imbalances" in contrast to "participatory multi-actor deliberation" (McKeon, 2017, p. 380).

gap, the WHO has turned to the private sector and philanthropic organizations for multistakeholder partnerships and voluntary budgetary contributions.[3]

However, greater corporate influence over the WHO governance and policy-making carries risks. There is a growing literature about the ways in which corporate activities and influences shape health outcomes (Freudenberg & Galea, 2008; Kickbusch et al., 2016). Freudenberg (2014, p. viii) argues that "a few hundred corporations have changed the world to suit their needs, and as a result set the stage for the twenty-first century disease epidemics". Without adequate safeguards, the increased influence of the private sector on global health policy-making,[4] norm-setting and governance at the WHO, including through the agency's reliance on and partnership with corporations and their associations, can result in substantive policy shaped to prioritize profits over public interest and health outcomes. There are also risks for the WHO as the global lead body on health in an evolving global health architecture, and for global health more broadly, including the potential for conflicts of interest, damage to institutional reputation, and deeper reliance on private funding in ways that undermine the WHO's mandate and normative functions.

Against this backdrop of the growing involvement of NSAs in global health governance, as part of a global shift toward multistakeholder approaches and public-private partnerships (PPPs)[5] to address financing challenges, this dissertation seeks to answer the following questions: 1) In what ways have profit-oriented NSAs engaged with the WHO as a site of global health governance on substantive policies and paradigms[6] that shape policy-making? 2) What are the implications for the

[3] This dissertation does not seek to prove causation between the WHO's budgetary gap and the agency's turn to the private sector for financing. Rather, it explores the ways in which the need to bridge this gap has potentially set up the WHO for even more in-depth influence on both substantive policy areas as well as health policy governance, and thereby both exposed the agency to potential conflicts of interest and conflicting interests (this distinction is discussed below) and also undermined its role as global health leader. This risk has significant implications for the agency and for global health.

[4] Drawing on Rushton and O. D. Williams (2012, p. 150), "global health policy" in this dissertation refers to "those policies, both formal and informal, adopted on either an international or domestic level that respond to or affect health." It includes "both formal instruments (such as laws, rules, standards, regulatory frameworks) and more informal outputs (such as principles, norms and guidance)" (Rushton & Williams, 2012, p. 150). It may refer to both single global policies addressing a particular issue, as well as "a range of overlapping and sometimes competing policies from various sources" (Rushton & Williams, 2012, p. 150).

[5] Interactions between the public and the private sectors are described in UN, academic and corporate literature by a number of terms, including PPPs; "collaboration or alliances with the business sector; public-private joint initiatives; voluntary initiatives; multi-stakeholder initiatives or dialogues; corporate social responsibility- or corporate citizenship initiatives; cause-related marketing; corporate sponsorship; venture philanthropy; and reputation- and issues-management" (Richter, 2004b, p. 5).

[6] Paradigms are, according to Campbell (1998, pp. 385 & 389), "underlying theoretical and ontological assumptions about how the world works" and operate in the "cognitive background" to "constrain action by

WHO of the agency's enhanced engagement with the private sector? This dissertation examines these questions broadly as well as through in-depth analyses of the specific cases of the baby food and soda industries.

1.1 Summary of findings and contributions

This dissertation finds that, despite their self-representation as trustworthy partners – "part of the solution" (Nixon et al., 2015), as they refer to themselves – in addressing health issues, private sector actors have worked to influence substantive initiatives by the WHO related to the sale and consumption of their products. Private sector actors have also engaged in a long-game to shape paradigms that determine which policies are pursued and what role private actors are able to play in developing them. These paradigms create an environment conducive to companies and their associations, for example, arguing against regulation and in favour of voluntary measures and representing corporate actors as legitimate partners in developing health-related policy. Like other industries, the baby food and soda industries have pursued their substantive and long-term interests by drawing on a so-called "corporate playbook" (Brownell & Warner, 2009; Madureira Lima & Galea, 2018; Wiist, 2010) of strategies and tactics to access and impact upon global health policy-making at the WHO. The "playbook" refers to a variety of similar strategies and tactics witnessed across many industries, which include using and shaping the political environment, political and public preferences, the knowledge environment, the legal environment and the extra-legal environment (Madureira Lima & Galea, 2018). These strategies and tactics are iterative and mutually reinforcing, which is to say an actor may use one strategy or tactic to increase its ability to utilize, and the effectiveness of, others.

Beyond substantive policy and the paradigms that shape it and the private sector's role in policy making, there are other implications for the WHO and for global health governance of the agency's enhanced engagement with the private sector. In its efforts to bridge its budgetary gap, the WHO has potentially set itself up for even more in-depth influence by opening itself to fuller engagement through multistakeholder arrangements and PPPs. This fuller engagement has been

limiting the range of alternatives that policy-making elites are likely to perceive as useful and worth considering". My understanding of paradigms also draws on Hall's (1993, p. 279) description of them as "a framework of ideas and standards that specifies not only the goals of policy and the kind of instruments that can be used to attain them, but also the very nature of the problems they are meant to be addressing. Like a *Gestalt*, this framework is embedded in the very terminology through which policymakers communicate about their work, and it is influential precisely because so much of it is taken for granted and unamenable to scrutiny as a whole".

formalized by the WHO's Framework of engagement with non-state actors (FENSA). Analysis of the contested development of FENSA serves to highlight the types of issues against which the WHO must guard itself if it is not to undermine the agency's independence, integrity, credibility and mandate. Although FENSA is ostensibly intended to safeguard against potential conflicts of interest, conflating "conflict of interest" with the different but related notion of "conflicting interests" leaves the WHO vulnerable to those very conflicts of interest and can lead the agency to greater, not less, influence from profit-based actor. Furthermore, as it continues to adopt a multistakeholder approach and widen its engagement with NSAs in order to address its financial challenges, the WHO is potentially setting itself up for greater dependence on for-profit entities, which can lead to further conflicts of interest and erosion of the WHO's role as lead global health body.

This dissertation makes both empirical and theoretical contributions. Empirically, this thesis contributes to the literature in the following ways: first, an analysis of the private sector's influence on, and participation in, global health policy-making in two issue areas and, second, an analysis of the evolution of the WHO's policies concerning its engagement with non-State actors (NSAs). As the first empirical contribution to analyze the potential for corporate influence on substantive policy and paradigms that shape policy-making, this dissertation uses qualitative case studies of the private sector's influence on, and participation in, global health policy-making in two issue areas.

The first case study involves the baby food industry[7] and its marketing of baby milks and foods in the context of infant health outcomes. Concern over the aggressive promotion of formula milks and related products and declining breastfeeding rates increased over the 1960s as doctors established the negative impact of marketing and advertising on breastfeeding practices. The baby food issue landed on the global agenda in the 1970s, when public outcry resulted in a boycott of market leader Nestlé. In response, the WHO and UNICEF were compelled to pursue an international code to regulate the marketing of baby milk and related products. The result was the WHO's adoption in 1981 of the International Code of Marketing of Breastmilk Substitutes (WHO, 1981b), which hereafter I will refer to as "the Code". Almost forty years later, the baby food industry has modified its marketing practices but continues to promote its products in ways that violate or stretch the Code and to lobby for policies that put profits before infant health (Mehdi &

[7] In this dissertation, the baby food industry refers to for-profit companies that manufacture, market or distribute BMS, foods for infants and young children, feeding equipment such as teats, bottles (including those used with breast pumps), and other products and ingredients used for feeding infants, young children, and pregnant and lactating mothers (Granheim et al., 2017). It also includes their business associations and front groups.

Wagner-Rizvi, 1998; Save the Children, 2007; Save the Children Pakistan, 2013; Anna Taylor, 1997; The Network, 1999; Yeong et al., 2010; Yeong & Allain, 2014, 2017).

The baby food issue is significant because it has a long history on the global health agenda. This case study also offers insight into the changing nature of global (health) governance. For example, in response to the problem, a WHO-UNICEF joint meeting in October 1979 brought together representatives of the UN, national-level governments, industry, experts from a range of disciplines, and NGOs including six organizations[8] that would create the International Baby Food Action Network (IBFAN) at the meeting (Allain, 2005). IBFAN is the first and longest-running single-issue transnational advocacy network (Allain, 1989) and works to keep the baby food industry's influence in check. This meeting marked the first time that industry and NGO actors sat as equal participants with government delegates in a UN summit (Allain, 1989, 2005; Chetley, 1986, pp. 63–65).

The analysis demonstrates that the baby food industry continues to engage with the WHO in connection with policy-making related to infant feeding half a century after the marketing of their products became recognized as a health issue. Given the fact that the WHO does not have regulatory authority, this engagement indicates that the agency nevertheless represents a significant site of policy-making for this industry. The analysis shows that the baby food industry's engagement with the WHO – using strategies and tactics from the corporate playbook to influence substantive policy and shape paradigms conducive to their interests – has been intended to protect the marketing of its products, including by creating doubt about the scope of the Code and undermining efforts for formal regulation at the national level by representing themselves as responsible, trustworthy and capable of self-regulation.

The second case study relates to soda (sugar-sweetened beverages), in the context of non-communicable diseases (NCDs). The WHO, scholars, NGOs and the media refer to the increased incidence of NCDs such as diabetes and obesity as an "epidemic" (for example, Herrera, 2015; NCD Alliance, 2017; Nesheim & Nestle, 2015; WHO, 2015b)[9]), although this framing is also

[8] International Organization of Consumers Unions (IOCU) – now called Consumers International, Interfaith Center on Corporate Responsibility (ICCR), Infant Formula Action Coalition (INFACT), OXFAM, War on Want, Déclaration de Berne.

[9] (Chopra et al., 2002; Daynard et al., 2004; De Vogli et al., 2014; Johnston & Finegood, 2015; Jönsson, 2014; Malik et al., 2006; Mann et al., 2015; Myers et al., 2015; Nulu, 2016; Pietrobelli & Agosti, 2017; Sacks et al., 2013; Schram et al., 2015; Schrecker & Bambra, 2015; Sridhar et al., 2013; Stuckler et al., 2012; A. Taylor et al., 2012; UNGA, 2011; Yancey et al., 2006).

contested, disputed and highly politicized, as are the terms "obesity" and "obese" [10]. Compared with the baby food issue, concerns about soda and the health effects from consuming it emerged more recently on the global agenda. The soda case also differs from the baby food case in that the causal relationship between the marketing and consumption of soda and health outcomes is more difficult to isolate and attribute than in the case of the marketing of infant formula, decreased breastfeeding and increased infant morbidity and mortality. Soda is not the exclusive cause of diabetes, obesity, and other NCDs, but extensive research points to its consumption as a contributing factor to, or even a key driver of, the global rise in their rates. Soda manufacturers play a significant role in driving up the consumption of soda through the tactics that will be examined below.

As with the baby food case, the analysis indicates that the soda industry's engagement with the WHO has aimed to protect its sales and profitability and to undermine calls for regulation by promoting its self-regulation and voluntary initiatives. Unlike the baby food case and the Code, there is no the WHO policy dealing specifically and exclusively with soda. The only global policy addressing soda specifically is with respect to its marketing (along with foods and other non-alcoholic beverages) to children. Instead the soda industry engages with the WHO on matters relating to its constituent ingredient (sugar) and to lifestyle (diet, physical activity and health) and NCDs, and to specific initiatives that could impact sales (for example, taxation). It also advocates a role for the private sector in policy-making and governance, especially in relation global efforts to prevent and control NCDs. The 2011 and 2018 Political Declarations for the Prevention and Control of NCDs, adopted by Special Sessions of the United Nations General Assembly, for example, specifically emphasize a role for, and partnerships with, the private sector. Having multistakeholder approaches and the private sector's role recognized and enshrined in such significant documents represents a major win for the soda industry as a global health governance actor.

The analysis of track-records of these two industries contributes to understandings of how private sector actors influence policy and policy-making at the WHO, which impacts upon the health and well-being of the world's population.[11] It outlines how private sector actors put their

[10] The framing of obesity as an "epidemic" is contested, disputed and highly politicized, however, as are the terms "obesity" and "obese" (see, for example, Firth, 2012; Medvedyuk, Ali, & Raphael, 2017; Millstone, 2010; Monaghan, Bombak, & Rich, 2017; Shelley, 2012). However, this discussion lies outside the scope of this dissertation.

[11] What this dissertation does *not* do in relation to the case studies, is independently evaluate the technical soundness or effectiveness of various policy options or make substantive policy recommendations. At most, it distinguishes which policies are preferred by health professionals and which by industry actors. This is to

profits ahead of health in the public interest, even while representing themselves as responsible corporate citizens. The analysis highlights the risks for the WHO, including to its independence, credibility and mandate, of its enhanced engagement with non-state actors, especially those that are profit-oriented, as will be discussed below with respect to the development and adoption of FENSA.

The dissertation's second empirical contribution is an analysis of the evolution of the WHO's policies concerning its engagement with non-State actors (NSAs), and specifically the for-profit sector, culminating in the agency's development and adoption of the "Framework of engagement with non-state actors" (FENSA). These policies, especially FENSA, provide a site for understanding the implications for the WHO and for global health governance of increasing industry influence on substantive policy and paradigms relating to their products and industries' roles as governance actors and the global shift toward multistakeholderism.

FENSA was adopted on May 28, 2016 (WHO, 2016f), after four contentious years of development. It was developed in the context of the agency's increasing reliance on public-private partnerships (PPPs) and multistakeholder collaborative initiatives for funding and carrying out its programs (Lhotska & Gupta, 2016). The purpose of the new policy was said to be to provide clear guidance to the WHO staff, its Member States and to civil society organizations (CSOs) on how to encourage and secure meaningful participation and collaboration of CSOs with the WHO (WHO, 2012f). However, the Secretariat's Report to the Executive Board in January 2014 on the November 2013 Financing Dialogue made it clear that financing was the purpose of FENSA. The Secretariat's report said the overall objective of the WHO's engagement with NSAs was to work towards fulfilling the agency's mandate "*by making better use of [NSAs] resources* (including knowledge, expertise, commodities, personnel and finances)" (emphasis added) (WHO, 2013j). It further stressed "the imperative need to conclude the framework for engaging with [NSAs], *in order to facilitate expansion of the contributor base beyond Member States*…, particularly in light of the growing demands for international health-related financing" (emphasis added) (WHO, 2013j).

The analysis of the development and adoption of FENSA considers the implications for the WHO of potentially opening itself to increased profit-driven influence and conflicts of interest, and

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say, for example, this dissertation does not make recommendations about the optimal duration of exclusive breastfeeding, for example, but it does provide reference to the duration recommended by health professionals as well as industry efforts to minimize this duration. Similarly, it does not make recommendations about the maximum sugar or soda consumption levels, but states the guidelines determined by the WHO through a scientific review and consultative process and notes the soda and sugar industries' efforts to challenge such guidelines.

for its integrity and independence, given the private sector's well-documented efforts to influence policy at the WHO. The dissertation considers the implications for global health governance of legitimizing actors with for-profit interests participating in global health standard-setting, norm-setting and policy-making. It also contributes an analysis of the extent to which the WHO is potentially setting itself up for greater dependence on for-profit entities, which can lead to additional conflicts of interest and further undermine the WHO's role as lead global health body.

Although the focus of this dissertation is the global health sector, the findings contribute to the understanding of similar developments in other fields where the corporate sector is promoting – and gaining – influence and legitimacy as governance actors through the entrenchment of multistakeholder approaches and PPPs. Locating the strategies and tactics deployed by the baby food and soda industries as part of a "corporate playbook" that is common across many industries, as mentioned above, allows for the analysis in the chapters to follow in relation to the baby food and soda companies and their business associations to be generalized to other sectors and fields.

Theoretically, this dissertation contributes to the literatures at the intersection of public health, global health, and international political economy in the following ways. The public health and global health literatures have identified the "corporate entity as a social structural determinant of disease" (Wiist, 2006a, p. 1370) and developed several useful conceptualizations for understanding corporate influence on health outcomes and disease burden. The first is the notion of "industrial epidemic" (Gilmore et al., 2011; Jahiel, 2008; Jahiel & Babor, 2007; Moodie, 2014; Moodie et al., 2013), adapting the traditional public health model of epidemics (host, agent vector) and applying it to the increase of diseases attributed to the consumption of industrial products such as tobacco, alcohol, food, cars, and guns. The second notion is "corporate (or commercial) determinants of health" (Hastings, 2012; Kickbusch, 2012; Kickbusch et al., 2016; Millar, 2013), which recognizes that the activities of companies and their associations shape the environments in which people live and make decisions and which have an impact on their health.

These literatures have classified the corporate sector's political activities as a playbook of strategies and tactics common across industries (Madureira Lima & Galea, 2018; Mialon et al., 2015). While recognizing the utility of the playbook concept for capturing corporate strategies and tactics, these literatures are lacking analysis of what types of power underpin the playbook, *how* the corporate sector goes about having this influence and what types of power it is able to access in order to do so, and the ways in which these strategies and different types of power are iterative and mutually reinforcing. To bring this depth and nuance to my analysis, I draw on the political science,

international relations, and international political economy literatures, wherein typologies and theories of power are central concepts (M. Barnett & Duvall, 2005; Fuchs, 2005; Lukes, 1974).

In summary, my analysis brings the following theoretical insights to the existing literature on global health governance:

a) An understanding of how corporations increase their legitimacy and influence as governance actors by participating in multistakeholder initiatives, PPPs, and self-regulatory platforms. This analysis shows the multistakeholder approach and self-regulation to be an extension of corporate actors' efforts to influence policy and shape paradigms and in the process, representing themselves as legitimate partners in global health policy-making and governance. For example, baby food company Nestlé has portrayed its membership in the UN Global Compact and the FTSE4Good index as indication of its responsibility through self-regulation in meeting international agreed baby food marketing standards although monitoring of its practices around the world has found that it does not. Companies' inclusion in such platforms and the acceptance of their voluntary codes and other self-regulation efforts as sufficient both draw on and reinforce their discursive, instrumental and structural power. It bolsters their ability draw on this power to represent themselves as responsible and trustworthy in order to influence substantive policy and reinforce a regulatory environment in which collaboration and partnership appears necessary and sufficient, and formal regulation unreasonable and unwarranted. Similarly, soda companies undertake self-regulation and other voluntary measures such as product reformulation, participating in collaborative initiatives and issuing "global public commitments" to send the message that the industry recognizes its role in addressing health concerns and it can be trusted to take responsible measures without government imposing legislation.

b) An application of the concept of the corporate playbook to the strategies and tactics undertaken by corporations and their associations at the international level, specifically at the WHO as the global lead body on health. Although the WHO lacks regulatory authority as it has no enforcement mechanisms, it remains a significant site for political activity by corporations and their business associations, such as those of the baby food and soda industries, seeking to influence both substantive policy recommendations and paradigms relating to health, their products, and their roles as governance actors. The baby food and soda industries both use strategies and tactics from the corporate playbook to exercise and

reinforce the types of power available to them, which leads to the third theoretical contribution.

c) A more nuanced understanding of the strategies in the "corporate playbook" as they are deployed to influence global health policy-making and governance at the WHO and how the strategies are accessible to the corporate sector. The analysis demonstrates how the corporate sector is able to access and draw upon different types of power – notably instrumental, structural and discursive power – in order to exercise various playbook strategies. For example, corporations can draw structural power from their market position and economic significance in national and global economies in order to shape the legal environment when governments understand that investments and jobs may move out of the country in response to unfavourable policies. The analysis also demonstrates that the exercise of one type of power often increases or reinforces access to another type of power. In other words, their strategies and tactics, as well as the different dimensions of power underpinning them, are iterative and reinforcing. For example, by using discursive power to represent itself as a "partner" and legitimate governance actor, the private sector increases its instrumental and structural power by shaping paradigms that determine which policies are pursued and what role private actors are able to play in developing them.

My analysis presents a critical evaluation of policy-making processes and mechanisms that are meant to safeguard the public interest but in fact increase private sector influence on global health policy with important implications for public health. Such a critical analysis is particularly necessary at a time when the agency increasingly seeks partnerships with the private sector and philanthropies to bridge its budgetary shortfalls due to Member States' non-payment of dues and caps on funding. This shift is taking place against a backdrop of an evolving global health architecture that increasingly involves multistakeholder initiatives and PPPs and an entrenchment of the role of private sector across the UN system (see, for example the Sustainable Development Goals (UNGA, 2015)). The UN's "rapprochement with business" was "motivated by both external changes in the UN's environment and internal bureaucratic dynamics" and the Secretariat's material interests (Pingeot, 2015, p. 8). It has led to private forms of authority such as multistakeholder initiatives and PPPs in global health governance being "widely, but not universally, seen as legitimate and desirable" (O. D. Williams & Rushton, 2011, p. 11) and the WHO's turn to the private sector not only acceptable but encouraged by its Member states.

1.2 Methodology

1.2.1 Positionality

My interest in the corporate influence on health and policy began 30 years ago, when – as an idealistic and environmentalist teenager – I became aware of the international boycott of baby food giant *Nestlé*. The company was marketing its products in ways that drew mothers away from breastfeeding, a more natural, healthier source for babies and better for the environment. Several years later, I worked with a health-related NGO in Pakistan on its advocacy campaign for a law prohibiting the marketing of baby milks and foods, in line with an international code on this issue. This work began nearly 25 years of involvement with the baby food issue, witnessing firsthand industry tactics to market their products and undermine government efforts to regulate these practices in Pakistan and elsewhere in the world. The more I got involved in this field the more aware I became of similar marketing and lobbying practices across industries and at different levels of governance. This experience informed my case selection and methodology for conducting the qualitative case studies for this research project.

1.2.2 Data sources

A challenge of conducting research about the corporate sector is accessing firsthand information about companies and industry associations (Kickbusch et al., 2016).[12] Companies are either unwilling to provide interviews or put forward a public relations person, which does not serve the purpose of this research. This was a particular concern for me because of my visibility in connection with the baby food issue in Pakistan and internationally[13] and I decided not to do interviews for this reason. Nevertheless, I was able to secure sufficient data from other sources in the public domain

[12] As will be discussed with respect to direction for future research, a new resource has become available for exploring food and beverage industry activities to influence both substantive policy and global health governance, although too late for inclusion in the analysis for this dissertation. The Food Industry Documents Archive was launched by the University of California, San Francisco Industry Documents Library on November 15, 2018 (UCSF, 2018). The Industry Documents Library is already home to archives about the tobacco, drug, and chemical industries that have made it possible to investigate corporate tactics for influencing public health policy.

[13] During my work in Pakistan, I published a Nestlé whistleblower's account of how the company markets baby milk in violation of the international marketing code and the company's own weaker policy. *Milking Profits* resulted in international media attention, an "internal audit" commissioned by Nestlé headquarters into the Pakistani subsidiary's operations, a hearing by a European Commission Special Committee, and a 2014 film (*Tigers)* by an Academy Award-winning director. The film had been in production for several years (as Nestlé was well aware (Nestlé, 2014)) and its release was pending as I embarked on my fieldwork for this project. The film remained on the film festival circuit for several years and remains available online.

and archives to make my case. Although most of what companies and their industry associations make publicly available is carefully crafted public relations material, such documents are a fundamental part of corporate efforts to "dominate the information environment, so they can significantly affect decision making" (Miller & Harkins, 2010, p. 566) and, as such, can provide insights into corporate motivations and strategies. These insights can then be corroborated with other sources from the grey literature – "that which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers" (New York Academy of Medicine, 2016) – and media reports.

Much of my information for the baby food case came from records acquired through my work with an NGO called The Network for Consumer Protection in Pakistan (formerly the Association for the Rational Use of Medication in Pakistan). The Network was a member of IBFAN, with which I remained involved to varying degrees and in different capacities over the years. These records were supplemented and updated by recourse to peer-reviewed academic articles and books (especially from the public and global health literatures), as well as the information collected from the websites, publications, and archives of the WHO, NGOs and networks (such as IBFAN and its member organizations), and baby food companies and their associations, as well as from the news media, business reports and other publicly available information (Mialon et al., 2015). In order to understand the baby food industry's formal engagement with the WHO, I collected submissions and interventions made by business associations during consultations and governing body meetings. These documents, which were available from the WHO and business association websites, pertained both to policies related to their products and infant nutrition and to the development of FENSA.

Because it was important to use the same method for both cases, data collection for the soda case relied similarly on peer-reviewed academic articles and books (again, especially from the public and global health literatures) and the relevant grey literature. I collected submissions and interventions made by business associations during consultations and governing body meetings. These documents, readily available from the WHO and business association websites, pertained both to policies related to their products and NCDs, as well as to the development of FENSA.

I also attended the 67th World Health Assembly (WHA) in May 2014 as a participant-observer in IBFAN's delegation. That WHA was expected to adopt the proposed FENSA but deferred it for further development. This participant-observation was particularly useful for the development of my analysis of the WHO's adoption of FENSA. It helped me to identify key issues

and critiques of early drafts of the proposed policy and the process through which it was being developed, and for answering my question about the implications for the WHO of the agency's enhanced engagement with the private sector.

1.2.3 Modes of analysis

To analyze the data, I developed timelines and documented the political activity of these two industries with respect to their engagement with the WHO. My analysis combined historical trends with insights from contemporary information, as well as with insights from other issue areas and industries, such as the tobacco, pharmaceutical and alcohol industries, with which it was possible to draw parallels. This analysis also benefited from my experience as an insider observer, having been involved with the baby food issue for many years.

To understand the strategies that corporations deploy to advance their political agendas, I undertook a document analysis (MacKenzie & Hawkins, 2016) of peer-reviewed articles, systematic reviews, and grey literature, including market analyses and reports published by government and intergovernmental agencies and NGOs. Documents of various types "can help the researcher uncover meaning, develop understanding and discover insights relevant to the research problem" (Merriam & Tisdale, 2015, p. 106). However, document analysis must take into consideration the provenance of the documents, including their source, intended audience, and intended purpose (MacKenzie & Hawkins, 2016).

My document analysis entailed an iterative process of "skimming (superficial examination), reading (thorough examination), and interpretation" that combined elements of content analysis and thematic analysis (Bowen, 2009, p. 32). In this sense, content analysis refers to "a first-pass document review" to identify meaningful and relevant text or data and to separate pertinent information from that which is not pertinent (Bowen, 2009; Corbin & Strauss, 2008). This was followed by a thematic analysis to recognize patterns in the data and themes for subsequent analysis (Fereday & Muir-Cochrane, 2006) to identify and track strategies for influencing both substantive policies and the paradigms that determine which policies are pursued and what role private actors are able to play in developing them. I corroborated these themes with insights from the submissions and interventions by NGOs and networks about their critiques with respect to industry influence and with respect to the development of FENSA.

My document examination also included a frame analysis of industry documents, including business reports, press releases and submissions to consultations, as well as corporate quotes and

representation in the media. Frames are "underlying structures of belief, perception and appreciation" (Schön & Rein, 1994, p. 23). Frames "emphasiz[e] a particular definition of a problem or solution and help shape policy discourses and the public policy agenda" (Scott & Nixon, 2017, p. 1). The framing of issues and actors make possible or encourage certain kinds of policy responses and preclude others (Hawkins & Holden, 2013; MacKenzie & Holden, 2016).

I also used document analysis to analyse the WHO's adoption of FENSA and its implications for the agency's integrity and independence. Document analysis here provided "the historical roots of specific issues and … indicate[s] the conditions that impinge upon the phenomena currently under investigation" and served "as a means of tracking change and development" (Bowen, 2009, pp. 29–30).

1.3 Overview of chapters

The chapters of this dissertation are as follows. To set the stage for the analysis of profit-oriented NSAs' engagement with the WHO as a site of global governance, Chapter 2 sets changes in global health governance in relation to the changing nature of global governance in general. These changes include the creation of openings for NSAs such as the private sector to influence upon and participate in governance and policy-making and the global shift toward a multistakeholder approach and PPPs. This shift exposes the WHO to potential risks, including undue corporate influence and conflicts of interest. For conceptualizing the impacts of corporate influence on health, including by influencing substantive policy and paradigms that shape policy-making, the chapter goes on to introduce the public and global health notions of "industrial epidemics" and "corporate (or commercial) determinants of health." In addition, while recognizing the utility of the concept of a corporate playbook (Madureira Lima & Galea, 2018) for capturing the strategies and tactics for-profit enterprises and their associations use to do this, the chapter goes on to develop a more nuanced conception that identifies as well the *instrumental*, *structural* and *discursive* dimensions of power that underpin them (Clapp & Fuchs, 2009b; Clapp & Scrinis, 2017; Fuchs, 2005, 2007; Levy & Egan, 2000).

As a way of situating this dissertation's analysis of corporate influence on substantive policies and paradigms that shape policy-making at the WHO and the implications for the agency of its enhanced engagement with the private sector, Chapter 3 provides context for understanding the WHO as a site of global governance and its financial challenges that have encouraged greater engagement with the private sector. The chapter opens with an overview of the antecedents,

creation and mandate of the WHO, followed by a description of its structure, governance, and financing. It then focuses on the emergence of the financing crisis – against the backdrop of the rise of neoliberalism[14] – that contributed to the agency's increasing engagement with the private sector in ways that make it vulnerable to conflicts of interests and corporate influence on substantive policy. The chapter assesses a number of reforms introduced by various Directors-General of the WHO with particular emphasis on the WHO's embrace of a multistakeholder approach in the late 1990s under then Director-General Gro Harlem Brundtland and lays out the resulting challenges to the WHO's role as global health leader in a changing global health landscape.

Chapter 4 provides background to the two case studies studied in depth to answer the question about private sector engagement with WHO as a site of global health governance on substantive policies and paradigms that shape policy-making. The chapter first presents the significance of breastfeeding to infant health. Following an overview of the baby food marketing issue, it introduces baby food market leaders Nestlé and Danone and the largest industry associations and outlines global policies and guidelines relating to baby milks and foods. With regard to the soda industry, the chapter discusses the effects of sugar consumption on health and NCDs, including diabetes and obesity and then identifies soda market leaders Coca-Cola and PepsiCo and the main soda industry business associations and outlines global policies and guidelines relevant to soda.

In order to answer in what ways profit-oriented NSAs have engaged with the WHO as a site of global health governance on substantive policies and paradigms that shape policy-making, the next two chapters, Chapters 5 and 6, turn to the in-depth analysis of the two case studies to show how corporations and their business associations in the baby food and soda industries draw on the "playbook" to influence substantive policy and shape public discourse (Brownell & Warner, 2009; Madureira Lima & Galea, 2018; Wiist, 2010). Chapter 5 analyzes corporate engagement on baby food, discussing how corporations have utilized the playbook at key moments in global health governance at the WHO regarding baby food marketing and infant and young child nutrition more

[14] Neoliberalism is a nebulous term applied to many different phenomena. Ward and England (2007) describe neoliberalism as having four faces, which Schrecker (2016, p. 1) summarizes as "simultaneously an ideology, a set of policies and programmes, a set of distinctive institutional forms, and a complex of normative conceptions of agency and responsibility that are rooted in the ideology and embodied in the policies, programmes and institutional forms". In terms of global health governance, neoliberalization has been characterized by the "deployment and privileging of market-based policy responses, … commodification, privatisation, liberalisation of health and healthcare, and … the individualisation of risk and responsibility for health" (Rushton & Williams, 2012, p. 163).

broadly. Chapter 6 analyzes corporate engagement in global policy-making at the WHO relating to soda consumption utilizing the strategies from the playbook. These two chapters demonstrate how the corporate sector is able to utilize these strategies and tactics by drawing on different types of power, including instrumental, structural and discursive power and that both these strategies and the power they rely on are iterative and reinforce one another (Fuchs, 2005).

Chapter 7 turns to the implications for WHO of the agency's enhanced engagement with NSAs, especially the for-profit sector, with an emphasis on the development and adoption in May 2016 of the contentious FENSA (WHO, 2016f). The chapter begins with an overview of the global shift toward multistakeholder approach and PPPs across the UN system in general and by the WHO in particular, and its entrenchment as a legitimate and preferred mode of operation. Such collaborations increase the risk of conflicts of interest, which the chapter distinguishes from conflicting interests. These constitute two distinct but related concepts that the WHO has repeatedly conflated, including throughout the development of FENSA, with the result that the agency has potentially opened itself to greater private sector influence, not less. It then reviews the WHO policies and proposals relating to engagement with NSAs, leading up to the adoption of FENSA, highlighting the main concerns raised by the private sector and critical NGOs. The chapter analyzes the final FENSA text, developments since its adoption, including the alignment of subsequent policies with its faulty conceptualization of conflicts of interest, and implications for the WHO and for global health governance more broadly.

Chapter 2 – Global Health Governance and the Private Sector: The "corporate playbook" and the exercise of power

2.0 Introduction

The concept of global governance, which gained traction in the 1990s, opens the way to recognizing a greater role for non-state actors (NSAs), including non-governmental organizations (NGOs), philanthropic organizations, and the private sector, including corporations and business associations in global political activity (Avant et al., 2010; Koppell, 2010; Lake, 2010; Moloney & Stone, 2019; Scholte, 2005). Although intergovernmental organizations like the World Health Organization (WHO) have long been sites for state cooperation and coordination on global issues, NSAs are increasingly able to impact upon and participate in global governance processes. Moloney & Stone (2019) capture this effect in the linked notions of global policy and transnational administration. As a result of growing space, private sector actors are having ever-increasing influence and are thus able to shape policies, regulations and institutions concerning global policy, including global health policy.

This chapter locates the changing nature of global health governance in relation to these broader developments in global governance in general. As we shall see, this shift toward a multistakeholder approach and public-private partnerships (PPPs) exposes the WHO to potential risks, including undue corporate influence and conflicts of interest. For conceptualizing the impacts of corporate influence on health outcomes and disease burden, the public health and global health literatures provide the useful notions of the "industrial epidemic" (Gilmore et al., 2011; Jahiel, 2008; Jahiel & Babor, 2007; Moodie et al., 2013) and "corporate (or commercial) determinants of health" (Buse et al., 2017; Hastings, 2012; Kickbusch, 2012; Kickbusch et al., 2016; Millar, 2013), which will be expanded upon below.

One way these corporate impacts are manifested is through the variety of strategies and tactics the private sector deploys to influence global health policy and policy-making, as will be analyzed in Chapters 5-7. Similar strategies are witnessed across many industries and have been dubbed the corporate "playbook" (Brownell & Warner, 2009; Madureira Lima & Galea, 2018; Wiist, 2010), as will be outlined below. A more nuanced understanding of the playbook requires an analysis of the different types of power – for example, instrumental, structural and discursive power – that underpin the strategies available to the corporate sector. These types of power are discussed below, drawing on international political economy literature.

2.1 The WHO in the changing landscape of global health governance

The global governance perspective abandons methodological nationalism that takes the state as the primary unit of analysis and instead examines a wide range of governance actors (Hettne, 2005). Some of the types of actors engaged in global governance include: international organizations (Avant et al., 2010; M. Barnett & Duvall, 2005; M. Barnett & Finnemore, 2004; M. N. Barnett & Finnemore, 1999; Lake, 2010; Strange, 1996), regimes (Krasner, 1983), corporations and other for-profit organizations (Avant et al., 2010; Lake, 2010; Ruggie, 2004; Strange, 1996), non-governmental organizations and international non-governmental organizations (Cooley & Ron, 2002; Keck et al., 1998; Lake, 2010; K. Lee, 2010; McKeon, 2016; Price, 2003), private governance authorities (Büthe & Mattli, 2011; Lake, 2010; Ruggie, 2004; Scholte, 2005, 2011), and regional formations. Networks are another type of global governance actor (Kahler, 2009), and one that includes a variety of sub-categories, such as transnational advocacy/activist networks (Gilson, 2011, 2011; Hudson, 2001; Keck et al., 1998; Price, 2003), epistemic communities (Haas, 1992), transgovernmental networks (Slaughter, 2004) and transnational municipal networks (Betsill & Bulkeley, 2006).

Corporate actors in particular are increasingly playing political roles and acquiring rule-setting powers (Fuchs, 2005; Pearson & Seyfang, 2001; Ruggie, 2004). In more and more issue areas, "firms are basically functioning like governments" (Cutler, 2002, p. 32), while the state has retreated from being a standard-setter and regulator (Pearson & Seyfang, 2001, pp. 54–55). Instead of state regulation, which in the era of neo-liberalism was rejected as it would raise public expenditure and become a disincentive for foreign investment, "greater governance responsibility is placed on companies themselves" (Detomasi, 2007, p. 323). Voluntary self-regulation is replacing state regulation in many industries and sectors (Pearson & Seyfang, 2001), although its effectiveness in improving corporations' behaviour and practices has been limited (Ollila, 2003). For Lister, however, governments are not so much retreating as transforming their role. Alongside traditional regulation, governments are also enabling private regulation within co-regulatory systems (Lister, 2011, p. 15).

Thus, the state has not completely lost its power and remains a significant, though not the only, actor in global health governance and global governance more broadly (Cerny, 2010; Sassen, 2007; Scholte, 2005; Slaughter, 2004). States have political mandate, legitimacy and accountability at both the national and global levels, including through intergovernmental organizations such as the WHO. States remain responsible for giving effect to global policies and commitments, including

through programing, legislation, and enforcement, at the national level. International agreements recognize the continuing significance of states and the intergovernmental organizations that they form. For example, the Political Declaration on the Prevention and Control of NCDs, adopted at the High-level meeting of the United Nations General Assembly (UNGA), September 19-20, 2011, recognizes the "primary role and responsibility of governments", as well as "the leading role of the [the WHO] as the primary specialized agency for health," and reaffirms the WHO's "leadership and coordination role" with respect to action against NCDs (UNGA, 2011).

From a rights perspective, states are duty-bearers: they have the duty to protect and fulfil the rights of their populations, and they are responsible for representing the public interest in decision-making. The right to health has been recognized in numerous international and regional human rights treaties as well as national constitutions all over the world. For example, the right to health is enshrined in the UN Declaration of Human Rights (UNGA, 1948); the International Covenant on Economic, Social and Cultural Rights (UNGA, 1966), and the subsequent General Comment on the Right to the Highest Attainable Standard of Health (Committee on Economic, Social and Cultural Rights, 2000); the WHO Constitution (WHO, 2006b), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (UNGA, 1979); and the Convention on the Rights of the Child (UNGA, 1989). Additionally, the Alma-Ata Declaration, adopted by the International Conference on Primary Health Care held in that city (present-day Almaty, Kazakhstan) in September 1978, emphasized the importance of primary health care and the role of the state in providing adequate health and social services and infrastructure. It was a major milestone in the field of public health, reaffirming health as a human right and setting a target of achieving Health for All by 2000 (ICPHC, 1978).

As duty-bearers with respect to the right to health, "governments must generate conditions in which everyone can be as healthy as possible"; this includes ensuring the availability of health services, healthy and safe working conditions, adequate housing and nutritious food (WHO/OHCHR, 2007). According to the International Covenant on Economic, Social and Cultural Rights (UNGA, 1966), and the subsequent General Comment No. 14 on the Right to the Highest Attainable Standard of Health (Committee on Economic, Social and Cultural Rights, 2000), State Parties have three types of obligations with respect to the right to health. They must *respect* (not interfere with its enjoyment), *protect* (ensure that third parties (NSAs, including corporations such as those discussed in this dissertation) do not infringe upon its enjoyment), and *fulfil* (take positive steps to realize it) the right to health (WHO/OHCHR, 2007).

Intergovernmental organizations like the WHO are sites for state cooperation and coordination on global issues. Comprised of Member States represented by government delegates, they represent an extension of states' political mandate, legitimacy and accountability to their citizenry, even if this accountability is flawed and even if there are other influences, such as from civil society (which also often claims to represent the public interest) and the private sector, which will be discussed in the following section. Yet, as this dissertation indicates, states and intergovernmental organizations such as the WHO are relinquishing some of their role and responsibility in terms of respecting, protecting and fulfilling the right to health to NSAs, including corporations, and to multistakeholder initiatives such as PPPs, which lack democratic political mandate, legitimacy and accountability.

2.2 The turn to multistakeholderism

One way that the ever-growing influence of private sector actors is manifested is through the shift toward multistakeholder initiatives and governance[15] – or multistakeholderism – across the UN system, including by the WHO. Not only are private actors asserting a greater governance role, but they are also increasingly recognized as governance partners as part of multistakeholder initiatives and PPPs. In response to pressures from the rise of neoliberalism, the 1990s saw the UN system looking to the private sector for financing and collaboration in solving development, poverty and human rights issues. In 1997, the then new UN Secretary General Kofi Annan announced reforms that stated that the relationship of the UN and the organizations of the UN system with the business community was of "particular importance" (Annan, 1997, 1998).

Seeking to strategically adapt the WHO to the dominant neoliberal logic (Chorev, 2013), then the WHO Director-General Gro Harlem Brundtland (1998-2003) spearheaded reform of the WHO, calling for "open and constructive relations with the private sector" (WHO, 1998, cited in Buse & Walt, 2000 and Lee, 2009). Her reforms led to a dramatic increase in PPPs in the form of vertical initiatives focused on specific diseases such as HIV/AIDS, tuberculosis and malaria. These reforms and the WHO's growing reliance on voluntary funding contributions are discussed in more detail in Chapter 3.

[15] Multistakeholder initiatives (or governance) bring together two or more classes of actors (i.e. state, intergovernmental, business and civil society actors to formulate, implement and/or monitor rules governing different policy fields (Raymond & DeNardis, 2015; Schneiker & Joachim, 2018).

Multistakeholder engagement, including with the private sector, is enshrined in the UNGA's 2011 and 2018 Political Declarations on NCDs. In addition to the primary role and responsibility of governments and the leadership and coordinating role of the WHO with respect to actions against NCDs, the 2011 Political Declaration also recognizes "the essential need for the efforts and engagement of all sectors of society" and acknowledges "the contribution of and important role played by all relevant stakeholders," including, "where and as appropriate, the private sector and industry" in efforts to prevent and control NCDs (UNGA, 2011, paras. 3 & 37). The Declaration makes repeated references to a multi-sector approach, multi-sector initiatives, including the private sector, as well as one reference specifically to multistakeholder engagement (UNGA, 2011). The 2018 Political Declaration calls for multistakeholder engagement, dialogue and partnerships (UNGA, 2018).

Multistakeholder partnerships are also highlighted in the 2030 Agenda for Sustainable Development, which outlined the Sustainable Development Goals, adopted at the UNGA's high-level plenary meeting on the topic in September 2015 (UNGA, 2015). Under the heading "Multi-stakeholder partnerships", Indicator 17.17, attached to Goal 17 – Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development – reads "Encourage and promote effective public, public-private and civil society partnerships, building on the experience and resourcing strategies of partnerships" (UNGA, 2015). The private business sector is called upon "to apply their creativity and innovation to solving sustainable development challenges" (UNGA, 2015 para 67). Indeed, as Horton (2019) describes, financing for the SDGS relies on various sources and formats of private funding, such as philanthropy from individuals and foundations and "impact investments" that take into consideration environmental, social and governance factors. The SDGs format encourages a "pay to play" approach where donors select activities to fund toward the attainment of specific goals while core funding to support integrated global goods is lacking (McKeon, 2016).

Advocates of the multistakeholder approach and PPP model maintain that global health issues are more complex than can be handled by states and other actors alone and that business can contribute expertise and resources (Sturchio & Goel, 2012), enable the sharing of risks and help overcome systemic challenges toward their solution (UN Global Compact, 2014). Proponents of PPPs argue that public health has become 'big business', involving large and influential companies and significant commercial activity. At the same time, following the 2008 financial crisis, public health receives less public revenue, necessitating private sector involvement (Majestic, 2009). Private

sector involvement in health initiatives also makes good business sense, maintain Sturchio and Goel (2012), because improving public health contributes to economic development and political stability. Essential to the success of such partnerships, writes Quelch (2016), are mutual understanding and respect.

However, not everyone welcomes the corporate sector's growing political influence on social policy and the trend toward multistakeholderism and PPPs (Farnsworth & Holden, 2006; Gilmore et al., 2011; Hastings, 2012; McKeon, 2017; Rundall & Brady, 2011; Savell et al., 2014). Critics view PPPs as "basically public relations and market expansion gambits for the private sector" (Ng & Ruger, 2011, p. 6). They also raise concerns that partnerships may blur the distinctions between the aims, roles and obligations of different types of actors (Buse & Walt, 2000; McKeon, 2017; Richter, 2004c), negate power imbalances (McKeon, 2017), and jeopardize the "independence, integrity and reputation" of the WHO and other agencies (Richter, 2004c) or co-opt government actors and public-interest NGOs (Fuchs, 2005). McKeon (2017, p. 380), for example, argues that the multistakeholder approach poses challenges for the "the legitimacy of governance, the protection of common goods, and the defence of human rights." Furthermore, ideational pre-alignments determine which actors participate in multistakeholder forums, the forums' governance processes and their results, among other things (Schneiker & Joachim, 2018), meaning that critical perspectives are left out.

Perspectives on the role and responsibilities of corporations are now more nuanced than Friedman's classic perspective that the *only* responsibility of business is to increase shareholder profits (M. Friedman, 1978). Nevertheless, the reason for corporations' existence is to generate profits and increase value for shareholders, and they have a fiduciary responsibility to pursue their best interests regardless on the effects on society (including its health) or the environment (Wiist, 2006b). A corporate official who takes action that results in poor financial performance can be held accountable for failing to maximize profits for investors (Wiist, 2006b).

In their pursuit of fulfilling this fiduciary responsibility, corporations seek to influence policy and regulations that would impact their activities. Corporations often call for strong regulations that would protect their interests (for example, contract law and intellectual property rights) while opposing or undermining regulations that could constrain their operations and ability to make a profit (such as restrictions on advertising and limits on unhealthy ingredients) (Rundall & Brady, 2011). One way that private sector actors seek to avoid more rigorous regulation by governments that might constrain their profitability and trustworthiness is by promoting voluntary self-regulation

and voluntary codes and initiatives (see, for example, Albareda, 2008; Bohme, Zorabedian, & Egilman, 2005; Nixon et al., 2015; Savell et al., 2014; Sharma, Teret, & Brownell, 2010). However, voluntary codes of conduct have had limited effect on improving corporations' behaviour and conduct (Ollila, 2003). Ultimately, the private sector's fiduciary motivation raises questions about its role in multistakeholder initiatives, especially when it comes to matters of governance and the setting of norms and standards.

2.3 Corporate impacts on health: industrial epidemics and corporate determinants of health

The public health and global health literatures provide useful ways of conceptualizing the implications of corporate impacts on health and disease burden – both directly through their promotion of products that can be harmful to health and indirectly by influencing substantive policy and paradigms relating to their products and industry role in governance and policy-making. The first concept is the notion of the "industrial epidemic" (Gilmore et al., 2011; Jahiel, 2008; Jahiel & Babor, 2007; Moodie et al., 2013). The concept was first developed in 1995 by Beatrice Majnoni d'Intignano to refer to the increase of diseases attributed to the consumption of industrial products such as tobacco, alcohol, food, cars, and guns. While acknowledging the role of the consumer, the concept drew attention to the responsibilities of industrial corporations (d'Intignano, 1995, 1998; d'Intignano & Philippe, 2001; Jahiel, 2008; Jahiel & Babor, 2007).

Traditional public health constructs of epidemics identify the role of the host, agent, environment and vector of disease spread. The agent is the cause of disease, the host is the individual exposed to the agent, the environment is the place where the host is exposed to the agent, and the vector is an organism where the agent may evolve and replicate, be carried through different environments and eventually exposed to the host (Jahiel, 2008). For example, an individual (host) may become infected with malaria after exposure to malaria plasmodia (agent) carried by a mosquito (vector) in the woods (environment). This model has been suggested as a way to address non-biological epidemics as well, such as obesity (Egger et al., 2003).

The "industrial epidemics" concept adapts this model to identify "the role of the host (the consumer), agent (the product, e.g. cigarettes, alcohol), environment and, crucially, the disease vector (the corporation)" (Gilmore et al., 2011). While in infectious disease epidemics the vectors are biological, in industrial epidemics the vectors are TNCs and their activities that undermine public health interventions (Gilmore et al., 2011; Jahiel & Babor, 2007). This approach shifts the focus

from the agent (for example, alcohol) or the host (the problem drinker) to the disease vector (the alcohol industry and its associates) and their responsibility for the exposure of vulnerable populations to the risks of alcohol (Jahiel & Babor, 2007).[16] The "corporate disease vectors" (Jahiel & Babor, 2007) have "have considerable power, resources and experience in shaping environments in ways that maximize their profits, while not seriously and comprehensively considering its public health impacts" (O'Flaherty & Guzman, 2016).

Infant mortality and morbidity as a result of decreased breastfeeding linked with the marketing of baby foods, and increased rates of diabetes and obesity linked with soda consumption are examples of industrial epidemics attributable in part to corporate (or industrial) disease vectors. The conceptualization has also been applied to the harmful effects on health of a wide variety of products, including tobacco (Reubi, 2012; Slade, 1989; Stuckler et al., 2012), alcohol (Babor et al., 2010; Jernigan, 2009; Moodie, 2014; Moodie et al., 2013), chemicals and lead (Markowitz & Rosner, 2013), asbestos (Lilienfeld, 1991), cars (MacLennan, 1988), and the food and drink industries (Jahiel & Babor, 2007; O'Flaherty & Guzman, 2016).

Another useful conceptualization calls corporate practices to promote the consumption of harmful products the "corporate (or commercial) determinants of health" (Buse et al., 2017; Hastings, 2012; Millar, 2013).[17] Kickbusch, Allen, & Franz (2016) define commercial determinants of health as: "strategies and approaches used by the private sector to promote products and choices that are detrimental to health". They argue that these corporate activities influence "the social environment in which people live and work: namely the availability, cultural desirability, and prices of unhealthy products. The environment shapes the so-called lifeworlds, lifestyles, and choices of individual consumers—ultimately determining health outcomes" (Kickbusch et al., 2016). While the social determinants of health have received considerable attention (Marmot, 2005; WHO Commission on Social Determinants of Health & WHO, 2008), the commercial (or corporate) determinants deserve as much concern (Hastings, 2012), along with political, environmental,

[16]Jahiel and Babor (2007) modified d'Intignano's conceptualization to include "diseases of consumers, workers and community residents caused by industrial promotion of consumable products, job conditions and environmental pollution, respectively, and to endemic as well as epidemic conditions." This modification is not the focus of this dissertation.

[17]This idea builds on the concept of social determinants of health, which refers to the conditions in which people are born, grow, live, work, and age, and the structural drivers that determine those conditions, and the impact these have on health (Marmot, 2005; WHO Commission on Social Determinants of Health & WHO, 2008).

behavioural and legal determinants (Gostin et al., 2019; Kickbusch, 2012; Ottersen et al., 2014; Whitmee et al., 2015).

The conceptualizations of industrial epidemics and corporate (or commercial) determinants of health are relevant to analysis of the baby food and soda industries because they acknowledge the potentially problematic nature of their products (baby foods and sodas) and the agency of consumers but also draw attention to the industries' role in marketing and advertising these products in ways that undermine consumers' healthy decision-making and interfere in efforts to introduce formal regulation that would protect consumers and their health. The strategies and tactics utilized by the corporate sector in pursuit of this influence are captured by the notion of the corporate "playbook", as explained below in section 2.4.

2.4 The corporate "playbook" and the types of power that underpin it

The corporate sector utilizes a variety of strategies and tactics to influence policies and the paradigms that shape them and policy-making, as will be analyzed with respect to the baby food and soda industries in Chapters 5 and 6, respectively. Similar strategies are witnessed across many industries, including tobacco, alcohol, pharmaceuticals, processed foods, asbestos, baby food, soda.[18] These strategies have been dubbed the corporate "playbook" (Brownell & Warner, 2009; Madureira Lima & Galea, 2018; Wiist, 2010). As will be demonstrated in Chapters 5-7, the strategies and tactics that comprise the corporate playbook are iterative and mutually reinforcing, which is to say an actor may use one strategy or tactic to increase its ability to utilize, and the effectiveness of, others.

What public health descriptions of the corporate playbook lack, however, is analysis of *how* the corporate sector is able to pursue these strategies, what power it is able to access in order to do so, and what power these strategies serve to enhance and reinforce. To inform my analysis in this regard, I draw on the political science, international relations, and international political economy literatures, where typologies and theories of power are central concepts. Some scholars in these disciplines maintain that only by examining the various elements of political power can its full extent and limitations be more comprehensively understood, and that these different facets of power are

[18] For examples, see Bond, 2010; Brownell & Warner, 2009; Dorfman, Cheyne, Friedman, Wadud, & Gottlieb, 2012; Granheim et al., 2017; Hawkins, Holden, Eckhardt, & Lee, 2016; Kearns Couzens & Taubes, 2012; Savell, Gilmore, & Fooks, 2014; Scott, Hawkins, & Knai, 2017; Weishaar et al., 2012; Wiist, 2010.

not competing with one another but can overlap and be complementary and, indeed, like the playbook strategies, one type of power can be used to enhance the others (Fuchs, 2007).

Various efforts have been made to conceptualize power as being composed of different dimensions (M. Barnett & Duvall, 2005; Clapp & Fuchs, 2009a; Fuchs, 2005; Fuchs & Lederer, 2008; Lukes, 1974; Strange, 2015). Lukes (2004), for example, views power as comprising of three dimensions: coercion ("power over") or decision-making power (those with power will prevail in the decision-making); agenda-setting power (those with power determine which issues will be discussed and can influence the context in which the decision will be made and therefore the decision itself); and co-option or ideological/ideational power (those with power shape perspectives such that they not only determine the agenda but manipulate others' thinking in such a way that it aligns with that of those in power. Barnett and Duvall's (2005) taxonomy identifies four conceptions of power: *compulsory*, *institutional*, *structural* and *productive* power.[19] My analysis in this dissertation, however, will examine the ways in which the corporate playbook of strategies and tactics is underpinned by the following three dimensions of power – *instrumental*, *structural* and *discursive* power, which often overlap and reinforce one another (Clapp & Fuchs, 2009b; Clapp & Scrinis, 2017; Fuchs, 2005, 2007; Levy & Egan, 2000).

Instrumental power refers to an actor's direct influence over another actor in order to affect political or policy output, for example through lobbying or financial support (Clapp & Scrinis, 2017; Fuchs, 2005). It is dependent on the "financial, organizational, or human resources, as well as access to decision-makers" (Fuchs, 2005). Combining Barnett and Duvall's (2005) *compulsory* and *institutional power* and called *relational power* by Strange (2015, p. 27), instrumental power is the idea behind Lukes' (2004) coercive or decision-making power and Dahl's (1957, pp. 202–203) notion of "A has power over B to the extent that he [sic] can get B to do something that B would not otherwise do." Such a perspective assumes unilinear causality and that actors have autonomy in their decisions and actions. It does not consider structural sources of power that predetermine the options available to actors (Fuchs, 2005).

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[19] *Compulsory power* is direct control by one actor over another. *Institutional power* is indirect control through diffuse or distant relations of interaction and focuses on differential constraints on action. *Structural power* shapes the "fates and conditions of existence" of actors by allocating differential capacities and advantages to different structural positions. It also shapes actors' self-understanding and subjective interests, "leaving them willing to 'accept their role in the existing order of things'." *Productive power* refers to "the socially diffuse production of subjectivity in systems of meaning and signification." It "concerns discourse, the social processes and the systems of knowledge through which meaning is produced, fixed, lived, experienced, and transformed" (M. Barnett & Duvall, 2005).

Structural power represents the "second face of power" or agenda-setting power (Clapp & Scrinis, 2017; Fuchs, 2005; Lukes, 2004). Referring to the "structural contexts that make alternatives more or less acceptable before the actual and observable bargaining starts" (Fuchs, 2005, p. 776), it pre-determines the behavioural options of decision-makers, making certain issues more possible to become a priority while others are not. As difficult as it may be to attribute the causal influence of instrumental power on policy outcomes, structural power is even more difficult to identify, as it may leave no traceable evidence (Fuchs, 2005).

Structural power allocates differential capacities and advantages to different structural positions (M. Barnett & Duvall, 2005). This is the power and influence that corporations, for example, draw from their market position and economic significance in national and global economies (Clapp & Scrinis, 2017). For example, a company may influence a government by suggesting – although it need not say so out right for it to be understood – that it may move its investments and jobs out of the country in response to an unfavourable policy (Clapp & Scrinis, 2017; Fuchs, 2005). Material structures may not only provide actors agenda-setting power, but also place them in a position to make decisions and set rules (Fuchs, 2005).

Structural power is determined by paradigms – "underlying theoretical and ontological assumptions about how the world works" (Campbell, 1998, p. 389). Often taken for granted, paradigms operate in the "cognitive background" to influence (often unconsciously) the ways in which actors think and talk about problems and the policy goals and instruments that are possible for addressing them (Campbell, 1998; Hall, 1993; Rushton & Williams, 2012). These ideational underpinnings depend on "deeply-embedded ideas dominant in the contemporary global political environment", or what is referred to as a "deep core" (Rushton & Williams, 2012, p. 149). For Rushton and Williams (2012, p. 149), neoliberalism is one such deep core "because it seems to operate across almost all areas of global governance, and appears to 'colonize' and influence all the major paradigms of global health governance". Deep cores such as neoliberalism, they argue, "seem to structure debates and shrink 'policy space' … , imposing constraints and limiting what is 'sayable', 'doable'—and even what is 'thinkable'" (Rushton & Williams, 2012, p. 149).

Structural power is also derived from, and exercised through, what Strange (2015, p. 134) has called the "knowledge structure".[20] The knowledge structure "determines what knowledge is discovered, how it is stored, and who communicates it by what means and on what terms" (Strange,

[20] The knowledge structure is one of four interacting structural sources of power that Strange (1996, 2015) writes about, the other three being the security structure, the production structure, and the financial structure.

2015, p. 134). It is comprised of "those who control access to knowledge and information and who are in a position to define the nature of knowledge" (Strange, 1996, p. ix). Strange writes that the knowledge structure persuades others to share fundamental beliefs – in other words, paradigms – about society and economy and to decide what knowledge is sought for and acquired and by whom, and to whom it is, or is not communicated (Strange, 1996, p. 70).

Discursive power refers to the power derived from, and the ability of actors to shape, norms and ideas. Policy is increasingly decided on the basis of "discursive contests over the frames of policies" and "linking problems to specific fundamental norms and values" (Fuchs, 2005, p. 777). Frames "emphasiz[e] a particular definition of a problem or solution and they help shape policy discourses and the public policy agenda" (Scott & Nixon, 2017, p. 1). Framings and contestations around global health problems and potential solutions depend on underlying paradigms. Framing is what links paradigms operating in the cognitive background to policy debates in the foreground (Rushton & Williams, 2012, p. 148).

Corporations and other actors "attempt to frame debates in ways that are amenable to their interests and objectives" (Rein & Schön, 1996; Snow & Benford, 1992). Through framing, they shape the way issues and stakeholders are conceptualized and which policy responses are possible and appropriate while others are improbable or precluded (M. Barnett & Duvall, 2005; Clapp & Scrinis, 2017; Hawkins & Holden, 2013), sometimes due to sufficient doubt having been manufactured about the cause of the problem or potential solutions. Framing is essential for corporations and their business associations seeking to create a conducive environment for policy-making that favours industry interests, both in terms of both substantive policy and the paradigms that shape it and the private sector role in developing it. Part of their strategy is to influence the terms used to discuss issues and which aspects of them receive the most attention (Hawkins & Holden, 2013).

Discursive power and framings not only *depend* on underlying paradigms, but, I maintain, are used to *shape* and *reinforce* them. For example, the private sector uses its discursive power to promote paradigms emphasizing partnership with, and a governance role for, the private sector. Tactics to achieve this aim include framing not only issues and possible policy options, but also corporations and industries as governance actors. These strategies are part of a long-game aimed at protecting or even increasing industry ability to influence substantive policy and seeking greater legitimacy and authority in policy-making. An actor's political legitimacy depends on its discursive power because it depends on the recipient's willingness to listen and to trust the validity of the message, as well as the

actor's expertise, capacities and intentions (Fuchs, 2005), which is possible only when the framings they advance align with underlying paradigms. These sources of political legitimacy are especially relevant to NSAs such as corporations and their business associations as will be discussed in chapters that follow.

Discursive power is "the most diverse and, at times, evasive dimensions of power" (Holzscheiter, 2005, p. 724) and can influence the political process in "the broadest possible way" (Fuchs, 2005, p. 779). It is the most difficult kind of power to recognize and measure because "it relies on persuasion, the perception of legitimacy, and voluntary compliance rather than coercion and hierarchies of legally assigned responsibility and thus the exercise of discursive power frequently will not even be perceived as an exercise of power and therefore not be questioned" (Fuchs, 2005, p. 780).

Like the playbook strategies and tactics, access to different types of power is iterative and mutually reinforcing. For example, as will be discussed in Chapter 7, using discursive power to represent itself as a "partner" and legitimate governance actor, the private sector has increased its instrumental and structural power by shaping paradigms that determine which policies are pursued and what role private actors are able to play in developing them.

The private sector exercises these different dimensions of power – instrumental, structural and discursive – through the strategies and tactics that comprise the playbook. Corporate actors seek to shape the political environment with tactics that include lobbying, campaign and party donations, and revolving doors. Lobbying is an exercise of instrumental power (Clapp & Scrinis, 2017; Fuchs, 2005); it reflects business's ability to influence politicians and policy-makers and resulting policy outputs. Lobbying is one of the corporate sector's oldest political activities (Fuchs, 2005) and most obvious way of influencing policy and governance outcomes (Clapp & Scrinis, 2017). Corporate donations to political parties can influence decisions and behaviours of government officials (Wiist, 2016), for example, increasing the likelihood of favourable votes on regulatory matters (D. A. Luke & Krauss, 2004) and reducing citations for corporate health and safety violations (Witko, 2013). Corporate lobbying and campaign finance activities are expanding both in quantity and in quality to include, for example, transnational strategies and participation in multistakeholder initiatives (Fuchs, 2005). Nevertheless, it can be difficult to access data and information about lobbying activities, and even harder to attribute causation (Fuchs, 2005; Lowery, 2013).

The revolving door, another exercise of both instrumental and structural power, refers to the movement of people between the public and private sectors (including lobbyists[21]), and vice versa, taking with them potentially confidential information, personal influence and connections, and professional aspirations that may contribute to corporate advantage or regulatory capture (Drutman & Furnas, 2014; Makkai & Braithwaite, 1992). When moving from private to public sector, personal connections and loyalties have the potential, like a Trojan horse, to bias an individual's positions and priorities in their new capacity and to pose conflicts of interest for that individual (Nestle, 2013).

Corporations and their business associations are increasingly able to shape the political environment by participating directly in governmental agencies, committees and commissions and in partnerships with government for policy delivery. Direct participation in policy-making and delivery represents a shift from the corporate sector exercising instrumental power to influence policy-makers and policy outputs to it having the ability to access structural power to have direct rule-setting power. Multistakeholder initiatives and PPPs described above and self-regulatory initiatives are other examples of the ways in which businesses and their associations are able to draw on structural power to participate directly in policy-making and governance, shifting rule-setting away from the exclusive domain of government to also include private authority in the process.

Putting pressure on international organizations such as the WHO and on international trade negotiations, and providing tied aid (meaning aid that is tied to, or requires, imports of food, other supplies, technical assistance, etc., from the donor country (Zedillo et al., 2001)) and in-kind donations to humanitarian efforts (Madureira Lima & Galea, 2018) are other ways for the corporate sector to exercise its instrumental power to shape the political environment. The policies and influence of international organizations and the provisions of various trade agreements determine the extent to which, and on what terms, corporations are able to, for example, expand into new markets, challenge regulatory efforts, seek increased protections, present themselves as responsible corporate citizens, and generally pursue their interests (Fooks & Gilmore, 2014; Friel et al., 2016; Neuwelt et al., 2015).

To shape preferences (Madureira Lima & Galea, 2018), corporations and their associations draw on both their instrumental and especially their discursive power to frame issues, themselves and other actors to fit their corporate interests, and to deflect attention and manufacture doubt. As will be discussed in Chapters 5 and 6, for example, both the baby food and soda companies frame

[21] As Nestle (2013, p. 99) puts it, "Today's public servant is tomorrow's lobbyist."

the issues as matters of consumer choice and responsibility. This "freedom of choice" rhetoric, disseminated using their discursive power, has the effect of shifting responsibility – or, blame – for any resulting problem away from companies and onto consumers (L. C. Friedman et al., 2014) in order to pre-empt any regulatory initiatives that may affect the industries' bottom lines as well as their structural and instrumental power. Modifying and reformulating their products is another way that industries exercise their discursive power to encourage framings of individual choice and responsibility, deflect attention away from corporations and avoid regulation (Scrinis, 2016). For example, as will be discussed in Chapter 6, using their discursive power, soda companies frame their product modification and reformulation efforts as initiatives to contribute to the prevention and control of NCDs (Clapp & Scrinis, 2017; Nixon et al., 2015).

To disseminate its preferred framings, the private sector exercises not only its discursive power but also its instrumental and structural power in order to capture the media, it markets and advertises its products, and it targets vulnerable populations, such as women, children, racialized communities, disaster-affected communities, and the populations of developing countries. Corporations and their associations also engage public relations companies, key opinion leaders (KOL) and health professions organizations to lend an authoritative and credible voice to their framing and messaging (Madureira Lima & Galea, 2018).

Corporations also shape preferences by establishing corporate foundations and conducting global health philanthropy and corporate social responsibility initiatives (McDaniel & Malone, 2009; Tesler & Malone, 2008). They are able to do so by drawing on the instrumental power available because of the financial resources at their disposal and the structural power afforded by the lack of public financing for such endeavours. Because such initiatives boost public image, deflect negative attention, critics consider them to be a corporate tactic used to prevent regulation and gain access to policy-makers (Dorfman et al., 2012; Fooks et al., 2011, 2013; Hirschhorn, 2004; Lhotska et al., 2012; WHO, 2003b; Yang & Malone, 2008). A similar way of shaping preferences is by coopting and capturing civil society and its formations (Madureira Lima & Galea, 2018) through partnerships and by forming organizations that resemble or represent themselves as civil society groups but actually pursue business interests. Such organizations in various industries have been called "front groups" (Baur, 2011; Dorfman et al., 2012; Madureira Lima & Galea, 2018; Miller & Harkins, 2010; Simon, 2013).

Corporate tactics for shaping the knowledge environment (Madureira Lima & Galea, 2018) include controlling the research process, for example by sponsoring research or publishing their own

research in academic publications (Aveyard et al., 2016; Bohme et al., 2005; Casswell, 2013; Kearns et al., 2015; Nestle, 2013, 2015), funding medical education and participating in or creating scientific advisory boards and science institutes (Bohme et al., 2005; Brownell & Warner, 2009; Egilman & Bohme, 2005; Jacobs, 2019; Nagarajan, 2014b; Nestle, 2013, 2015). These strategies enable corporations to exercise their instrumental and structural power to generate favourable research findings and then their discursive power to disseminate and amplify them in order to influence scientific and public opinion about the safety and appeal of their products and their credibility as a source of information. Corporations use these tactics to manufacture doubt about the nature and scope of problems, their responsibility in causing them, and the feasibility and efficacy of solutions (McDaniel & Malone, 2009). In this way, corporations are part of the "knowledge structure" described by Strange (2015, p. 134).

Corporations make use of legal systems and the law by limiting their liability, threatening litigation and externalizing costs using unregulated areas of activity (Madureira Lima & Galea, 2018). These corporate strategies rely on law firms and public relations companies, which go beyond typically expected duties to also contract scientific studies, formulate scientific defences, lobby public officials, create "citizens' groups" to support their industry or products, and work to discredit research or scientists that are unfavourable to the corporate interests (Bohme et al., 2005). These strategies and tactics are possible for the private sector because of the instrumental and structural power available due to the financial resources at their disposal. Simply said, corporations and business associations can afford to engage in multiple legal proceedings at once, and to draw them out at a cost that NGOs and the public sector in many countries are unable to match. The mobility of capital also affords structural power that pre-empts the introduction of regulations or legal challenges by governments concerned with retaining investments in their countries.

Finally, the extra-legal tactics used by the corporate sector include fragmenting opposition groups by using corporations' instrumental power and discursive power to discredit them or by seeking greater legitimacy by partnering with more "moderate" groups. Corporations may also exercise their structural power by engaging in illegal activities such as bribing, smuggling and illicit trade, and price fixing. Corporations either avoid prosecution altogether through out-of-court settlements, or receive fines that remain a small fraction of their profits (Madureira Lima & Galea, 2018).

2.5 Conclusion

This chapter has outlined the changing nature of global governance, and global health governance in particular, which involves the opening up of spaces for NSAs to influence and participate in policy-making and governance, including through the global shift toward a multistakeholder approach and PPPs. This shift has left the WHO vulnerable to conflicts of interest as it continues to adopt a multistakeholder approach and widen its engagement with NSAs in order to address its financial challenges, as will be discussed in Chapter 3.

Drawing on the public health and global health literatures, the notions of "industrial epidemic" (Gilmore et al., 2011; Jahiel, 2008; Jahiel & Babor, 2007; Moodie et al., 2013) and "corporate (or commercial) determinants of health" (Buse et al., 2017; Hastings, 2012; Kickbusch, 2012; Kickbusch et al., 2016; Millar, 2013) were introduced as useful ways of capturing the impacts of corporate actors on health and disease burden. Of particular importance for the analysis to follow are the conceptions of different forms of power that corporations may exercise. The concept of the corporate playbook (Madureira Lima & Galea, 2018) will prove especially helpful in identifying the various strategies and tactics corporate actors in the two sectors under study have employed. Chapters 5 and 6 analyze the how corporations and their business associations in the baby food and soda industries draw on the playbook of strategies common across many industries to influence substantive policy and shape public perception and discourse (Brownell & Warner, 2009; Madureira Lima & Galea, 2018; Wiist, 2010).

Chapter 3 – WHO reforms: Enhancing engagement with non-state actors

3.0 Introduction

This chapter locates the WHO as an important actor/institution in global health governance. The WHO is the only international health body that comprises all Member States of the United Nations. This composition grants the agency a unique political legitimacy and, at least in theory, democratic representation and accountability that does not exist in the case of other, more recently created global health bodies. The WHO's main decision-making body, the WHA, is the only place where global health rules can be negotiated, adopted and monitored for compliance.

Illuminating the factors behind the WHO's turn to NSAs, the chapter places particular emphasis on resource constraints that have prompted it to seek partnerships with private sector actors to carry out its programs. Faced with this financial reality and to respond to the changing global health architecture, several the WHO Directors-General have undertaken reform processes, which have included policies to facilitate engagement with NSAs, such as the Framework of engagement with non-State actors (FENSA).

This chapter provides a brief overview of the WHO and traces the financing crisis that has contributed to the agency's increasing engagement with the private sector in ways that have implications for the agency and global health governance more broadly and that make it vulnerable to conflicts of interests and corporate influence on substantive policy and potentially sets itself up for greater dependence on for-profit entities. The chapter opens with the antecedents, creation, and mandate of the WHO, followed by a description of its structure and governance. It then traces the WHO's embrace of closer relationships with NSAs to challenges to the WHO's role as a global health leader, including the changing global health architecture, the WHO's financing crisis, and its multistakeholder approach. This sets the stage for an analysis of reform processes undertaken by various Directors-General and the WHO's engagement to NSAs.

3.1 Antecedents to the WHO

The WHO is not the first institutionalized form of global health governance. Between 1851 and 1938, fourteen International Sanitary Conferences were held to reach agreements on health and sanitation issues. The first International Sanitary Convention on maritime quarantine requirements was adopted in 1851, but it became inoperative in 1865. This initial agreement was followed by a

multitude of conventions of limited scope relating quarantine regulations with respect to cholera, plague, and eventually yellow fever (WHO, 1958).[22]

In December 1902, the First General International Sanitary Convention of the American Republics, held in Washington DC, ushered in the creation of an International Sanitary Bureau, which in 1923 changed its name to Pan American Sanitary Bureau (PASB). This organization was to influence the WHO's structure and conflicting approaches to achieving its mandate. Evidence of PASB's focus on disease surveillance and control remain, for example, in the WHO's mass campaigns against specific diseases or health problems (the "vertical approach"). The other, "horizontal" approach seeks to address problems more holistically and for the long-term through social medicine (addressing the broad determinants of health) and the development of general health services. Upon the creation of the WHO, PASB was renamed the Pan American Sanitary Organization (PASO) and integrated into the new global agency, becoming its Regional Office for the Americas (as discussed below)) (K. Lee, 2009; WHO, 1958). In 1958, PASO was again renamed, becoming the Pan American Health Organization (PAHO) to signal "a redirection of interest from sanitation and the control of communicable diseases to health more broadly defined" (Fee & Brown, 2002). It remains the most prominent of several regional health organizations, and is the oldest continuously functioning international health agency (K. Lee, 2009).

Shortly after the creation of the International Sanitary Bureau in the Americas (now PAHO), in 1907 the Office International d'Hygiène Publique (OIHP) was established in Paris as a permanent body to collect and report epidemiological data from its Member States (K. Lee, 2009) and disseminate general public health information (WHO, 1958). The League of Nations Health Organization (LNHO) was created in 1920 but failed to take off, largely because the politically isolationist US, which had not ratified the League's founding treaty, wanted to work through the OIHP and did not want it included in the LNHO framework (Weindling, 2006). There was considerable overlap, tension, and rivalry between these three major international organizations, LHNO, OIHP, and PASB (K. Lee, 2009; Weindling, 2006). Nevertheless, by consolidating OIHP and the International Sanitary Regulations and reflecting inter-relationships between health, trade, peace and stability, the LHNO presented an idea of what a global health institution could look like and provided the institutional basis for the eventual the WHO (Harman, 2012).

[22] After the creation of the WHO, these conventions were consolidated into a new set of International Sanitary Regulations, adopted by the Fourth World Health Assembly in May 1951 (WHO, 1958) and were the forerunner to the International Health Regulations adopted by the WHO in 1969 that remain in place, albeit amended, to this day (K. Lee, 2009).

Alongside these international (intergovernmental) organizations, non-state charitable and philanthropic organizations were also active in international health initiatives. The League of Red Cross Societies (later the International Federation of Red Cross and Red Crescent Societies) was founded in 1919 "in view of a worldwide crusade to improve health, prevent sickness, and alleviate suffering." The Rockefeller Foundation's International Health Commission was created in 1913 and renamed the International Health Board in 1916. It extended the work of the Rockefeller Sanitary Commission for the Eradication of Hookworm Disease. The Board was disbanded in 1927 and its work continued by the Foundation's International Health Division (K. Lee, 2009). Other early international health actors included the Save the Children Fund, founded in 1919 (Dodgson et al., 2002); the Ford Foundation, founded in 1936; and the Wellcome Trust, created in 1936 (K. Lee, 2009).

3.2 Creation of the WHO

The idea of a world health body had not been included in the agenda for the founding meeting of the United Nations in 1945, with health work envisioned to be done by UNICEF (founded in 1946) and UN Relief and Rehabilitation Administration (UNRRA) (founded in 1943). However, the Brazilian and Chinese delegations submitted a joint declaration at the meeting, calling for a General Conference to be convened within a year to establish an international health organization. They argued that "medicine is one of the pillars of peace". A Technical Preparatory Committee of 16 international health experts, mostly national health ministers or senior health officials, met in Paris from March to April 1946 to prepare an annotated agenda, a proposed constitution and various resolutions to be considered at the conference. These addressed the organization's mandate, governing structure, administration and financing, but left unresolved the location of the headquarters and whether regional organizations would be associated or fully integrated with the new organization.

The International Health Conference was convened in June 1946, the first conference held under the UN's auspices. It was attended by all 51 members of the UN and 13 non-Member States, the Allied Control Authorities for Germany, Japan and Korea and observers from relevant UN bodies. Existing international health organizations such as OIHP were invited in a consultative capacity. The Conference agreed, over the next four and half weeks, on the new organization's constitution, a protocol for the dissolution of OIHP, and the setting up of an Interim Commission to take over health work previously done by the LNHO and UNRRA until the WHO could be

formally established. The Interim Commission, created to bridge the time between the drafting of the WHO Constitution and its coming into effect, was comprised of technical experts not representing their respective governments.

The new body was different from previous international health bodies in that it was to take a worldwide scope of membership and operations (WHO, 1958). The Constitution stated that the WHO was to serve as "the directing and coordinating authority on international health work" (WHO, 2006, Article 2(a)). Its objective, reflecting the optimism and idealism of the post-World War II period in which it was established (Clift & Royal Institute of International Affairs, 2014; Hoffman & Røttingen, 2014), was "the attainment by all peoples of the highest possible level of health" (WHO, 2006, Article 1). The Constitution came into force on April 7, 1948, and the WHO was formally established in September 1948 (K. Lee, 2009; WHO, 1958).

The WHO Constitution lists 22 wide-ranging functions, the first of which is "to act as the directing and co-ordinating authority on international health work" (WHO, 2006b Article 2(a)). Its other functions can be categorized as technical assistance and emergency aid (for example, helping governments to strengthen health services), normative work (for example, proposing conventions, agreements and regulations, making recommendations with respect to international health matters, setting standards), and promoting and advocating for better health (for example, in specific areas of health, and by promoting and conducting research, and by providing information, counsel and assistance in the field of health) (Clift et al., 2013). To perform these functions, the methods of operation adopted by the WHO include projects, technical meetings, expert advisory panels and committees, training, coordination and cooperation, and investigation and research (WHO, 1958).

Davies (2010) describes four phases in the WHO's authority over global health policy. During the first phase, from 1948 through the mid-1970s, its role was largely technical, with a focus on disease specific interventions and optimism about disease eradication. In the second phase, from the mid-1970s through to the mid-1980s, there was more emphasis on humanitarianism and using the WHO to promote health equity. Under the leadership of then Director-General Halfdan Mahler (1973-1988), the organization had a more activist orientation. It was under his leadership that the Alma-Ata Declaration was adopted in 1978. In the third phase, from the mid-1980s to the mid-1990s, the WHO took a neoliberal turn, exemplified by its extensive collaboration with the World Bank. During this period, the WHO's budget was frozen, and its influence was in decline, eclipsed by the World Bank. The fourth phase, from the mid-1990s to 2010 saw a reassertion of the WHO as

the leading international health actor and collaboration with a diverse set of actors, including NGOs and private actors (Davies, 2010).

Today the WHO remains the lead body with respect to global health governance. Some consider it to play a necessary and essential role in global health (Legge, 2012; Sridhar et al., 2014), offering unique capabilities and assets, such as its visionary Constitution that "affirms a social view of health and health as a human right", technical expertise, normative influence, and authority to make global health rules, including binding treaties such as the International Health Regulations and the Framework Convention on Tobacco Control (Kamradt-Scott et al., 2015; Legge, 2012; Ollila, 2003, 2005; Sridhar et al., 2014).

However, its role in the "new and crowded institutional environment" (Clift et al., 2013) is blurred or possibly challenged by actors like the well-funded Gates Foundation and global health partnerships like Gavi, the Vaccine Alliance[23] and the Global Fund (formerly the Global Fund to Fight AIDS, Tuberculosis and Malaria) (Clift & Royal Institute of International Affairs, 2014; Hoffman & Røttingen, 2014; Szlezák et al., 2010). Questions have been raised about the WHO's role and mandate in light of this changing global health architecture (O. D. Williams & Rushton, 2011) and the organization's financial constraints, discussed below. It has faced criticisms for being ineffective and irrelevant leading to calls for its reform (Hawkes, 2011; K. Lee & Pang, 2014; Pang & Garrett, 2012; Robbins & Freeman, 2015), not least following its delayed response to the 2014 Ebola crisis in West Africa (Belluz & Hoffman, 2015; Gostin, 2015; Kamradt-Scott, 2016). There have been calls for strengthening the WHO (Kamradt-Scott et al., 2015; Legge, 2012; Moon et al., 2010) and upholding its constitutional mandate as "the directing and coordinating authority on international health work" (WHO, 2006b).

Among the proposals for change, Hoffman and Røttingen (2014) suggest splitting the WHO in two, thereby separating its technical and political mandates. Lee and Pang (2014) call for the retirement of the old the WHO and the reinvention of the global health organization, perhaps with curtailed mandate and powers but more binding authority, and Smith and Lee (2017) argue that institutional innovation, not renovation, is what is necessary. The reform efforts of various Directors-General are discussed below, and former Director-General Chan's efforts to facilitate greater engagement with NSAs, and the increasing influence of the private sector on global health through such partnerships and hybrid organizations are discussed in Chapter 7.

[23] Formerly the GAVI Alliance, and before that the Global Alliance for Vaccines and Immunisation (GAVI).

3.3 Structure and governance

The WHO was intended to form a core part of the post-war order, providing more concerted international cooperation with respect to health and uniting pre-existing health bodies "through clear leadership and unrivalled technical expertise" (K. Lee, 2009). The new agency was set up with three tiers, with its governance and operations distributed to global, regional, and country levels. While this arrangement has "enabled the WHO to combine centralized policy leadership with decentralized operational capacity" (K. Lee, 2009), "in practice, the appropriate distribution of staff, financial resources and perhaps most importantly, decision-making power across the headquarters, regional and country levels has remained an ongoing source of tension" (Gostin et al., 2015).

The main components of the WHO's organizational structure include the World Health Assembly (WHA), the Executive Board, the Secretariat, the Director-General, Regional Offices and Country Offices. These components have remained unchanged since the WHO's formal establishment in 1948 (K. Lee, 2009).

WHA is the decision-making body for the WHO. It meets in Geneva each May to determine the organization's policies. It appoints the Director-General, supervises the Organization's financial policies and reviews and approves the proposed programme budget. The WHA considers reports by the Executive Board, and instructs it on matters upon which further action, study, investigation, or report may be required (WHO, 2018g). The WHA can also adopt regulations, which are binding on Member States unless they opt out (K. Lee, 2009).

The WHA is comprised of delegations from Member States, of which there are currently 194 (WHO, 2018g). All Member States are able to send delegations (Youde, 2012), which may consist of not more than three delegates (K. Lee, 2009). While these delegates are representatives of governments, and preferably the national health administration, from the outset there has been an emphasis on technical capabilities and competence in the field of health (K. Lee, 2009). Relevant international organizations and NGOs that have been recognized with Official Relations status, as is discussed below, may send delegates as observers with certain non-voting privileges.

Decisions are made following the "one state, one vote" principle. In theory, this means that all countries have equal say, no matter their size or power, in determining the WHO's direction. In practice, however, many decisions are never put to a vote. Some are agreed by consensus and presented as a recommendation in the form of resolutions. Some key decisions about priority setting may be made by the Executive Board, Secretariat, or by Member States or other actors providing earmarked funding (K. Lee, 2009). As will be discussed below, this extra funding for specific

programs, over which the WHA has no control, has financed an increasing proportion of the WHO's budget, effectively shrinking the WHA's control over the WHO's activities (Davies, 2010). "Each state may have one vote, but due to variable technical capacity, they are not equally able to influence the policy process" (K. Lee, 2009).

The main functions of the Executive Board are to oversee implementation of the WHA decisions, put WHA priorities into practice, and to advise the WHA as it requests (WHO, 2018g). The WHA elects Member States to select delegates, alternates and advisors. The Executive Board is comprised of 34 members who are "technically qualified in the field of health" (not including alternates and advisors) (Youde, 2012). They are expected to serve in their individual capacity as technical experts and not represent the interests of their respective states. Members are elected for three-year terms, and each year one-third of the members are changed (K. Lee, 2009).

The Executive Board meets in Geneva typically twice a year. The main meeting in January agrees upon the agenda for the forthcoming WHA and adopts resolutions to be forwarded to the WHA. The second, smaller meeting is held in May, immediately following the conclusion of the WHA, to address more administrative matters (WHO, 2018g). Additional meetings are held as required (Youde, 2012).

The Secretariat is the WHO's administrative and technical organ, and is responsible for implementing the organization's activities, including carrying out most of the programmatic work and ensuring the organization functions when the WHA and Executive Board are not in session (K. Lee, 2009)Youde, 2012). The Secretariat has a decentralized structure that embodies the three tiers comprising the single institution that is the WHO. It consists of the headquarters in Geneva, six regional offices and 149 field offices (K. Lee, 2009; WHO, 2019e). The decision to place the headquarters in Geneva was made at the International Health Conference in 1946, and it is located at the former site of the LNHO (K. Lee, 2009). The Secretariat is headed by a Director-General (discussed below) based in Geneva, who leads the organization as a whole and oversees permanent bureaucratic structures (Youde, 2012). In January 2019, the WHO employed more than 7,000 people, including technical and support staff from more than 150 countries across its three tiers (WHO, 2019d). Technical staff is mostly medical professionals. This number is down from 8,500 technical and support staff in 2009 (K. Lee, 2009).

The Director-General is the organization's chief technical and administrative officer. The Director-General is appointed for a five-year term, which is renewable for another term. The Director-General oversees implementation of the WHO policy and programs, including

appointment of Secretariat staff, preparation of annual financial statements, and drafting the program budget (K. Lee, 2009). Historically, the Executive Board assessed candidates that Member States nominated for the position and advanced one individual to be formally elected — "rubber-stamped" — by the WHA. Political jostling and campaigning would take place behind the scenes during the nomination and selection process. However, under pressure by public health campaigners, the election process has become increasingly more open. As of the election in 2017, the WHA elects the Director-General from a short-list of up to three candidates that the Executive Board selects from nominations made by Member States (WHO, 2018b).

The current Director-General is Dr. Tedros Adhanom Ghebreyesus of Ethiopia. He was elected by the WHA on May 23, 2017, out of a short list of three candidates.[24] His five-year term began on July 1, 2017. He succeeded Dr. Margaret Chan, who had served as Director-General from January 4, 2007, having been appointed by a special meeting of the WHA on November 9, 2006. In May 2012 the WHA appointed Chan for a second term that started July 1, 2012 and ended June 30, 2017 (WHO, 2006a, 2012a).

Another element of the WHO's three-tiered structure is its six regional offices. This arrangement was designed to allow the WHO to maintain global and regional cohesions, but also flexibility to address the particular health needs of different regions and countries (WHO, 1958). Within three years of the WHO's creation, existing regional health organizations were incorporated into the new organization and new ones were created to ensure geographical balance (K. Lee, 2009).

Regional offices are responsible for carrying out much of the WHO's programmatic work but, having a high degree of independence and decision-making power, may undertake their own initiatives as well (Youde, 2012; Lee, 2009). As a part of this autonomy, each regional office selects its own Regional Director, and the WHO Director-General does not have direct control over leadership at the regional level. This was intended to promote stronger ties with Member State governments while incorporating existing organizations but has resulted in some tensions between the Secretariat and regional offices (Youde, 2012).

The six regions and the corresponding offices are: African Region (AFRO), the Region of the Americas (AMRO)[25], South-East Asia Region (SEARO), European Region (EURO), Eastern

[24] The other two candidates were Sania Nishtar of Pakistan and David Nabarro of the UK.

[25] PAHO serves as the WHO's Regional Office for the Americas, but maintains its independence, embodying the "ongoing tension between independent regional bodies and need for the WHO to provide cohesion and centralized leadership" (K. Lee, 2009). An example of the types of issues raised by this dynamic is discussed in Chapter 6; PAHO in October 2012 accepted financial support from food and beverage

Mediterranean Region (EMRO), and the Western Pacific Region (WPRO). Each Member State is associated with a regional office, usually on a geographic basis but in some exceptional cases for political reasons. For example, Israel is part of EURO because Arab countries in EMRO objected to cooperating with the Israeli government (K. Lee, 2009), and South Korea is part of the Western Pacific region along with geographic neighbours Japan and China while North Korea belongs to the South-East Asia region (Youde, 2012).

In 2005 there were around 144 the WHO country offices located in Member States deemed in need of country-level support (K. Lee, 2009). In 2017 the WHO operated 149 field offices in addition to its Geneva headquarters. Countries that do not have a WHO office are covered by a nearby field office of the appropriate regional office (WHO, 2019e). Country offices vary in size. Each one is headed by a WHO Representative, who is a trained physician not of that country, and appointed and answerable to the relevant regional office (K. Lee, 2009).

The role of country offices is to work with the respective government to implement the WHO policies and programs and to support the development of the country's health system. The office is located within the country's ministry of health. The WHO country offices serve three main functions: providing policy advice and technical support; information, public relations and advocacy; and management and administration (K. Lee, 2009).

3.4 Financing the WHO: model and challenges

Financing for the WHO comes in two forms. Assessed contributions by the WHO's Member States (or Regular Budget Funds, RBFs) are used to finance the organization's core budget and are meant to provide "guaranteed, long-term, predictable financing" (Sridhar et al., 2014). Assessed contributions are calculated biennially according the UN scale of ability to pay (GNP and population), similar to the formula used by other UN specialized agencies (Davies, 2010), frozen in 1982 (Legge, 2012). As a result, a small number of high-income countries provide most of its core funding, although according to the formula, no single state can contribute more than one-third of the WHO's annual budget (K. Lee, 2009). The largest provider of assessed contributions is the US, which was originally responsible for 25% of core funds, but that share dropped to 22% after protests by the US government in 2001 (K. Lee, 2009).

companies as part of a multistakeholder initiative on noncommunicable diseases (NCDs), which the WHO rules would prohibit the office's other legal entity, AMRO, doing (Moscetti & Taylor, 2015; Philpott, 2012; WHO, 2012g; Wilson & Kerlin, 2012).

The second form of financing is voluntary contributions (or Extra-budgetary Funds, EBFs) earmarked for specific projects. This financing is given primarily by other UN organizations, Member States, NGOs, private companies or individuals (K. Lee, 2009). The WHO's Constitution states that it "may accept and administer gifts and bequests made to the Organization provided that the conditions attached to such gifts or bequests are acceptable and are consistent with the objectives and policies of the Organization." Although present as a small proportion of the WHO's budget from early in the organization's existence, voluntary contributions now comprise the vast majority of the WHO's financing. This has had an impact on not only its operations (Youde, 2012) but also its role as a global health leader and its norm-setter (Kruse & Kaya, 2017; Ollila, 2005), as is discussed below and in Chapter 7.

The increased proportion of the WHO's financing that comes from voluntary contributions has had a major impact on the WHO operations and its role as a global health leader (Youde, 2012). Since the 1980s, an ever-increasing proportion of the WHO funding comes in the form of voluntary contributions for special programs, over which the WHO has no control, as is discussed below. Although financing for global health more than quadrupled between 1990 and 2011, much of the money has bypassed the WHO (van de Pas & van Schaik, 2014), which some in the international and donor communities see as "clodhopping and ineffective" (Clift & Royal Institute of International Affairs, 2014). This situation has prompted discussion over whether the WHO should undertake a wide range of activities by spreading resources thinly or concentrate its attention and efforts on certain strategic activities to make more impact in fewer areas. There is also debate over whether the WHO should direct its resources to certain levels, whether global, regional or country (K. Lee, 2009). The WHO was never intended to perform every function that might contribute to global health, such as serving as a funding agency, nor even a research organization. In the current "far more complex institutional environment," it is all the more necessary for it to perform its much-needed coordinating role (Clift & Royal Institute of International Affairs, 2014).

The WHO budget included voluntary contributions from very early in its existence, although on a limited scale. Until the 1950s, voluntary contributions came from two main sources. The first was the Expanded Programme for Technical Assistance (1949) established to promote economic development through the transfer of skills and to channel voluntary contributions through UN organizations for development activities. The WHO used funds from the EPTA to strengthen health administrations, control communicable diseases, and train professional and auxiliary staff. The second source was the UN Special Fund (1950) established to mobilize greater resources for UN

economic and social development activities, which was consolidated in 1962 as the UNDP (K. Lee, 2009). From the 1950s onward, however, there was a significant and steady increase in the amount of voluntary contributions made to the WHO, providing a vital source of financing for disease control and eradication programs such as the Intensified Malaria Eradication Programme (1955) and the Intensified Smallpox Eradication Programme (1967) (K. Lee, 2009).

By 1970, 20% of the total budget came from voluntary contributions, with over half of this coming from other UN agencies. The proportion increased steadily in the following years with the creation of special programs for research on human reproduction and tropical diseases. A study of voluntary contributions published in 1975 concluded that an upward trend was necessary if the WHO was to pursue its constitutional mission and that these funds could allow an increase in technical cooperation with a broader array of actors and draw attention to new areas of work. At that time, voluntary contributions were seen as a vote of confidence in the WHO, helping it to expand its programmatic portfolio (K. Lee, 2009).

Member States have contributed to this imbalance between assessed and voluntary contributions in several significant ways. Member States have resisted any increase in their assessed contributions. In the 1980s, in a context of financial austerity and the rise of neoliberalism, major donors (known as the Geneva Group) introduced a policy of zero real growth (adjusting for inflation) to the assessed contributions to all UN organizations. This policy was replaced in 1993 by an even more austere policy of zero *nominal* growth (not inflation adjusted), thereby reducing the WHO's budget in real terms (K. Lee, 2009) by as much as 20% in the 1990s (Bloom et al. 1999, 911). This zero growth, first real and then nominal, necessitated attracting more voluntary contributions (Vaughan et al., 1996). Furthermore, Member States have not always paid their dues in full and remained in arrears (K. Lee, 2009; Sridhar et al., 2014). In 2001, 61% of Member States had paid their assessed contributions in their entirety, 25% had made no payments; in 1992 only 49% had paid in full. In 2004, for example, the voting rights were suspended of 23 Member States that were in arrears: Afghanistan, Antigua and Barbuda, Argentina, Armenia, Central African Republic, Chad, Comoros, Djibouti, Dominican Republic, Georgia, Guinea-Bissau, Iraq, Kyrgyzstan, Liberia, Nauru, Niger, Republic of Moldova, Somalia, Suriname, Tajikistan, Togo, Turkmenistan and Ukraine (WHO, 2004c).

By the early 1980s the voluntary contributions proportion of the total the WHO budget was steadily increasing. Alongside the policy of zero growth in assessed contributions (discussed above), this trend represented a vote of confidence in special programs, and also a vote of no-confidence in

the WHO and its operations (Godlee, 1995; K. Lee, 2009). Leading Member States increasingly questioned the WHO's efficacy and its political commitments. For example, critics called the Alma-Alta Declaration overly idealistic, too expensive and perhaps even socialist. They wanted more vertical interventions focusing on specific diseases and conditions (Magnussen et al., 2004). Donors financed vertical programs with voluntary contributions, over which they had a high degree of control compared with assessed contributions, the use of which was determined by the entire WHA (Godlee, 1995; Youde, 2012). Because voluntary contributions are directed toward specific, particular interests[26] (not a general fund), the WHA has next to no control over them (Davies, 2010). Indeed, the special programs they finance are not under the control of the WHA, the Executive Board, or the Director-General and secretariat, with each program having its own director and "a management executive committee made up of donors' representatives" (Godlee, 1995).

Some Member States have raised concerns about the impact of the imbalance between assessed and voluntary contributions on the WHO's effectiveness (Youde, 2012), its programmatic autonomy and budgetary decision-making powers (K. Lee, 2009; Legge, 2012; Walt, 1993), and its potentially distorting impact on the WHO's priorities and the coherence of its programs (Legge, 2012). A report commissioned by the governments of Australia, Norway and the UK in 1994 concluded that donor preferences expressed through voluntary contributions unduly influenced the WHO's policy agenda (Vaughan et al., 1995). The report found that voluntary contributions lead to distorted and disproportionate funding of programs, competition among programs, variation in systems of accountability and transparency, and prevented longer-term program planning because of their time-limited nature (Vaughan et al., 1995). Special programs financed through voluntary contributions were described as "undermining from above" (Godlee, 1995). Sridhar and Woods (2013) draw attention to what they term "Trojan multilateralism", whereby wealthy states provide earmarked funding that may look like multilateralism, but actually "is covertly introducing bilateral goals and interests into multilateral institutions.

Nevertheless, voluntary contributions remain a significant part of the WHO's financing and appear unlikely to decline. In 2007, the US and UK were the top two sources of voluntary contributions, at 25% and 24%, respectively, followed by the World Bank-GAVI affiliate (16%), Canada (12 %), Bill and Melinda Gates Foundation (11.8%), and Commission of European Communities (10.2%) (Sridhar, 2012). By 2010, the Gates Foundation, giving US $446 million, was

[26] The vast majority of voluntary contributions — 91% in 2010-2011 (van de Pas & van Schaik, 2014) — are earmarked for specific donor-driven priorities and programs.

the second biggest financial contributor to the WHO after the US (van de Pas & van Schaik, 2014), and it remained in the top three alongside the US and UK in 2013 (Sridhar et al., 2014).

The proposed 2008-09 budget recommended a level of assessed contributions from Member States of US$929 million, an increase of 4% over the previous biennium. At about 23% of the total budget of 4.227 billion, this level of assessed contributions combined with miscellaneous income of $40 million was intended "to maintain a reasonable balance" with voluntary contributions of $3.268 billion (WHO, n.d.c). A proposal in 2015 to increase assessed contributions by 5% was not approved by the WHA (Clift & Røttingen, 2018). In 2017, the WHA approved an increase in assessed contributions from US$929 million (covering only 20% of the total program budget in 2016-2017) to US$ 956.9 million for the 2018-2019 program budget (WHO, 2016g, 2017a). This additional US$28 million represents an increase of about 3%, far short of the 10% increase that had been proposed by then Director-General Chan (WHO, 2016g).

3.5 Responding to financing challenges: the WHO reform

A series of analyses in the early 1990s highlighted several concerns about the operations of the WHO that remain relevant today. These concerns included the growing imbalance, described above, between core programs and special programs financed by voluntary contributions and accountable to donors rather than the WHA, the increased emphasis on technical assistance and project execution instead of the WHO's analytical and normative functions; weak performance at country level and deficiency in skills related to health policy economics and management; the tension between the WHO's vertical programing and its advocacy for integrated primary health care; the autonomy of the regional offices and their politicization; and a series of deficiencies in management, including finance, recruitment, coordination, budgetary planning, and general bureaucratic inefficiencies (Clift et al., 2013).

A number of reports in 1993 identified similar issues and made recommendations for reforms. For example, a UN Joint Inspection Unit report identified "serious and complex problems of constitutional, political, managerial and programmatic nature" in the WHO's three-tier organizational structure. It recommended that regional directors should no longer be elected by Regional Committees, but instead they should be selected and nominated by the Director-General and confirmed by the Executive Board (Clift et al., 2013). Under Hiroshi Nakajima, the Director-General at the time, these issues were discussed at length by the Executive Board but little change was undertaken (Clift et al., 2013).

Director-General Gro Harlem Brundtland, who held the office from 1998 to 2003, arrived to the position with a clear vision for reform. In her view, the WHO had two main tasks. One was its "work on the ground" to combat disease, to provide advice on best practices, to set norms and standards and to support research and development (Clift et al., 2013). The other was "to put health on the world stage and secure a role for the WHO in the definition of the new development agenda underpinned by the values of equity, human dignity and human rights" (van de Pas & van Schaik, 2014). A key component of Brundtland's efforts toward advancing this second task was ushering in the WHO's first binding treaty, the Framework Convention on Tobacco Control (FCTC), which was aimed at reining in the powerful tobacco industry (van de Pas & van Schaik, 2014). As the FCTC was developed, NGOs collaborated with the Secretariat against the tobacco industry's aggressive strategies. This was an unprecedented role for NGOs in global health governance and allowed them to gain importance in diplomatic policy deliberations on global health issues (van de Pas & van Schaik, 2014).

Irrespective of her firm stance on the tobacco industry, Brundtland was a strong advocate of multistakeholder cooperation and partnering with the private sector.[27] Her stance concurred with the shift toward the private sector for financing and collaboration in addressing development, poverty and human rights issues, within the broader UN system engineered by Secretary General Kofi Annan. In her first speech after her election, Brundtland set the tone for her term in office by calling, for "open and constructive relations with the private sector" (WHO, 1998, cited in Buse & Walt, 2000, Reid & Pearse, 2003 and Lee, 2009).

Brundtland promoted the new global business model of multistakeholder cooperation and sought to align the WHO's way of working along the lines of the new Global Compact[28] (van de

[27] Even before she was the WHO Director--General, she favoured partnership between government and industry. She said in 1990:
"Partnership is what is needed in today's world, partnership between government and industry, between producers and consumers, between the present and the future. We need to build new coalitions. We must agree on a global agenda for the management of change. We must continue to move from confrontation, through dialogue to cooperation. Collective management of the global interdependence is … the only acceptable formula in the world of the 1990s" (Lohmann, 1990 cited in (Richter, 2004c)).

[28] The UN Global Compact was started in July 2000 on the initiative of former UN Secretary-General Kofi Annan. Under the scheme, corporations pledge to implement ten principles relating to human rights, labour standards and environmental sustainability. From 50 initial corporations, the Compact now engages more than 9,500 companies in more than 160 countries. Partners included UN agencies, transnational NGOs such as Amnesty International, World Wide Fund for Nature, and Oxfam, and international labour federations (Ruggie, 2004). However, from the outset many public-interest NGOs and NGO networks feared that "the Global Compact would weaken rather than strengthen efforts to hold corporations publicly accountable and democratic decision-making during a time of neoliberal economic globalization" (Richter, 2004a, p. 12).

Pas & van Schaik, 2014). Soon after assuming office, she formed the cluster on External Relations and Governing Bodies, whose mission included a call "to build partnerships and alliances with other key actors such as other UN agencies, NGOs and the private sector" (K. Lee, 2009). According to David Nabarro, then Executive Director at Brundtland's office, financial constraints were a motive for increasing partnerships with the private sector: "We certainly needed private financing. For the past decades, governments' financial contributions have dwindled. The main sources of funding are the private sector and the financial markets" (quoted in Motchane, 2003, p. 396). In addition to financial contributions, Brundtland appointed individuals from the private sector to prominent positions within the WHO's senior ranks (K. Lee, 2009).

Brundtland's reforms resulted in an expansion in voluntary contributions, including public-private partnerships (PPPs) in health, as mentioned above. However, some of the many global public-private initiatives preferred not to channel resources through the WHO, seeing it as a potential partner rather than lead or coordinating agency (K. Lee, 2009). The Bill and Melinda Gates Foundation has been particularly influential in this respect, helping to shape the decisions of other funding bodies and also, thereby, global health priorities, to the extent that it has been referred to as "the 'pied piper' of global health" (Birn, 2014).

Despite her reform efforts, Brundtland was unable to secure an increase in core funding for the organization, which is even more precarious today, and partnerships with the private sector were, and remain, controversial (Clift et al., 2013). Her successor, Lee Jong-Wook (2003-2006)[29], who had been closely involved in Brundtland's the WHO reform process as her Senior Policy Advisor in her cabinet, picked up where she left off. As her policy advisor, he remained committed to supporting Member States by strengthening the WHO's regional and country structure (WHO, 2019b) and this commitment continued into his time as Director-General. In his address to the WHO staff in July 2003, he made clear his intention to decentralize the WHO and strengthen its presence and impact at the country level. He aimed to do this by giving country offices greater resources and authority, and empowering them to "work more effectively and accountably" with governments in responding to local health needs (J. Lee, 2003a). In November of that year he remarked several times that change, renewal and reform were important values, but so was continuity (J. Lee, 2003b, 2003c).

Director-General Margaret Chan (2007-2017) initiated a reform process in January 2010 by convening an informal consultation on the future of financing for the WHO and the need for

[29] Dr. Lee passed away suddenly on May 22, 2006.

predictability and sustainability in this respect (WHO, 2011a). Participants in the consultation raised more fundamental questions about the role of the WHO and the nature of its operations in a rapidly changing global health environment. The reform was expanded to include priority setting, governance and management, but financing remained the fundamental problem at the core of the initiative. The reform process began in earnest in May 2011 when the WHA considered the Director-General's report on the future of financing, and gave the official mandate for reform (WHO, 2011a).

With respect to engaging with NSAs, while initiating the reform process, in 2011 the WHA requested a detailed concept paper on the subject of holding a World Health Forum in November 2012 (WHO, 2011a), which will be discussed in more detail in Chapter 7. However, the idea was later abandoned due to a lack of support among Member States (MMI & DGH, 2011; van de Pas & van Schaik, 2014; WHO, 2011d, p. 2). The Executive Board held a Special Session on the WHO reform (also discussed in Chapter 7) in November 2011, where several options were discussed for expanding engagement with NSAs. In the longer-term, it was agreed that options for a framework to guide stakeholder interactions (while expressing the WHO's role as a directing and coordinating authority) would be explored (WHO, 2011d). At its 65th meeting in May 2012, the WHA requested several draft policy papers about the WHO's engagement with NGOs and private commercial entities, respectively, and about the WHO's hosting of health partnerships (WHO, 2012c). This initiated a four-year process of consultation and development resulting in the WHA's adoption of FENSA in May 2016 (WHO, 2016f).

Although the reforms initiated by Chan sought to address a wide range of issues, they did not address head-on the WHO's role in the changed, and changing, global health architecture, and whether more fundamental changes to the organization's governance, management and financing structures were necessary in order for it to reach its potential (Clift et al., 2013). Among other challenges, one observer noted, the process was "bedevilled by the same problem that led to the funding crisis in the first place—a switch in power from the assembly of Member States to donors (including some Member States as well as other donors) with specific interests" (Legge, 2012).

One initiative under Chan's leadership that was aimed at "improving the transparency, alignment, and predictability of the WHO's financing," was the establishment of a financing dialogue to address budgetary gaps before the implementation of biennial budgets begin.[30] Civil

[30] An extraordinary meeting of the Programme, Budget and Administration Committee of the Executive Board in December 2012 proposed several new initiatives, one of which was the financing dialogue. These

society organizations expressed concerns early on, however, that rather than leading to increases in assessed contributions by Member States, the new approach would further institutionalize the WHO's donor dependence (van de Pas & van Schaik, 2014). The financing dialogue was launched on June 24, 2013, underpinned by the principles of alignment, predictability and flexibility, and transparency. Member States made specific commitments relating to these principles. Subsequent financing dialogues were held in November 2013, November 2015, and October 2016.

The October 2016 finance dialogue meeting was held to address the expected budgetary gap in the 2016-2017 program biennium. In May 2016, the WHA had approved a budgetary increase of US$160 million for the new the WHO Health Emergency Programme, raising the agency's total budget for 2016-2017 to US $3.354 billion. However, there was expected to be a gap between budget and financing of US$500 million by the end of the biennium. During the meeting numerous Member States announced new financial contributions (WHO, 2016h). Director-General Chan also made the case for a 10% increase in assessed contributions, which would amount to an additional US$93 million (WHO, 2016g). As mentioned above, Member States at the WHA in May 2017 did not approve an increase of this size, but agreed to a 3% increase (WHO, 2017a).

The Director-General since July 1, 2017 is Tedros Adhanom Ghebreyesus. As Minister of Health in Ethiopia from 2005-2012, Tedros led a comprehensive reform of the country's health system. Within months of taking office as the WHO Director-General, he outlined his vision for "A transformed the WHO". To meet the health needs of the 21st century, in Tedros' view, the WHO will need to broaden and intensify its engagement with a wider range of stakeholders across the public, private and civil society sectors. His priorities include "strong, visionary leadership to put the WHO at the centre of global health," managerial reform aimed at attracting and retaining talent, and securing "more predictable and flexible funding for the WHO by positioning health as a security, economic and development priority" (WHO, 2018f).

Yet, by the end of his first year in the office, Tedros was seen by some observers in May 2018 as having "quietly abandoned Margaret Chan's reform agenda" (Huang, 2018). Rather than addressing issues concerning the WHO's internal management, such as the balance of staff skills and accountability, and its funding structure, Tedros chose to focus – with early indications showing some success – on improving the agency's emergency response capacities (Huang, 2018). Others, however, were more generous in their assessment of Tedros's first year. Richard Horton, Editor in

proposals were then endorsed by the Executive Board at its meeting in January 2013 (WHO, 2013f) and by the WHA in May 2013 (WHO, 2013g).

Chief of the medical journal The Lancet said during a panel at the WHA that "there has been a dramatic change at the WHO in the past year under the leadership of Dr. Tedros" (Ravelo & Chadwick, 2018 n.p). He indicated that the door had been opened to cooperation between the WHO and the academic community, which the WHO had not been receptive to previously. The Director-General of the International Federation of Pharmaceutical Manufacturers and Associations also appreciated Tedros's continued focus on partnerships (Ravelo & Chadwick, 2018).

In his opening speech at the Executive Board in January 2019, Tedros outlined his vision for transforming the WHO into a "modern" and "agile organization". He said, "Transformation is not about tinkering at the edges," and called it instead a "fundamental revamp" (Tedros, 2019). He said the transformation was building on the efforts of his predecessor Chan and aligned with wider reforms taking place across the UN. He outlined four main shifts: measurable impact, relevance in all countries, normative and technical excellence, and innovation, with a focus on digital health. He said that in practice, the transformation would consist of four parts: a new strategy, new processes, a new operating model and a new culture for the WHO (Tedros, 2019).

Now two years into his term, it is still too soon to gauge whether Tedros's reforms – or transformation, to use his more recent terminology – will be any more successful than those initiated by Brundtland, Lee, and Chan at structuring, managing, and positioning the WHO in such a way that it is able to provide the leadership and coordination that global health requires.

3.6 Conclusion

This chapter gave an overview of the antecedents, history and structure of the WHO. Particular emphasis was placed on the challenges posed by growing budgetary gaps caused by Member States refusal to increase their assessed contributions. The WHO has tried to bridge the budgetary gaps by relying on voluntary contributions, including by partnering with private sector actors in multistakeholder initiatives and PPPs. Several Directors-General have undertaken reform to try to address the agency's financial constraint. These reforms have included adopting a multistakeholder approach and turning to the private sector and philanthropic organizations for partnerships. More recently, then Director-General Margaret Chan initiated reforms that included the introduction of FENSA, a new policy to govern and facilitate the WHO's engagement with NSAs. The contentious development and adoption of FENSA are analyzed in Chapter 7. The analysis includes critiques of the policy and its implications for the WHO and for global health governance more broadly, as well as its effect on the ability of profit-oriented NSAs to engage with the WHO in order to influence

substantive policies and paradigms that shape policy-making. Increased reliance on and partnership with the private sector comes with risks by exposing substantive policy at the WHO and its policy-making, norm-setting and governance to corporate influence and by creating deeper reliance on private funding in ways that undermine the WHO's mandate.

Chapter 4 – Contextualizing the case studies: baby food and soda industries

4.0 Introduction

As described in Chapter 1, this dissertation examines two issue areas to evaluate corporate influence on, and participation in, global health policy-making amid the changing nature of global (health) governance. The chapter serves two purposes within the dissertation. The first is to outline the health effects of policy decisions taken at the World Health Organization (WHO) in terms of the health and well-being of the world's population and the significance, therefore, of the baby food and soda industries' engagement to influence global policies and regulations relating to their products in order to increase their sale and consumption, and to shape paradigms that determine which policies are pursued and what role private actors are able to play in developing them. The second is to introduce the structural context within which these industries work to influence both substantive policies and paradigms to create environments conducive to their interests. This context determines the strategies and types of power available to these industries, but it has also been shaped by these and other industries by drawing, iteratively, on these same strategies and sources of power.

The case studies, discussed in detail in Chapters 5 and 6, analyze the ways in which private sector actors in these two industries use the corporate playbook to influence substantive policy and paradigms relating to their products. Their track-records of putting their profits ahead of health in the public interest, along with concerns about non-state actor participation in global health governance and policy-making, raise questions about the implications for the WHO and global health policy-making as the lead global health agency seeks to increase its engagement with such actors, especially for-profit entities and their associations.

The first case study focuses on the marketing of baby milks and foods and their impact on infant health outcomes. The marketing of these products is linked with decreased breastfeeding rates, resulting in increased infant illness and mortality. It was identified as a global health problem nearly five decades ago (Baer & Marguiles, 1980; Jelliffe, 1972; Sokol, 2005). While baby milk marketing is "a problem that most people thought had gone away [in] the 1970s and 1980s," it is "the forgotten issue of our time" (Mason & Greer, 2018, p. 1) and one that continues to have widespread impacts on infant health around the world. The medical journal *The Lancet* has said the shift to formula, "[m]ultiplied across populations and involving multinational commercial interests, … has catastrophic consequences on breastfeeding rates and the health of subsequent generations" (Lancet, 2016, p. 404). The second case study concerns sugar-sweetened beverages, or soda, and

their contribution to NCDs such as obesity and diabetes. Soda manufacturers play a significant role in driving up the consumption of soda, just as Big Food contributes to the increased consumption of processed foods high in salt, sugar, and fat (Beaglehole & Yach, 2003; Stuckler et al., 2012; Wiist, 2006b, 2010). The two cases are examples of what the public and global health literatures term "industrial epidemics", recognizing the industries' products and activities as vectors of disease. These activities shape the environment in which consumers make decisions about feeding their babies, making them what these literatures call the "corporate determinants of health".

This chapter begins with an overview of the health benefits of breastfeeding for infants and mothers, its economic benefits for families and states and what's at stake if breastfeeding is not protected through substantive policy and actions. It describes the link between the marketing of baby milk and declining breastfeeding rates, and growing calls for the regulation of baby food marketing at the global level. The chapter introduces baby food market leaders Nestlé and Danone, and the main baby food industry associations. It also outlines relevant global policies that relate to the marketing of baby milk and to infant and young child nutrition. Turning to the soda industry, the chapter provides an overview of the issue, starting with the effects of soda consumption on health, specifically in terms of NCDs such as diabetes and obesity. It provides an introduction to soda market and industry, including market leaders The Coca-Cola Company and PepsiCo, as well as soda industry business associations such as the International Food and Beverage Association and the American Beverage Association. The chapter also outlines relevant global policies that relate to the soda industry.

4.1 Baby food issue and importance to public health

Breastfed babies are generally healthier and more likely to achieve optimal growth and development compared with those who are fed formula milk. The lives of an estimated 800,000-823,000 children could be saved every year, and the health and development of millions more children greatly improved, if breastfeeding practices were improved to recommended optimal standards (Black et al., 2013; Victora et al., 2016). The WHO recommends that all babies be breastfed within an hour of birth and exclusively breastfed (no other food or drink, not even water) for their first six months, and that breastfeeding continue along with complementary foods to the age of two years or beyond (Kramer & Kakuma, 2012; WHO, 2019g). Breastfeeding provides protection against mortality due to infectious diseases (Sankar et al., 2015), incidence and severity of diarrhea and respiratory infection (Horta & Victora, 2013), and ear infections (Bowatte et al., 2015). There are also long-term

health benefits for breastfed infants and young children. Breastfeeding is associated with a lower prevalence of obesity among children (Woo & Martin, 2015), a decreased likelihood of type 2 diabetes and of overweight/obesity among adults (Horta et al., 2015b), and improved cognition and performance in intelligence tests (Horta et al., 2015a).

Breastfeeding also confers health benefits to mothers. For example, breastfeeding is protective against breast and ovarian cancers (Chowdhury et al., 2015). Present rates of breastfeeding prevent almost 20,000 annual deaths from breast cancer, and another 20,000 could be prevented by scaling up breastfeeding practices (Victora et al., 2016). Exclusive and predominant breastfeeding delays the return of postpartum menstruation, which has the effect of preserving iron stores and spacing pregnancies, which benefits women's health. Breastfeeding also reduces the mother's risk of type 2 diabetes (Aune et al., 2014; Chowdhury et al., 2015).

In addition to touting health benefits for babies and mothers, some breastfeeding advocates have also appealed to economic perspectives by pointing to the cost of not breastfeeding to families (Sobel et al., 2012) and states (Bartick & Reinhold, 2010; Bhutta et al., 2013; Gupta & Khanna, 1999; Gupta & Rohde, 1993; M. J. Renfrew et al., 2012; J. P. Smith et al., 2007)), the economic benefits of improving breastfeeding practices (Pokhrel et al., 2014; M. J. Renfrew et al., 2012), and the amount of investment necessary to do so (Holla et al., 2013; Horton et al., 2009; Rollins et al., 2016; UNICEF, 2013).

Advocates maintain that breastfeeding is a matter of children's and women's rights (Holla et al., 2013; UNICEF, 2013). In November 2016, UN human rights experts[31] issued a joint statement that said: "Breastfeeding is a human rights issue for both the child and the mother" (OHCHR, 2016). The experts reminded States of their obligations under relevant international human rights treaties to provide all necessary support and protection to mothers and their infants and young children to facilitate optimal feeding practices, including by ending inappropriate marketing of breast-milk substitutes (OHCHR, 2016).

Although many factors influence infant feeding decisions,[32] a vast literature finds that the marketing practices of baby food companies have been particularly detrimental to global breastfeeding rates (Baer & Marguiles, 1980; J. P. Brady, 2012; Lancet, 2016; Sokol, 2005; C.

[31] UN Special Rapporteurs on the Right to Food and on the Right to Health, the Working Group on Discrimination against Women in Law and in Practice, and the Committee on the Rights of the Child.
[32] Other factors that influence infant feeding decisions include mother's health and perceptions of breastfeeding, societal attitudes, birthing experience, lactation counseling, availability of maternity leave, support from family and friends, etc.

Williams, 1939).[33] Advertising is designed to represent formula-feeding as aspirational, convenient, and more nourishing than breastfeeding, and to create doubt in mothers' minds about their ability to breastfeed. Free samples disrupt the establishment of breastfeeding and an adequate milk supply. Incentives to doctors and other health workers (in the form of gifts, sponsorships, trips, and so on) encourage their endorsement of company products to mothers. All of these tactics contribute to normalizing bottle-feeding and making it appear preferable to breastfeeding.

The replacement of breastmilk with other less nutritive and protective or inappropriately prepared milks or other fluids has a negative impact on infant morbidity and mortality due to a downward spiral of undernutrition and infection. This phenomenon has been dubbed "bottle baby disease" (Baer & Marguiles, 1980). Declining breastfeeding rates were linked with the promotion of milks for babies as early as 1939 by paediatrician Dr. Cicely Williams, who argued that deaths resulting from such "misguided propaganda on infant feeding" should be considered murder (M. Brady & Oliveira Brady, 2004; C. Williams, 1939). Concern over the aggressive promotion of formula milks increased over the 1960s as more doctors published research that echoed Dr. Williams' observation and established the negative impact of marketing and advertising on breastfeeding practices. One pediatrician scholar coined the term 'commerciogenic malnutrition' to describe the impact of the promotion of milks and baby foods on infant nutrition status (Jelliffe, 1972). The WHO passed two resolutions (in 1974 and 1978) calling on Member States to make efforts to promote breastfeeding, including by regulating sales promotion (WHO, 1974, 1978). The 1974 resolution explicitly noted: "the general decline in breastfeeding, related to socio-cultural and environmental factors, including the mistaken idea caused by misleading sales promotion that breastfeeding is inferior to feeding with manufactured breastmilk substitutes" (WHO, 1974 Preamble para 1). The United Nations Children's Fund (UNICEF) had also identified aggressive promotion of baby milks as a key factor contributing to the decline of breastfeeding in many areas of the developing world (Baer & Marguiles, 1980).

UN agencies first met to discuss the matter in November 1970; however, the statement that was issued as an outcome reflected the baby food industry's participation in the discussions (Sokol,

[33] Conversely, industry executives have admitted that increases in breastfeeding are bad for business. "There's definitely an offset from – a slight increase or an uptick in breastfeeding rates," Kasper Jakobsen, Chief Executive of Mead Johnson until June 2017, has said (Mason & Greer, 2018, p. 31). Abbott's chief executive Miles White also acknowledged that "an increasing breastfeeding rate in China" may limit the company's sales in the long term, although annual sales increases of 6% are "still a healthy rate" (Mason & Greer, 2018, p. 32).

1997). In 1972, the International Organization of Consumers Unions (IOCU), now called Consumers International, proposed a draft *Code of practice for advertising of infant foods*. The Codex Alimentarius Commission (the UN agency that deals with international quality and labelling standards for food products) felt the Code was outside its mandate, however, and should be taken up instead by the WHO and UNICEF (Chetley, 1986; Sokol, 1997).

The issue entered the public's purview in 1973 when it was highlighted in *New Internationalist* magazine (Geach, 1973). The following year, the development agency War on Want published a booklet entitled *The Baby Killer* (Muller, 1974). The booklet was translated into German by a small Swiss student group called the Arbeitsgruppe Dritte Welt (Third World Working Group) and published under a new title that translated as *Nestlé Tötet Babies (Nestlé Kills Babies)* (Sasson, 2016; Sokol, 1997). The press in Switzerland, where Nestlé's headquarters are based, gave the report extensive coverage (Sokol, 1997). Nestlé was furious and sued the students for libel, earning the company a great deal of negative publicity over the course of the two-year court case (Allain, 2005; Sasson, 2016). The group was eventually found guilty on one count of libel concerning the book title, and Nestlé dropped the other three counts. The judge told Nestlé to change its marketing tactics if it wished to be "spared the accusation of immoral and unethical conduct" (Sokol, 2005, pp. 7–8). Perhaps unsurprisingly, however, the company changed little. On July 4, 1977, a consumer boycott of Nestlé was launched in North America in protest at the company's inaction.

Then US Senator Edward Kennedy, as chair of a subcommittee on Health and Scientific Research, held a hearing on the advertising and promotion of infant formula in developing countries. The hearing drew more public attention to the issue and led to increased pressure on the infant food companies. Senator Kennedy requested then WHO Director-General Halfdan Mahler to convene and international meeting on the topic (Sokol, 2005).

In October 1979, the WHO and UNICEF held a joint meeting on infant and young child feeding that brought together 150 participants, including officials from the UN and other specialized agencies, delegates from governments, non-governmental organizations (NGOs) and industry as well as experts in various disciplines. It was the first time that NGOs and industry sat as equal participants with government delegates in a UN meeting (Baer & Marguiles, 1980; Chetley, 1986). The meeting called for "'urgent action to promote the health and nutrition of infants and young children' and cited 'poor infant feeding practices and their consequences' as 'one of the world's major problems'" (Baer & Marguiles, 1980, p. 72). The meeting recommended: "There should be an international code of marketing of infant formula and other products used as breastmilk substitutes"

and the WHO and UNICEF were "requested to organize the process for its preparation" (WHO/UNICEF, 1979, p. 29). The World Health Assembly (WHA), the policy-making body of the WHO, endorsed this call in May 1980 (WHO, 1980a).

The WHO and UNICEF led the drafting process in consultation with experts, government delegations, NGOs and industry. The industry lobbied through the International Council of Infant Food Industries (ICIFI), which Nestlé had set up along with seven other infant formula manufacturers to counter negative publicity during the company's libel trial, to try to influence the drafting process. NGOs also lobbied the WHO and UNICEF, urging that the Code should be as strong and protective as possible. The NGOs resented that the two UN agencies seemed to be acting as mediators between the NGOs and industry, rather than taking the lead to protect infant health (Sokol, 2005). Four drafts of the Code were prepared over a period of 18 months leading up to its presentation before the WHO Executive Board in January 1981 and the WHA in May 1981.

Nestlé expected that attention to the issue and the Boycott would die down with high-level negotiations over the Code underway. But with the US vote against the Code came renewed attention to the issue and growing calls to boycott. To salvage the company's suffering reputation, in December 1983 Nestlé management decided to negotiate with the activists. Two months later, the company signed an agreement to comply fully with the International Code of Marketing of Breast-milk Substitutes, described below, in all markets but Europe. The Boycott was suspended for six months and then called off in September 1984. However it started again in 1988, coordinated from the UK, when Nestlé continued to market its products in violation of the Code (Allain, 1989, 2005; Sasson, 2016).

4.2 The baby food market and industry

The baby food market was valued at US$44.8 billion in 2014,[34] a figure that was projected to reach $70.6 billion by 2019 (Rollins et al., 2016). These sales, unlike those of other commodities, seem to be resilient to market downturns. Even during a global recession in 2009, baby formula sales continued to grow by 7-8% annually (E. Renfrew, 2014; Rollins et al., 2016). It was projected in 2014 to be "the fastest growing packaged food category over the next 5 years, achieving growth in excess of 7% a year" or even as high as 8-9%, until 2019 (E. Renfrew, 2014). In 2013, four

[34] Up from $2 billion in 1987 (Mokhiber, 1987), less than $15 billion in 1998 (Mason & Greer, 2018), US $17 billion in 2001 (Allain, 2005) and $36 billion in 2011 (Euromonitor, 2011, cited in Mason, Rawe, & Wright, 2013).

companies together controlled 55% of the global baby milk market value: Nestlé, Danone, Mead Johnson[35] and Abbott Laboratories (Baker et al., 2016).

Two companies dominate the baby food market. Nestlé has for a long time been considered the market leader, both in terms of its size and its influence. In 2011, the company reportedly claimed 23% of the baby food market. Next in terms of market share is Danone, which had 14% of the market since acquiring Royal Numico in 2007, and Mead Johnson was in third position with 11% of the global market (Euromonitor, 2011; Mason et al., 2013; Yeong & Allain, 2014). Nestlé was also the leader in terms of its marketing scale and aggressiveness, although in recent years Danone has amped up its promotional efforts (see, for example, Yeong & Allain, 2014, 2017).

Growth in the baby food market is largely dependent on emerging economies, especially the lucrative Asia Pacific market, where the middle class is growing. Danone Baby Nutrition saw sales grow by 10.7% in 2011, largely because of markets in Asia, which accounted for 40% of its business (Danone SA, 2012). Also in 2011, Mead Johnson reported net sales growth[36] of 17%, with growth of 26% in Asia and Latin America, compared with growth of just 3% in North America/Europe (Mead Johnson Nutrition, 2012).

Despite stiff competition for market share, baby food companies put aside their commercial competition to protect their interests and fight for their common good. The baby food industry formed two main bodies to represent its collective interests, the International Council of Infant Food Industries (ICIFI) and the International Association of Infant Food Manufacturers (IFM). ICIFI was initiated by Nestlé in 1975 ahead of the Third World Action Group libel trial. The eight initial members were Cow & Gate, Dumex, Meiji, Morinaga, Nestlé, Snow Brand, Wakado and Wyeth (Sokol, 2005). By 1981, it represented companies accounting for 85% of baby food sales to the developing world (ICIFI, 1981).

In 1984, ICIFI was replaced by IFM, which continued to represent the industry's interests regarding baby food marketing. The IFM started out representing 33 companies but lost 13 by 1985 and dropped to 14 by 2005 (Allain, 2005). Described in 2015 on its website as a "non-profit organization founded in 1984 to protect and promote infant and young child nutrition around the globe" (IFM, 2015), IFM continued to represent industry's interests globally, including at the WHO,

[35] Mead Johnson was purchased by Reckitt Benckiser (RB) in February 2017 for $16.6 billion (Jarvis, 2017; Mead Johnson Nutrition, 2017).

[36] Mead Johnson focuses on paediatric nutrition; many, but not all, of its products are breastmilk substitutes.

the Food and Agriculture Organization, the Codex Alimentarius Commission, and UNICEF, until it was disbanded at the end of 2016 (Abbott, 2017).

The baby food industry presents the issue as being a matter of individual consumer choice (for examples, see Mehdi & Wagner-Rizvi, 1998; Yeong & Allain, 2014, 2017). They say that breastfeeding is not always desired or possible, and that they manufacture a product to fill a legitimate need. Baby food companies try to represent themselves as trustworthy and responsible by introducing company or industry codes of conduct (Danone, 2016; ICIFI, 1975; Nestec Ltd., 2010, 2017) and participating in various voluntary self-regulation initiatives such as the United Nations Global Compact and the FTSE4Good Index (FTSE Russell, 2019; UN Global Compact, 2019). These framings and activities by baby food companies and their industry associations – and the corporate playbook strategies and types of power underpinning them – are analyzed in Chapter 5.

4.3 Key global policies regulating baby food marketing

The *marketing* of baby food products is at the heart of the issue and has been the most contentious subject of global policy-making in connection with infant and young child nutrition. The International Code of Marketing of Breast-Milk Substitutes (the Code), along with subsequent, relevant WHA resolutions, is the key global instrument in this regard. The WHA adopted the Code in May 1981 (WHO, 1981b). The vote was 118 in favour, one against (the US), and three abstentions (Argentina, Japan, and Korea) (Chetley, 1986; Joseph, 1981). The International Code was adopted as a "minimum requirement," and governments were to "implement it in its entirety" as "national legislation, regulations or other suitable measures" (WHO, 1981d). The Code provides for Member States to report annually to the WHO Director-General and for the Director-General to report to the WHA in even years on the status of its implementation (Articles 11.6 and 11.7) (WHO, 1981b). The WHA also adopts a resolution on infant and young child feeding in even years, with the exceptions of 1998[37] and 2020[38]. These subsequent resolutions provide clarity, respond to new

[37] That year, although it was reporting year, Nestlé and IFM successfully lobbied to convince government representatives that a resolution was not necessary "since the new Director-General of the WHO would arrange global consultations with the NGOs." In a last-ditch effort to make sure a resolution on infant feeding would be adopted, Zimbabwe tabled a resolution and gathered co-sponsors. However, a day before the debate, Zimbabwe ceded to the pressure of the lobbyists and the WHO Secretariat (likely due to time constraints because of several big-name guest speakers in connection with celebrations of the WHO's 50th anniversary) and withdrew the proposed resolution (Allain, 2005).

[38] Held virtually for the first time ever, the WHA in May 2020 considered only a single subject: the ongoing COVID-19 pandemic.

product or marketing trends or other relevant matters, or introduce new initiatives to protect, promote and support infant and young child nutrition.

The provisions of the Code stipulate that, with respect to products covered by the scope of the Code,[39] there is to be no advertising to the public, no free samples provided to mothers, and no promotion of products in health care facilities. Company representatives may not contact mothers. Companies may not provide financial or material inducements or product samples to health workers. Product labels may not bear baby pictures or other pictures or text that may idealize formula use and must include a statement of the superiority of breastfeeding and instructions for safe preparation, among other things. Unsuitable products, such as sweetened condensed milk, may not be promoted for use by babies. Information to health workers should be restricted to scientific and factual matters. Health professionals are to disclose to their institution any fellowships, research grants, or conferences provided by baby food manufacturers (WHO, 1981b).

The International Code acknowledges in its Preamble that the baby food industry has "an important and constructive role to play in relation to infant feeding, and in the promotion of the aim of this Code and its proper implementation" (WHO, 1981b, p. 7). It also specifies in Article 11.3 that companies are to abide by the Code's provisions whether or not the countries they operate in have enacted legislation to implement it:

> Independently of any other measures taken for implementation of this Code, manufacturers and distributors of products within the scope of this Code should regard themselves as responsible for monitoring their marketing practices according to the principles and aim of this Code, and for taking steps to ensure that their conduct at every level conforms to them. (WHO, 1981b, p. 14)

Although the WHO is the home agency for the Code, it does not directly monitor company compliance. Responsibility for monitoring was assigned to governments, although professional groups and NGOs were also designated a watchdog role.

In May 2016, the WHA "welcome[d] with appreciation" through resolution 69.9 (WHO, 2016b) another important policy on baby food marketing: the "technical guidance on ending the inappropriate promotion of foods for infants and young children" (WHO, 2016e, para. 1). Significantly, the Guidance clarifies that the Code and subsequent relevant WHA resolutions apply to all commercially produced foods or beverages specifically marketed as suitable for feeding children up to 36 months (3 years) of age, including "follow-up-formulas" and "growing-up milks"

[39] The Code applies to the marketing of breastmilk substitutes, baby foods and products such as bottles and teats. The determination of milks and foods that fall within the scope of the Code is discussed in Chapter 5.

(WHO, 2016e). The industry had long maintained these milk products did not fall within the scope of the Code. Indeed, as will be discussed in Chapter 5, baby food companies invented these differentiated products in order to circumvent the Code. The Guidance also specifies the conditions under which complementary foods may be promoted (including which messages may and may not be included in their promotion) and explicitly prohibits cross-promotion to promote breastmilk substitutes and practices such as sponsorships, gifts, and free supplies, and address the prevention of conflicts of interest (WHO, 2016e).

The civil society group and IBFAN-member International Code Documentation Centre noted that the Resolution could have closed some vulnerable gaps by explicitly urging Member States to "implement the Guidance as a minimum requirement, prioritize public health obligations over trade obligations, and ensure Codex standards be coherent with all the WHO policies" (ICDC, 2016 n.p.) The group also pointed to the recently published Joint WHO/UNICEF/IBFAN report on national implementation of the International Code and relevant resolutions as evidence that "much still remains to be done to protect children against commercial greed" (ICDC, 2016 n.p. WHO et al., 2016).

The most recent the WHO policy document specifically on infant feeding is a resolution adopted at the WHA in May 2018. Member States met four times ahead of the WHA to develop a draft consensus text for the resolution (WHO, 2018j), which observers expected to be adopted without incident. However, unhappy with the provisions in the draft resolution, the US delegation threatened countries that supported it with trade sanctions and advanced its own proposed text (Byatnal, 2018; Jacobs, 2018; US Delegation to WHO, 2018; WHO, 2018k). After several days of redrafting, a decidedly weaker resolution was adopted (Byatnal, 2018). These events will be discussed in more detail in Chapter 5.

Also at the WHA in May 2018, the Director-General brought to the notice of Member States a report about a Draft Approach for the Prevention and Management of Conflicts of Interest in the Policy Development and Implementation of Nutritional Programmes at Country Level. Although this policy has potential relevance to baby food industry activities at the national level, it is discussed in this dissertation in Chapter 7 in connection with FENSA.

In a resolution WHA 65.6, which also endorsed a Comprehensive Implementation Plan (CIP) on maternal, infant and young child nutrition (WHO, 2012d, 2012e),[40] the WHA in May 2012

[40] The Comprehensive Implementation Plan (CIP) aims to alleviate the double burden of malnutrition (over- and under-nutrition) in children, focusing efforts on the period from conception through the first two years

had requested the Director-General to "develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with the WHO's overall policy and practice" (WHO, 2012e, para. 3(3)). Two years later, WHA decision 67(9) requested informal consultations to develop these assessment and management tools for conflicts of interest in nutrition for consideration by the Assembly in 2016 (WHO, 2014f).

A technical consultation was held in Geneva on October 8 and 9, 2015, bringing together experts from various fields and diverse stakeholders, as well as Member States as observers. The Secretariat then prepared a draft approach taking into consideration the WHO's overall policies and practices, including the Framework of engagement with non-state actors (FENSA),[41] which is discussed in detail in Chapter 7. A public consultation was held September 11-29, 2017. The draft approach to preventing and managing conflicts of interest in country-level nutrition programs was presented at the WHO Executive Board and the WHA in January and May 2018, respectively, as a living document that may be revised as necessary and that "the Secretariat [would] pilot … at country level in the six the WHO regions to test its applicability and practical value" (WHO, 2017c, para. 28, 2018i, para. 28).

4.4 Soda and its association with non-communicable diseases (NCDs)

Soda is not the sole cause of NCDs such as diabetes and obesity, but extensive research points to its consumption as a contributing factor to, or even a key driver of, the global rise in rates of obesity and diabetes, beginning in childhood and continuing into adulthood (Basu et al., 2013; Bleich & Vercammen, 2018; Hu & Malik, 2010; Malik et al., 2006, 2010; Singh et al., 2015; Vartanian et al., 2007).

The WHO, NGOs, various scholars, and the media refer to the increased incidence of NCDs such as obesity and diabetes as an "epidemic"[42] (for example, Gertner & Rifkin, 2018;

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of life. It sets six global targets to be achieved by 2025, the fifth of which is to increase the rate of exclusive breastfeeding in the first six months to 50% (WHO, 2012d, 2012e).

[41] Policies on the WHO's engagement with NGOs and the private sector had also been requested by Member States at the 2012 WHA in decision 65(9) (WHO, 2012c). FENSA was adopted in 2016 through resolution WHA69.10 (WHO, 2016f).

[42] The framing of obesity as an "epidemic" is contested, disputed and highly politicized, however, as are the terms "obesity" and "obese" (see, for example, Firth, 2012; Medvedyuk, Ali, & Raphael, 2017; Millstone, 2010; Monaghan, Bombak, & Rich, 2017; Shelley, 2012). However, this discussion lies outside the scope of this dissertation.

Herrera, 2015; NCD Alliance, 2017; Nesheim & Nestle, 2015; the WHO, 2015). NCDs contribute 41 million deaths (or 71% of all deaths) worldwide each year (WHO, 2018l). This is an increase from 36 million deaths (or 64% of all deaths) globally in 2012 (WHO, 2012g). NCDs disproportionately affect people in low- and middle-income countries; more than 75% (32 million) of global deaths due to NCDs occur in these countries (WHO, 2018l). Diabetes accounts for 1.6 million NCD deaths and is the fourth leading cause of NCD deaths, after cardiovascular diseases (17.9 million), cancers (9.0 million), and respiratory diseases (3.9 million) (WHO, 2018l).

The prevalence of diabetes is increasing (International Diabetes Federation, 2017; Mathers & Loncar, 2006; WHO, 2018m; Wild et al., 2004). According to the International Diabetes Federation (2017), 425 million adults (8% of, or 1 in 11, adults) aged 20-79 years have diabetes, although half of these (212 million) are undiagnosed. For the age range 18-99 years, the number of people with diabetes is 451 million. If trends continue, by 2045, 629 million 20-79-year-olds or 693 million 18-99-year-olds will have diabetes. Diabetes was estimated to cause the deaths of 4.0 million people aged between 20 and 79 years of age, which is the equivalent of one death every eight seconds. Deaths due to diabetes comprised 10.7% of deaths among people in this age group – more than the combined total of deaths from infectious diseases. Nearly half (46.1%) of the people in this age group who died due to diabetes were under the age of 60 years (International Diabetes Federation, 2017).

Diabetes was once considered a disease of the West and of affluence, but it has now spread to every country in the world and is increasingly common among the poor (Hu, 2011; Hu & Malik, 2010). Three-quarters of people with diabetes live in low- and middle-income countries; approximately two-thirds of people with diabetes (279 million) live in urban areas. Spending on diabetes comprises 12% ($727 billion) of global health expenditure (International Diabetes Federation, 2017).

According to the WHO, overweight and obesity are linked to more deaths worldwide than underweight, and are major risk factors for NCDs such as cardiovascular diseases (which were the leading cause of death in 2012), diabetes, musculoskeletal disorders, and some cancers (WHO, 2018h). The prevalence of obesity tripled between 1975 and 2016 (WHO, 2018h). There are more people worldwide who are obese than who are underweight. According to global estimates by the WHO, 39% of the world's adult population (aged 18 years and older) – 39% of men and 40% of women – were overweight in 2016. This equates to more than 1.9 billion overweight adults. Of

these, 650 million – 13% of the world's adult population (11% of men and 15% of women) – were obese in 2016 (WHO, 2018h).

Overweight and obesity were once considered problems seen primarily in high-income countries. However, their rates are now increasing in low-and middle-income countries as well, especially in urban areas (WHO, 2018h). The global spread of western diets – energy-dense foods high in fat and sugars but low in vitamins, minerals and other micronutrients (WHO, 2019a) – is exacerbating preventable chronic conditions such as diabetes (Hu, 2011).

The increasing rates of overweight and obesity among children are especially alarming. The WHO terms childhood obesity "one of the most serious public health challenges of the 21st century" (WHO, 2019a). According to estimates by the WHO, in 2016, 41 million children under the age of 5 years were overweight or obese. Over 340 million children and adolescents between 5 and 19 years of age were overweight or obese; this figure comprises just over 18% of all children and adolescents in this age bracket (18% of girls and 19% of boys), up from just 4% in 1975. Of these, 124 million children and adolescents aged 5-19 years (6% of girls and 8% of boys, up from just under 1% in 1975) were obese (WHO, 2018h). In 2016, nearly half of the children under five who were overweight or obese lived in Asia, and in Africa, the number of overweight children had increased by nearly 50% since 2000 (WHO, 2018h).

The reasons why soda consumption contributes to obesity and diabetes go beyond excessive caloric intake (i.e. more calories consumed than expended). Research shows increased insulin demand (Hu, 2011) and decreased satiety associated with calories derived from sodas and other fructose-laden beverages (Bellisle & Rolland-Cachera, 2001; James & Kerr, 2005; Pan & Hu, 2011; Popkin, 2012), and suggest that preventing or reducing soda consumption can play a major role in preventing obesity and diabetes (Hu, 2011; James et al., 2004; James & Kerr, 2005; Malik et al., 2010).

4.5 The soda market and industry

The global carbonated soft drink market was valued at $392.6 billion in 2016 (Grand View Research Inc., 2018). More than half of all sodas are produced by large multinational corporations, primarily market leaders Coca-Cola and PepsiCo (Alexander et al., 2011), which together controlled 72% of the global sales market in 2014 (StreetAuthority, 2014). Coca-Cola, the largest non-alcoholic beverage company in the world, controlled 42% of the global soda market in 2014, with soda comprising 75% of its global sales (StreetAuthority, 2014). Pepsi controls 30% of the global soda

market, although soda comprises a smaller proportion – and shrinking, due to product diversification – of its overall sales compared with Coca-Cola (StreetAuthority, 2014). The third-largest soda manufacturer is Dr. Pepper Snapple (Nestle, 2015). The product line of Nestlé, the world's largest food and beverage company (and manufacturer of baby milk and foods, as discussed above and in Chapter 5), also includes sugar-sweetened beverages.

In the decade between 2000 and 2010, Coca-Cola and PepsiCo experienced increased growth in sales volume, net revenue and net profit. Over that period, Coca-Cola's net revenue increased more than 100% to $35,119 million (The Coca-Cola Company, 2011), and PepsiCo's rose 159% to $54,538 million (PepsiCo, 2011). Coca-Cola's global profit rose more than 400% from $2,177 million in 2000 to $11,859 million in 2010. PepsiCo's net profit increased nearly 150% to $6,320 over the same period (Kleiman S. et al., 2011).

However, these global figures conceal the US soda market's negative sales trend over the same period. Although Coca-Cola's soda sales grew by 4% between 2000 and 2005, its sales fell 13% between 2005 ($15,318 million) and 2010 ($13,348 million), resulting in an overall decline of 9% over the decade. Similarly, PepsiCo's soda sales increased 4% in the first half of the decade, and then fell 17% from 2005 ($11,755 million) to 2010 ($9,792 million) for an overall decline of 13% (Kleiman S. et al., 2011).

In response to these declining sales in the US, soda companies are turning their attention to international markets (Nestle, 2015), which the companies have long recognized as growth opportunities (Nesheim & Nestle, 2015) with their larger profit margins, growing populations, and rising purchasing power. As an example of the potential for international market growth, in Brazil, PepsiCo's soda sales grew 131% from $293 million in 2000 to $675 million in 2010, and Coca-Cola's sales grew by 72% to $5,686 million over the same decade (Kleiman S. et al., 2011). Soda sales in China over the same period similarly increased: by 149% to $3,539 million for Coca-Cola and by 129% to $1,653 million for PepsiCo (Kleiman S. et al., 2011).

Coca-Cola markets its products in more than 200 countries, and 82% of its revenues come from international (i.e. non-US) sales, especially from Mexico, China, Brazil, and Japan, which accounted for 31% of worldwide sales volume (Coca-Cola Company, 2018). Sparkling beverages, including soda, comprised 70% of international sales, and trademark Coca-Cola comprised 46%, in 2018 (Coca-Cola Company, 2018). PepsiCo also sells its products in more than 200 countries, but only 43% of its net revenue came from outside the US, with 20% coming from Mexico, Russia, Canada, the United Kingdom and Brazil (PepsiCo, 2018).

Coca-Cola and PepsiCo (as well as Nestlé and eight other of the world's largest food companies) are members of the International Food and Beverage Alliance (IFBA), an international lobby group founded in 2008 "to empower consumers to eat balanced diets and live healthier lives" (IFBA, 2018c) in response to the 2004 Global Strategy on Diet, Physical Activity and Health, discussed below. IFBA actively lobbies at global and national levels to protect the interests of its members, including in connection with the Political Declaration on the Prevention and Control of NCDs, which the United Nations General Assembly High-Level Meeting on the topic adopted in September 2011, the WHO's Draft Guideline on sugars intake for adults and children in March 2014 (IFBA, 2013), which will be discussed in Chapter 6, and the development of FENSA, which will be discussed in Chapter 7.

The current Co-Chairs of IFBA are Michael Goltzman, Vice President of International Government Relations & Public Affairs, The Coca-Cola Company, and Chavanne Hanson, Deputy Head, Global Public Affairs, Nestlé (IFBA, 2018a). Past Co-Chairs have included Jorge Casimiro, Group Director, International Government Relations and Public Affairs at Coca-Cola, and Janet Voûte, Global Head of Public Affairs at Nestlé and former Partnership Advisor with responsibility for the UN Global Compact and the Global Network for NCDs, as discussed in Chapters 5 and 6 (Baby Milk Action, 2010; Voûte et al., 2012).

Another significant industry trade group is the American Beverage Association (ABA), founded in 1919.[43] Soda market leaders Coca-Cola, PepsiCo and Dr. Pepper Snapple are members, as are Canada Dry and Nestlé. The ABA "serves as liaison between the industry, government and the public, and provides a unified voice in legislative and regulatory matters. As the national voice for the non-alcoholic refreshment beverage industry, the ABA staff of legislative, scientific, technical, regulatory, legal and communications experts effectively represent members' interests" (ABA, 2018). The group has lobbied heavily against soda taxes, including by creating a front group and promoting individual responsibility as the solution to obesity (Dorfman et al., 2012). Both of these tactics are discussed in Chapter 6.

Sugar industry trade organizations often represent soda industry interests because sugar is a constituent ingredient in many soda products. For example, the Sugar Association, Inc. represents the sugar industry in the US. It is also a member in another trade organization, the World Sugar

[43] ABA was founded in 1919 as the American Bottlers of Carbonated Beverages and renamed the National Soft Drink Association in 1966 (ABA, 2018).

Research Organisation (WSRO), which represents more than 30 international members, including the Sugar Association, Inc. and Coca-Cola (WSRO, 2012).

Like the baby food industry, soda companies and trade associations frame the issue as a matter of individual consumer choice and responsibility (ABA, 2014; AFBC, 2018; Brownell & Warner, 2009; Firth, 2012; Kwan, 2009; Nestlé, 2019a; Nestle, 2015; Scott et al., 2017). In addition, they frame soda consumption as a question of balancing caloric intake with output (Freedhoff, 2014; Huehnergarth, 2015; Koplan & Brownell, 2010; The Coca-Cola Company, 2012). Like the baby food industry, soda companies undertake self-regulation and other voluntary measures to draw attention to their role in addressing health concerns, thereby suggesting that they can be trusted to take responsible measures without government imposing legislation. One such voluntary measure is through product reformulation or modification, such as by reducing the sugar content of their beverage portfolios (Coca-Cola, 2018; PepsiCo, 2014). For example, PepsiCo reported in its 2013 Sustainability Report that it had removed 402,000 metric tons of added sugar from its total beverage portfolio in North America (US and Canada only) as compared to 2006 levels (PepsiCo 2014). These framings and activities by soda companies and their industry associations – and the corporate playbook strategies and types of power underpinning them – are analyzed in Chapter 6.

4.6 Key global policies relating to soda

The only global policy relating directly to soda is a set of recommendations on the marketing of food and non-alcoholic beverages to children. However, policies relating to NCDs and to diet and physical activity are also relevant to, and impact upon, the soda industry. Similarly, because sugar is a constituent ingredient in many soda products, the WHO's guideline on sugar intake levels is also relevant to the soda industry. Industry interventions during the development of several of these polices will be discussed in Chapter 6.

In 2000 the WHA adopted the Global Strategy for the Prevention and Control of NCDs (A53/14) (WHO, 2000b). To achieve its three main objectives,[44] the Global Strategy spells out the

[44] The Global Strategy's three main objectives are: 1) to map the emerging epidemics of NCDs and to analyze the latter's social, economic, behavioural and political determinants with particular reference to poor and disadvantaged populations, in order to provide guidance for policy, legislative and financial measures related to the development of an environment supportive of control; 2) to reduce the level of exposure of individuals and populations to the common risk factors for NCDs, namely tobacco consumption, unhealthy diet and physical inactivity, and their determinants; and 3) to strengthen health care for people with NCDs by developing norms and guidelines for cost-effective interventions, with priority given to cardiovascular diseases, cancer, diabetes and chronic respiratory diseases (WHO, 2000b).

different roles for international partners, the WHO and Member States. While adopting the Strategy through resolution WHA53.17 (WHO, 2000c), the WHA recognized "the leadership role that the WHO should play in promoting global action against NCDs and its contribution to global health based on its advantages compared to other organizations." To coordinate efforts by international partners, it calls for "an innovation mechanism" to "ensure joint work within the United Nations system and with major international agencies, [NGOs], professional associations, research institutions and the private sector".

According to the Global Strategy, "the WHO has the unique authority and the clear mandate to lead the development and implementation of the global strategy for the prevention and control of [NCDs] …" (WHO, 2000b). The WHO is to provide the leadership and necessary evidence base, and to set the general direction and priorities for 2000-2003 "consonant with the corporate strategy of the WHO Secretariat", with a focus on global partnerships, global networking, technical support, and strategic support for research and development (WHO, 2000b). While adopting the Strategy through resolution WHA53.17, the WHA requested the Director-General "to strengthen existing partnerships and develop new ones, notably with specialized national and international [NGOs]" and "to pursue dialogue with the pharmaceutical industry" (WHO, 2000c). Notably, there was no mention of partnerships with the private sector, and no dialogue with industries other than the pharmaceutical industry.

An Action Plan for the Global Strategy for 2008-2013 was adopted by the WHA in May 2008 (WHO, 2008). The action plan, based on the Global Strategy on NCDs adopted in 2000, built on the additional mandate provided to the WHO by the adoption in 2003 of the Framework Convention on Tobacco Control (WHO, 2005) and the WHO Global Strategy on Diet, Physical Activity and Health (WHO, 2004a). It was intended to provide Member States with "a roadmap to establish and strengthen initiatives for the surveillance, prevention and management of NCDs" and to "highlight] the pressing need to invest in NCD prevention as an integral part of sustainable socioeconomic development" (WHO, 2008). The Action Plan sets out six objectives.[45] Under each,

[45] The Action Plan's six objectives are: 1. To raise the priority accorded to NCDs in development work at global and national levels, and to integrate prevention and control of such diseases into policies across all government departments; 2. To establish and strengthen national policies and plans for the prevention and control of NCDs; 3. To promote interventions to reduce the main shared modifiable risk factors for NCDs: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol; 4. To promote research for the prevention and control of NCDs; 5. To promote partnerships for the prevention and control of NCDs; and 6. To monitor NCDs and their determinants and evaluate progress at the national, regional and global levels (WHO, 2008).

actions are listed for Member States, the WHO Secretariat and international partners to undertake. In developing the Action Plan, the WHO also held two separate consultations with NGOs and the food and non-alcoholic beverages industry, respectively, in February and March 2008 (WHO, 2008).

An updated Global Action Plan (GAP) was developed for 2013-2020 (WHO, 2013a). Like its predecessor, the GAP was intended to provide "a road map and a menu of policy options for all Member States and other stakeholders, to take coordinated and coherent action, at all levels, local to global, to attain … nine voluntary global targets" (WHO, 2013a, p. 8). Following on from commitments made in the Political Declaration, the GAP recognizes that governments have the primary role and responsibility in responding to the challenge of NCDs, and the importance of international cooperation to support national efforts (WHO, 2013a, p. 12). The GAP states it is "consistent with the WHO's reform agenda, which requires the Organization to engage an increasing number of public health actors, including foundations, civil society organizations, partnerships and the private sector in work related to the prevention and control of [NCDs]" (WHO, 2013a, p. 9). The soda industry's efforts to shape the paradigms in connection with the GAP are discussed in Chapter 6.

The Global Strategy on Diet, Physical Activity and Health (Global Strategy on DPAH) constitutes another policy with relevance to the soda industry (WHO, 2004a). The WHA endorsed the Strategy in May 2004 (resolution WHA57.17). The Global Strategy on DPAH contends that "the private sector can be a significant player in promoting healthy diets and physical activity" and lists many different sectors, including the food industry, that "all have important parts to play as … advocates for healthy lifestyles. All could become partners with governments and [NGOs] … to encourage healthy eating and physical activity" (WHO, 2004a, sec. 61). The WHO commits in the Global Strategy on DPAH to "hold discussions with the transnational food industry and other parts of the private sector in support of the aims of the Strategy, and of implementing the recommendations in countries" (WHO, 2004a, sec. 50).

An expert committee formed as part of the development of the Global Strategy on DPAH in February 2003 published a draft report that recommended limiting the intake of sugars to less than 10% of daily energy intake (WHO/FAO, 2003). The draft report received extensive criticism from the soda and sugar industries and their sugar dependent country allies, especially the United States (Boseley, 2003c; Brownell & Nestle, 2004; Brownell & Warner, 2009). The Global Strategy on DPAH subsequently presented to the WHA no longer contained the 10% limit, and instead recommended simply "limit the intake of free sugars" (WHO, 2004a). Chapter 6 discusses these

events and the soda industry's response to new guidelines on sugar intake (described below) that were proposed in 2014 and finalized in 2015. The intervention of the soda industry and their allies demonstrates the significance to them of guidelines limiting sugar intake.

In May 2010 the WHA adopted a Set of Recommendations on the Marketing of Food and Non-Alcoholic Beverages to Children. Developed with substantial input from Member States and other stakeholders, the purpose of the recommendations was to guide Member State efforts in developing or strengthening policies in this connection (WHO, 2010b). The development process for the set of recommendations included dialogues with NGOs and the private sector, respectively in November 2008 (WHO, 2010a).

The set of recommendations begins by describing the background and development process of the recommendations, followed by an evidence section. Twelve recommendations are then organized under the following five sub-headings: rationale, policy development, policy implementation, policy monitoring and evaluation, and research. The resolution endorsing the set of recommendations urges Member states and the Director-General to take proposed actions to implement the recommendations (WHO, 2010b). Member states are urged "to cooperate with civil society and with public and private stakeholders in implementing [these recommendations]... in order to reduce the impact of that marketing [of non-alcoholic beverages], while ensuring avoidance of potential conflicts of interest" (WHO, 2010d).

However, according to Taylor et al. (2012, p. 3), the set of recommendations "does not effectively address the extent or underlying nature of the global challenge" and "fails to articulate global standards, engage industry in the development and compliance of relevant standards or fully engage the WHO in the monitoring of potentially abusive marketing practices." On these grounds, Taylor et al. (2012) have called for the development of a the WHO/UNICEF Global Code of Practice on the Marketing of Unhealthy Foods and Beverages to Children.

The 2011 and 2018 Political Declarations on the Prevention and Control of NCDs are two other policy documents with relevance to the soda industry (UNGA, 2011, 2018). These Political Declarations were the outcome documents from the UN General Assembly High-level Meetings on the Prevention and Control of NCDs. The Political Declaration from the first meeting, held in New York on September 19-21, 2011, outlines actions to be taken by the international community. With respect to the private sector, the 2011 Political Declaration calls on it, where appropriate, to take measures to implement the Set of Recommendations on the Marketing of Food and Non-Alcoholic

Beverages to Children, and to produce and promote healthier food products, including through reformulation, among other actions (UNGA, 2011, para. 44).

Another High-level Meeting of the General Assembly on NCDs was held in July 2014. The outcome document of this meeting was a resolution that acknowledged that there had been "limited progress" toward achieving the measures directed at the private sector in the 2011 Political Declaration (UNGA, 2014, para. 26). The General Assembly's third High-level Meeting on NCDs was held in September 2018. This meeting approved a second Political Declaration on NCDs, which reaffirmed the WHO's leadership role and committed to measures to combat NCDs. With respect to the private sector, the 2018 Political Declaration re-iterated the directions to industry in the first Political Declaration (UNGA, 2018, para. 44).

The WHO's creation of the Global Coordination Mechanism on NCDs (GCM/NCD) in 2014 represented a significant step toward institutionalizing the multistakeholder approach to preventing and controlling NCDs. According to terms of reference adopted by the WHA in May 2014, the purpose of the GCM/NCD is "to facilitate and enhance coordination of activities, multistakeholder engagement and action across sectors" at all levels, and "to contribute to the implementation of the WHO Global NCD Action Plan 2013–2020." It is to do so while "avoiding duplication of efforts, using resources in an efficient and results-oriented way, and safeguarding the WHO and public health from any undue influence by any form of real, perceived or potential conflicts of interest" (WHO, 2014e Annex, Appendix 1, para. 1). The GCM/NCD is to be led by Member States, and other participants may include United Nations funds, programmes and agencies and other international partners, and non-State actors (NSAs) (WHO, 2014e Annex, Appendix 1, para. 5).

An Information Note on GCM/NCD participants states that organizations that are to be invited to pre-register for selection consideration would include business associations that had participated in informal dialogues that the WHO had organized relating to NCDs. They also would include NGOs in Official Relations with the WHO (WHO, 2014g, para. 8 a.1), which at the time, as will be discussed in Chapter 7, included business associations, such as the International Life Sciences Institute (representing Nestlé, Coca Cola, Kellogg, Pepsi, Monsanto, Ajinomoto, Danone, General Mills and others). According to the Note, interested organizations were to be screened to ensure they "Are *not in any way involved* in production or marketing of products that directly harm human health, including specifically tobacco and arms" (emphasis added WHO, 2014g, para. 7). However, the Principles, Eligibility and Selection Criteria for Participants subsequently introduced has softened

this stance, to say: "GCM/NCD will exercise particular caution, especially while performing a screening and risk assessment, when engaging with the private sector and other non-State actors whose policies or activities are negatively affecting human health and are not in line with the WHO's policies, norms and standards, in particular those related to noncommunicable diseases and their determinants" (WHO, n.d.-a, para. 7). Although the prohibition on entities related to the tobacco or arms industries remains part of the criteria (WHO, n.d.-a, paras. 5–6), the food and beverage industry association IFBA, described above, made it through the screening and is included in the list of GCM/NCD participants (WHO, 2019c).

Early documentation related to the GCM/NCD made reference to the then under development rules relating to engagement with NSAs, the Principles, Criteria and Selection of Participants document establishes that engagement with NSAs as part of the GCM/NCD is governed by FENSA (WHO, n.d.-a, para. 1,4-5). As a result, for example, the assessment of NSAs will determine which of the four policies that comprise FENSA will apply, that is NGOs, private sector entities/international business associations, philanthropic foundations or academic institutions (WHO, n.d.-a, para. 8). The GCM/NCD selection of participants would also consider "a balanced representation of the four groups of non-State actor entities" (WHO, n.d.-a, para. 10).

In March 2015 the WHO released an updated Guideline on sugars intake for adults and children (WHO, 2015b). The new guideline recommended that both adults and children reduce their intake of free sugars to less than 10% of total energy intake, or in other words, to less than six teaspoons. In a change from the previous guideline (from 2003, described above in connection with the Global Strategy on DPAH), it additionally recommended further reducing sugar consumption to below 5% of total energy intake for additional health benefits. The previous guideline, from 2003, had also suggested that sugar should account for no more than 10% of a healthy diet, without the suggestion of a further reduction to below 5% of total energy intake.

The soda industry and its allies intervened in 2003, as mentioned above, and again in 2014 to try to influence the recommended maximum sugar intake level in both sets of guidelines, as will be discussed in Chapter 6. This intervention demonstrates the significance of the sugar intake guidelines to the soda industry.

Taxes are sometimes imposed on certain products such as tobacco and alcohol in order to discourage behaviours that could be harmful to the individual or to others in society. Soda is another product for which taxation is being considered. There is increasing evidence that "appropriately designed taxes on sugar-sweetened beverages would result in proportional reductions in

consumption levels" (Waqanivalu et al., 2016). With soda consumption identified as contributing to diabetes, obesity, and other NCDs, as discussed above, its reduction would lead to improved health outcomes.

Soda taxation can take several forms, including as an excise tax (levied before point-of-sale, resulting in an increased shelf price), a sales tax (added at point-of-sale), and a value-added tax (levied by percentages at each stage of production and distribution) (Chriqui et al., 2013). Proponents see so-called "sin taxes", such as a tax on soda, as a means to improving public health and also raising revenue for social programs, while opponents consider them a paternalistic government intervention and regressive in the sense that they target products most heavily consumed by the poor (Allcott et al., 2019; Brownell et al., 2009).

Soda taxes have been introduced in many countries and municipalities, including in seven cities in the US, and in 39 countries (Allcott et al., 2019), and proposed in many more. However, the soda industry has resisted – and prevented – the introduction of soda taxes in many jurisdictions by deploying the strategies of the corporate playbook.[46] At the global level, the US – home to Coca-Cola and PepsiCo – blocked soda's inclusion alongside tobacco and alcohol in a the WHO report as a product for which taxation was recommended as an appropriate fiscal policy for addressing NCDs (Keaton & Cheng, 2018; WHO Independent High-level Commission on Noncommunicable Diseases, 2018), as will be discussed in Chapter 6.

4.7 Conclusion

This chapter established the significance of, and context for, the baby food and soda industries' engagement with the WHO to influence global policies and regulations and to shape paradigms relating to their products in order to increase their sale and consumption. It drew attention to the effects of policy decisions taken at the World Health Organization (the WHO) on the health and well-being of the world's population. The marketing of baby food products is linked with decreased breastfeeding rates, resulting in increased infant illness and mortality. Breastfeeding has many health benefits for infants and mothers and economic benefits for families and states. The consumption of soda is related to higher risk of NCDs, such as diabetes and obesity. These health effects highlight the importance of the baby food and soda industries' efforts to influence global policies and regulations and shape paradigms relating to their products in order to increase their sale and

[46] These activities to influence national and municipal taxation initiatives are outside the scope of this dissertation.

consumption. The chapter also provided relevant background for Chapters 5 and 6 by introducing market leaders in the baby food and soda industries, the respective industry business associations, and relevant global policies and guidelines relating to the industries' products and operations. This chronology of policies and guidelines shows that numerous efforts have been made at the global level to minimise negative health impacts relating to these products and their marketing; Chapters 5 and 6 will analyze industry efforts to minimise the impact of these initiatives on the sale and consumption of their products. The structural context within which these industries work to influence both substantive policies and paradigms to create environments conducive to their business interests determines the strategies and types of power available to them. At the same time the structural context has been shaped by these and other industries by drawing, iteratively, on a "corporate playbook".

Chapter 5 – Corporate engagement on baby food policy

5.0 Introduction

This chapter analyzes the ways in which baby food companies and their associations have worked to access global health policy-making at the WHO relating to their products. The baby food industry seeks to influence substantive recommendations by the WHO, especially with respect to the marketing of its products, which can have both immediate and long-term impacts on corporate profitability. The baby food industry also makes efforts to shape paradigms that determine which policies are pursued and what role private actors are able to play in developing them.

The *marketing* of baby food products is at the heart of the issue and has been the most contentious subject of global policy-making in connection with infant and young child nutrition. As described in Chapter 4, the marketing of breastmilk substitutes (such as infant formula, and beverages or foods intended for use from too young an age) has been linked with declining breastfeeding rates, and the resultant impact on infant morbidity and mortality. As outlined in Chapter 2, the public and global health literatures have captured such negative health outcomes to which corporate products or activities contribute by terming them "industrial epidemics". The corporate impacts on health – both directly through the promotion of products that can be harmful to health and indirectly by influencing substantive policy and paradigms relating to their products and industry role in governance and policy-making – are also understood as the "corporate (or commercial) determinants of health" (Buse et al., 2017; Hastings, 2012; Kickbusch, 2012; Kickbusch et al., 2016; Millar, 2013).

As discussed in Chapter 2, similar strategies to influence policy and shape paradigms are witnessed across many industries who follow what some have called the corporate "playbook". Section 5.1 below analyzes how the baby food industry uses the corporate playbook's strategies and tactics to influence the WHO's substantive policies relating to baby food products, especially with respect to their marketing, product differentiation and the optimal duration of exclusive breastfeeding. Some of the types of strategies that are evident in the analysis include lobbying, inventing and shaping perceptions about differentiated products to circumvent global and national regulations and to extend their product line, and manufacturing doubt about the scope of the Code and the optimal duration of exclusive breastfeeding. The analysis also considers the types of power upon which the industry draws in pursuit of these strategies and tactics, as well as, where relevant, their reinforcing effects on the industry's strategies and the power subsequently available to it.

After this examination of baby food industry efforts to influence substantive policy, section 5.2 analyzes the ways in which the industry uses the playbook strategies to shape paradigms conducive to both its substantive policy interests and its long-game interests, including the establishment of the industry as a governance actor. The paradigms analyzed below are: 1) individual consumer choice, 2) corporate responsibility and trustworthiness, and 3) industry legitimacy as a governance actor. These paradigms create an environment conducive to companies and their associations arguing against regulation and in favour of voluntary measures and representing themselves as legitimate partners in developing health-related policy. Some of the types of strategies for encouraging these paradigms that are evident in the analysis include shaping the knowledge environment, perceptions and the political environment by framing issues and actors, undertaking self-regulation and other voluntary measures and participating in collaborative initiatives.

5.1 Corporate efforts to influence substantive policy

This section analyzes five key substantive policies or policy areas that affect the sale and consumption of baby food products and the ways in which the industry uses playbook strategies and tactics from the corporate playbook to influence them, especially in relation to the marketing of baby milk and food products. The five key substantive policies or policy areas analyzed below are as follows: 1) the International Code of Marketing of Breast-Milk Substitutes, 2) product differentiation and reformulation, 3) the optimal duration of exclusive breastfeeding 4) the Guidance on ending inappropriate promotions of foods for infants and young children, and 5) the 2018 World Health Assembly (WHA) Resolution on Infant and Young Child Nutrition. In doing so, it considers the types of power upon which the industry is drawing while pursuing these strategies and tactics, as well as, where relevant, the reinforcing effects on the strategies, tactics, and power subsequently available to it.

5.1.1 International Code of Marketing of Breast-Milk Substitutes

The International Code of Marketing of Breast-Milk Substitutes (the Code), described in Chapter 4, is the key global instrument relating to baby food. Adopted in May 1981, the Code prohibits the marketing of breastmilk substitutes and related products, making it easier for women and families to make informed decisions about feeding their infants and young children. In October 1970 the WHO and UNICEF had held a joint meeting on infant feeding that resulted in the recommendation to establish a code to regulate the marketing of infant formula and related products (WHO/UNICEF,

1979). The first draft prepared by the WHO and UNICEF staff (published in February 1980) incorporated many of the suggestions included in the background material for the October meeting and many made during the meeting. Thinking the draft was near completion, the WHO staff organized a series of consultations in February and March 1980 to address any outstanding concerns, with the intention of having the code presented as a final document in the May 1980 WHA for ratification.

During the drafting process, however, the baby food industry utilized the playbook strategy of shaping the political environment by putting pressure on international organizations. The industry found an ally in doing this in the United States, a milk exporting country, and was able to draw on the instrumental and structural power afforded that country by its size and influence as a political and economic actor. Deploying their structural and instrumental power as companies based in the US, Wyeth, Abbott/Ross and Bristol-Myers lobbied American delegates to the WHO's Code drafting consultations, and the American delegates in turn lobbied representatives from other countries as well as the WHO staff (Chetley, 1986; Sokol, 2005). Apart from its political and economic significance globally, the US at that time contributed 25% of WHO's regular budget (Chetley, 1986).

When the first draft of the Code was published in February 1980, the three American baby food companies worked to shape the knowledge environment by using their discursive power to manufacture doubt about the document. These companies said the draft Code was "seriously defective by almost any measure. It contained a long series of unwarranted and absolute prohibitions and restriction of legitimate commercial activity" (Chetley, 1986, pp. 76–77). Wyeth hired former under-secretary of state Bill Rogers to arrange a private briefing with State Department officials. Wyeth's hiring of Rogers is an example of the so-called "revolving door" between the public and private sectors, a tactic for controlling the political environment by bringing to his new position with Wyeth potentially confidential insider information and personal influence and connections within the State Department. The private briefing was an opportunity for Wyeth to mobilize the company's structural and instrumental power as a US-based company to convey its position on the draft Code to the instrumentally and structurally powerful and internationally significant State Department and to recruit it as an ally. Nine days after the March 20 briefing, the US government sent a letter to the WHO calling for a voluntary or recommendatory code of general nature, adding that a mandatory code "could not be accepted by the United States" (Chetley, 1986, p. 77). In addition to shaping the political environment through lobbying and putting pressure on the WHO, the letter from the US

government on behalf of the US-based baby food companies also aimed to shape the policy discourse and preferences away from mandatory code and toward voluntary measures, including by framing the former as unfeasible.

Besides the three American companies, much of the baby food industry's lobbying to shape the political environment and influence the Code's drafting process was undertaken by the International Council of Infant Food Industries (ICIFI), which Nestlé had set up along with seven other infant formula manufacturers to counter negative publicity during the company's libel trial (discussed in Chapter 4). A spokesperson from ICIFI, which was headed by a Nestlé vice-president, called the first draft of the Code "wholly irresponsible" and said that if adopted, "it would surely kill hundreds and hundreds of babies" (Chetley, 1986, p. 77). His statement aimed to shape preferences by manufacturing doubt and framing the draft Code as a dangerous policy response.

Although developing countries supported the first draft of the Code, milk-exporting countries – Denmark, France, West Germany, Netherlands, New Zealand, Switzerland and the US – rejected it. The US also called for full inter-governmental negotiation of the contents of the Code, a move that at once implied that the WHO and UNICEF had overstepped their mandates, and sought to drag out the negotiation process and weaken the resulting provisions (Chetley, 1986). As a result, several more drafts were developed with consultations held between May and November 1980.

That summer, ICIFI hired retiring WHO Assistant Director-General Dr. Stanislaus Flache as its first executive secretary (Chetley, 1986). His official first day with ICIFI was August 1, 1980; however, a leaked letter from Nestlé lawyer Carlo Fedele to a Nestlé director suggested that Flache was already working informally for ICIFI as early as June 1980, while he was still with the WHO (Ratner, 1981). ICIFI's hiring of Flache is another example of the "revolving door" between the public and private sectors, a well-known playbook tactic for controlling the political environment. Flache brought to his new position with ICIFI potentially confidential insider information and personal connections within the WHO that could contribute to the association's instrumental power to influence the negotiations surrounding the drafting of the Code. More recent examples of the revolving door between the public sector and the baby food industry are discussed below.

During the Code negotiations, ICIFI made its presence felt at the WHO meetings in Geneva, not far from Nestlé's headquarters in Vevey, and elsewhere, "wining and dining country delegates and the WHO officials" (Ratner, 1981). During the WHA in May 1981, when the Code was up for debate, ICIFI hosted a "Hospitality and Information" Suite at Geneva's luxurious International Hotel. All government delegates as well as journalists were invited to the Suite where

they were offered food and drink. Industry lobbyists also took government delegates to expensive restaurants to win them over to opposing the Code (Sokol, 2005). Lobbying, "one of the oldest forms of political activity by business" (Fuchs, 2005, p. 780), is a playbook tactic for shaping the political environment through state and institutional capture. It is a tactic especially accessible to corporate actors because of the range and scale of resources – instrumental power – at their disposal, relative to those available to other actors, such as civil society organizations.

In public ICIFI claimed that it was participating in the negotiations in good faith and intended to abide by the resulting Code, however, it was a different story behind the scenes. For example, the Multinational Monitor reports that an ICIFI memo circulated at consultations the summer before the Code was adopted made it clear that the industry would not comply if certain changes were not made to the draft Code. When the WHO Executive Board met in January 1981 to approve the draft Code for presentation to the WHA, some members received a letter from ICIFI that said that the "World Industry has found this present draft code unacceptable" (Ratner, 1981). In April 1981, ICIFI circulated a summary statement in which it described the Code as being "detailed and unnecessarily restrictive" and its provisions as "unacceptable," "too detailed, counterproductive and, in parts, incompatible with the constitutional requirements of a number of countries," and "unworkable and unrealistic" (ICIFI, 1981).

WHO officials decided to present the Code to the WHA in May 1981 for adoption as a recommendation rather than a regulation. While a recommendation is not legally binding on Member States, it was thought that a unanimously-supported recommendation would carry more moral weight and be more persuasive than a regulation that did not have unanimous support, especially the backing of the US (Chetley, 1986; WHO, 1981b, 1981a). According to the WHO Constitution, "Regulations … come into effect for all Member States after due notice has been given of their adoption by the Health Assembly except for such Members as may notify the Director-General of rejection or reservations within a period stated in the notice" (WHO, 2006b Article 22).[47] In contrast, recommendations rely entirely on moral force.

The Executive Board's decision to present the Code for adoption as a recommendation rather than a regulation was in response to pressure from the American delegates (Chetley, 1986; Sokol, 2005), who had exercised the country's structural and instrumental power to shape the

[47] This differs from conventions or agreements, which Member States must ratify within 18 months after the adoption of the convention or agreement by the WHA, or in case of non-acceptance, provide a statement of the reasons (WHO, 2006b Article 20).

political environment and policy response preferences. Although the American delegation had indicated that the US would support the Code if it were adopted as a recommendation, this position changed with the election of Ronald Reagan as president. The US was the only country to vote against the Code when it was adopted during the WHA in May 1981 (Chetley, 1986; Joseph, 1981; Sokol, 2005).

5.1.2 Product differentiation - Follow-on milk, growing up milk, milk for mothers

Almost as soon as the Code was adopted in 1981, baby food companies invented differentiated products called follow-up (or follow-on) formulas in order to circumvent its provisions (Faircloth, 2007; Mason et al., 2013; NCT, 2010; Sokol, 2005). The Code of course makes no mention of such formulas because they did not exist when it was being developed and adopted.

Baby food manufacturers sought to shape the perceptions of, and preferences for, these newly-created formulas by manufacturing doubt about the scope of the Code and the nature of the products. Baby food manufacturers claimed that milks for babies over six months of age were not "breastmilk substitutes" because they were promoted only for older babies who were no longer breastfeeding. As will be discussed below, the Code does not specify by age the products covered within its scope. The baby food companies thus could argue that these follow-up milks were not covered by the Code and therefore not subject to the same marketing restrictions as infant formula intended for younger babies. Flexing their instrumental and structural power as significant economic actors, baby food companies have also lobbied many governments, especially in less industrialized countries, not to include follow-up milk within the scope of their national measures (Faircloth, 2007; Sokol, 2005).

Baby food companies' aggressive marketing of these new products worked to persuade parents that they were necessary for the growth and development of their babies and young children (Mason & Greer, 2018). This manufactured demand for these products is an example of the playbook strategy of preference shaping exercised through the use of discursive power, as well as the structural power afforded by the growing (and also manufactured) perception of baby food companies as experts on infant feeding and the endorsement of health care providers. Furthermore, the labels and promotion of follow-up formulas cross-promoted the nearly identical labels of the companies' standard infant formula brands, which the companies were not permitted by the Code and regulations in many countries to advertise (Champeny et al., 2016; Pereira et al., 2016; WHO/UNICEF, 2019).

Addressing this trend by baby food manufacturers, in 1986 the WHA adopted resolution WHA 39.28, which declared that "the practice being introduced in some countries of providing infants with specially formulated milks (so-called follow-up milks) is not necessary" (WHO, 1986). The WHO reiterated this position in a statement on the use and marketing of follow-up formula, additionally noting their potential for confusion and for undermining exclusive breastfeeding up to six months of age and sustained breastfeeding up to two years or beyond. The statement also stated explicitly that when follow-up formula is marketed as suitable as a partial or total replacement for breastmilk, or when it is represented in a manner that results in it being perceived or used as such, it falls within the scope of the Code (WHO, 2013h).

No longer able to argue that follow-up milks were not covered by the Code, the industry introduced "growing-up" or "toddler milks" for one-, two-, or three-year-old children. Similar branding and packaging resulted in cross-promotion of the full product line of breastmilk substitutes while advertising products not covered by the Code or national regulations. Not surprisingly, one type of milk formula has sometimes been mistaken for another (Baumslag & Michels, 1995; Berry et al., 2010, 2012; Cattaneo et al., 2015; Mason & Greer, 2018; NOP World for Department of Health, 2005; Palmer, 2009; Richter, 2001; Scientific Advisory Committee on Nutrition, United Kingdom, 2008; Sobel et al., 2011; WHO, 2013h; Yeong et al., 2010).

In response to this development, in May 2016 the WHA adopted a resolution welcoming technical guidance on ending the inappropriate promotion of foods for infants and young children (WHO, 2016b), which specifically addressed the baby food industry's expanding product line and cross-promotion. This Guidance will be discussed below along with industry efforts to weaken the resolution. In early 2019, the WHO and UNICEF issued an Information Note on the cross-promotion of infant formula and toddler milks. The note stated explicitly that the "promotion of toddler milks is a strategy to circumvent national Code legislation" (WHO/UNICEF, 2019, p. 1). It also says that cross-promotion is a common and effective strategy and that it creates potentially dangerous confusion for families (WHO/UNICEF, 2019).

5.1.3 Optimal duration of exclusive breastfeeding

The baby food industry has worked to shape preferences by using its discursive power to manufacture doubt about the products included within the scope of the Code. As noted, the Code does not specify by age the products covered within its scope. Instead it defines a *breastmilk substitute* as "any food represented as a partial or total replacement for breastmilk, whether or not suitable for

that purpose" and a *complementary food* as "any food … suitable as a complement to breastmilk or to infant formula, when either becomes insufficient to satisfy the nutritional requirements of the infant" (WHO, 1981b). Any liquid or food consumed by a baby before the recommended age for introducing complementary foods following the period of exclusive breastfeeding, *necessarily* replaces breastmilk and is therefore covered by the Code, as does any milk-type product consumed during the entire recommended duration of breastfeeding.

As noted in Chapter 4, technical guidance in May 2016 clarified that the Code and subsequent relevant WHA resolutions apply to all commercially produced foods or beverages specifically marketed as suitable for feeding children up to 36 months (3 years) of age, including "follow-up-formulas" and "growing-up milks" (WHO, 2016e). Until then, however, the Code's definitions of breastmilk substitutes and complementary foods hinged on the optimal duration of exclusive breastfeeding and age for introducing complementary foods. The baby food industry had a lot at stake in this respect. The shorter the recommended duration of exclusive breastfeeding and the lower the age at which complementary foods are recommended to be introduced, the earlier their follow-up formulas and complementary foods can be marketed for use by, and, according to the industry's interpretation of the definition of breast-milk substitutes, actively promoted. A change from four months to six months of exclusive breastfeeding means two months of missed promotion and lost sales of follow-on formulas and complementary foods.

The optimal duration of exclusive breastfeeding and age for introducing complementary foods have been the subject of numerous reviews (Kramer & Kakuma, 2012; Lutter & World Health Organization, Diarrhoeal Disease Control Programme, 1992; H. A. Smith & Becker, 2016; Underwood B. A. & Hofvander Y., 1982; WHO, 2002) and WHA resolutions. The recommended duration of exclusive breastfeeding evolved over time from "four to six months" to "about six months" but, despite these numerous reviews and resolutions, it remained a subject of great debate.[48]

[48] In 1990, WHA Resolution 43.3 recommended exclusive breastfeeding for the first "four to six months" of life, a range that was considered a transitional period for adjusting to solid foods. In 1992, WHA resolution 45.34 reaffirmed exclusive breastfeeding during the first four to six months of life and that complementary foods should be introduced "from about six months". In 1994, WHA Resolution 47.5 recommended complementary feeding from about six months of age, along with continued breastfeeding" (WHO, 1994). Despite this resolution, however, the WHO continued to refer to exclusive breastfeeding for four to six months (Sokol, 2005). In 1995, a WHO Expert Committee report reaffirmed the recommendation of 4-6 months as the duration of exclusive breastfeeding and the age for introducing complementary foods. This sparked debate over whether the recommendation should be a range (four to six months) or whether the phrase "about six months" allowed suitable flexibility for individual and regional variations (Brown et al.,

Baby food companies used their discursive power to shape preferences and frame the scope of the issue by insisting that *only* infant formula marketed for use below the recommended duration of exclusive breastfeeding was covered by the Code. They continued, therefore, to market all other products, such as follow-up milks discussed above, for use after that age (Berry et al., 2010). They also lobbied hard to try to prevent the recommended duration of exclusive breastfeeding being changed from "four to six months" to "about six months" (Sokol, 2005). At the WHA in May 2000, the Brazilian delegation proposed a resolution that reaffirmed 1994's WHA Resolution 47.5 and its unambiguous recommendation of "appropriate complementary feeding practices from the age of about six months, along with continued breastfeeding" (WHO, 1994), which more than 61 countries had by then adopted as national policy (Rundall & Sterken, 2000). The proposed resolution sparked a long debate, following which the Assembly eventually requested that the next Executive Board meeting, scheduled for January 2001, set up a drafting group to incorporate necessary amendments. The revised draft resolution was to be tabled at the WHA in May 2001 (Peck, 2000; Rundall & Sterken, 2000).

However, in July 2000 the baby food industry, represented by the International Association of Infant Food Manufacturers (IFM), which had replaced ICIFI in 1984, set out to lobby the WHO to delay "[a]ny action dealing with Infant and Young Child Nutrition … until the WHA *2002*" (emphasis original, IFM, 2000). To support this position, IFM's lobbying message pointed to a large international growth study and a review of the relevant scientific literature, based on which the WHO planned to submit updated infant and young child feeding recommendations to the 2002 WHA. Aiming to influence perceptions surrounding the matter and make clear the industry's position, the IFM document says: "The current pressure to push through a Resolution on Infant and Young Child Feeding in 2001 does not allow sufficient time to conduct the kind of reasoned, science-based study that the WHO had planned" (IFM, 2000).

According to civil society activists, however, IFM wanted the delay because the Codex Alimentarius Commission (which determines quality and labelling standards for food products) was due to decide its labelling standard at the end of November 2001. The activists maintained that the industry knew it would be in a better position to push through four-months as the Codex labelling

1998). In 1998 the WHO published a thorough review of scientific evidence with respect to the recommended length of exclusive breastfeeding and the appropriate age of introduction of complementary foods. The authors of the review recommended that full term infants should be exclusively breastfed until they are about six months of age (Brown et al., 1998).

standard if the WHA resolution could be delayed until after the Codex meeting (Baby Milk Action, 2001). This manoeuvre represents another example of the IFM's exercise of its existing structural and instrumental power with the aim of further enhancing it.

The British Medical Journal (BMJ) reported on the baby food industry's lobbying effort by simply detailing the content of the IFM document (Yamey, 2000). Eager to counter possible negative impressions created by the lobbying and to make the industry position appear reasonable, IFM's secretary general responded with a letter that said the BMJ article "[did] not reflect reality and deliver[ed] information out of its complete context" (Bronner, 2000). He added that the association believed January 2001 was too soon to recommend raising the age of introduction of complementary foods on the basis of the scientific studies being undertaken at the time (Bronner, 2000).

The BMJ article also quoted the WHO's technical officer in nutrition calling the tabling of a resolution on infant feeding in 2001 "'a distraction' from the 'cyclical mandate to go to the [WHA] every two years, on even years, to report on infant and young child nutrition'" (Yamey, 2000, p. 591). IBFAN activists pointed out that tabling a resolution in 2001 had been instructed by the WHA. The technical officer's comment was therefore inappropriate, given the WHA's decision-making process, and did not respect the wishes of the Assembly (Peck, 2000; Rundall & Sterken, 2000). Far from being "a distraction", as the technical officer had described it, a proposed resolution on infant feeding in 2001 was the fulfillment of the instructions in 2000 of the Assembly as the decision-making body of the WHO.

In 2000, the WHO had commissioned a systematic review of scientific studies relating to the optimal duration of exclusive breastfeeding. In 2001 the review concluded that there was no benefit to, and in fact some harm in, introducing complementary foods between four and six months, rather than waiting until about six months of age (Kramer & Kakuma, 2002). In March 2001, the WHO convened an expert consultation to consider the results of the review. The report of the expert consultation recommended definitively "exclusive breastfeeding for six months, with introduction of complementary foods and continued breastfeeding thereafter" (WHO, 2001a, p. 3, 2002, p. 2).

Referencing the expert consultation report, in May 2001 the WHA adopted the revised resolution (WHA54.2) on infant feeding, as it had requested the year before, which recommended "exclusive breastfeeding for six months" and "safe and appropriate complementary foods, with continued breastfeeding for up to two years of age or beyond" (WHO, 2001b). However, the clarity of this resolution did not end the baby food industry's efforts to create confusion about the scope of

the Code and to market its products, necessitating additional interventions by the WHO to end inappropriate promotion.

5.1.4 Guidance on ending the inappropriate promotion of foods for infants and young children (2016)

The 2016 *Guidance on ending inappropriate promotion of baby foods* is a substantive policy that brings together the abovementioned concerns about marketing, product differentiation and the optimal duration of breastfeeding. As discussed in Chapter 4, through resolution 69.9 in May 2016 the WHA "welcome[d] with appreciation" the "technical guidance on ending the inappropriate promotion of foods for infants and young children" (WHO, 2016b, para. 1). Significantly, the Guidance clarifies that the Code and subsequent relevant WHA resolutions apply to all commercially produced foods or beverages specifically marketed as suitable for feeding children up to 36 months (3 years) of age, including "follow-up-formulas" and "growing-up milks" (WHO, 2016e). The baby food industry had long maintained that these milk products did not fall within the scope of the Code and had invented differentiated products in order to circumvent its provisions, as discussed above. The Guidance also specifies the conditions under which complementary foods may be promoted (including which messages may and may not be included in their promotion) and explicitly prohibit cross-promotion to promote breastmilk substitutes and practices such as sponsorships, gifts, and free supplies, and address the prevention of conflicts of interest (WHO, 2016e).

Business associations representing the baby food industry intervened to shape preferences and perceptions during the development of the Guidance. In a joint statement in response to the draft Guidance presented at the Executive Board meeting in January 2016, the International Special Dietary Foods Industries Federation (ISDI) and IFM said: "It is inappropriate and arbitrary to designate all milk based products for young children up to 36 months of age as breast milk substitutes (BMS)" (ISDI & IFM, 2016). In terms of the Guidance's recommendation on optimal infant and young child feeding, which emphasizes "the use of suitable, nutrient-rich, home-prepared, and locally available foods that are prepared and fed safely"[49] (WHO, 2016e, para. 10), ISDI and IFM emphasized individual consumer choice, saying the recommendation was "penalizing the right to choose and denying parents, caregivers and [health care providers] the right of access to

[49] In accordance with Guiding principles for complementary feeding of the breastfed child (PAHO, 2003), Guiding principles for feeding non-breastfed children 6–24 months of age (World Health Organization, 2005), and the Global strategy for infant and young child feeding (WHO, 2003a).

information may lead to unintended health consequences" (ISDI & IFM, 2016, p. 1). This argument both relies on and reinforces underlying paradigms that emphasize individual choice, thereby shifting responsibility away from companies and onto consumers, in order to create an environment conducive to the industry's preferred policy responses. Baby food industry strategies to shape such paradigms will be analyzed in Section 5.2.

ISDI and IFM's statement sought to shape perceptions surrounding the promotion of their follow-up and growing-up milks. The Guidance recommends that "there should be no cross-promotion to promote breast-milk substitutes indirectly via the promotion of foods for infants and young children" (WHO, 2016e, para. 15). Specifically, it says complementary foods and breastmilk substitutes should not have similar package designs, labelling and materials. Moreover, companies that market breast-milk substitutes should not establish relationships with parents and other caregivers through direct or indirect promotion of their other food products (WHO, 2016e). ISDI and IFM countered that "disproportionate provisions restricting branding and intellectual property rights threaten incentives for innovation, jeopardizing the continued advancement of nutritional science" (ISDI & IFM, 2016, p. 2). They argued for the removal of the proposed prohibition against using similar colour schemes, designs, names, slogans, mascots or other symbols and direct or indirect promotion of non-breastmilk substitute products with parents, other caregivers and health care providers (ISDI & IFM, 2016). Part of the justification for calling for the removal of these proposed restrictions was that it may "negatively impact consumer trust" and that implementation would be "extremely challenging … without violating existing international trade obligations" (ISDI & IFM, 2016, p. 2). Trustworthiness is essential to the baby food industry's discursive power and its ability to shape paradigms to create environments conducive to the sale of its products and policies in support of their interests.

The baby food industry also benefited from the actions of its allies in related industries, such as the International Dairy Foods Association (IDFA).[50] IDFA sent its comments on the draft Guidance to the US government. Its statement worked to shape perceptions about the consultative process and the resulting draft Guidance, and about the private sector's role as a governance actor. IDFA's comments endorsed ISDI and IFM's position and expressed concern "about the

[50] IDFA is a Washington D.C.-based association representing 550 companies in the U.S.'s $125-billion/year dairy manufacturing and marketing industries and their suppliers. It is composed of three constituent organizations: the Milk Industry Foundation (MIF), the National Cheese Institute (NCI) and the International Ice Cream Association (IICA) (IDFA, 2016).

overreaching and dangerous direction the guidance takes toward prohibiting the marketing and promotion of safe, healthy and nutritious dairy foods" that are "widely-recognized as being good for young children during the complementary feeding and post-breastfeeding stages of early life" (IDFA, 2016, p. 1). The statement says: "These restrictions would directly conflict with the nutritious foods that the U.S. government provides to infants and young children through the federal child nutrition programs" (IDFA, 2016, p. 1). IDFA said that it was "also alarmed by the non-transparent, flawed process by which the WHO has developed this guidance and others, and urge[d] the U.S. government to work aggressively toward improving the WHO's processes and procedures to ensure the organization builds and maintains greater trust among all stakeholders" (IDFA, 2016, p. 1).

However, the consultative process surrounding the development of the Guidance was open and extensive: when the draft WHO recommendations were open to public comment between July and August 2015, more than 300 comments were received from a wide range of stakeholders, including industry, NGOs and academia. The WHO also consulted Member States and other United Nations organizations in August and held dialogue meetings with NGOs and baby food manufacturers. In January 2016, the Executive Board discussed a revised version of the draft Guidance. The WHO reviewed additional comments from Member States in the Spring of 2016 (Grummer-Strawn, 2018), before the WHA adopted Resolution 69.9, welcoming the Guidance attached as an annex. The IDFA's undated comments to the US government appear to have been prepared in connection with this review.

Manufacturing doubt and shaping perceptions about the Guidance, Nestlé's website emphasized the fact that the document was "neither adopted or approved", but "welcomed with appreciation" (Nestlé, 2019b). The company attributed this decision to what it called a "misalignment" between the Guidance's "extension of the restrictions on the marketing of products designed for children aged up to 36 months" and the position "expressed by Nestlé and others" (such as ISDI and IFM, as mentioned above) that "infant nutrition products for babies aged 6–36 months are not 'breast-milk substitutes' (with the marketing restrictions this implies) but are part of a broader diet for infants and young children" (Nestlé, 2019b).

Nestlé maintained that the fact that the Guidance had been merely "welcomed with appreciation" in Resolution 69.9 and not "adopted" or "approved" meant Member States were under no obligation to implement it. The company said that the WHO's Office of Legal Counsel had clarified this point, yet "some organizations were still pushing for implementation of Resolution

69.9 by Member States" (Nestlé, 2019b). However, the Office of Legal Counsel's clarification had been to correct the misrepresentation by the WHO representative at the Thirty-ninth Session of the Codex Committee on Nutrition and Foods for Special Dietary Uses. The WHO representative had said that the operative terms "welcomes", "welcomes with appreciation", "notes", and "notes with appreciation" all express approval, although somewhat less strongly (Codex Alimentarius Commission, 2018, para. 13). The Office of Legal Counsel's correction clarified that these terms have different meanings and are not used synonymously with "approves", adding that Resolution WHA69.9 had been adopted by consensus on May 28, 2016 (Codex Alimentarius Commission, 2018 Addendum). Nevertheless, contrary to Nestlé's stance, the Office of Legal Counsel's clarification does not indicate that Member States are under any less obligation to implement the Guidance than had it been "approved" or "endorsed" by the WHA in the resolution.

Indeed, WHA Resolution 69.9 urges Member States "to take all necessary measures in the interest of public health to end the inappropriate promotion of foods for infants and young children, including, in particular, implementation of the guidance recommendations" (WHO, 2016e, para. 2). It called upon manufacturers and distributors of foods for infants and young children "to end all forms of inappropriate promotion, as set forth in the guidance recommendations" (WHO, 2016e, para. 2). The Resolution requests the Director-General "to provide technical support to Member States in implementing the guidance recommendations" (WHO, 2016e, para. 7(1)). As Grummer-Strawn (2018, p. 683) notes, "It seems hard to argue that the WHA did not accept the Guidance recommendations when it called for implementation by all relevant stakeholders."

5.1.5 2018 Resolution on IYCF

A resolution on infant and young child nutrition was tabled at the WHA in May 2018, an even year, as prescribed by the Code. Led by Ecuador, Member States had met four times ahead of the Assembly to develop a draft consensus text for the resolution (WHO, 2018j). The draft resolution addressed five critical areas: the Baby-Friendly Hospital Initiative (BFHI), implementation and monitoring of the Code and subsequent, relevant WHA resolutions; the Guidance on ending inappropriate marketing of foods for infants and young children (adopted in 2016), appropriate infant and young child feeding in emergencies, and conflicts of interest in nutrition programs (IBFAN/ICDC, 2018).

As Member States had agreed on a draft consensus text, the resolution was expected to be adopted without incident. However, unhappy with various provisions of the proposed resolution,

the US delegation threatened countries that supported the resolution with trade sanctions and withdrawal of military aid (Byatnal, 2018; Jacobs, 2018). The US delegation submitted its own one-page "Decision Point" for maternal, infant and young child nutrition (US Delegation to WHO, 2018; WHO, 2018k). Of the five critical areas the consensus text aimed to safeguard, the US text makes little mention of the International Code, the need for marketing restrictions, especially the 2016 Guidance, or the need for safeguards against conflicts of interests (Baby Milk Action, 2018). As a result of the US intervention, the Chairman of the WHA sent the proposed resolution for several days of further drafting by a committee chaired by Thailand, with the US delegation participants outnumbering those from other countries (IBFAN/ICDC, 2018). Amid the threats of trade retaliation and withdrawal of military aid, Ecuador eventually withdrew from introducing the proposed resolution (Byatnal, 2018; Jacobs, 2018). The proposed resolution was instead tabled by the Russian Federation, co-sponsored by 14 other Member States[51], and supported by all others except the United States (Baby Milk Action, 2018). The US delegation was able to make this threat aimed at controlling to control the political environment on behalf of the American baby food companies because of the milk-producing country's instrumental and structural powers.

The resolution that the WHA ultimately adopted (WHO, 2018e) was decidedly weaker than that which had been initially proposed. The resolution contained only one mention of the Code and omitted references to subsequent relevant WHA resolutions, the 2016 Guidance, and mechanisms for Code monitoring and enforcement (Baby Milk Action, 2018; Byatnal, 2018; IBFAN/ICDC, 2018). These are all elements that would have reinforced measures to regulate the baby food industry's ability to market their products. Reflecting the troublesome global trend toward multistakeholderism, the resolution also mentions "multisectoral approaches" in connection with the development, implementation, and monitoring and evaluation of laws, policies and programmes aimed at protection and promotion, including education, and support of breastfeeding (IBFAN/ICDC, 2018). Critics saw the "significantly weak" (Byatnal, 2018) resolution as "an overt and gradual attempt by industry-friendly countries to water-down a whole body of work that [had been] built up around the Code over the years" (IBFAN/ICDC, 2018). One veteran civil society activist[52] described the move by the US as "tantamount to blackmail" and "holding the world

[51] Nepal, Sierra Leone, Canada, Botswana, Pakistan, Panama, Gambia, Georgia, Ghana, Senegal, Mozambique, Thailand and Zambia

[52] Patti Rundall, OBE, Policy Director of UK-based Baby Milk Action.

hostage" while "trying to overturn nearly 40 year of consensus on the best way to protect infant and young child health" (Jacobs, 2018).

The above analysis of five key substantive policies or policy areas that affect the sale and consumption of baby food products has shown that the baby food industry has used strategies and tactics from the corporate playbook underpinned by various types of power. Baby food companies and their business associations lobbied the WHO and Member States, finding allies in milk-exporting countries such as the US, which rejected early drafts of the Code and lobbied on the industry's behalf. To circumvent the Code and national legislation and to extend their product line, baby food companies invented differentiated products – so-called "follow-up (or follow-on) milk" for older infants and later "growing-up (or toddler) milks" for one-, two-, or three-year-old children. They worked to shape perceptions of such products, thereby manufacturing demand for them and arguing that they were not included within the scope of the Code. The baby food industry has also created doubt about the scope of the Code by using its discursive power to manufacture doubt about the optimal duration of exclusive breastfeeding, which it has lobbied to keep as low as possible. It lobbied intensely in connection with a substantive policy that brings together marketing, product differentiation and the optimal duration of breastfeeding: the 2016 Guidance on ending inappropriate promotion of baby foods. Business associations representing the baby food industry intervened to shape the parameters of the debate during the development of the Guidance. The analysis shows that these strategies and the power that underpin them have been iterative and reinforcing.

5.2 Shaping paradigms to create a conducive environment

In addition to intervening on specific substantive policy areas, the baby food industry uses the playbook strategies to shape paradigms conducive to both its substantive policy interests and its long-game interests, including the establishment of the industry as a governance actor. Business operates within an existing social system of certain norms and ideas – or, paradigms – and can be both benefitted and at times constrained by them. However, business also uses its discursive power to shape these very norms and ideas (Fuchs, 2005). The baby food industry uses a variety of corporate playbook strategies and tactics to promote paradigms emphasizing, for example, 1) individual consumer choice, 2) corporate responsibility and trustworthiness, and 3) industry's legitimacy as a governance actor, as we shall see below. Some of the types of strategies for encouraging these paradigms that are evident in the analysis include shaping the knowledge

environment, perceptions and the political environment by framing issues and actors, undertaking self-regulation and other voluntary measures and participating in collaborative initiatives.

5.2.1 Framing the baby food issue as a matter of individual consumer choice

An environment for policy-making conducive to the baby food industry's interests depends on perceptions about the baby food issue itself. One way the industry shapes consumer and policy-maker perceptions, a strategy from the corporate playbook, is by using its discursive power to frame the issue as a matter of individual consumer choice. Baby food companies and their associations often refer to mothers' "choices" about infant feeding, emphasizing the individual's right to choose. This "freedom of choice" rhetoric has the effect of shifting responsibility – or, blame – for any resulting problem away from companies and onto consumers (L. C. Friedman et al., 2014).

In an effort to shape perceptions, baby food product labels indicate that they are for use "when breastfeeding is not possible". This message seeks to create the impression that mothers often have difficulty breastfeeding and must look for alternatives. Baby milks are thus portrayed as filling a legitimate need. To be sure, the need *is* legitimate; however, the extent of the "need" has been manufactured in part by the industry's efforts to undermine breastfeeding. The baby food industry also works to shape preferences by positioning its product as a close replica of mother's milk, often going so far as to claim that it is "closest to mother's milk" or "approaches breastmilk" (Mehdi & Wagner-Rizvi, 1998; Yeong & Allain, 2014, 2017). This messaging also gives the impression that the product is a safe and equivalent alternative to breastfeeding.

Baby formula manufacturers also try to shape preferences by distinguishing their product from their competitors' with health claims about allergies and intelligence enhancement, for example, that play off parents' desire to choose the best product for their babies (Mehdi & Wagner-Rizvi, 1998; Yeong & Allain, 2014, 2017). Many of these health claims are misleading, unsubstantiated by scientific evidence, and even fraudulent (see for example, Boyle et al., 2016; British Medical Journal Publishing Group, 2015; Jasani, Simmer, Patole, & Rao, 2017; White, 2015). Like Big Food, the baby food industry uses nutritional claims and reformulation to boost sales and to bolster perceptions of its trustworthiness as a responsible corporate citizen (Clapp & Scrinis, 2017; Scott et al., 2017). In so doing, it thus uses its discursive power to augment its structural power.

5.2.2 Corporate responsibility and trustworthiness

It is critical to the baby food industry's discursive power and its playbook strategies for controlling the political environment and shaping preferences to appear trustworthy. Nestlé, in particular, seeks to demonstrate that it has left behind the marketing practices that led to the bad publicity back in the 1970s and instead aims to win the trust of consumers and policy-makers. Market leaders Nestlé and Danone, for example, have worked to gain public trust by participating in various voluntary initiatives such as the United Nations Global Compact and the FTSE4Good Index[53] (FTSE Russell, 2019; UN Global Compact, 2019) and by self-regulating with their own codes of conduct (Danone, 2016; Nestec Ltd., 2010, 2017). Besides framing companies as trustworthy, self-regulation and voluntary initiatives are a way to pre-empt or weaken formal regulation (Fuchs, 2005; Hawkes C., 2005; Sharma et al., 2010; Utting & Clapp, 2008), as will be discussed below.

Corporations subscribing to the Global Compact pledge to implement ten principles relating to human rights, labour standards, environmental sustainability and anti-corruption measures. Nestlé became a member of the Global Compact in 2002, two years after it was launched. Membership in the Global Compact provided the company (and by extension the baby food industry) a new platform for establishing its political legitimacy and shaping norms in favour of self-regulation. Critics of Nestlé's inclusion feared that it served as an endorsement of this political legitimacy and of its preferred solution of self-regulation, and facilitates closer ties with top political officials (Richter, 2004a). There was concern that, despite the Global Compact's stated intentions, corporations "might still use such a value-based learning platform to avoid complying with existing international regulatory instruments, such as the International Code … and to undermine any future attempts to regulate their behaviour and other efforts to curb corporate power such as public exposure and pressure" (Richter, 2004a). It is important to note that the baby food corporations' participation in the Global Compact does *not* depend upon or reflect their compliance with the Code.

Representing an opportunity similar to that of the Global Compact, the FTSE4Good Index is "designed to measure the performance of companies demonstrating strong environmental, social and governance practices" (FTSE Russell, 2019 n.p.). Unlike the Global Compact, however, the FTSE4Good Index *does* consider the marketing practices of baby food companies, albeit with lower – and diminishing – standards. Baby food manufacturers were initially obliged to demonstrate compliance with the *Code* in order to be included in the FTSE4Good index, but new criteria adopted

[53] FTSE stands for Financial Times Stock Exchange. The FTSE Group operates around 250,000 financial indices, including FTSE4Good, a series of ethical investment stock market indices (FTSE Russell, 2019).

in 2003 require only that they demonstrate that policies and systems are in place to eventually achieve *Code* compliance (Save the Children, 2007). Yet, no manufacturers were able to meet even this reduced standard. FTSE4Good revised the criteria again in September 2010, maintaining that it was not able to engage with companies that were excluded from the index, and that it was better to introduce requirements that companies were able to meet and gradually raise the standards over time (FTSE, 2011; Makepeace, 2011).

In March 2011, Nestlé became the first baby food manufacturer to be included in the FTSE4Good Index (FTSE, 2011; Nestec Ltd., 2017). This provided the company with opportunity to exercise its discursive power to protect its instrumental and structural power. It enabled it to suggest that its marketing practices complied with the *Code,* and to undermine regulatory efforts to hold it accountable. In at least one instance Nestlé referred to the WHO compliance in the same sentence as its inclusion in FTSE4Good. However, FTSE wrote to Nestlé to clarify that its assessment is based on the FTSE4Good criteria and does not reflect compliance with the *Code*. Therefore the two should not be conflated (Makepeace, 2011). Despite this clarification, in January 2014 *The Guardian* quoted Nestlé Chairman Peter Brabeck-Letmathé as having described the company as: "the only infant formula producer which is part of FTSE4Good. We are being checked and controlled by FTSE4Good. They make their audits in different parts of the world and we have to prove that we are complying with the WHO Code and up to now we can prove that in everything we are" (Confino, 2014). This statement leaves readers with the impression that the company is meeting international baby food marketing standards, when it is only meeting the much narrower FTSE4Good criteria.

Danone met the FTSE4Good criteria in 2016 and joined Nestlé in the index (Mason & Greer, 2018). A third baby food manufacturer, Mead Johnson, has been included on the index by way of its purchase by RB (formerly Reckitt Benckiser), which was already included on the index. RB had to bring Mead Johnson in line with the FTSE4Good criteria for baby food manufacturers by mid-2019 if it was to remain on the index (Mason & Greer, 2018). RB announced in December 2018 that it had secured continued FTSE4Good accreditation by satisfying the index's baby food criteria (RB, 2018). Now that more baby food companies have been included, FTSE4Good could strengthen the watered-down criteria for inclusion so the index becomes more credible (Mason & Greer, 2018). However, FTSE4Good has declined to review its criteria for the time being. In any case, FTSE4Good itself reported in June 2017 that its latest breastmilk substitute marketing verification process had revealed continued violations by both Nestlé and Danone. By early 2018, it

appeared no action had been taken to remove either company from the index (Mason & Greer, 2018).

Besides building trust, engaging in self-regulation and voluntary initiatives like the Global Compact and the FTSE4Good Index is intended to help companies prevent or undermine calls for more stringent and effective formal regulation by public actors (Fuchs, 2005; Hawkes C., 2005; Sharma et al., 2010; Utting & Clapp, 2008). Such efforts are examples of the playbook strategies that both draw on and reinforce companies' discursive, instrumental and structural power. In this regard, the trend in global governance toward self-regulation is an important source of structural power for business. The extent to which voluntary codes of conduct are accepted as sufficient grants individual companies like Nestlé and the baby food industry collectively political legitimacy that bolsters their instrumental and discursive power in order to influence substantive policy and reinforce a regulatory environment in which collaboration and partnership appears necessary and sufficient, and formal regulation unreasonable and unwarranted.

The baby food industry has been lobbying against government regulation and in favour of voluntary codes of conduct and self-regulation since the 1970s when ICIFI, spearheaded by Nestlé, circulated and widely publicized a *Code of Ethics* (ICIFI, 1975) two days after the end of the first hearing of the Nestlé libel trial (Sokol, 2005). The move was meant to counter the bad publicity and demonstrate that the baby food industry was working to solve the problem. However, in this case, the ICIFI *Code of Ethics,* which allowed most marketing practices as long as breastfeeding was mentioned as the first choice for infant nutrition (Sokol, 2005), did not satisfy calls for the regulation of baby food marketing, and the industry was not able to prevent the adoption of the public regulation in the form of the Code.

In February 1982, Nestlé developed its own set of instructions on how its employees were to implement the newly adopted Code as evidence that the company conducts its business in a responsible and ethical manner and that it is therefore trustworthy. Revised versions of the *Nestlé Charter* were issued in October 1982, in 1996, and 2004. In July 2010, Nestlé issued a completely revised *Policy and Instructions for Implementation of the WHO International Code of Marketing of Breast-Milk Substitutes* (Nestec Ltd., 2010) as part of its efforts to meet the FTSE4Good Inclusion Criteria for the Marketing of Breast Milk Substitutes (Nestec Ltd., 2017). This document was updated and re-issued in September 2017 as *The Nestlé Policy and Procedures for the Implementation of the WHO International Code of Marketing of Breast Milk Substitutes* (Nestec Ltd., 2017). Danone also developed a *Policy for the marketing of breast-milk substitutes* and a *Procedures manual* for its implementation in July

2011, which has undergone three revisions, with the most recent edition taking effect June 1, 2016, the same month the company was included in the FTSE4Good index, having met the inclusion criteria regarding breastmilk substitute marketing.

However, Nestlé's and Danone's self-regulation policies and procedures fall short of the requirements set out in the Code because they make geographical distinctions about where and to which products the policies apply and disregard subsequent, relevant WHA resolutions that clarify certain provisions of the *Code* and are to be taken together with it as a whole. Nestlé, for example, frames the negative impacts of formula promotion as a problem that affects only low- and middle-income countries (LMICs) and therefore does not warrant *Code* compliance or formal restrictions on product promotion in high income countries. For example, its current *Policy and Procedures for the Implementation of the WHO Code of Marketing of Breast Milk Substitutes* creates a false distinction between 'lower-risk countries' and 'higher-risk countries' based on levels of mortality, morbidity and acute malnutrition among children under five years of age, noting that in 'higher-risk countries', the company follows the Nestlé Procedures when they are stricter than the local legislation (Nestec Ltd., 2017).

Nestlé's *Policy and Procedures* apply only to formulas for use up to the age of twelve months (Nestec Ltd., 2017), while the expert consultation on the optimal duration of breastfeeding (WHO, 2001a, 2002), referenced in WHA Resolution 54.2 (WHO, 2001b), recommended that infants should continue to be breastfed for up to two years or beyond, along with nutritionally adequate complementary foods, meaning milk products marketed for use during that period are covered by the *Code*. Furthermore, the 2016 *Guidance on ending inappropriate promotion of foods for infants and young children* clarify that the Code and subsequent relevant WHA resolutions apply to all commercially produced foods or beverages specifically marketed as suitable for feeding children up to 36 months (3 years) of age, including "follow-up-formulas" and "growing-up milks" (WHO, 2016e). This means that Nestlé's *Policy and Procedures* fall far short of the *Code*'s requirements, even if they do meet the FTSE4Good inclusion criteria.

Danone makes the same distinction between 'lower-risk' and 'higher-risk' countries, using the same criteria, and extends the range of products covered by its policy in 'higher-risk countries'. Worldwide its policy covers infant formula for use up to six months of age and any other food or beverage for use below six months of age, as well as bottles and teat. In 'higher risk countries', it also applies to follow-on formula for use from six to twelve months, and complementary foods and drinks for use under six months of age (Danone, 2016). This distinction between lower and higher-

risk countries can be traced back to the FTSE4Good Breast Milk Substitutes marketing inclusion criteria (FTSE Russell, 2017). The *Code*, and subsequent WHA resolutions, however, apply equally to *all* countries, and make no distinction based on rates of mortality or acute malnutrition.

5.2.3 Industry legitimacy as a governance actor

Baby food companies and their associations have sought legitimacy as governance actors by copying civil society formations and creating their own organizations to represent themselves as civil society organizations even though they actually pursue business interests. Such organizations, found in in various industries, have been called "front groups" (Baur, 2011; Dorfman et al., 2012; Madureira Lima & Galea, 2018; Miller & Harkins, 2010; Simon, 2013). Madureira Lima and Galea (2018) label this tactic "civil society capture" and note that such groups confer legitimacy to industry claims [and policy positions] and deflect criticism. This tactic coopts the structural power increasingly accorded to civil society organizations as political actors and enhances the instrumental, structural and discursive power available to corporate actors.

To institutionalize this power, several of these groups have applied – some of them successfully – for Official Relations status with the WHO, even though one of the criteria for being granted that status, according to the Principles governing relations between the WHO and NGOs, was that the applicant must be "free from concerns which are primarily of a commercial or profit-making nature" (WHO, 1987a, para. 3.1). Official Relations status confers certain privileges on organizations, including the ability to attend certain the WHO meetings, access documents and influence certain processes. In this way, the status bestows additional instrumental power on organizations, boosts their structural power and lends credibility and legitimacy to their discursive power. It positions corporations, through their business associations, to lobby and influence the WHO and its Member States. It also provides a platform from which to deploy the playbook strategies of shaping the political environment and shaping preferences, perceptions and paradigms surrounding various issues.

The baby food industry association ICIFI applied for Official Relations status in 1981, under the new leadership of Dr. Stanislaus Flache, who, as described above, had recently retired as the WHO Assistant Director-General (Chetley, 1986; Ratner, 1981) and thus possessed connections within the WHO, insider understanding of the significance of the status and the criteria and procedure for having it granted. The Executive Board considered ICIFI's application in January 1981, but deferred its decision for a year in order for working relations between the WHO and

ICIFI to be strengthened (Chetley, 1986; WHO, 1980b, 1981c). The following year, the Standing Committee on NGOs again recommended that a decision regarding ICIFI's application be deferred for another year while its activities in relation to the Code were observed (WHO, 1982, p. 38). Yet another deferral came in 1983, when the Standing Committee requested more information about the potential benefits and usefulness of, and concerns about, collaboration between ICIFI and the WHO. The question was also raised as to whether a group comprised entirely of commercial companies should be given Official Relations status, although it was pointed out that two other such groups[54] were already in Official Relations with the WHO (WHO, 1983). ICIFI did not reapply for Official Relations the following year, and in 1984 the organization was replaced by the International Association of Infant Food Manufacturers (IFM), which did not pursue this status.

The International Special Dietary Foods Industries Federation (ISDI), representing the global specialized nutrition industry, including Nestlé and Danone, is another business group that applied for Official Relations status with the WHO. The WHO granted the status to ISDI in 1987 (WHO, 1987b), but withdrew it in January 2014 (WHO, 2014c) not because of the group's close connection with commercial entities, even though this was forbidden by the eligibility criteria detailed in the Principles, but because "the organization had reported inadequate progress in the implementation of the plan of collaboration. The WHO had not received the deliverables expected during the collaboration period" (WHO, 2014c, para. 20).

Although ICIFI, IFM and ISDI were transparently named, the intentions and business interests of some groups can be less clear. The International Life Sciences Institute (ILSI), for example, is a front group that represents itself as a non-profit organization with a mission to "provide science that improves public health". ILSI's members include manufacturers of baby food – and, relevant to Chapter 6, soda[55] (ILSI, 2016). The WHO granted Official Relations status to ILSI in 1988 and withdrew it in January 2015 when the group came up for review in accordance with the Principles (WHO, 2015e). During the review, the Standing Committee noted that "a member company of one of the group's branches is owned by a company that manufactures and sells tobacco products" (WHO, 2014h, para. 8). The Standing Committee's concern was not ILSI's

[54] Official Relations status had already been granted to the International Federation of Pharmaceutical Manufacturers' Associations (IFPMA) in 1971, and the World Federation of Proprietary Medicine Manufacturers in 1977.

[55] For example, baby food manufacturers Abbott Nutrition, DSM Nutritional Products, Fonterra, FrieslandCampina, Mead Johnson, Nestlé, and Danone, and soda companies Coca-Cola and PepsiCo (ILSI, 2016, 2018).

ties with commercial enterprises in general, which the Official Relations eligibility criteria forbid, but ILSI's link with tobacco, one of two industries with which the WHO explicitly refuses to work.[56] To address these concerns and try to pre-empt loss of its Official Relations status, at the 2015 ILSI Annual Meeting, the ILSI Board amended its bylaws to prohibit membership of any company or affiliate that "engages in the manufacture, production, marketing, sale or distribution of tobacco products" (Hentges, 2015; WHO, 2015d, para. 9). Despite these efforts, the Standing Committee withdrew ILSI's Official relations status. The Standing Committee noted that, considering that the bylaws had been amended just a few days earlier, and only after the review had been published, "the Institute had not been fully transparent in its relations with the WHO," and it was furthermore not possible to verify that the changes had been implemented (WHO, 2015d, para. 9).

Like Wyeth, which hired Rogers, and ICIFI, which hired Flache, Nestlé has deployed the revolving door strategy to bolster its credibility and trustworthy reputation. It has recruited several senior UNICEF officials into prominent roles within the company. With the WHO, UNICEF co-hosted the 1979 meeting that led to the adoption of the Code and it has supported national efforts to introduce legislation to give the Code legal effect. The former executive director of UNICEF from 2005 to 2010, Ann Veneman, was voted onto the Nestlé Board of Directors at its April 14, 2011 shareholder meeting (AP, 2011). After the shareholder meeting, she acknowledged that "Nestlé isn't fully complying with a voluntary breast milk code adopted by World Health Organization" and pledged to "work from within to change the world's biggest food and beverage company" (AP, 2011). Veneman currently serves on the Nestlé's Creating Shared Value Council (Nestlé, 2020). Given Veneman's expertise and experience with UNICEF, her recruitment and retention not only suggest her personal and professional endorsement of Nestlé, but also provide the company access to her insider information and personal connections acquired as UNICEF's top official, including those of its close ally the WHO.

Distancing UNICEF from Veneman's new role, a spokesperson had a day earlier said that Veneman had left the agency a year before and was now a private citizen. She also confirmed that UNICEF did not take funding from Nestlé, and that Nestlé continued to violate the Code (Nebehay, 2011). Whereas Veneman waited a year after leaving UNICEF before joining Nestlé, Janet Voûte, joined Nestlé in December 2010 as Global Head of Public Affairs with no cooling off period following her position at the WHO as Partnership Advisor with responsibility for the UN

[56] The other forbidden industry is the arms industry.

Global Compact and the Global Network for NCDs (NCDnet), which she masterminded (Baby Milk Action, 2010). She is now Chairperson of the Nestlé Creating Shared Value Council (Nestlé, 2020).

The analysis in this section has shown that the baby food industry has used playbook strategies and tactics to promote paradigms emphasizing individual consumer choice, corporate responsibility and trustworthiness, and industry's legitimacy as a governance actor. Some of the types of strategies evident in the above analysis include shaping the knowledge environment, perceptions and the political environment by framing issues and actors, undertaking self-regulation and other voluntary measures and participating in collaborative initiatives. These paradigms create an environment conducive to companies and their associations arguing against regulation and in favour of voluntary measures and representing themselves as legitimate partners in developing health-related policy.

5.3 Conclusion

This chapter has analyzed the ways in which baby food companies and their associations have used the corporate playbook to influence global health policy-making at the WHO. The baby food industry seeks to shape the WHO's substantive recommendations that are related to its products and thus can have both immediate and long-term impacts on profitability.

The analysis in this chapter has shown that in order to influence these substantive policies and policy areas, baby food companies and their business associations lobbied the WHO and Member States, finding allies in milk-exporting countries such as the US, which rejected early drafts of the Code and lobbied on the industry's behalf. To circumvent the Code and national legislation and to extend their product line, baby food companies invented differentiated products – so-called "follow-up (or follow-on) milk" for older infants and later "growing-up (or toddler) milks" for one-, two-, or three-year-old children. They shaped perceptions of such products, thereby manufacturing demand for them and arguing that they were not included within the scope of the Code. The baby food industry has also created doubt about the scope of the Code by using its discursive power to manufacture doubt about the optimal duration of exclusive breastfeeding, which it has lobbied to keep as low as possible. The baby food industry lobbied intensely in connection with a substantive policy that brings together marketing, product differentiation and the optimal duration of breastfeeding: the 2016 Guidance on ending inappropriate promotion of baby foods. Business

associations representing the baby food industry intervened to shape the parameters of the debate during the development of the Guidance.

The chapter has also analyzed the ways in which the baby food industry has engaged in a long-game to shape the paradigms that determine which policies are pursued and what role private actors are able to play in developing them. The analysis in this connection shows that the baby food industry also uses these playbook strategies to promote paradigms emphasizing individual consumer choice, industry legitimacy as a governance actor, and corporate responsibility and trustworthiness. These paradigms create an environment conducive to companies and their associations arguing against regulation and in favour of voluntary measures and representing themselves as legitimate partners in developing health-related policy. The baby food companies' ultimate objective in encouraging these paradigms is to protect or increase their ability to make a profit.

The baby food industry's well-documented track-record of using the corporate playbook to influence substantive policy and paradigms conducive to its interests raises questions about the implications for WHO as the agency seeks to increase its engagement with such actors, especially for-profit entities, a point to which we will return in Chapter 7.

Chapter 6 – Corporate engagement on soda policy

6.0 Introduction

This chapter analyzes the ways in which soda companies and their associations, like the baby food industry, have worked to shape global health policy-making at the WHO. The soda industry seeks to influence the WHO's substantive policies and recommendations that can have both immediate and long-term impacts on profitability. The soda industry also makes efforts shape paradigms that determine which policies are pursued and what role private actors are able to play in developing them.

Corporate impacts on health – both directly, through promotion of products that can be harmful to health, and indirectly, by influencing substantive policy and paradigms relating to products and industry's role in governance and policy-making – can be labelled "corporate (or commercial) determinants of health" (Hastings, 2012; Kickbusch, 2012; Kickbusch et al., 2016; Millar, 2013). Others argue that corporate efforts to shape global health governance contribute to an "industrial epidemic" of non-communicable diseases (NCDs), such as obesity and diabetes(Gilmore et al., 2011; Jahiel, 2008; Jahiel & Babor, 2007; Moodie et al., 2013).

As discussed in Chapter 2, similar strategies to influence policy and shape paradigms are witnessed across many industries who follow what some have called the corporate "playbook". Section 6.1 below analyzes how the soda industry uses strategies and tactics from the corporate playbook to influence the WHO's substantive policies relating to soda products, particularly with respect to the WHO's guidelines on sugar intake levels (because sugar is a constituent ingredient in many soda products) and the taxation of soda products as a part of efforts to prevent and control NCDs. Some of the types of strategies that are evident in the analysis include shaping perceptions and preferences by lobbying and manufacturing doubt about soda's contribution to the obesity epidemic and its appropriateness as a product recommended for taxation for addressing NCDs. The analysis also considers the types of power upon which the soda industry is able to draw in pursuit of these strategies and tactics, as well as, where relevant, the reinforcing effects on the strategies, tactics, and power subsequently available to it. For example, as a part of these strategies, the soda industry also drew on the instrumental and structural power of allies in the US government and other sugar dependent countries.

Compared with the baby food industry, there have been fewer substantive policy initiatives relating to soda. This difference is partly because, as mentioned in Chapter 1, the negative health

effects of consuming soda are a relatively recent global concern, and also because the causal relationship between the marketing and consumption of soda and health outcomes is more difficult to isolate. Soda is not the exclusive cause of diabetes, obesity, and other NCDs, but extensive research points to its consumption as a contributing factor to, or even a key driver of, the global rise in their rates. Perhaps aided by this less attributable causal link, the soda industry puts considerable effort into shaping norms and paradigms surrounding the consumption and governance of soda.

Section 6.2 analyzes the ways in which the industry uses the playbook strategies and the types of power that underpins them to shape paradigms conducive to both its substantive policy interests and its long-game interests, including the establishment of the industry as a governance actor. The paradigms analyzed in Section 6.2 are: 1) individual responsibility, consumer choice, and caloric balance; 2) corporate social responsibility and trustworthiness through self-regulation and voluntary measures, and 3) industry legitimacy as a governance actor. These paradigms create an environment conducive to companies and their associations arguing against regulation and in favour of voluntary measures and representing themselves as legitimate partners in developing health-related policy. Some of the types of strategies for encouraging these paradigms that are evident in the analysis include shaping the knowledge environment, perceptions and the political environment by framing issues and actors, undertaking self-regulation and other voluntary measures and participating in collaborative initiatives.

6.1 Shaping substantive policy

Due to the fact that sugar is a constituent ingredient in many soda products, the soda industry (as well as sugar industry associations) engages with the WHO on matters relating to sugar, such as the development in 2003 and 2014 of recommendations on sugar intake levels. Deploying playbook strategies to shape perceptions and preferences, the soda and sugar industries used their discursive power to manufacture doubt about soda's contribution to the obesity epidemic. They also opposed "restrictive" recommendations by relying on the paradigms of individual responsibility and energy balance and by accessing the instrumental and structural power of allies in the US government.

In February 2003, the WHO published online the draft report of an expert committee formed as part of the development of the Global Strategy on Diet Physical Activity and Health (Global Strategy on DPAH) (Norum, 2005). The report, *Technical Report Series 916, Diet, Nutrition, and the Prevention of Chronic Diseases* (TRS916), recommended limiting the intake of sugars to less than 10% of daily energy intake (WHO/FAO, 2003). When the report was made available for

consultation prior to its official launch, the soda industry worked to shape the results to protect its position. Exercising their discursive power, soda and sugar business associations criticized the draft report, rejecting its conclusion that sweetened soft drinks contribute to the obesity pandemic. The National Soft Drink Association, based in Washington, said the recommended limit on added sugars intake was "too restrictive", saying it supported instead a 25% limit (Boseley, 2003c). The Sugar Association, representing the US sugar industry, also opposed the report, saying it needed more external peer review and economic analysis. It wrote to then Director-General Gro Harlem Brundtland, calling for the cancellation of the report's official launch on April 23, 2003 and vowing to use "every avenue available to expose the dubious nature" of the report (Boseley, 2003c; Brownell & Nestle, 2004; Brownell & Warner, 2009).

Seven big food industry groups, including the US Council for International Business, to which Coca-Cola and PepsiCo belong, and the Sugar Association, also wrote to the US Secretary of Health and Human Services, Tommy Thompson, asking him to intervene to get the report withdrawn (Boseley, 2003c). Two US senators who co-chair the US Senate Sweetener Caucus urged the Secretary to use his "personal intervention" to block the report. A Department of Health and Human Services assistant secretary sent the WHO a 28-page, single-spaced critique of the report's science, putting forward the same three points emphasized by the industry: personal responsibility, stronger focus on physical activity, and no good or bad foods (Brownell & Warner, 2009). These groups sought to have Congress withdraw the US's $406 million contribution to the WHO (Boseley, 2003c; Brownell & Warner, 2009; Madureira Lima & Galea, 2018; Norum, 2005). These tactics were available to the soda and sugar industry groups because of their structural power within the US economy and because of the US government's instrumental and structural power as the largest financial contributor to the WHO (Sridhar et al., 2014; van de Pas & van Schaik, 2014).

Meanwhile, the WHO was holding consultations to develop the Global Strategy on DPAH mentioned above, which was to be presented to the WHA in 2004. NGOs participating in the consultations made suggestions for controlling and collaborating with the private sector. The private sector, meanwhile, worked to shape perceptions and preferences using its discursive power to assert that NCDs were an individual's problem; that there were no bad foods, only bad diets; and that diet is a matter of personal choice (Norum, 2005). Sugar associations continued to lobby against using the TRS916 as the basis for the intake levels recommend in the Global Strategy on DPAH. They argued that a reduction in recommended sugar intake levels would negatively impact the economies

of sugar producing countries. The latter used the same wording as the sugar industry had used in its letters to them in making their argument (Norum, 2005).

WHO forwarded a draft Global Strategy on DPAH to Member States in November 2003 for their feedback ahead of the January 2004 meeting of the Executive Board. Ahead of the Executive Board meeting, there was extensive lobbying from the Sugar Association. The US Department of Health and Human Services sent a letter signed by the senior adviser to Secretary Thompson, William Steiger, arguing against the TRS 916 in terms identical to those used by the Sugar Association. Delivered ahead of the Executive Board meeting, the letter seemed designed to derail discussion about the Global Strategy. Nevertheless, the Executive Board decided to forward the draft Global Strategy to the WHA in May 2004, after opening it to feedback from Member States until February 29, 2004 (Norum, 2005). By the time the Global Strategy on DPAH reached the WHA, however, it no longer included the TRS916's recommendation that sugar intake be limited to less than 10% of daily energy intake, replaced instead with the non-specific recommendation to "limit the intake of free sugars" (WHO, 2004a).

On March 5, 2014, the WHO released its "Draft Guideline: Sugars intake for adults and children" for public consultation (WHO, 2014d). Many associations that represent soda companies worldwide made submissions to the consultation, including the International Food and Beverage Alliance (IFBA), American Beverage Association (ABA), and the Canadian Beverage Association, as did sugar industry groups including World Sugar Research Organisation (WSRO) (of which Coca-Cola is a member), The Sugar Association, Inc., Sugar Nutrition UK, and the Canadian Sugar Institute (WHO, n.d.b). Some groups, such as the Sugar Association, Inc., questioned the legitimacy of, and scientific basis for, the recommendations, pointing out weaknesses in the evidence and the conclusions drawn from it (Canadian Sugar Institute, 2014; Sugar Nutrition UK, 2014; The Sugar Association, Inc., 2014). Some groups, such as The Sugar Association, Inc., Sugar Nutrition and WSRO, challenged the recommendations for not meeting the standards of evidence required by the WHO's own "Handbook for Guideline Development" (Sugar Nutrition UK, 2014; The Sugar Association, Inc., 2014; World Health Organization, 2012; WSRO, 2014). IFBA took the consultation as an opportunity to describe its voluntary initiatives – "doing [its] part" – in support of the WHO's priorities for preventing and controlling NCDs (IFBA, 2014b, p. 1). IFBA also stressed that "it is essential that all stakeholders work together," emphasizing "energy balance" between calories consumed and those expended through physical activity as "one of the most important factors in maintaining a healthy weight" (IFBA, 2014b, pp. 1–2). These tactics, using the soda and

sugar industries' discursive power, rely on the broader paradigms these two industries promote to create an environment conducive to their interests, as will be discussed below.

In March 2015, the WHO released its updated *Guideline: sugars intake for adults and children* (WHO, 2015b). The new guideline recommended that both adults and children reduce their intake of free sugars to less than 10% of total energy intake, or in other words, to less than six teaspoons. In a change from the previous guideline, it made a conditional recommendation for further reducing sugar consumption to below 5% of total energy intake for additional health benefits.

Another relevant substantive policy area is with respect to the taxation of soda as a fiscal policy for addressing NCDs. A 2016 the WHO technical meeting on fiscal policies for diet and prevention of NCDs had concluded "there is reasonable and increasing evidence that appropriately designed taxes on sugar-sweetened beverages would result in proportional reductions in consumption levels" (Waqanivalu et al., 2016). It was therefore striking that, although the first report of the WHO Independent High-level Commission on Noncommunicable Diseases, which provides governments and policy-makers recommendations aimed at the prevention and control of NCD, included taxation as an appropriate fiscal policy for addressing NCDs, soda was not mentioned alongside tobacco and alcohol as a product recommended for taxation (WHO Independent High-level Commission on Noncommunicable Diseases, 2018). While nutrition and public health experts and activists were disappointed in the Commission's position, the IFBA applauded it as well as the Commission's recommendation that governments increase engagement with the private sector to achieve public health goals.

The report, launched on June 1, 2018, said:

> The Commissioners represented rich and diverse views and perspectives. There was broad agreement in most areas, but some views were conflicting and could not be resolved. As such, some recommendations, such as reducing sugar consumption through effective taxation on sugar-sweetened beverages and the accountability of the private sector, could not be reflected in this report, despite broad support from many Commissioners. (WHO Independent High-level Commission on Noncommunicable Diseases, 2018, p. 4)

In fact, one Commissioner, US deputy secretary for health and human services Eric Hargan, had managed to block the inclusion of soda as an appropriate product for taxation, arguing that there was insufficient evidence that taxes on sugary drinks would improve public health (Keaton & Cheng, 2018). The US Commissioner's position is not surprising given the significance of Coca-Cola and PepsiCo, both of which are based in the US. Their economic weight readily translates into instrumental and structural power. The influence of the US on the WHO deliberations in turn reflects its instrumental and structural powers. News of the US's role in blocking the soda tax

recommendation in the Commission's report came on the heels of the US delegation to the WHA blocking a resolution on infant feeding by threatening countries that supported it, as was discussed in Chapter 5.

The analysis in this section has shown that the soda and sugar industries used strategies from the corporate playbook to influence substantive policy in the areas of recommended limits on sugar consumption and on the inclusion of soda as a product recommended for taxation as part of efforts to control NCDs. Some of the types of strategies evident in the analysis include shaping perceptions and preferences by lobbying and manufacturing doubt about soda's contribution to the obesity epidemic and its appropriateness as a product recommended for taxation for addressing NCDs. To use these strategies, the soda industry relied heavily on its discursive power, but was also able to access the instrumental and structural power of allies in the US government and other countries with economies dependent on sugar.

6.2 Shaping paradigms to create a conducive environment

In addition to intervening on specific substantive policy areas, the soda industry uses the playbook strategies to shape paradigms conducive to both its substantive policy interests and its long-game interests, including the establishment of the industry as a governance actor. Business operates within an existing social system of certain norms and ideas – or, paradigms – and uses its discursive power to shape them. To shape an environment conducive to their long-game interests as well as their substantive policy interests, soda companies individually and collectively promote a paradigm centred on individual responsibility, consumer choice, and caloric balance; corporate social responsibility and trustworthiness through self-regulation and voluntary measures. The industry exercises its discursive and instrumental power to bolster its legitimacy as a governance actor, including by participating in multistakeholder initiatives, funding and forming groups that resemble civil society organizations and seeking Official Relations status with the WHO, and recruiting former senior the WHO employees through the so-called "revolving door", giving the impression of their endorsement and lending their credibility, in addition to their insider information and connections. These arrangements create an environment conducive to companies and their associations arguing against regulation and in favour of voluntary measures and facilitate the representation of companies and their associations as legitimate partners in developing health-related policy.

While many of these efforts are directed at the WHO, much of this work is undertaken within the US by PepsiCo and Coca-Cola, exercising their instrumental power afforded by their status as industry heavyweights. Nevertheless, this exercise of discursive power by the soda industry in the US has a global impact on perceptions about soda consumption, the industry as a responsible and trustworthy corporate and political actor, and the individualization of choice and responsibility.

6.2.1 Framing soda as a matter of individual consumer choice

Like baby food companies, soda companies shape perceptions and preferences using their discursive power to frame soda consumption as being a matter of individual consumer choice and responsibility (ABA, 2014; AFBC, 2018; Brownell & Warner, 2009; Firth, 2012; Kwan, 2009; Nestlé, 2019a; Nestle, 2015; Scott et al., 2017). This "freedom of choice" rhetoric has the effect of shifting responsibility – or, blame – for any resulting problem away from companies and onto consumers (L. C. Friedman et al., 2014). Additionally, the industry frames soda consumption as a question of balancing caloric intake with output (Freedhoff, 2014; Koplan & Brownell, 2010). Examples of this emphasis on choice, responsibility and balance will be discussed below.

Using a playbook strategy common amongst Big Food corporations (Clapp & Scrinis, 2017), soda companies, their associations and front groups frame soda consumption as a question of balancing caloric intake (diet) with output (exercise), and thus try to deflect attention away from its consumption as a factor contributing to obesity and type 2 diabetes (Freedhoff, 2014; Koplan & Brownell, 2010). Health experts, however, say the message that exercise can balance caloric intake, regardless of the quality of the calorie, is misleading: exercise does little to affect weight (Cook & Schoeller, 2011; Dugas et al., 2011; A. Luke & Cooper, 2013; Wilks et al., 2011; Wing, 1999). Rather, obesity is linked more with energy intake than exercise (Slater et al., 2009; Swinburn et al., 2009), and physical activity is determined by energy balance, not the other way around (Klaas R. Westerterp, 2015).

During the development of the Global Action Plan for the Prevention and Control of NCDs 2013-2020, IFBA submissions emphasized the notion of balance between diet and physical activity. For example, its response to the discussion paper on the topic stressed the importance of balanced diets and healthy, active lifestyles and supported interventions to increase physical activity. The statement also individualized responsibility for diet, saying the industry aimed to "empower and support people to make informed, balanced choices" (IFBA, 2012b, p. 8) IFBA's submission in response to the Zero Draft of the GAP made several references to balanced diet and suggested

changing language in the draft from "healthy food" to "balanced diets and healthy, active lifestyles" (IFBA, 2012c). Balanced diets, healthy, active lifestyles and empowered consumer choice all figure prominently in IFBA's submissions in response to the revised drafts dated February 11, 2013 and March 15, 2013 (IFBA, 2013a, 2013c).

The Global Energy Balance Network (GEBN) promoted the perspective that soda can be part of a lifestyle that balances diet with exercise. The GEBN was a non-profit organization founded at the University of Colorado and University of South Carolina in 2014, ostensibly created to fund research into the causes of obesity (Huehnergarth, 2015; O'Connor, 2015). The bulk of its funding – at least $1.5 million in 2015 – however, came from Coca-Cola, a point it did not initially make it evident. Exposure of GEBN as a front group for Coca-Cola only occurred following investigations published by the New York Times in August 2015 (Huehnergarth, 2015; O'Connor, 2015). This was prompted by the discovery that the group's website was registered to the Coca-Cola headquarters in Atlanta[57] (O'Connor, 2015). Further investigations revealing the extent of Coca-Cola's role in shaping GEBN and its research agenda, led to the group being shut down on November 30, 2015 (O'Connor, 2015).

The GEBN illustrates two playbook tactics. The first tactic is "civil society capture" (Madureira Lima & Galea, 2018). As was seen in the baby food case, soda companies and the industry collectively form "front groups" and associations that resemble or represent themselves as civil society organizations but actually pursue business interests. Both industries use the tactic to coopt the increasing structural power accorded to civil society organizations as political actors and, by association, enhance the instrumental, structural and discursive power available to corporate actors.

The second playbook tactic demonstrated by Coca-Cola's creation and financial support of the GEBN is shaping the knowledge environment by controlling the research process and through the exercise of discursive power. The GEBN initiative was intended to deflect attention away from diet – and specifically soda – as a contributor to obesity and type 2 diabetes, promoting instead exercise as the key to balancing energy intake and output in order to maintain a healthy weight. GEBN's message was that "weight-conscious Americans are overly fixated on how much they eat and drink while not paying enough attention to exercise". Instead, it emphasized getting more exercise (calories out) and worrying less about cutting calories (calories in) (Huehnergarth, 2015;

[57] GEBN president James O. Hill claimed that the website was registered to Coca-Cola's headquarters because nobody within GEBN knew how to register a website (O'Connor, 2015).

O'Connor, 2015). Before GEBN, Coca-Cola had funded Exercise is Medicine, similarly blaming inactivity for many public health issues – although at least one study indicates we are not less active than we had been 30 years earlier (K. R. Westerterp & Speakman, 2008) – and promoting exercise (energy output) as a solution to obesity (Slater et al., 2009; Swinburn et al., 2009).

Soda companies use their discursive power to detract attention from their products' role in contributing to obesity and diabetes by framing soda consumption as a matter of personal choice and responsibility (Brownell & Warner, 2009; Firth, 2012; Ken, 2014; Kwan, 2009; Nestle, 2015; Nixon et al., 2015; Scott, Hawkins, & Knai, 2017). For example, combining the framings of energy balance (discussed above) and consumer responsibility, PepsiCo CEO Indra Nooyi said in a 2010 interview that "If all consumers exercised, did what they had to do, the problem of obesity wouldn't exist" (Huehnergarth, 2015). On the ABA website, for example, a blog post titled "In the grocery store, it's your choice" argues: "Getting serious about obesity starts with education – not laws and regulation" (ABA, 2014). It provides a link to the website for a coalition called Americans for Food and Beverage Choice (AFBC) "for more information about how [consumers] can help prevent politicians from poking around in your grocery cart" (ABA, 2014). AFBC (2018) says it is working "to protect consumer choice by uniting against unfair taxes and regulations". Throughout the IFBA website, the emphasis is on healthy food choices and active lifestyles and helping consumers to make better choices. The main webpage highlights in bold letters: "We innovate, empower and collaborate to help consumers eat balanced diets and live healthier lives" (IFBA, 2018b).[58] Similarly, in its 2018 CSR report, Nestlé presents itself as "offering tastier and healthier choices" (Nestlé, 2019a).

Using their discursive power, soda companies frame their product modification and reformulation efforts as initiatives to contribute to the prevention and control of NCDs (Clapp & Scrinis, 2017; Nixon et al., 2015). These voluntary efforts are a response to increased political pressure on the industry aimed at pre-empting formal regulation by governments (Scott & Nixon, 2017). By introducing smaller package sizes to aid in calorie control and pledging to remove calories from their product lines, soda companies frame obesity as a problem of caloric balance that can be corrected through healthier consumer choices paired with physical activity. For example, bringing together framings of consumer choice, balanced diet, healthy lifestyles and the company's reformulation efforts, Coca-Cola wrote at the end of 2012:

[58] Note the evolution from "Collaborating, educating and innovating to help consumers achieve balanced diets and active healthy lifestyles" (cited by Clapp & Scrinis, 2017). "Innovate" (which presumably includes reformulation) has been moved to first priority. "Educating" has been replaced by "empower"; both terms indicate consumer choice but empower suggests more of a right to choose than simply the ability.

> All of our beverages can be consumed as part of a balanced diet. Consumers who want to reduce the calories they consume from beverages can choose from our continuously expanding portfolio of more than 800 low- and no-calorie beverages, nearly 25 percent of our global portfolio, as well as our regular beverages in smaller portion sizes. We believe in the importance and power of "informed choice," and we continue to support the fact-based nutrition labeling and education initiatives that encourage people to live active, healthy lifestyles. (The Coca-Cola Company, 2012)

Clapp and Scrinis (2017) note that by emphasizing product differentiation, portion size and physical activity, food and beverage companies aim to influence public understanding about the causes of obesity while also stressing individual responsibility for food choices. This discursive framing places the onus on consumers to make healthy choices rather than on governments or corporations to limit the production, distribution, advertising, and availability of unhealthy and poor quality products (Clapp & Scrinis, 2017; Simon, 2006). Their use of discursive power in this way aims to shape preferences and protect the industry's structural power.

Soda companies' exercise of discursive power to frame soda consumption as a question of balance and individual choice and responsibility works to protect their structural power by blocking regulation of the industry. In a survey in 2013, the WHO found that most Member States had introduced policies to reduce obesity and diet-related diseases, but only one-third had regulated the marketing of sodas to children, about half of which included restrictions on soda marketing in schools. Most countries considered obesity to be a problem of personal responsibility, rather than a public health of governmental concern, and therefore most policies were directed at helping individuals make healthy eating choices rather than regulating the food and beverage industries (WHO, 2013b).

6.2.2 Corporate responsibility and trustworthiness

Soda companies undertake self-regulation and other voluntary measures to send the message that the industry recognizes its role in addressing health concerns and it can be trusted to take responsible measures without government imposing legislation. Like the framings of energy balance and individual choice and responsibility, corporate social responsibility and voluntary initiatives serve to shape perceptions of the companies and their products. Engaging in self-regulation and voluntary measures is intended to help companies prevent or undermine calls for accountability and more stringent and effective formal regulation by public actors (Fuchs, 2005; Hawkes C., 2005; Sharma et al., 2010; Utting & Clapp, 2008).

Product reformulation or modification is one such voluntary measure aimed at pre-empting formal regulation. The aim is to maintain the companies' market while also ostensibly addressing health concerns related to over-consumption of their products (Clapp & Scrinis, 2017). Companies prefer these types of voluntary initiatives, which they publicize as part of their corporate social responsibility initiatives (see, for example, Nestlé, 2019), overformal governmental regulation. Publicity of voluntary product reformulation and modification is an example of companies using their discursive power to protect their structural power.

Soda companies have adopted several of the reformulation and product modification strategies typically applied by food and beverage industries, framing these as efforts to reduce their impact on chronic disease. These strategies include reducing added sugars, reducing total calories, making smaller-sized packing for portion control options, and providing nutritional information about their products (Acharya et al., 2011). Individual companies and their alliances, such as the IFBA, have pledged to reduce sugar levels in their products (IFBA, 2015). Product reformulation was the first of five "global public commitments" that the IFBA made in May 2008 as its contribution to efforts in connection with the Global Strategy on DPAH (Acharya et al., 2011). IFBA made repeated reference to these industry commitments in its various submissions as part of the development of the GAP on NCDs 2013-2020 (IFBA, 2012b, 2012c, 2013a, 2013c). By highlighting these initiatives, the industry intended to present itself as a responsible corporate citizen and thereby pre-empt moves toward formal regulation and promote a role for the industry in future collaborations. IFBA member companies reviewed these commitments and adopted a set of "enhanced commitments" in September 2014 (IFBA, 2015). PepsiCo revealed its own set of goals and commitments in March 2010, one of which was product reformulation, to encourage healthier lifestyles (Acharya et al., 2011).

In 2012, the Healthy Weight Commitment Foundation, representing the largest food and beverage manufacturers, pledged to take 1.5 trillion calories out of the US food supply by 2015 (Scrinis, 2016). An independent evaluation of the initiative by the Robert Wood Johnson Foundation in 2014 found that companies that were part of the initiative had reduced 6.4 trillion calories from the US market in 2012 compared to 2007. While PepsiCo claimed the achievement as evidence that business plays an important role in tackling obesity (PepsiCo, 2014), skeptics noted that decreasing soda consumption in the US was responsible for a good proportion of the reduction in sugar intake from these products. Furthermore, the focus on reducing overall caloric consumption was designed "to deflect attention from specific types of food products that are

particularly high in calories, especially sugary soft drinks (Clapp & Scrinis, 2017). Low-calorie, low-sugar sodas were similarly central to Coca-Cola's 2013 "Coming Together" anti-obesity advertising campaign. Directed at countering the growing perception that soda is a major contributor of obesity, this campaign suggests that physical activity is as important as diet in weight management, and that all calories are created equal (Nestle, 2015). Like the GEBN described above, the campaigns aim to deflect attention from the role of specifically sugar sweetened beverages in causing obesity and placing the onus of responsibility on the individual consumer by framing the Coming Together campaign and the Healthy Weight Commitment Foundation pledge as a matter of overall caloric intake (with all calories mattering equally, regardless of their food source) balanced with caloric output through exercise (Clapp & Scrinis, 2017; Nestle, 2015).

On its "Transparency" webpage, Coca-Cola says: "We've been clear that we believe we can play an important role in helping consumers moderate their consumption of added sugar by evolving our portfolio of drinks to reduce sugar in existing recipes, introducing more low- and no-sugar brands globally, investing in sugar alternatives and continuing to expand the availability of smaller packages like mini-cans across our markets" (Coca-Cola, 2018). Coca-Cola claimed that it had reduced sugar in more than 200 drinks globally in 2016 alone, and it was set to reduce sugar in more than 500 more in 2017 (Coca-Cola, 2018). PepsiCo reported in its 2013 Sustainability Report that it had removed 402,000 metric tons of added sugar from its total beverage portfolio in North America (US and Canada only) as compared to 2006 levels (PepsiCo 2014). This figure for "North America" notably excluded Mexico, where soda consumption had continued to increase until the introduction of a soda tax came into effect from January 1, 2014 (Colchero et al., 2016, 2017).[59]

6.2.3 Industry legitimacy as a governance actor

Soda companies pursue legitimacy as governance actors by collaborating in multistakeholder initiatives and public-private partnerships (PPPs) that resemble and often include civil society organizations, as well as government or intergovernmental organizations. As was discussed in Chapter 2, such collaborations have many proponents (Majestic, 2009; Sturchio & Goel, 2012; UN Global Compact, 2014). However, they also raise a number of concerns, including the risk that they blur distinctions between the aims, roles and obligations of different types of actors (Buse & Walt,

[59] During the first year of implementing the tax, 2014, sales volumes of taxed beverages were 6% lower than would have been expected without the tax (Colchero et al., 2016). In the second year, purchases of taxed beverages were 9.7 percent lower than would have been expected without the tax (Colchero et al., 2017). Sales of untaxed beverages increased over the same two years (Colchero et al., 2017).

2000; McKeon, 2017; Richter, 2004c) and negate power imbalances (McKeon, 2017). Collaborations with the private sector may jeopardize the "independence, integrity and reputation" of WHO and other agencies (Richter, 2004c) or co-opt government actors and public-interest NGOs (Fuchs, 2005). The multistakeholder approach poses challenges for the "the legitimacy of governance, the protection of common goods, and the defence of human rights" (McKeon, 2017, p. 380).

One such initiative is the Pan American Forum for Action on NCDs (PAFNCD) (Moscetti & Taylor, 2015) – a multistakeholder forum on NCDs initiated by the WHO's regional office for the Americas in the office's capacity as the Pan American Health Organization (PAHO) (WHO, 2012g). In October 2012, Reuters reported: "… the WHO's regional office [for the Americas] has turned to the very companies whose sugary drinks and salty foods are linked to many of the maladies it's trying to prevent." The story said: "The office, the Pan American Health Organization, not only is relying on the food and beverage industry for advice on how to fight obesity. For the first time in its 110-year history, it has taken hundreds of thousands of dollars in money from the industry" (Wilson & Kerlin, 2012).

The contributions to this initiative from food and beverage companies included $50,000 from Coca-Cola, the world's largest beverage company, and $150,000 from Nestlé (Wilson & Kerlin, 2012),[60] the world's largest food company and baby food market leader. These two companies were able to make such a financial contribution because of their structural and instrumental power as market leaders, which they were able to leverage into further structural and instrumental power. PAHO said it spends more than $30 million each year combatting NCDs. Partnerships with the private sector fill a resource gap that exists because "the WHO has cut its own funding for chronic disease programs by 20 percent since 2010 – an even bigger decline than for the agency as a whole" and therefore PAHO is relying more heavily on public private partnerships (Wilson & Kerlin, 2012).

However, the financial contributions posed a potential conflict of interest for PAHO, in that its ability to pursue activities to prevent and control NCDs, which might negatively impact the food and beverage industry, could be hampered by its sense of obligation toward these companies or by its interest in securing additional resources from them. Apart from the potential conflict of interest, the optics of accepting money from companies with competing interests – the manufacturers of products that contribute to NCDs – could undermine PAHO's credibility as a health leader in the region and, by extension in the public's perception, the WHO's as lead global body for health.

[60] Unilever, a British-Dutch food conglomerate whose brands include Ben & Jerry's ice cream and Popsicles, contributed $150,000 (Wilson & Kerlin, 2012).

The WHO issued a statement from Director-General Margaret Chan who said the media reports about the contribution were "creating misinformation and confusion" and that allegations about the WHO receiving funding from the food and beverage industry were "wrong" (WHO, 2012g). Seeking to distance the WHO from the PAHO's move, Chan's statement said: "The WHO Global Strategy on [DPAH] commits the WHO to hold discussions with the private sector, but the Organization will not take money from private companies active in food and beverage production for work on NCD prevention and control as implied by the media articles" (WHO, 2012g). The WHO statement clarified that unlike other the WHO regional offices, PAHO contains two separate legal entities, the WHO Regional Office for the Americas (AMRO) and PAHO. In some areas their policies may differ. For example, while the WHO may engage with the private sector sometimes, in order to "protect its work from undue industry influence", the agency is prohibited from accepting funding "from enterprises that have a commercial interest in the outcome of the project to which they would be contributing" (WHO, 2012g). In contrast, PAHO's rules permit such funding, although only in February 2012 did it start accepting money from food and beverage companies.

Although PAHO officials stress they maintain control of policy, one critic[61] said "the WHO is getting hijacked" because it is are cash-strapped and that it is "very dangerous" (Wilson & Kerlin, 2012). The World Public Health Nutrition Association said in a 2013 letter to the incoming Director of PAHO "The fact that PAHO received money from The Coca-Cola Company and other food and beverage corporations has damaged its reputation as the leading UN organization concerned with nutrition and public health in our Hemisphere" (WPHNA, 2013).

A top official from Coca-Cola was part of the PAFNCD Interim Advisory Steering Group on behalf of IFBA (IFBA, 2012a; Wilson & Kerlin, 2012). Coca-Cola's inclusion in the initiative's governing body reflected an exercise of the industry's structural and instrumental power. In turn its participation enabled the industry to use its discursive and instrumental power to further augment its future discursive, instrumental and structural power by influencing which policies and initiatives are pursued and what role the private sector will play in them.

Although the PAFNCD was said to be intended for program implementation, not policy formation (and its inherent norm-setting), it gave food and beverage companies regular access to representatives from national governments from the region who would be directly involved in policy-making through the Pan American Sanitary Conference, PAHO's governing body meeting.

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[61] "Boyd Swinburn, an Australian professor and long-time member of the WHO's nutrition advisory committees" (Wilson & Kerlin, 2012).

Indeed, in 2012, the same year PAHO increased its engagement with industry through the PAFNCD, it developed a new regional Plan of Action for the Prevention and Control of Noncommunicable Diseases in the Americas, 2013-2019, which was adopted at the 28th Pan American Sanitary Conference. The Plan of Action encourages governments to pursue multi-sectoral partnerships, including with the private sector, and codifying these approaches as part of national NCD plans. The regional plan also mandates PAHO to monitor national progress by assessing the number of countries implementing national multi-sectoral plans (PAHO, 2014), thereby establishing the expectation that governments are to follow this approach (Moscetti & Taylor, 2015).

In June 2012, the IFBA submission on the PAHO Strategy and Plan of Action for the Prevention and Control of NCDs and a Proposed Resolution recalled the 2011 Political Declaration's call for the establishment of multistakeholder action and applauded the launch of the multistakeholder PAFNCD. The majority of the IFBA submission, however, outlined the voluntary measures that the Alliance and its members had undertaken through collaborative initiatives, self-regulation and voluntary measures, suggesting that statutory regulation is therefore not necessary (IFBA, 2012a). However, using its discursive power to frame itself as a trustworthy partner that wants to be "part of the solution", pre-empting formal regulation with voluntary measures, and promoting measures such as product reformulation as their contribution to the prevention and control of NCDs, are all strategies used by the soda industry and food and beverage industry more broadly to protect their structural power, increase their legitimacy and instrumental power as governance actors, protect their markets, and deflect attention from their contribution to the problem (see for example: (Clapp & Scrinis, 2017; Moscetti & Taylor, 2015; Nixon et al., 2015; Scott & Nixon, 2017). IFBA also suggested changes to the proposed resolution to include the term multistakeholder as it better reflected the inclusion of civil society and the private sector, and to add the private sector to a list of sectors across which dialogue and partnerships should be promoted (IFBA, 2012a). These suggested changes increase the structural, instrumental and discursive power of NSAs, including the private sector, by institutionalizing their inclusion and the multistakeholder approach to efforts relating to the prevention and control of NCDs, despite the potential for conflicts of interest and competing interests.

As part of their pursuit of legitimacy as governance actors, soda companies capture civil society by forming or funding front groups that resemble civil society organizations, as in the case of the GEBN. In addition to coopting the structural power accorded to civil society organizations as

political actors and enhancing the instrumental, structural and discursive power available to corporate actors via their association, another advantage for corporations of such civil society formations and multistakeholder collaborations has been the ability to be granted Official Relations status with the WHO. As was discussed in Chapter 5 with respect to baby food manufacturers' associations, Official Relations status granted to business associations, front groups and multistakeholder initiatives institutionalizes their power and lends credibility and legitimacy to their discursive power. Corporate members of such groups are positioned to lobby and influence the WHO and its Member States, and to shape the political environment and preferences, perceptions and paradigms surrounding various issues.

The International Life Sciences Institute (ILSI), for example, is a front group that represents itself as a non-profit organization with a mission to "provide science that improves public health". It counts Coca-Cola and PepsiCo (and numerous baby food manufacturers[62]) among its members (ILSI, 2016, 2018). The WHO granted ILSI Official Relations status in 1988 but withdrew it in 2015, not because of the organization's commercial ties, which were not permitted under the Principles governing relations between the WHO and NGOs (WHO, 1987a), but because of its link with a tobacco manufacturer (Hentges, 2015; WHO, 2014h, para. 8, 2015d, para. 9).

Another such organization is the GAIN Business Alliance, which the Global Alliance for Improved Nutrition (GAIN) created in 2005. PepsiCo and Coca-Cola were among a number of Big Food companies included in its membership (Nagarajan, 2014a; Schuftan & Holla, 2012). GAIN is a PPP established in 2002 that seeks market solutions to micronutrient deficiencies in developing countries, especially through food fortification (GAIN, 2008). The WHO postponed consideration of GAIN's 2013 application for Official Relations status due to questions about its links with the for-profit sector (WHO, 2013c). To address these concerns, GAIN dissolved the Business Alliance in December 2013 (Nagarajan, 2014a).

Satisfied with the dissolution, the WHO granted GAIN Official Relations status in January 2014 (WHO, 2014c). That same week, the Business Alliance's replacement (Nagarajan, 2014a) – the Scaling Up Nutrition (SUN) movement's new SUN Business Network (SBN), which GAIN and the World Food Programme co-convene (SBN, 2018b) – was launched at the World Economic Forum in Davos. The SBN was formed by industry participants in SUN as its private sector arm. PepsiCo is

[62] Abbott Nutrition, DSM Nutritional Products, Fonterra, FrieslandCampina, Mead Johnson, Nestlé, and Danone (ILSI, 2016, 2018).

one of 186 companies (45 multinational, 141 national) that have made commitments to improve nutrition and track their progress (SBN, 2018a).

Despite these changes, some observers remained concerned about the group's proximity to for-profit entities (the logos of PepsiCo, Coca-Cola, DSM and others remained at the time on GAIN's website), its commercial goal (to create markets for products) and its activities to undermine efforts to regulate baby food marketing in Kenya[63] (IBFAN, 2014a; Nagarajan, 2014a). Critics maintain that SUN has inadequate safeguards against conflicts of interest and permits the participation of the manufacturers of highly processed and packaged foods and baby food products included in the scope of the Code, discussed in Chapter 4. They argue that it allows the private sector too much influence over nutrition programming and relies too heavily on technical responses to nutrition issues. Naming itself a "movement" suggests a bottom-up, grassroots momentum and greater legitimacy, when it is actually an initiative driven by its partnerships with the private sector (Lhotska et al., 2012; Schuftan & Greiner, 2013).

Another playbook tactic utilized by the soda industry is the so-called "revolving door" between the public and private sectors. Soda giant PepsiCo was able to recruit Derek Yach as a Senior Vice President for Global Health and Agriculture Policy in February 2007.[64] Yach had been the WHO Executive Director for Chronic Disease and Mental Health between 1995 and 2004, a role that gave him considerable influence within the WHO and with health policy-makers around the world. In this capacity, Yach had spearheaded the development of the Global Strategy on DPAH and the Framework Convention on Tobacco Control (Norum, 2008; The Vitality Group, 2012). In line with then Director-General Gro Harlem Brundtland's desire to increase the WHO's engagement with the private sector, Yach had helped strengthen the organization's relationship with

[63] GAIN had written to the Kenyan government with concerns about the proposed law, including that it could threaten the country's ability to meet its commitments as a Scaling Up Nutrition (SUN) country (GAIN, 2012).

[64] Yach left PepsiCo in October 2012 to join The Vitality Group, an incentive-based wellness program, where he lead the new Vitality Institute, a multi-disciplinary thought leadership organization (The Vitality Group, 2012). From there, he went on to found in September 2017 the controversial Foundation for a Smoke-Free World (FSFW) with a pledge from tobacco company Philip Morris International of $80 million annually for 12 years, starting in 2018 (FSFW, 2017). While at the WHO, Yach had spearheaded the development, negotiation and ratification of the Framework Convention on Tobacco Control (FCTC). A statement from the WHO in response to the FSFW noted that the FCTC expressly encourages governments to limit interactions with the tobacco industry and avoid partnership, and that governments should not accept financial or other contributions from the tobacco industry or those working to further its interests, such as FSFW (WHO, 2017b).

the food and beverage industries, including by helping arrange ongoing consultations with them while developing the new global strategy (Moscetti & Taylor, 2015).

It was Yach who responded to media reports in 20013 that documented industry influence, claiming that "the food industry had infiltrated the WHO just as the tobacco industry did and succeeded in exerting 'undue influence' over policies intended to safeguard public health" (Boseley, 2003b n.p. 2003a). Yach countered by noting that "[F]ood is not tobacco. The food and beverage industries are a part of the solution. They have an important role to play in achieving the best possible global strategy. We have been arranging a series of transparent discussions where all parties can discuss practical solutions for better diet, which do not in any way compromise the interests of public health" (WHO, 2003c).

Although Yach may have believed he could effect more change from within PepsiCo (Norum, 2008; Uauy, 2008; Yach, 2008), during his tenure the company continued its activities to influence public policy and public opinion. The company's tactics included emphasizing "self-regulation, its participation in voluntary commitment organizations, and the positive contributions it could make in public-private partnerships" (Moscetti & Taylor, 2015). These tactics show the use of discursive power to increase the company's – and, by extension, the entire private sector's – structural and instrumental power by positioning it as a responsible corporate citizen and legitimate partner in governance. For example, PepsiCo gave Yach a prominent role at the 2011 High Level Meeting of the General Assembly on NCDs, a tactic designed to improve the company's image and standing within global health circles (Moscetti & Taylor, 2015). His presence during the meeting included addressing the Pepsi Breakfast in the UN Dining Hall on September 19, 2011 (Baby Milk Action, 2012).

As an example of the industry's efforts to control the knowledge environment, Yach and five other senior PepsiCo employees co-authored an article about the important role of the private sector in collaborations to address chronic disease (Yach et al., 2010). The article notes that three of the authors had held positions in the public health sector: one co-author at the Center for Disease Control, another at the Mayo Clinic, and Yach at the WHO (Yach et al., 2010). Their experience in these positions bolsters the industry's image as an authority on health issues, while also lending credibility to the authors' scholarly writing. While the authors' employment with PepsiCo is noted, the only conflict of interest identified is Yach's earlier involvement in steering the consultative process for meetings with the CEOs of leading food companies and the WHO while he worked at the WHO under then Director-General Brundtland (Yach et al., (2010). While serving as a paid

advisory member of the PepsiCo Scientific Advisory Board Yach (2013) also argued in favour of industry-led efforts to improve population health, including tackling public health problems such as the obesity problem.

In an invited editorial in Public Health Nutrition explaining his decision to join PepsiCo, Yach also revealed that Gro Harlem Brundtland, his former boss at the WHO, had also been recruited by the company to its Blue Ribbon Advisory Board (PepsiCo, 2008; Yach, 2008). Brundtland had served as Director-General of the WHO from 1998 to 2003 and championed the WHO Strategy on DPAH despite opposition from the food and beverage industries (Norum, 2008). This revelation was disturbing in terms of its implications with respect to the insider information that Brundtland brought to her new role, but perhaps not surprising given the fact that it was she who had shepherded the WHO toward a closer relationship with the private sector, especially the food and beverage industries. Like Yach, Brundtland had declared that "food is not tobacco" (Brundtland, 2003), but more like the pharmaceutical industry that works with the WHO to protect public health (Cannon, 2012).

Another example of the revolving door is Janet Voûte's decision to join Nestlé in December 2010 as Global Head of Public Affairs with no cooling off period following her position at the WHO as Partnership Advisor with responsibility for the UN Global Compact and the Global Network for Non-Communicable Diseases (NCDnet), which she masterminded (Baby Milk Action, 2010). She has also served as Co-Chair of the International Food & Beverage Alliance (Voûte et al., 2012) and Chair of the Nestlé Creating Shared Value Council (Nestlé, 2020).

Another playbook strategy for influencing paradigms to create an environment conducive to the soda industry is shaping the knowledge environment by influencing (or controlling) research agendas and processes by funding studies and by positioning themselves as legitimate sources of scientific information. To use this strategy, the soda industry exercises its instrumental, structural and discursive power, thereby iteratively reinforcing all three dimensions of power. For instance, a 2016 review of 60 studies examining the effects of soda consumption on obesity and diabetes-related outcomes found that those funded by the soda industry were significantly more likely to find no associations than independently funded studies. Twenty-six of 26 negative association studies had funding ties to the soda industry, while only 1 of 34 positive association studies had industry funding (Schillinger et al., 2016). The researchers observed: "This industry seems to be manipulating contemporary scientific processes to create controversy and advance their business interests at the expense of the public's health" (Schillinger et al., 2016).

A 2013 systematic review found that industry-funded studies examining the relationship between sugar-sweetened beverages and weight gain or obesity were "five times more likely to present a conclusion of no positive association" (Bes-Rastrollo et al., 2013). An earlier study found "a strong association between the type of funding … and the conclusions that were drawn. Articles sponsored exclusively by food/drinks companies were four to eight times more likely to have conclusions favorable to the financial interests of the sponsoring company than articles which were not sponsored by food or drinks companies" (Lesser et al., 2007, p. 6).

Studies that are funded entirely or in part by the soda industry, meanwhile, are more likely to reach conclusions that are favourable to soda consumption and to the soda industry (Bes-Rastrollo et al., 2013; Forshee et al., 2008; Lesser et al., 2007). The aim of these studies is to cast doubt about the contribution of soda consumption to obesity and diabetes, in an effort to counter calls for regulation and taxation intended to reduce soda consumption (see, for example, Forshee et al., 2008). For example, a meta-analysis in 2008 funded by the ABA found "the relation between [sugar sweetened beverage] consumption and [body mass index] among children and adolescents is near zero" (Forshee et al., 2008). One of the authors accepted a position with ABA after the study had been accepted, and the research center with which the authors were affiliated had previously received funding from Coca-Cola (Forshee et al., 2008). As another example, six senior employees of PepsiCo published an article about the important role of the private sector in collaborations to address chronic disease (Yach et al., (2010). While serving as a paid advisory member of the PepsiCo Scientific Advisory Board, Yach (2013) also argued in favour of industry-led efforts to improve population health, including tackling public health problems such as the obesity problem.

Another avenue to influencing the research process is sponsoring researchers in gatekeeper positions with academic journals. For example, the editorial board of the American Journal of Clinical Nutrition, the ASN's flagship publication, in 2015 included David Allison, who had declared conflicts of interest involving PepsiCo, Dr. Pepper Snapple, The Sugar Association, World Sugar Research Organization, and other food and beverage companies[65] (Simon, 2015).

Employees of the soda companies and their associations themselves also publish articles in academic journals. Although their affiliations are listed, and conflicts of interest or competing interests are inconsistently declared[66], the content of the articles remains to influence discourse

[65] Red Bull, Kellogg, Mars, Campbell (Simon, 2015).

[66] Goldberg (2018) maintains that disclosure of conflicts of interest are not only ineffective but may intensify partiality and should not continue to be treated as a primary remedy.

surrounding their subject matter. For example, Yach published several articles during his employment with PepsiCo. He co-authored an article with five of his senior colleagues at PepsiCo titled, "The role and challenges of the food industry in addressing chronic disease" (Yach et al., 2010). The article advances several of the industry's key framing messages, asserting that food companies play an important role in combatting nutrition related NCDs, and that there is a need for increased private-public[67] collaboration – i.e. they are part of the solution. It reflects the company's emphasis on consumer choice, support for physical activity programs (in line with its energy-balance message), and self-regulation (justified by describing the voluntary commitments – mostly with respect to product modification and reformulation – made by PepsiCo and by IFBA (Yach et al., 2010). The only conflict of interest declared is the fact that Yach, while employed at the WHO, had played a role in steering the consultative process for meetings between the CEOs of leading food companies and the WHO under Brundtland (Yach et al., 2010).

In another article titled "Major multinational food and beverage companies and informal sector contributions to global food consumption: Implications for nutrition policy", Yach and another Pepsi employee and a consultant with the company argue that IFBA's five "global public commitments" would not be met unless small and medium companies step up with the multinational companies to improve the health of the public, globally (Alexander et al., 2011). This article lists the authors' affiliations with PepsiCo as competing interests, and includes a disclaimer stating that the statements and opinions expressed were those of the authors and did not necessarily represent the official position of PepsiCo Inc. (Alexander et al., 2011). As in the article described above, Yach and his colleagues promote paradigms about corporate responsibility and self-regulation, which enables the industry to argue against formal regulation and to promote a role for the industry in future collaborations.

The analysis in this section has shown that the soda industry uses playbook strategies to shape paradigms that emphasize individual responsibility, consumer choice, and caloric balance; corporate social responsibility and trustworthiness through self-regulation and voluntary measures; and industry legitimacy as a governance actor. Some of the types of strategies for encouraging these paradigms evident in the analysis include shaping the knowledge environment, perceptions and the political environment by framing issues and actors, undertaking self-regulation and other voluntary

[67] This word order – "private-public" – eschews the usual descriptions of such initiatives as "public-private," denoting public leadership.

measures, and participating in collaborative initiatives, taking advantage of the revolving door between the public and private sectors, and controlling the research process and scholarly writing.

6.3 Conclusion

This chapter has analyzed the ways in which soda companies and their associations have used the strategies from the corporate playbook to influence global health policy-making at the WHO. The soda industry seeks to influence substantive recommendations by the WHO related to its products that can have both immediate and long-term impacts on profitability, for example in connection with the WHO's guidelines on sugar intake levels, because sugar is a constituent ingredient in many soda products, and the taxation of soda products as a part of efforts to prevent and control NCDs. In these instances, the soda industry, supported by the sugar industry trade associations that include soda companies as their members, used its discursive power to manufacture doubt about soda's contribution to the obesity epidemic and opposed "restrictive" recommendations by relying on the paradigms of individual responsibility and energy balance. It also drew on the instrumental and structural power of allies in the US government, as well as other sugar dependent countries. Similarly, when the WHO Independent High-level Commission on Noncommunicable Diseases recommended taxation as an appropriate fiscal policy for addressing NCDs, soda was not mentioned alongside tobacco and alcohol as a product recommended for taxation. Soda's inclusion as a suitable product for taxation was successfully blocked by the Commissioner from the US, home to Coca-Cola and PepsiCo.

The soda industry also uses playbook strategies to shape paradigms that determine which policies are pursued and what role private actors are able to play in developing them. Paradigms can determine the success of industry influence on substantive matters and also form part of a long-game with the aim of protecting or even increasing industry ability to influence substantive policy and seeking a greater governance role. In this regard, the soda industry works to promote paradigms emphasizing individual responsibility regarding diet choices and corporate responsibility, trustworthiness and legitimacy as a governance actor. These paradigms create an environment conducive to companies and their associations arguing against regulation and in favour of voluntary measures and representing themselves as legitimate partners in developing health-related policy. The ultimate objective is to have greater influence over policy-making with the aim of protecting or increasing their ability to make a profit. Some of the types of strategies for encouraging these paradigms evident in the analysis include shaping the knowledge environment, perceptions and the

political environment by framing issues and actors, undertaking self-regulation and other voluntary measures, and participating in collaborative initiatives, taking advantage of the revolving door between the public and private sectors, and controlling the research process and scholarly writing.

The soda industry's track-record of using the corporate playbook to influence substantive policy, as analyzed above, and concerns relating to NSA participation in global health governance and policy-making, as discussed in Chapter 2, raise questions as the WHO seeks to increase its engagement with such actors, especially for-profit entities, which will be the focus of Chapter 7.

Chapter 7 – Framework of engagement with non-State actors (FENSA)

"I am deeply concerned by … efforts by industry to shape the public health policies and strategies that affect their products. When industry is involved in policy-making, rest assured that the most effective control measures will be downplayed or left out entirely.… In the view of the WHO, the formulation of all policies must be protected from distortion by commercial or vested interests."

Dr. Margaret Chan, Former Director-General, the WHO[68]

7.0 Introduction

This chapter analyzes the WHO's policies concerning its engagement with non-State actors (NSAs), and specifically the profit-oriented sector, which culminated in the agency's adoption of the "Framework of engagement with non-state actors" (FENSA). FENSA was adopted on May 28, 2016 (WHO, 2016f), after four contentious years of development, which suggests just how much was at stake in the new policy for both the WHO and the private sector. It was developed in the context of the agency's increasing reliance on voluntary contributions and multistakeholder collaborative initiatives such as public-private partnerships (PPPs) for funding and carrying out its programs (Lhotska & Gupta, 2016). It was initiated as part of reforms led by former Director-General Margaret Chan and presented in documentation associated with its development process[69] as necessary for overcoming existing constraints affecting engagement with NGOs.

The chapter analyzes the development and adoption of FENSA and its implications for the WHO's integrity and independence, given the private sector's well-documented efforts to influence policy at the WHO analyzed in Chapters 5 and 6. It considers FENSA's potential for increasing industry influence on substantive policy and paradigms and the implications for global health governance of the WHO's legitimation of a prominent role for actors with for-profit interests. The chapter makes the case that through FENSA, the WHO is potentially setting itself up for greater dependence on for-profit entities, which can lead to further conflicts of interest and undermine the WHO's role as lead global health body. Although FENSA is ostensibly intended to safeguard the WHO against potential conflicts of interest, faulty understanding of this term has resulted in a policy that can lead the agency to greater, not less, influence from profit-based actors, like the baby food

[68] Opening comments at Global Conference on Health Promotion, Helsinki, Finland in June 2013 (Chan, 2013).

[69] See, for example, "Issues to consider in the formulation of a policy" (WHO, 2012f).

and soda industries. FENSA institutionalizes the influence of private authority, especially profit-motivated entities, by, for example, making business associations eligible for Official Relations status and the privileges and increased access that this confers.

The chapter begins with an overview of the global shift toward multistakeholder approaches and public private partnerships across the UN system in general and by the WHO in particular. It then turns to a discussion of the often-conflated but distinct concepts of *conflicts of interest* and *conflicting interests*, both of which are central to discussions of the WHO's engagement with NSAs. The chapter continues with a review of the WHO policies and proposals relating to the agency's engagement with NSAs, including those policies that FENSA replaces or complements. It then examines the WHO's development and adoption of FENSA, and the main concerns highlighted by the private sector and by critical NGOs, including inadequate protection against conflicts of interest, and (initially) no distinction made between public-interest and private-interest actors or between different types of engagement. The conclusion highlights the significance of FENSA in terms of its implications for the WHO and for global health governance more broadly.

7.1 Global shift toward multistakeholder approach and engaging with NSAs

As discussed in Chapter 2, multistakeholder approaches and PPPs are increasingly seen as not only legitimate but also the preferred modes of operations across the UN system, including at the WHO. While the WHO prohibits any collaboration with the tobacco and arms industries, its normative guidelines have not excluded food and beverage industries, including baby food (provided they abide by the Code) and soda manufacturers and their associations, from active participation in multistakeholder initiatives. Instead, multistakeholder engagement and collaboration with the private sector is enshrined, for example, in the Global Strategy for the Prevention and Control of Noncommunicable Diseases (NCDs) (WHO, 2000b) and its 2008-2013 and 2013-2020 Action Plans (WHO, 2008, 2013a), the Global Strategy on Diet, Physical Activity and Health (WHO, 2004a), and the Political Declaration on NCDs (2011) (Moscetti & Taylor, 2015).

For example, in addition to the primary role and responsibility of Governments and the leadership and coordinating role of the WHO with respect to actions against NCDs, the Political Declaration adopted by the UNGA High-Level Meeting on the Prevention and Control of NCDs in September 2011 recognizes "the essential need for the efforts and engagement of all sectors of society" (UNGA, 2011, para. 3). It acknowledges "the contribution of and important role played by all relevant stakeholders," including, "where and as appropriate, the private sector and industry" in

efforts to prevent and control NCDs (UNGA, 2011, para. 37). It makes repeated references to a multi-sector approach and multi-sector initiatives, including with the private sector, as well as one reference specifically to multistakeholder engagement (UNGA, 2011).[70] The private sector has also been included in some capacity in the governing boards of many of the new global health PPPs, such as the Global Fund (formerly the Global Fund to Fight AIDS, Tuberculosis and Malaria), the Global Alliance for Improved Nutrition (GAIN), and GAVI (formerly the GAVI Alliance) (Bezanson & Isenman, 2012; Sridhar, 2012).

This global shift toward increased engagement with the private sector has implications for global health governance and for the WHO in several ways. First, it increases the instrumental power of profit-oriented entities, which the private sector exploits to further its own interests at the expense of public health interests. Second, such collaborations can expose the WHO to the risk of conflicts of interest, damage the agency's independence, integrity, credibility, and reputation and its capacity to protect and promote health in the public interest and perform its normative functions. Third, the trend increases not only the instrumental power but also the structural power of corporations and their business associations and foundations by contributing to the entrenchment of the multistakeholder approach to global health programs, policies, and governance. The increased entrenchment of the multistakeholder approach predetermines the types of program, policy and governance alternatives that are considered both feasible and acceptable, and reduces the prospects for more wholistic, horizontal programing and governance in the public interest, financed through assessed contributions by Member States.

7.2 Conflicts of interest and conflicting interests

The increased role of the private sector as governance actors, the WHO's financing challenges, and the global shift toward a multistakeholder approach expose the organization to the risk of potential conflicts of interest. Perhaps surprisingly, the WHO does not have an overarching policy on conflicts of interest. This is a matter that should form a cornerstone of the organization's functioning and policy-making if it is to maintain its independence, integrity, credibility and reputation in pursuit of its constitutional mandate. Instead, in order to address its financing

[70] In remarks in response to the Political Declaration, IBFA Co-Chair Donna J. Hrinak appreciated that the Political Declaration recognized contribution the food and beverage industry can make. She stressed that, since its inception, the UN had worked with the private sector, and encouraged Member States to look to the private sector as a willing and effective partner in implementing the Political Declaration in their respective countries (IFBA, 2011).

challenges, the organization has embraced a multistakeholder approach wholeheartedly, and with a principle of "inclusiveness" (CSOs at WHA 69, 2016), without a clear conceptualization of what the term conflicts of interest refers to or how to manage them.

Conflicts of interest and *conflicting interests* are different, though related, concepts. A conflict of interest is "a set of conditions in which professional judgment concerning a primary interest (such as a patient's welfare or the validity of research) tends to be unduly influenced by a secondary interest (such as financial gain)" (Thompson, 1993, p. 573). "Conflict of interest" refers to conflicts *within* an individual or organization whereby a secondary interest raises the possibility that the individual or organization would be unable to pursue its primary interest. This is not to be confused with "conflicting interests" (or diverging or competing interests) *between* actors (Peters & Handschin, 2012, pp. 5–6, incl. fn 3; 363; Richter, 2014). Yet these two concepts are often conflated, including among intergovernmental organizations such as the WHO and the UN system more broadly[71] as well as by various NSAs, with the result that neither risk is appropriately addressed.

Throughout the development of FENSA, which deals with situations rife with the potential for conflicts of interest, there was a lack of conceptual clarity about what constitutes conflicts of interest *within* an actor, as opposed to conflicting interests *between* actors. These two separate but related concepts were repeatedly conflated throughout in the documents produced by the WHO Secretariat, as well as by NSAs in their interventions at governing body meetings and submissions to various consultations. For example, conflating conflicting interests *between* actors with conflicts of interest *within* an actor, IFBA said in its submission to the public, web-based consultation in March 2013: "The argument is often made that there is a *fundamental conflict of interest between the public health and private sectors*" (emphasis added) (IFBA, 2013b). This common, colloquial use of the term "conflict of interest" conflates two related but different concepts and has had negative implications for the development of a clear and effective policy.

In addition to *conflicts of interest*, in evaluating potential engagement with NSAs, the WHO needs also to consider *conflicting interests*. Indeed, the potential for harm due to a conflict of interests is arguably greater when there also exist conflicting interests. Namely, it is necessary for the WHO to consider the extent to which each type of NSAs' (and each individual NSAs') interests align with public health interests and how much they are oriented toward profit-making. It is also necessary to

[71] For example, the Political Declaration on NCDs (UNGA, 2011) includes only one mention of conflicts of interest: in paragraph 38 where it recognizes "the fundamental conflict of interest between the tobacco industry and public health." However, these are conflicting (or competing) interests *between* these two sectors, not a conflict of interest (*within* one actor).

consider how much the NSAs' interests are aligned with maintaining the independence, integrity and credibility of the WHO as a global health leader. This is based on the principle that public health interests, and not profit-making interests, are fundamental in determining global health policy, and also the legitimacy and influence of NSAs in the policy-making process. The corporate sector's interests are profit-driven, not public health-driven. They do not align with either public health interests or with maintaining the independence, integrity and credibility of the WHO as a global health leader and, therefore, measures must be taken to protect substantive policy and global health policy-making against its influence. Some corporations may be necessary and even important global health *actors,* but this does not grant them a role as global health *policy-makers.* Corporations may contribute to the common good but, as Marks (2019, p. 51) stresses, "they cannot and should not be considered [its] guardians," which is the responsibility of public officials, government bodies, and intergovernmental organizations, such as the WHO.

7.3 The WHO policies and proposals relating to engagement with NSAs

Although the trend toward multistakeholderism is relatively new, since its inception the WHO has recognized the need for engaging with a wide variety of organizations and has had numerous policies in place to govern such engagement. The WHO's Constitution, which came into force on April 7, 1948 (K. Lee, 2009; WHO, 1958), mandates the agency to engage with NSAs. Article 2(b) states that, in order to achieve its objective, the agency is to collaborate with a variety of organizations as may deemed appropriate, and Article 18(h) authorizes WHA to invite "any organization, international or national, governmental or non-governmental" to participate, without voting rights, in any meeting under its authority, with national government consent in the case of national organizations. Article 71 allows for making suitable arrangements for consultation and cooperation with international NGOs, and with national Government consent, national organizations whether governmental or non-governmental (WHO, 2006b).

Subsequent policies included the "Principles governing relations between the WHO and NGOs," which was adopted (WHA40.25) by the Fortieth World Health Assembly (WHO, 1987a),[72] and the "Guidelines on working with the private sector to achieve health outcomes" (EB107/20) (WHO, 2000a). The Principles were subsequently deemed "inadequate", eventually to be replaced by FENSA. In the meantime, however, a number of approaches were proposed that failed to get any

[72]These Principles replaced the Principles adopted by the First and Third World Health Assemblies.

traction. The progression of ideas for handling the relationship suggests that the WHO has struggled with finding appropriate ways of engaging with NSAs in ways that advance its interests – both programmatic and financial – without compromising its independence, integrity, credibility and reputation in pursuit of its constitutional mandate as "the directing and coordinating authority on international health work" (WHO, 2006b).

The first WHA in 1948 adopted a set of working principles that governed Official Relations between NGOs and the WHO. These principles served as a policy for accreditation but did not provide guidance for consultative and collaborative processes (WHO, 2012f, p. 2). The principles were amended and expanded at several later WHAs[73] (Civil Society Initiative, 2002), most recently in 1987 with the adoption of the current "Principles Governing Relations between the WHO and [NGOs]" (WHA40.25) (WHO, 1987a). These Principles constitute the legal basis for all aspects of relations between the WHO and NGOs. According to the Principles, NGOs that meet the prescribed criteria are able to enter into Official Relations with the WHO, at the discretion of the Executive Board.

Certain privileges are conferred on NGOs with Official Relations status, including "the right to appoint a representative to participate, without right of vote, in the WHO's meetings or in those of the committees and conferences convened under its authority" and to make a statement at the invitation of the chairman (WHO, 1987a, para. 6.1). These statements are part of the official record but, coming after statements and discussion by Member States, they are not likely to persuade decisions. Instead, ahead of the agenda item of their interest, these organizations lobby Member States that may be receptive to their position and looking for technical advice. As of January 2016, the last review before FENSA changed the criteria, there were 207 NGOs in Official Relations with the WHO (WHO, 2016a).

One of the criteria for admission into Official Relations status specified in the Principles was that organizations must be "free from concerns which are primarily of a commercial or profit-making nature" (WHO, 1987a, para. 3.1). Nevertheless, several NSAs that represent commercial entities have been granted Official Relations status by emphasizing their non-profit nature (Lhotska & Gupta, 2016). In these cases, the NGO Standing Committee had simply endorsed the Secretariat's recommendations (Consumers International, 2011). Industry associations that have been granted Official Relations status include: CropLife International (representing Monsanto, Syngenta, Bayer,

[73] WHA resolutions WHA1.130, WHA3.113, WHA11.14 and WHA 21.28.

CropScience, Dow Agrosciences, DuPont and other companies promoting GMO technologies), the International Federation of Pharmaceutical Manufacturers and Associations (WHO, 2019f).

The International Life Sciences Institute (representing Nestlé, Coca Cola, Kellogg, Pepsi, Monsanto, Ajinomoto, Danone, General Mills and others), the International Special Dietary Foods Industries Federation (ISDI, representing the global specialized nutrition industry, including Nestlé and Danone) and the Industry Council for Development (representing Nestlé, Mars, Unilever and Ajinomoto) have also previously been in Official Relations with the WHO (IBFAN, 2014, Notes for editors), but have had this status withdrawn. As noted in Chapter 5, ISDI, lost its Official Relations status in 2014, not due its close connection with commercial entities, but because "the WHO had not received the deliverables expected during the collaboration period" (WHO, 2014c, para. 20). Similarly, ILSI lost its status in January 2015 only because of ILSI's link with tobacco, one of two industries with which the WHO explicitly refuses to work.

The criterion requiring that organizations in Official Relations with the WHO must be "free from concerns which are primarily of a commercial or profit-making nature" was complicated by the blurred lines between public interest and profit-making entities through the formation of PPPs and hybrid organizations that partner corporations with NGOs, coalitions and associations, often while ostensibly remaining at arm's length from their business interests. One benefit for corporations of such initiatives and collaborations has been the ability to get Official Relations status with the WHO. GAIN, for example, is a hybrid NGO that was granted Official Relations status in January 2014 (Nagarajan, 2014a; WHO, 2014c).

According to the International Baby Food Action Network (IBFAN), such hybrid NGOs and business-interest NGOs (sometimes called "BINGOs") are "driven by market profit-making logic" and "their primary interest clashes with that of the WHO" (IBFAN, 2014, Notes for editors). It should be noted that, although IBFAN has been vocal elsewhere with its concerns about conflicts of interest, what the group has described here is not a conflict of interest (within the WHO), but conflicting interests (between the WHO and hybrid NGOs/BINGOs). While conflicting interests are also important for the WHO to consider, civil society statements of concern about them, like this one from IBFAN, may have contributed to existing conflations of these two concepts.

With the adoption of FENSA in May 2016, the criteria for being admitted Official Relations changed. The status can now be granted to NGOs, international business associations and philanthropic foundations.

The other key document that FENSA replaced was the "Guidelines on working with the private sector to achieve health outcomes" (EB107/20), which were presented to the Executive Board in January 2001 as a Report by the Secretariat (WHO, 2000a). Draft guidelines on interaction with commercial enterprises, defined as the for-profit part of the private sector, had been written in mid-1999 and sent for comment to Member States and NGOs in Official Relations with the WHO, among others. Having also been tested in practice during 2000, the draft guidelines were revised in light of feedback received (WHO, 2000a, para. 3).

The Guidelines' intended purpose was stated as "primarily to help the WHO staff interact appropriately with commercial enterprises in order to achieve positive outcomes for health" (WHO, 2000a, para. 1). In addition to for-profit businesses, "Some or all of these guidelines can also apply to a variety of other institutions, including State-run enterprises, associations representing commercial enterprises, foundations not at arm's length from their sponsors, and other not-for-profit organizations such as academic institutions" (WHO, 2000a, para. 3). The Guidelines note that the WHO not only serves its membership (which is Member States only), but also collaborates in various ways "with other public bodies, civil society and commercial enterprises" with the objective "to further the WHO's mission and policies" (WHO, 2000a, para. 4).

The Guidelines note:

> In developing relationships with commercial enterprises, the WHO's reputation and values must be ensured. Scientific validity must not be compromised. Staff should thus always consider whether a proposed relationship might involve a real or perceived conflict of interest, either for the staff member or for the work of the Organization. The Staff Rules and Staff Regulations (and the forthcoming ethical framework) should guide decisions on conflict of interest relating to the personal situation of staff. The present guidelines contain provisions relating to conflict of interest for the Organization. (WHO, 2000a)

However, one provision of the Guidelines tempers that statement by drawing attention to the impact the agency's work might have on market demand or profitability of specific goods and services. According to the Guidelines: "In establishing such relationships it should be borne in mind that the WHO's activities affect the commercial sector in broader ways, through for example its public health guidance, its recommendations on regulatory standards, or other work that might influence product costs, market demand, or profitability of specific goods and services" (WHO, 2000a). This expression can be construed as indicating a potential conflict of interest, in that the market demand and profitability of specific goods and services – while no doubt an interest of certain Member States – is of only secondary interest to the WHO and must not interfere with the pursuit of its mandated mission. The WHO's primary interest is to serve as "the directing and

coordinating authority on international health work" (WHO, 2006b Article 2(a)) towards fulfilling its objective of "the attainment by all peoples of the highest possible level of health" (WHO, 2006b Article 1).

The Guidelines similarly conflated *conflicts of interest* with *conflicting interests*. The conflation in the Guidelines of these two separate (although related) concepts undermined their efficacy and shaped the conceptualization of the term "conflicts of interest" during the development of subsequent policies, such as FENSA. For example, in a provision about identifying potential areas of conflict of interest, the Guidelines stated that in assessing potential partnerships with commercial enterprises, "the public image, and financial stability and integrity of the company" are to be taken into consideration and that "relationships should be avoided with commercial enterprises whose activities are incompatible with the WHO's work, such as the tobacco or arms industries" (WHO, 2000a). However, the nature of the commercial enterprise does not inherently create a *conflict of interest* for the WHO but may present *conflicting* (or *competing*) *interests* that could contribute to a potential *conflict of interest*. While the WHO has determined that the tobacco and arms industries have prohibitively conflicting interests, they do not because of their nature inherently pose *more* of a conflict of interest (which would be *within* the WHO, not *between* the WHO and these industries) than, for example, a philanthropic organization whose approach and operations are contrary to the WHO's Member State-led mandate and systems-approach.

Donations are an important type of collaboration where it is especially important to avoid conflicts of interest. However, here again the Guidelines conflated *conflicting interests* (which relate to the nature of the commercial enterprise making the donation) with *conflicts of interest* (which relates to the WHO's ability pursue its primary interest): "Funds may be accepted from commercial enterprises whose business is unrelated to that of the WHO, provided they are not engaged in any activity that is incompatible with the WHO's work" (WHO, 2000a, para. 14). Funds from a commercial enterprise (or other source) can raise the potential for conflict of interest irrespective of whether or not its activities are incompatible with the WHO's work. The determining factor is whether the secondary financial interest interferes with the WHO carrying out its mandate, regardless of whether the source of the donation is a commercial enterprise whose business is related or unrelated to that of the WHO, whether its activities are compatible or incompatible with the WHO's work, or whether it is from a philanthropic organization whose activities are compatible or incompatible with the WHO's work.

Although providing an exception for clinical trials or product development, the Guidelines here correctly identified and prohibited conflicts of interest: "Funds may not be sought or accepted from enterprises that have a direct commercial interest in the outcome of the project toward which they would be contributing." Furthermore, the guidelines said "caution should be exercised in accepting financing from commercial enterprises that have even an indirect interest in the outcome of the project (i.e. the activity is related to the enterprise's field of interest, without there being a conflict as referred to above)" (WHO, 2000a, para. 16).

That the efficacy of the Guidelines had been compromised was indicated by the intervention by the International Federation of Pharmaceutical Manufacturers' Associations (IFPMA) at the 107th Executive Board meeting in January 2001 where the draft Guidelines were considered. The IFPMA is a business association representing pharmaceutical manufacturers that has been granted Official Relations status. In its intervention, the IFPMA, highlighted various partnerships between the private sector and the WHO, adding that such partnerships "[play] an important role in the WHO achieving its aim of improving health for all" (IFPMA, 2001). IFPMA said "guidelines concerning cooperation, such as those being discussed today, need to *support* and foster cooperation, not discourage it," and "should enhance efforts towards our common goal of improving health, while obviously avoiding conflicts of interest that would compromise all parties' objectives" (IFPMA, 2001). Significantly, IFPMA said it had "no difficulties with the content of the current draft guidelines" (IFPMA, 2001), indicating that the Guidelines would not interfere with the Association's pursuit of its interests on behalf of its corporate members.

However, conflicts of interest featured prominently in the intervention that civil society organizations Consumers International (CI), Health Action International (HAI) and IBFAN made at the same Executive Board meeting. They said in their intervention that transparency and accountability should be the "cardinal principle" of the Guidelines, but that they fall short in several key areas. The Guidelines "fail to give a clear definition of conflict of interest" (Consumers International, 2001, p. 1). As a consequence, according to these three civil society organizations, "secondment of staff from the private sector [was] not perceived as a conflict of interest" and "the risks related to involving the commercial sector in research" were not addressed (Consumers International, 2001, p. 2). These organizations said that the proposed in-house assessment and approval of partnerships was "inherently flawed because of potential conflicts of interest" (Consumers International, 2001, p. 2).

In the statement CI, HAI and IBFAN requested the Executive Board ensure that the Guidelines include: "a clear definition of conflict of interest; complete transparency on contractual agreements with all commercial enterprises; assessment of potential donor companies according to recognized the WHO and other international standards; regular monitoring and evaluation of all private sector interactions by an external body including representatives of governments and civil society; a 'whistle-blowing' mechanism so that people can report problems without damage to their professional position or reputation; annual reports to the Executive Board on contractual agreements made, their implementation and the public health outcomes" (Consumers International, 2001). These concerns were borne of their experiences with the activities of health-impacting industries, including the pharmaceutical industry, the food and beverage industry and, in the case of IBFAN, the baby food industry analyzed in Chapter 5. As will be discussed below, Member States and civil society organizations continued to raise many of these concerns, including with respect to a clear definition of conflict of interest and measures for dealing with them, throughout the development of FENSA.

In 2001, the same year that the Guidelines on working with the private sector were introduced, then Director-General Brundtland established the Civil Society Initiative (CSI) to "Establish a programme of evidence collection, consultation with a broad range of actors and analysis – within and outside the WHO – to identify and develop propositions for more effective and useful interfaces and relationships between civil society and the WHO" (Civil Society Initiative, 2002, p. 2). The CSI conducted a review of the WHO's current policy and practice regarding interactions with civil society and NGOs, including through consultations with the WHO headquarters, regional and some country offices, as well as other UN agencies and NGOs/civil society organizations (CSOs) (Civil Society Initiative, 2002).

The CSI review reported "an overall consensus that the current *Principles* are inadequate and less relevant to the realities of the WHO and to the needs and aspirations of civil society" (WHO Civil Society Initiative, 2002, p. 18). The report said there was "a lack of distinction between … public interest NGOs and those linked with commercial interests", "a lack of systematically accumulated knowledge about the sponsors and the interest groups behind individual NGOs" and "insufficient safeguards" against conflict of interest (WHO Civil Society Initiative, 2002, pp. 14, 16).

It recommended that the Principles be replaced by a new, twofold policy addressing accreditation and collaboration. Accreditation would no longer be dependent, as the "Official Relations" system is, on the NGO's working relationship with the WHO. The collaboration policy

would, among other things, provide clarity on differentiating between organizations. The review report said the new policy "would continue to use the term NGOs defined as non-state, not-for-profit, voluntary organizations" but would "establish principles to distinguish between different kinds of NGOs and their related interests" (WHO Civil Society Initiative, 2002, p. 18). In other words, the review acknowledged that within this classification, there may be actors with different types of interests, but emphasized the not-for-profit nature of NGOs.

The review report also noted the newly introduced Guidelines and cited their indication that they can apply not only to commercial enterprises but also to other entities, including "associations representing commercial enterprises, foundations and other not-for-profit organizations …" (WHO, 2000a; WHO Civil Society Initiative, 2002). The report noted: "These guidelines, therefore, have a hitherto untapped potential in guiding the WHO interactions with NGOs linked to private (for-profit) sector interests as well" (Civil Society Initiative, 2002, p. 9). In making this statement, the review report indicated that NGOs linked with private (for-profit) sector interests would fall within the scope of the Guidelines for engaging with the private sector rather than under the proposed twofold policy addressing accreditation of and collaboration with NGOs. It was not, however, within the purview of this 2001 CSI review of the WHO's relations with NGOs to assess the adequacy of the Guidelines.

A draft policy to replace the 1987 Principles was discussed at the 57th WHA in May 2004 (WHO, 2004b). The draft resolution to which the proposed policy was annexed included a request for the Director-General to "institute [an external, independent review of] mechanisms to safeguard the WHO's integrity and independence, including the WHO Guidelines for Interactions with Commercial Enterprises]" (*sic*).[74] The draft policy addressed two elements of the WHO relations with NGOs, as the 2002 CSI Review Report had recommended: accreditation and collaboration. Among the requirements for accreditation, the draft policy specifies that NGOs in collaboration with the WHO must "be non-profit in nature", must have existed for three years before their application, and must be transparent about their operations, governance and financing. Collaboration, the policy says, must "not compromise the independence and objectivity of the WHO" and be "designed to avoid any conflicts of interests" (WHO, 2004b). However, the draft policy's definition of NGO included "not-for-profit organizations that represent or are closely

[74] The square brackets indicate points lacking consensus in the consultations held over three days in February 2004. Note that an opening bracket is missing, making it unclear where the lack of consensus begins, but logically it would go before "including".

linked with commercial interests" (WHO, 2004b Annex, para 4). This definition would allow any of the business associations and front groups described in previous chapters to collaborate with the WHO on the same terms as public-interest NGOs and thus provide them influence over policy-making.

The 57th WHA (2004) did not adopt the draft resolution and the attached proposed policy but decided instead to postpone discussion of the proposed policy "to a subsequent Health Assembly" to allow time for consultations and reaching a consensus (WHO, 2004d). Typically, when the WHA defers any matter, it is specified precisely when the matter will be taken up for further consideration and what steps are to be taken in the meantime. That the WHA did not specify a meeting for resuming discussion of the proposed policy on the WHO relations with NGOs suggests the lack of support among Member States for the proposed policy.

As previously noted, there has been an increase in recent years in global health partnerships and other forms of collaboration. Examples include legally incorporated entities external to the WHO, such as the Global Fund, GAVI, the Medicines for Malaria Venture, as well as unincorporated partnerships within the WHO with their own governance, such as Stop TB Partnership, Partnership for Maternal, Newborn and Child Health, Roll-Back Malaria Partnership, UNITAID, the Global Heath Workforce Alliance, and the Health Metrics Network. In light of the growth in such partnerships, the 63rd WHA in May 2010 endorsed a "Policy on the WHO engagement with global health partnerships and hosting arrangements" (WHO, 2010c). The policy spelled out criteria for the WHO's engagement in partnerships, as well as considerations with respect to hosting arrangements and other aspects of partnerships. The WHA requested the Director-General to create an operational framework for the WHO's hosting of formal partnerships (WHO, 2010c). FENSA does not replace this policy, although it applies to both hosted and external partnerships and the implementation of the partnerships and hosting arrangements policy is to be coordinated and aligned with FENSA (WHO, 2016f, 2018c).

One proposal that came from outside the WHO for facilitating NSA participation in global governance was the creation of a Committee C of the WHA (Clift & Royal Institute of International Affairs, 2014; Kickbusch et al., 2010; Silberschmidt et al., 2008). Currently, Committee A deals with programme matters and Committee B with budget and managerial matters. The proposed Committee C would provide a forum for NSAs to debate major health initiatives and share their plans and achievements, and for coordination. A limited number of actors would be included in the proposed committee, including "international agencies, philanthropic organizations,

multinational health initiatives, and representatives from major civil-society groups, particularly those who legitimately represent the most vulnerable populations". It would not replace but complement existing mechanisms for NGO participation in Committees A and B, which should be applied to Committee C as well (Silberschmidt et al., 2008). However, this proposal did not move beyond consideration in academic circles.

7.4 Widening the WHO engagement with NSAs

After the draft policy to replace the 1987 Principles was abandoned in 2004, the WHO did not take up the matter of improving its engagement with NSAs until it came up during the reform process launched under then Director-General Margaret Chan in May 2011 under a banner of "the future of financing the WHO"[75]. Rather than re-visiting the failed 2004 draft policy, the Director-General's report that called for reforms proposed the creation of a multistakeholder forum for global health convened by the WHO to increase engagement and trust among the growing number of actors in global health. The envisioned Forum would "help shape decisions and agendas", but "not usurp the decision-making prerogative of the WHO's own governance, which [would] remain intergovernmental" (WHO, 2011a, para. 86). Specifically, the proposal envisioned a World Health Forum to be held in the fourth quarter of 2012 and subsequently every two years. Participants would include Member States, civil society, private sector, academia and other international organizations (WHO, 2011a, para. 87). In the resolution giving the mandate for reform, the WHA requested a concept paper about holding a World Health Forum in November 2012, including its objectives, participants, format and costs, to be presented at the 130th Executive Board in January 2012 (WHO, 2011b).

According to the concept paper circulated in June 2011, "As an informal, multi-stakeholder body the World Health Forum will make it possible to capture a wide range of views and perspectives on major current and future issues in global health" (WHO, 2011c, p. 1). It said the Forum, the first of which was to be held over three days in November 2012 in Geneva, "will not take decisions affecting individual organizations, nor will it change the decision-making prerogative of the WHO's own governing bodies" (WHO, 2011c, p. 1). In other words, the Forum's decisions may not have had any bearing whatsoever on either participating organizations or the WHO.

[75] In May 2011 the 64th WHA gave the mandate for reform of the WHO as described in the Director-General's report entitled: "The future of financing the WHO - World Health Organization: Reforms for a healthy future" (WHO, 2011a).

The purpose of the Forum was "to explore, in an informal and multi-stakeholder setting, ways in which the major actors in global health can work more effectively together – globally *and* at country level – to increase effectiveness, coherence and accountability and to reduce fragmentation and duplication of effort." Its specific objectives were to "(a) identify the major obstacles and constraints to more collaborative work across all the partners engaged in global health; (b) to define principles and approaches that will promote policy coherence and more effective working relationships at global and country level; and (c) to outline the steps needed to translate principles into practice" (WHO, 2011c, pp. 1–2). The list of participants was expanded from the list in the initial resolution to include Member States, representatives of major global health organizations and partnerships, as well as CSOs (NGOs), academic institutions/think-tanks, professional associations, foundations and the private sector (WHO, 2011c, p. 2).

NGOs and Member States raised many questions about the proposal, especially about the inclusion of not only not-for-profit NGOs but also the private (commercial) sector without what they considered to be adequate policies and mechanisms for avoiding conflicts of interest and for protecting the sovereignty and decision-making prerogative of existing governance bodies (Clift & Royal Institute of International Affairs, 2014; DGH, n.d.; van de Pas & van Schaik, 2014).

By the time the Executive Board Special Session (EBSS) on the WHO Reform took place in Geneva on November 1-3, 2011, the World Health Forum had been abandoned due to lack of Member State support (MMI & DGH, 2011; van de Pas & van Schaik, 2014; WHO, 2011d). However, the Director-General's report to the Special Session proposed three formats for widening engagement with stakeholders. These included multistakeholder forums on key global health issues, separate consultations with different groups of stakeholders, and face-to-face meeting or web-based forums (WHO, 2011d). Although the Director-General's report makes frequent reference to partners and partnership, neither the report nor the Executive Board's decisions make reference to the existing Policy on the WHO engagement with global health partnerships and hosting arrangements (WHO, 2011d). The partnerships and hosting policy, adopted by the WHA in May 2010, spells out criteria for the WHO's engagement in partnerships, as well as considerations with respect to hosting arrangements and other aspects of partnerships (WHO, 2010c).

The EBSS decisions outlined principles to guide engagement with other stakeholders:

> "(i) the intergovernmental nature of the WHO's decision-making remains paramount;(ii) the development of norms, standards, policies and strategies, which lies at the heart of the WHO's work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest; (iii) the need for due consultation with all relevant parties keeping in mind the principles and guidelines laid down for the WHO's

> interactions with Member States and other parties; (iv) any new initiative must have clear benefits and add value in terms of enriching policy or increasing national capacity from a public health perspective; (v) building on existing mechanisms should take precedence over creating new forums, meetings or structures, with a clear analysis provided of how any additional costs can lead to better outcomes." (WHO, 2011e)

The EBSS decisions stated that "dialogue and collaboration with other stakeholders should be strengthened as appropriate, while taking into account the importance of full engagement of Member States and of managing conflicts of interest." As a longer-term approach, while expressing the WHO's role as a directing and coordinating authority) would be explored, it was agreed that options for a framework to guide stakeholder interactions (WHO, 2011e). The Executive Board requested the Director-General to submit to its next meeting, in January 2012, "further analysis of proposals to promote engagement with other stakeholders" and "further analysis on modalities to improve Member State involvement with and oversight of partnerships including the possible expansion of the mandate of the Standing Committee on NGOs in this regard" (WHO, 2011e).

NGOs raised concerns about the rationale for the proposed reform and said it failed to address what were fundamentally financial issues. They also were concerned about conflicts of interest, which would continue throughout the development of policies to regulate its engagement with NSAs, including NGOs, commercial enterprises, and philanthropic organizations. They noted that the WHO needed to establish clear definitions of and policies on both institutional and individual conflicts of interest and highlighted the importance of protecting the WHO's norm-setting and public health role (Consumers International, 2011; DGH, 2011; HAI, 2011; MMI & DGH, 2011; PHM & DGH, 2011).

At the Executive Board meeting in January 2012, the Secretariat made two proposals with respect to engagement with stakeholders (i.e. NSAs). The first was to review and update the Principles governing the WHO's engagement with NGOs, including "widening and improving" modalities for NGO participation in governing body meetings; seeking their views in the development of new health policies and strategies; updating practices and criteria for accreditation (including considering ways of differentiating between the different types of NGOs that interact with the WHO) (WHO, 2011f, para. 14(a)).

The second proposal was to develop comprehensive policy frameworks to guide interaction with the private, for-profit sector as well as not-for profit philanthropic organizations, which were expected to address the issue of institutional conflicts of interest (WHO, 2011f, para. 14(b)). Some countries – notably the United States and Switzerland, both home to market leaders in the baby food

and soda industries– as well as the International Pharmaceutical Federation urged caution about distinguishing between different types of stakeholders (WHO, 2012b). Switzerland's delegate argued against differentiation, "given the specific characteristics, roles and interests of nongovernmental, private-sector and other organizations" (WHO, 2012b), although this is precisely why such differentiation is desirable and even necessary. Significantly, Switzerland was represented by Dr. Gaudenz Silberschmidt, Head of International Affairs in the Swiss Office of Public Health, who went on to be seconded to the WHO as Director for Partnerships and NSAs, providing another example of the "revolving door" between industries and the WHO. Although Silberschmidt did not move between the private and public sectors, Switzerland is home to baby food and soda market leaders and the country has taken positions aligned with corporate interests, as in this example.

Meanwhile, other countries – notably India, Chile, and Iran – expressed concern that the risk of conflicts of interest needed to be adequately addressed. The Executive Board agreed that further discussion on this matter was necessary, which could take place at the WHA in response to a report to be prepared by the Director-General (WHO, 2012b). In May 2012, the 65th WHA requested the Director-General to present a draft policy on engagement with NGOs to the Executive Board at its meeting in January 2013 (Decision 65(9), and one on relationships with private commercial entities at the Executive Board meeting in May 2013. A report was also to be presented at the January 2013 meeting about the WHO's hosting of health partnerships including proposals for their harmonization (WHO, 2012c). The Director-General was to be guided in development of these documents by the principles outlined by the EBSS, described above (WHO, 2012c).

7.5 Development of the Framework of engagement with non-State actors (FENSA)

The Issues Paper prepared by the Secretariat for a consultation with NGOs in October 2012 in response to the WHA request for a draft policy paper on the WHO's engagement with NGOs stated that the purpose of such a policy was to provide clear guidance to the WHO staff, its Member States and to CSOs[76] on how to encourage and secure meaningful participation and collaboration of CSOs with the WHO (WHO, 2012f).

FENSA had two objectives: to widen the WHO's engagement with NSAs and attract new voluntary funding, and to protect the WHO's mandate and strengthen safeguards against conflicts of interest. A group of CSOs at the WHA in 2016, however, maintained in a collective statement that

[76] The report refers to "civil society at large and nongovernmental organizations in particular" but appears also to use "NGOs" and "CSOs" interchangeably (WHO, 2012f, para. 5).

the Framework aimed, contradictorily and irreconcilably, both to widen the WHO's engagement with NSAs and attract new voluntary funding and simultaneously to protect the WHO's mandate. They felt that the Framework offered inadequate protection against conflicts of interest (CSOs at WHA 69, 2016).

That financing was the purpose of FENSA was indicated in the Secretariat's Report to the Executive Board in January 2014 on the November 2013 Financing Dialogue, which said the overall objective of the WHO's engagement with NSAs was to work towards fulfilling the agency's mandate "*by making better use of [NSAs] resources* (including knowledge, expertise, commodities, personnel and finances)" (emphasis added) (WHO, 2013j). It further stressed "the imperative need to conclude the framework for engaging with [NSAs], *in order to facilitate expansion of the contributor base beyond Member States*…, particularly in light of the growing demands for international health-related financing" (emphasis added) (WHO, 2013j). Nevertheless, Dr. Gaudenz Silberschmidt, the WHO Director for Partnerships and NSAs,[77] maintained in 2016 that "funding [was] the least of reasons" for increasing the WHO's engagement with private entities, but rather "it's all about partnerships and how we can work together" (Vogel, 2016).

To develop the requested policy papers, the WHO held a series of consultations, both in person and web-based, with NGOs, private commercial entities, and Member States. From the outset, NSAs contributed to the consultations and made interventions at meetings of the WHO governing bodies to critique and influence the proposed Framework. From the promising, if imperfect, background paper prepared for a consultation with NGOs in October 2012 (WHO, 2012f) to the fundamentally flawed proposed Framework ultimately adopted in May 2016, subsequent drafts of the new policy – and the WHO itself – came under scrutiny for inadequately protecting the organization against conflicts of interest and for allowing private sector influence over global health policy-making – in effect, letting the fox build the chicken coop (Gupta & Lhotska, 2015; Richter, 2014). Some of the areas that NGOs were particularly critical of in various drafts included the reluctance to distinguish between different types of NSAs, and failure to distinguish between different types of engagement for different types of NSAs, and failure to clearly define and guard against conflicts of interest.

With respect to distinguishing between different types of NSAs, the Director-General had been requested from the outset – in Decision WHA65(9) – to draft separate policies for the WHO's

[77] Formerly Head of International Affairs in the Swiss Federal Office of Public Health.

engagement with NGOs and for its relationships with private commercial entities (WHO, 2012c). The issues paper developed by the WHO in October 2012 to inform a consultation with NGOs held the same month noted that to date, the WHO had "made no differentiation between the organizations and entities interacting with it and all organizations [were] considered to be NGOs" … "despite the key criterion for admission of NGOs into Official Relations is that the NGO "shall be free from concerns which are primarily of a commercial or profit-making nature" (WHO, 2012f). It also said it was "imperative to differentiate between NGOs with commercial interests/links and those without such interests and links, as market interests/links can conflict with health outcomes" (WHO, 2012f). As described in Chapters 5 and 6, as part of their playbook some corporations have formed their own NGOs – BINGOs or "astroturf" NGOs[78] – and associations to protect and advance their business interests on their behalf, often while ostensibly remaining at arm's length from their profit-making entities. They also participate in PPPs and hybrid organizations that partner corporations with NGOs, coalitions and associations, as mentioned above, again at arm's length from their business interests.

The Executive Board in January 2013 called for further work on engagement with NGOs and requested the Director-General to submit to the Board's next session in May 2013 "overarching principles for the WHO's engagement with NSAs, defining separate operational procedures for both NGOs and private commercial entities., and to harmonize the development of the policies on engagement with NGOs and the WHO's relations with private commercial entities" (WHO, 2013d). The Executive Board also requested the Director-General to conduct public web-based consultations on the draft principles and policies, and convene one consultation with Member States and NGOs and one with Member States and the private commercial sector (WHO, 2013d).

However, by the time a web consultation was held in March 2013, the issues and questions provided by the Secretariat appeared to aggregate all actors that are not governments or intergovernmental organizations under the umbrella of NSAs (WHO, 2013e). This aggregation not only makes no distinction of the fundamental differences between public interest NGOs and profit-oriented corporations and the many types of organizations in between, but also muddied the discussion of the issues involved and possible ways forward. Framing the consultation in this way undermined the development of separate policies for engagement with NGOs and relationships

[78]NGOs that look like they grassroots organizations but were created and driven by the private sector.

with private commercial entities, as had been requested by the WHA in Decision 65(9) (WHO, 2012c).

Industry association and BINGOs took the position that the same rules should apply equally to all actors with which the WHO engages, with no differentiation between those with "public" interests (e.g. NGOs) versus those with "for profit" interests. For example, its submission to the web-based consultation in March 2013, IFBA said it believed it would be a "fundamental error" if the WHO were to "create a 'hierarchy' of non-State entities, each with special roles and differing 'access' to the organization based on a pre-determined view of the 'value' of an organization in relation to achieving certain goals" (IFBA, 2013b). IFBA suggested getting rid of the Official Relations system established under the 1987 Principles, perceiving it as "creating a hierarchy due to its exclusion of for-profit enterprises". It maintained that the WHO should have flexibility in which actors it can engage with so as not to miss out on opportunities, and mentioned emergency situations and argued that a multistakeholder partnership approach was the only way to address complex health problems (IFBA, 2013b). In comments on the Secretariat's report on FENSA published on January 8, 2014, IFBA similarly argued: "(a)ttempts to arbitrarily categorize or classify or create a 'hierarchy' of NSAs, each with special roles and differing access to the WHO based on a pre-determined view of the value of an organization with the goal of exclusion, will inevitably work to the detriment of the organization (...)" (IFBA, 2014a). These submissions demonstrate that IFBA feared being excluded outright, and also the creation of a "hierarchy" with different actors having different access and influence. However, "differentiation" amongst NSAs under the proposed policy does not mean "exclusion" or "hierarchy", and neither could the system of categorization or classification being developed be characterized as "arbitrary".

In contrast to the private sector's position, public-interest NGOs (PINGOs) argued: "While overarching principles should govern all interaction with external actors, separate policies are needed to ensure clarity and transparency regarding the fundamental difference between NGOs and private commercial entities, including their philanthropic foundations, business associations and front groups, some of them being currently registered by the WHO as NGOs in Official Relations" (DGH, 2013b).

A discussion paper prepared for an informal consultation with Member States and NSAs in October 2013 listed the types of interactions in which the WHO already engages with various types of NSAs. These included 1. Attendance at the WHO governing body sessions; 2. More meaningful participation in the governing body sessions; 3. Participation in consultations in preparation of

intergovernmental meetings;4. Financial contributions; 5. Human resources; 6. In-kind contributions; 7. Evidence generation, information gathering and research; 7. Advocacy and awareness raising; 8. Provision of technical advice to countries; and 9. Collaboration with NGOs in Official Relations (WHO, 2013i). In contrast, NGOs emphasized the importance of distinguishing the types of engagement based on the types of actor. Only after recognizing the fundamental different natures of NGOs and the for-profit and philanthropic sectors could "a meaningful matrix of interactions with each category of actors be developed," they maintained (DGH, 2013b). "The way the WHO engages with each category of external actors should be rooted in the consideration of whether that actor has a primary interest in line with the organization's public interest mandate. The result will be that the WHO will need to engage differently with different types of actors" (DGH, 2013b).

In the report to the Executive Board in January 2014, the types of engagement were narrowed to five: participation, resources, evidence, advocacy and technical cooperation (WHO, 2014b). However, no connection was made in terms of which of these five types of engagement might be appropriate, under what circumstances and terms, for each of four categories of NSAs (NGOs, private commercial entities, philanthropic foundations and academic institutions) (WHO, 2014b). This absence of connection between types of engagement and categories of NSAs effectually makes both distinctions hollow. This gap remained in the final FENSA document adopted in May 2016 (WHO, 2016f), preventing the WHO from engaging differently with different types of actors in line with the agency's public interest mandate.

Most criticism of the draft Framework, and of the WHO itself in relation to the development process, was with respect to its inadequate protection against conflicts of interest (Gupta & Lhotska, 2015; Lhotska & Gupta, 2016; Richter, 2014, 2014). Several Member States – mainly developing countries, including India, Pakistan, Brazil, Bolivia and the Union of South American Nations (UNASUR) – expressed concerns about the lack of a conceptualization and policy on conflict of interest in various drafts of the proposed FENSA and repeatedly rejected it when it was put before the WHA for adoption (Gupta & Lhotska, 2015).

The WHO Secretariat raised its own concerns about FENSA on October 14, 2015, when it published a so-called "non-paper" titled "Implications of Implementing [FENSA]" (WHO Secretariat, 2015). The non-paper was intended for consideration at the informal meeting of Member States on FENSA that was held October 19-23, 2015. It cautioned that implementation of FENSA would have "detrimental consequences on the work of the WHO" (WHO Secretariat,

2015). It listed a number of risks associated with implementing the proposed new policy, FENSA, such as significantly increasing the workload due to the thousands of NSAs with which the WHO engages and the tens of thousands of engagements each year. It says additional financial and human resources would be required (WHO Secretariat, 2015).

Public interest groups and networks responded to the non-paper with a letter of concern to Director-General Chan. In the letter, these groups questioned the motives behind such a paper, which provides no constructive contribution to the new Member State-led process, in the midst of negotiations. The public interest groups questioned the basis on which the non-paper was prepared, as there was no evidence of any such decision by the WHA as the non-paper claimed. The letter said its signatories were "very concerned that the non-paper could "undermine further strengthening of a FENSA and prevent it becoming a truly robust framework," noting that "the paper lists potential 'unintended consequences' often in an exaggerated manner, as assumptions, without providing any empirical evidence to back up these claims" (CSOs, personal communication, October 22, 2015).

An Open-Ended Intergovernmental Meeting on the draft Framework met April 25-27, 2016 to resolve differences over the draft Framework and prepare a consensus text and draft resolution to be presented at the WHA the following month. An Audit Report developed with the assistance of an External Auditor prior to the meeting proposed that FENSA be finalized as a consensus text for adoption by the WHA in May 2016 because "it had been through a long arduous corridor" (WHO, 2016c).

Critics from IBFAN found this argument unacceptable, considering that "the WHO's integrity, independence, credibility and reputation [were] at stake," and the Audit Report itself had observed that "there is no price for a strong and solid framework" (Lhotska & Gupta, 2016). They found the recommendation that FENSA be adopted surprising given that the Audit Report noted important methodological problems in the data collection, due to, among other [reasons], 'lack of documentation records"' (Lhotska & Gupta, 2016). It also mentioned "a lack of clarity of (or inconsistencies between) many of the terms and provisions" of FENSA (Lhotska & Gupta, 2016). These critics maintained that the Audit Report failed to propose correcting "the inaccurate conceptualization of the FENSA conflicts of interest section". They maintained that "the April FENSA negotiations did little to address this and other key concerns of public interest advocates", adding that "if conflicts of interest [were] not properly identified, resolved and managed, they [could] undermine the work and reputation of an entire institution" (Lhotska & Gupta, 2016). They urged Member States to "resist the pressure to adopt an ill-conceived consensus document which

risks increasing channels of undue influence," such as expanding the types of actors who are able to apply for Official Relations status with the WHO (Lhotska & Gupta, 2016).

The Times of India in May 2015 reported a leaked email from IFBA Secretary General Rocco Renaldi around March 2015 that showed that the group had lobbied developed countries ahead of the intergovernmental meeting about the draft FENSA on March 30-April 1, 2015 (Nagarajan, 2015; Renaldi, 2015; Vogel, 2016). The email indicated that there was "full alignment" among the Western European and Others Group (WEOG) countries (Western Europe, Australia, Canada, Israel, New Zealand and the US) on "a position that is essentially equivalent" to IFBA's. Importantly, WEOG had agreed not to accept any document that excludes the food and beverage industry from the Framework. Among other "outreach" listed in the email, Brazil's Minister of Health had been contacted "to highlight the incongruity of the Brazilian suggestion to exclude private sector organizations from Official Relations with the WHO" (Nagarajan, 2015; Renaldi, 2015; Vogel, 2016).

A confidential draft of the text of the proposed FENSA as it appeared on the screen at 5:00 pm on the last day of the meeting indicates that consensus was not reached on numerous paragraphs (WHO, 2016d).[79] A meeting document outlining the agreed next steps indicates that Member States at WHA69 were to finalize paragraphs where there is not yet agreement, "including paragraph 14 of private sector policy" (WHO OEIGM, 2016).[80]

The 69th WHA adopted the Framework on May 28, 2016 (WHO, 2016f). The final policy consists of an overarching framework and four specific policies on engagement with NGOs, private sector entities, philanthropic foundations and academic institutions (WHO, 2016f). The overarching framework outlines the rationale, principles, benefits and risks of the WHO engagement with NSAs. It identifies five types of interaction in which the WHO engages with NSAs. The five categories of interaction are: participation in the WHO meetings (e.g. Executive Board and WHA meetings, consultations and hearings, resources (financial or in-kind contributions; however, secondment from private sector entities, which includes companies and their business associations, are expressly prohibited), evidence (sharing of up-to-date information and knowledge on technical issues), advocacy (and awareness-raising on health issues), and technical consultation (product development,

[79] Available here: http://media.ip-watch.org/weblog/wp-content/uploads/2016/04/FENSA-document-progress-April-2016.pdf?ecfb22.
[80] Obtained by Intellectual Property Watch. Available at: http://media.ip-watch.org/weblog/wp-content/uploads/2016/04/FENSA-Next-steps-on-27-April-2016.pdf?ecfb22.

capacity-building, operational collaboration in emergencies, contributing to the implementation of the WHO's policies).

As mentioned above, under the Principles governing relations between the WHO and NGOs, one of the criteria for being eligible for Official Relations status was that groups were to be "free of commercial interests" (WHO, 1987a). Under FENSA, which replaces the Principles, Official Relations status may be granted to NGOs, business associations, and philanthropic foundations that meet additional criteria (WHO, 2016f). As was the case under the Principles, NSAs with Official Relations status are able to attend the meetings of the WHO governing bodies, that is, the Executive Board and the World Health Assembly. FENSA's inclusion of business associations in the list of types of organizations eligible for Official Relations status represents the formalization and entrenchment of what had been transpiring in a grey area of interpretation of the Principles, as was discussed above, and legitimizes lobbying by business associations and philanthropic foundations with business ties at the WHO governing bodies. Critics from IBFAN maintained that granting Official Relations status to business associations and philanthropic foundations under FENSA would "legitimize once and for all [their] lobbying at the WHO governing bodies" and "normalize the inclusion of business agendas into public health decision-making" (Lhotska & Gupta, 2016). As of February 2019, there were 217 NSAs in Official Relations with the WHO (WHO, 2019f).

FENSA lays out a number of steps for "managing, including by, where appropriate, avoiding," conflict of interest and other potential risks of engagement. These steps include due diligence, risk assessment, a publicly available register of NSAs, and an electronic tool for the management of individual conflicts of interest (WHO, 2016f). Importantly, FENSA deals only with institutional engagement with NSAs, and therefore only institutional conflicts of interest, while individual conflicts of interest are to be dealt with in accordance with Staff Regulations and Staff Rules (WHO, 2016f, para. 21, f.n. 1 & 49(c)).[81]

The faulty conceptualization of conflict of interest observed throughout the development of FENSA remains in the adopted policy, intermixing the notion of conflicting interests, with the result

[81] Individual conflicts of interest are defined as "circumstances that create a risk that professional judgments or actions regarding a primary interest will be unduly influenced by a secondary interest" (Institute of Medicine (US) Committee on Conflict of Interest in Medical Research, Education, and Practice, 2009, p. 6). Institutional conflicts of interest, on the other hand, "arise when an institution's own financial interest or those of its senior officials pose risks of undue influence on decisions involving the institution's primary interests" (Institute of Medicine (US) Committee on Conflict of Interest in Medical Research, Education, and Practice, 2009, p. 218).

that neither risk is appropriately addressed. FENSA's conceptualization of conflict of interest rightly recognizes the risk of having the independence or objectivity of professional judgement or actions regarding the WHO's primary interest unduly influenced, or perceived to be unduly influenced, by a secondary interest (WHO, 2016f). However, it gives an inaccurate indication of what constitutes a secondary interest – "a vested interest in the outcome of the WHO's work in a given area" (WHO, 2016f, para. 22) – that suggests the secondary interest is, or belongs to, an actor other than the WHO. This interpretation is confirmed several paragraphs later when an institutional conflict of interest is defined as: "a situation where the WHO's primary interest as reflected in its Constitution may be unduly influenced *by the conflicting interest of [an NSA]* in a way that affects, or may reasonably be perceived to affect, the independence and objectivity of the WHO's work" (emphasis added) (WHO, 2016f, para. 24). The Handbook for NSAs on engagement with the WHO (discussed below) similarly describes conflict of interest as "improper influence exercised *by [an NSA]* on the WHO's work, especially in policy setting, norms and standards; and an engagement that would negatively affect the WHO's integrity, independence, credibility and reputation, and public health mandate" (emphasis added) (WHO, 2018d).

Instead, FENSA's conceptualization of conflicts of interest would be correct if it specified that these occur when the WHO's primary interest (the WHO's work, and as has been argued in this dissertation and elsewhere,[82] to this end, its independence, integrity, and credibility) may be unduly influenced, or perceived to be unduly influenced, by (one of) *the WHO's* secondary interest(s) (such as securing financial resources).[83] As has been repeated throughout this dissertation, a conflict of interest occurs *within* an actor, and conflicting interests occur *between* actors, and the confusion, conflation and intermixing of these two separate but related concepts has the result that neither risk is appropriately addressed.

As argued above, in addition to conflict of interest, it is important for the WHO to consider conflicting (or, competing) interests. While the nature of the commercial enterprise does not inherently create a *conflict of interest* for the WHO, it may present *conflicting* (or *competing*) *interests* that could contribute to the harm caused by a *conflict of interest,* as was discussed above in connection with the 2001 Guidelines on working with the private sector. FENSA rightly acknowledges: "For the

[82] Including in the Handbook for NSAs on engagement with the WHO (WHO, 2018d).

[83] Although other actors engaging with the WHO may also experience conflicts of interest – that is, secondary interests that unduly influence (or conflict with) those actors' primary interests – it is the responsibility of those actors (not the WHO) to determine and prevent or manage those internal matters.

WHO, the potential risk of institutional conflicts of interest could be the highest in situations where the interest of non-State actors, in particular economic, commercial or financial, are in conflict with the WHO's public health policies, constitutional mandate and interests, in particular the Organization's independence and impartiality in setting policies, norms and standards" (WHO, 2016f, para. 26).

However, having intermixed the notion of conflicting interests within its definition of institutional conflicts of interest, as mentioned above, FENSA gives the impression that conflicts of interest *depend* on the nature of the NSA. This is reinforced by the paragraph that reads: "In actively managing institutional conflict of interest and the other risks of engagement …, the WHO aims to avoid allowing the conflicting interests of [an NSA] to exert, or be reasonably perceived to exert, undue influence over the Organization's decision-making process or to prevail over its interests" (WHO, 2016f, para. 25).

NSAs with interests that conflict with those of the WHO – for example, the tobacco and arms industries – do not because of their profit-oriented nature inherently pose more of a conflict of interest (which would be *within* the WHO, not *between* the WHO and those industries) than, for example, a philanthropic organization whose approach and operations are contrary to the WHO's Member State-led mandate and systems-approach. Nevertheless, the WHO explicitly does not engage with the tobacco and arms industries, which is reiterated in the "Specific Provisions" section of FENSA. However, no other industries were added to the list of prohibited industries although their products do not align with the WHO's mandate, such as fast food or alcohol. Instead, FENSA includes a paragraph on "Engagement where particular caution should be exercised". It states:

> The WHO will exercise particular caution, especially while conducting due diligence, risk assessment and risk management, when engaging with private sector entities and other [NSAs] whose policies or activities are negatively affecting human health and are not in line with the WHO's policies, norms and standards, in particular those related to [NCDs] and their determinants. (WHO, 2016f, para. 45)

7.6 Developments since adoption of FENSA

As stipulated in FENSA, the WHO developed a Handbook to guide NSAs in engaging with the agency in line with the Framework (WHO, 2018d) and a Guide for staff on implementation of the Framework (WHO, 2018c). The Handbook is intended to guide NSAs in "engaging in a systematic way" with the WHO "by walking them through" FENSA's principles and processes to ensure smooth implementation of the Framework. The Handbook is considered a living document to be updated based on the experience with FENSA's implementation (WHO, 2018d). The Guide for

staff is meant to help the WHO staff at all three levels of the organization understand and apply the FENSA's provisions and offer guidance on how to encage with NSAs and the process to be followed (WHO, 2018c).

Resolution WHA65.6, endorsing the 2012 Comprehensive implementation plan on maternal, infant and young child nutrition, which was described in Chapter 4, also requested the Director-General to "develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with the WHO's overall policy and practice" (WHO, 2012e). In 2014, decision WHA67(9) requested the Director-General to convene informal consultations to develop these assessment and management tools for conflicts of interest in nutrition for consideration by the Assembly in 2016 (WHO, 2014f).

A technical consultation was held in Geneva on October 8 and 9, 2015, bringing together experts from various fields and diverse stakeholders, as well as Member States as observers. According to the WHO's report of the meeting, some of these experts emphasized the need to explain clearly the difference between "conflicts of interest" and "conflicting" or "diverging" interests or fiduciary duties (which occur *between* actors) (WHO, 2015c). Following the technical consultation, the Secretariat prepared a draft approach taking into consideration the WHO's overall policies and practices, including FENSA, which was adopted in May 2016.

It bears noting that it was WHA67 in May 2012 that requested both these tools to safeguard against possible conflicts of interest in a specific context (national nutrition programs) and a set of policies to improve the WHO engagement with NSAs, a broad subject wherein the prevention of conflicts of interest is fundamental. Yet, technical consultation of experts on conflicts of interest was never conducted in connection with the development of FENSA, despite having been suggested by several NGOs and networks (DGH, 2013a; WHO, 2014a, 2015a). However, a technical consultation on conflicts of interest in nutrition programs was held in October 2015, months before FENSA – by then plagued by four years of criticism about its conceptualization of conflicts of interest – was adopted in May 2016, and could have been used to develop an approach on preventing and managing them across all of the WHO's activities and at all levels of activity, and to correct the Framework and inform its further development. Instead, the Framework that was adopted is based on a faulty conceptualization which has become the reference point for future policies, such as the approach on preventing and managing conflicts of interest in national nutrition programs.

A draft approach to preventing and managing conflicts of interest in nutrition programs was

made available for public consultation from September 11-29, 2017. Several submissions by civil society groups and technical experts who had participated in the October 2015 consultation noted that the draft, particularly its conceptualization of conflict of interest, did not reflect the guidance that had been provided by the experts at the technical consultation held in this connection in October 2015 (GIFA, 2017; IBFAN, 2017; Richter, 2017). Civil society groups such as IBFAN and the Geneva Infant Feeding Alliance were concerned that the approach was designed to align with FENSA and had adopted the Framework's same faulty conceptualization (GIFA, 2017; IBFAN, 2017). Marc A. Rodwin,[84] one of the expert participants in the technical consultation, noted that instead of "definitions of conflicts of interests that follow the traditional way the term is used" in law, government regulations and public policy and by the Organisation for Economic Cooperation and Development, the World Bank and most corporations, the proposed approach uses "variations of more popular definitions used in medical journals recently" (Rodwin, 2017, p. 1). The use of such variations "causes conceptual confusion and muddies the water," he wrote, and "it would be better to employ the more traditional definition to remain faithful to the concept" (Rodwin, 2017, p. 1). He takes issue with the suggestion that nations should just conduct a cost-benefit analysis of proposed partnerships and that conflicts of interest are one part of that analysis. "Conflicts of interest is a distinct concept," he asserts, "and [this approach] confuses matters" (Rodwin, 2017, pp. 1–2).

Another expert from the technical consultation, Jonathan H. Marks,[85] emphasized that "the guidance [in the draft approach was] significantly more permissive than the approach [he] proposes" (Marks, 2017, p. 1). In his work on "the ethical hazards that arise when public health agencies enter into close relations with the private sector actors," he argues for "a presumption against close relations with such actors" and contends that "arm's length relations should be the default" (Marks, 2017, p. 1). "Where a proposed relationship would undermine the integrity of a public health agency," he wrote, "the agency should be advised not to enter into that relationship at all" (Marks, 2017, p. 1). He opposed folding integrity into a cost-benefit analysis, as the proposed approach suggests, and said public health agencies should be "advised to develop strategies to counter industry influence—strategies that include but are not limited to conflicts of interest policies" (Marks, 2017, p. 1).

[84] Professor of Law, Suffolk University Law School, Boston, MA and Senior Research Fellow, IMéRA Institute for Advanced Study, University of Aix-Marseille, Marseille, France (2017-18).
[85] Director of Bioethics Program at Penn State University, USA.

Judith Richter,[86] who also participated in the technical consultation, noted the struggle during the development of FENSA to have its problematic conflict of interest definitions and conceptualization debated and corrected. She expressed her disappointment that the consultant hired to develop the background paper for the discussion had been asked to align the approach with FENSA and to supplement it were necessary with definitions from the Scaling-Up Nutrition (SUN) movement. She noted that the Draft Approach disregards the input by the experts at the technical consultation. She concluded that the advice and tools building on the draft approach's conceptualization of conflicts of interest "will lead to undermining rather than supporting national efforts" in this respect (Richter, 2017).

Despite these concerns, the Director-General brought the proposed Approach on preventing and managing conflicts of interest in nutrition programing at country level to the notice of the Executive Board and the Assembly in January and May 2018, respectively, noting that "the Secretariat [would] pilot the approach at country level in the six the WHO regions to test its applicability and practical value" (WHO, 2017c, 2018i).

Early indications after FENSA's adoption suggested that its purported objective of safeguarding against conflicts of interest had been sidelined in favour of fundraising objectives. For example, and perhaps most notably, when the Bill and Melinda Gates Foundation, a top financial contributor to the WHO, was admitted in January 2017 into Official Relations status with the organization, there was no disclosure of its ties to the profit-making sector. The BMGF receives its revenue from the Bill and Melinda Gates Foundation Trust endowment, which is heavily invested in many of the food and beverage companies and stores that contribute to, or profit from the treatment of, NCDs. For example, the Trust has invested directly in a Coca-Cola regional company (Americas south of the US) ($466 million), Walmart ($837 million), Walgreen-Boots Alliance ($280 million), and indirectly in Coca-Cola and Kraft Heinz Inc (40 CSOs, 2017).

This situation creates a conflict of interest for the WHO, in that its secondary interest of securing its large financial contributions from BMGF may interfere in its ability to fulfil its primary interest – its mandate of protecting and promoting public health with respect to nutrition and NCDs – due to the fact that BMGF benefits from the sale of products that are subject to the WHO standards and advice to governments and whose interests conflict with those of the WHO by contributing to poor nutrition and communicable diseases have conflicting interests.

[86] Independent Researcher.

FENSA was to be fully operational within two years of adoption and its implementation and impact on the WHO's work were to be evaluated by 2019. The results of the evaluation and any proposals for revision are to be submitted to the Executive Board meeting in January 2020 (Seitz, 2016). However, several significant concerns about the operationalization and implementation have already been raised. The first is that the department in charge of implementing FENSA is Health and Multilateral Partnerships, known prior to the March 2019 restructuring as Partnerships and Non-State Actors. Some observers had expected that responsibility for FENSA implementation would be shifted to either the Office of the Legal Counsel or Office of Compliance, Risk Management and Ethics as part of the restructuring process.

The department is responsible for both implementing FENSA and promoting and entering into partnerships with NSAs. These two functions create potential risk of conflict of interest for the department. India raised this matter at the Executive Board meeting in January 2018, and argued that implementation of FENSA should be the responsibility of the Office of the Legal Counsel, not the department also in charge of resource mobilization (WHO, 2018a). The Geneva Global Health Hub (G2H2), a civil society platform, in November 2017 raised the same concern and added: Independent of the skills and integrity of this official, the institutional arrangement of combining responsibilities for both tasks in one person risks compromising the WHO's stand on FENSA. The responsibility of FENSA implementation should be rather moved to the Office of Legal Counsel" (G2H2, 2017).

G2H2 also highlighted the fact that "although the term conflict of interest is mentioned multiple times in FENSA … there is still no consistent conflict of interest policy in the WHO regulating institutional conflicts of interest" (G2H2, 2017). Instead of first developing and finalizing a conflict of interest policy and having it form the cornerstone of the WHO's policy on engagement with NSAs and other policies, subsequent policies are now being aligned with FENSA's faulty conceptualization of the term.

Another concern has been that implementation of FENSA has been slow. For example, FENSA requires determination of whether an NSA is subject to the influence of private sector entities to the extent that it needs to be considered itself a private sector entity. This is essential for determining the nature of the WHO's engagement with the NSA, whether it is eligible for Official Relations status, and in finalizing a collaborative work plan. As of April 2019, no such determination had been made (Gopakumar, 2019).

7.7 Conclusion

Against the backdrop of a global shift toward multistakeholder approaches across the UN system and by the World Health Organization (WHO) in particular, this chapter has analyzed the WHO's policies regarding its engagement with non-State actors (NSAs), and specifically the for-profit sector. The progression of policies and proposals, culminating in the agency's adoption of FENSA, suggests that the WHO has struggled with finding appropriate ways of engaging with NSAs, including NGOs and profit-oriented entities, in ways that advance its interests – both programmatic and financial – without compromising its independence, integrity, credibility and reputation in pursuit of its constitutional mandate as "the directing and coordinating authority on international health work" (WHO, 2006b Article 2(a)), including through conflicts of interest.

The chapter analyzed the development and adoption of FENSA and its implications for the WHO in terms of its integrity and independence and for global health governance and its legitimization of actors with for-profit interests in capacities that influence global health standards, norm-setting and policy-making. Without adequate safeguards, the private sector's influence on governance and policy-making can result in conflicts of interest as well as policy outcomes and practices that prioritize profits over public interest and health ideals. However, throughout FENSA's development, there was a lack of conceptual clarity about what constitutes conflicts of interest *within* an actor, as opposed to conflicting interests *between* actors, and these two separate but related concepts were repeatedly conflated.

The question of *conflicts of interest* remained a contentious point throughout the development process and was one of the reasons the FENSA was not adopted earlier. Although the Framework was expected by many to be adopted, weaknesses and flaws intact, at the WHA in both 2014 and 2015, several Member States expressed enough concern, especially about the lack of clarity on conflicts of interest, as discussed above, that the draft was sent for further consultation and revision. That concerns about conflicts of interest and corporate influence could still not be resolved in the final version of FENSA after many consultations and drafts shows how much is at stake for the corporate sector and their allies and how much influence they possess. To this extent, the WHO's difficulty in developing and having FENSA adopted are emblematic of the very institutional conflicts of interest against which the WHO must guard itself if it is to engage with these actors in ways that do not undermine its core values and mandate. That the Framework could not be pushed through to adoption until 2016 *despite* this influence reveals that corporations and their powerful home and ally countries – such as Switzerland and the WEOG group (Western Europe, Australia,

Canada, Israel, New Zealand and the US) singled out in this chapter – do not possess all the power. Member States that shared NGO concerns about conflicts of interest (and conflicting interests), as mentioned above, had sufficient power to keep the Framework under revision, for better or worse (Gupta & Lhotska, 2015) until its adoption in May 2016.

As evidenced by the analysis in this dissertation, it is necessary that global health actors mandated to protect and promote health in the public interest, such as the WHO, exercise caution when engaging with the private sector in any capacity, but especially as part of multistakeholder initiatives and PPPs. This caution is especially necessary at a time when many global health actors, including the WHO, governments and NGOs, increasingly look to collaborate with the private sector as part of the global trend toward multistakeholder approaches and PPPs in order to bridge resource gaps. Although FENSA is ostensibly intended to safeguard against potential conflicts of interest, faulty conceptualization of this term has resulted in a policy that can lead the agency to greater openness to influence from profit-based actors, not less. Furthermore, in FENSA, the WHO is potentially setting itself up for greater dependence on for-profit entities, which can lead to further conflicts of interest and undermine the agency's role as lead global health body. Its (secondary) interest of bridging budgetary gaps must not be allowed to jeopardize its Constitutional mandate as "the directing and coordinating authority on international health work" (WHO, 2006b).

Chapter 8 – Conclusion

8.0 Introduction

As in other areas of global governance, global health governance has experienced a shift away from state-centered governance and institutions. This has opened spaces for non-state actors (NSAs) such as transnational corporations and non-governmental organizations (NGOs) to influence health policy and policy-making at both global and national levels, resulting in the growing involvement of NSAs in global health governance, including as part of a global shift toward multistakeholder approaches and public-private partnerships (PPPs).

At the same time, as described in Chapter 3, in the decades since the WHO was established in 1948, it has become increasingly resource-constrained as some Member States have refused to increase assessed contributions to regular budget funds that could provide a stable source of financing for the WHO's core functions. In order to bridge its budgetary gap, the WHO relies more and more on Member States and private donors providing voluntary contributions and has adopted a multistakeholder approach, turning to the private sector and philanthropies for support. Such voluntary funding is typically earmarked for specific, vertical programs that are not under the WHO's direct control. This development further compromises the WHO's ability to fulfil its mandated role as lead coordinating agency for health as new private and hybrid public-private actors are created.

Faced with this financial reality and responding to the changing global health architecture, several Directors-General of the WHO have undertaken reform processes. Reform initiatives have included the introduction of new policies intended to facilitate engagement with NSAs, such as the Framework of engagement with non-State actors (FENSA), which was discussed in Chapter 7. As this dissertation has argued, increased engagement by the WHO with the private sector is not without risks.

This chapter proceeds as follows: it begins by summarizing the findings of this dissertation in response to the following questions: 1) In what ways have profit-oriented NSAs engaged with the WHO as a site of global health governance on substantive policies and paradigms that shape policy-making? 2) What are the implications for the WHO and for global health governance of the agency's enhanced engagement with the private sector? The chapter outlines the dissertation's two empirical contributions and its theoretical contributions. The chapter then identifies three possible directions for future research: drawing on new sources of food industry documents to shed additional light on that industry's tactics, further analysis of FENSA itself such as the WHO's engagement with the

three other types of NSAs addressed by the policy, and finally FENSA's operationalization since adoption and its effectiveness with respect to conflicts of interest and undue influence by corporate actors.

8.1 Summary of findings and contributions

In order to answer in what ways profit-oriented NSAs have engaged with the WHO as a site of global health governance, Chapters 5 and 6 analyzed how the baby food and soda industries have worked to influence the WHO initiatives related to the sale and consumption of their products. Chapter 5 analyzed the baby food industry's activities in connection with five key substantive policies and policy areas: 1) the International Code of Marketing of Breast-Milk Substitutes, 2) product differentiation and reformulation, 3) the optimal duration of exclusive breastfeeding 4) Guidance on ending inappropriate promotions of foods for infants and young children, and 5) the 2018 World Health Assembly (WHA) Resolution on Infant and Young Child Nutrition. In order to influence these policies and policy areas, baby food companies and their business associations lobbied the WHO and Member States, finding allies in milk-exporting countries such as the US, which rejected early drafts of the Code and lobbied on the industry's behalf. To circumvent the Code and national legislation and to extend their product line, baby food companies invented differentiated products – so-called "follow-up (or follow-on) milk" for older infants and later "growing-up (or toddler) milks" for one-, two-, or three-year-old children. They shaped perceptions of such products, thereby manufacturing demand for them and arguing that they were not included within the scope of the Code. The baby food industry has also created doubt about the scope of the Code by using its discursive power to manufacture doubt about the optimal duration of exclusive breastfeeding, which it has lobbied to keep as low as possible.

The baby food industry lobbied intensely in connection with a substantive policy that brings together marketing, product differentiation and the optimal duration of breastfeeding: the 2016 Guidance on ending inappropriate promotion of baby foods. Business associations representing the baby food industry intervened to shape the parameters of the debate during the development of the Guidance.

Chapter 6 analyzed the soda industry's activities in connection with the WHO's guidelines on sugar intake levels, because sugar is a constituent ingredient in many soda products, and the taxation of soda products as a part of efforts to prevent and control NCDs. In these instances, the soda industry, supported by the sugar industry trade associations that include soda companies as

their members, used its discursive power to manufacture doubt about soda's contribution to the obesity epidemic and opposed "restrictive" recommendations by relying on the paradigms of individual responsibility and energy balance. It also drew on the instrumental and structural power of allies in the US government, as well as other sugar dependent countries. Similarly, when the WHO Independent High-level Commission on Noncommunicable Diseases recommended taxation as an appropriate fiscal policy for addressing NCDs, soda was not mentioned alongside tobacco and alcohol as a product recommended for taxation. Soda's inclusion as a suitable product for taxation was successfully blocked by the Commissioner from the US, home to Coca-Cola and PepsiCo.

Chapters 5 and 6 also analyzed the ways in which private sector actors have also engaged in a long-game to shape the paradigms that determine which policies are pursued and what role private actors are able to play in developing them. Both the baby food and soda industries promote paradigms emphasizing individual choice and responsibility. They also emphasize corporate responsibility, trustworthiness and the private sector as a partner in developing health-related policy, aiming to gain legitimacy as governance actors and a more direct influence on substantive policies that affect their profitability.

This dissertation has shown that the baby food and soda industries, like other industries, have pursued their substantive and long-term interests, by drawing on a "playbook" of strategies to access and impact upon global health policy-making at the WHO. In deploying these strategies and tactics, companies in these industries, their associations and front groups draw on different types of power, including instrumental, structural and discursive power. The strategies and the power they rely on are iterative and reinforce one another. The baby food and soda industries' well-documented track-records of using the playbook strategies, and the corporate power that underpins them, to influence substantive policy, as analyzed in Chapters 5 and 6, expose the WHO to influence. Such corporate influence raises questions as the WHO seeks to increase its engagement with such actors, especially for-profit entities, as was analyzed in Chapter 7.

Beyond substantive policy and the paradigms that shape it, there are other implications for the WHO and for global health governance of the agency's enhanced engagement with the private sector. As mentioned above, to supplement lagging core funding, the WHO increasingly relies on voluntary contributions, including from the private sector and philanthropic organizations. However, by opening its doors to fuller engagement through multistakeholder arrangements and PPPs, the WHO has potentially set itself up for even more in-depth corporate influence and deeper

reliance on private funding, in ways that undermine its core mandate and erode its role as lead global health body.

As a site for understanding the implications for the WHO and for global health governance of the agency's enhanced engagement with the private sector, Chapter 7 examined the adoption of FENSA, which formalized this fuller engagement, and assessed its implications for the WHO's independence, integrity and credibility. That FENSA was adopted in May 2016 after four contentious years of development, suggests just how much was at stake in the new policy. The debates are indicative of the types of issues against which the WHO must guard itself if it is to engage with these actors in ways that do not undermine the agency's core values and mandate.

The WHO presented the Framework as necessary to facilitate engagements with NSAs. Some observers interpreted this as referring primarily to the private sector and philanthropies as the agency looked to multistakeholder partnerships to supplement its lagging core funding. While FENSA has been termed "a necessary but insufficient response to the part the private sector plays in determining population level health outcomes" (Buse & Hawkes, 2016), its adoption further institutionalizes the influence of private authority, especially profit-motivated entities, by, for example, making business associations eligible for Official Relations status and the privileges and increased access that this confers.

Although FENSA is ostensibly intended to safeguard the WHO against potential conflicts of interest, confusion over the conceptualization of this term has resulted in a policy that can lead the agency to greater openness to influence from profit-based actors, not less. The development process revealed that the WHO, as well as many Member States and NSAs participating in various consultations, did not understand what is meant by a "conflict of interest", how it is different from "conflicting interests" (perhaps better referred to as "competing" or "diverging interests"), and each one's potential for harm. Unfortunately, the conflation of these two different but related concepts plagued the development of FENSA and remains in the final policy as adopted by the WHA in May 2016. FENSA entrenches a faulty conceptualization of conflicts of interest into the WHO's operations and future discussions and policies and has since been taken as the basis on which to frame subsequent policies.

Additionally, FENSA further institutionalizes of the WHO's multistakeholder approach and entrenches its reliance on voluntary contributions, described in Chapter 3, whereby programs are increasingly donor-driven instead of Member State-driven. It facilitates Member States and private organizations opting for vertical programs or PPPs instead of increasing assessed contributions

toward the WHO's core budget. As a result, the WHO's capacity to perform its core functions is gutted, and its role as a global health leader further compromised. The WHO is being decentered or bypassed altogether with the creation of new institutions and partnerships within the changing global health architecture. Lost in this process is the WHO's social view of health and its affirmation of health as a human right. The WHO can only recover its independence and effectiveness if Member States enhance their political and financial support of the WHO and increase their assessed contributions substantially (Seitz, 2016).

These findings contribute to the literature in several ways. Empirically, they provide in-depth case studies of the baby food and soda industries that contribute to understandings of how private actors engage with the WHO deploying strategies and tactics from the corporate playbook and drawing on the different types of power that underpin them. For example, despite framing themselves as trustworthy partners in addressing health issues – "part of the solution" (Nixon et al., 2015) – corporate actors seek to influence substantive policy that can have negative impacts on health outcomes and global health governance and policy-making more broadly as they shape paradigms that that determine which policies are pursued and the role private actors play in developing them. Although the dissertation focused on the global health sector, the findings contribute to the understanding of similar developments in other fields where the corporate playbook is used to influence policy and promote the legitimacy of corporate actors as governance actors.

The dissertation's second empirical contribution is an analysis of the development and adoption of FENSA and its implications for the WHO in terms of its integrity and independence, given the private sector's well-documented efforts to influence policy at the WHO, as described in Chapters 5 and 6 in relation to policies and paradigms regarding the baby food and soda industries. FENSA represents a shift toward private authority, giving transnational corporations and some civil society actors a greater voice in determining global health policy. As a result, substantive policy may be weaker than had the public interest been the primary consideration. The dissertation analyzes the implications for global health governance of legitimizing and institutionalizing actors with for-profit interests, such as baby food and soda companies and their business associations and front groups, in capacities that influence global health standards, norm-setting and policy-making. It also contributes an analysis of the extent to which the WHO is potentially setting itself up for greater dependence on for-profit entities, which can lead to further conflicts of interest and undermine the WHO's role as lead global health body.

As a theoretical contribution, this dissertation builds on the public and global health literature's notion of corporate (or commercial) determinants of health and classification of the corporate sector's political activities into a playbook of strategies that is common across industries. It has drawn on the international political economy literature to contribute an analysis of the types of power that underpin the strategies in the playbook, and to analyze the ways in which these strategies and different types of power are iterative and mutually reinforcing. In doing so, my analysis brings to the existing literature:

a) An understanding of how corporations increase their legitimacy and influence as governance actors by participating in multistakeholder initiatives, public private partnerships, and self-regulatory platforms. This analysis shows the multistakeholder approach and self-regulation to be an extension of corporate actors' efforts to influence policy and shape paradigms to enhance their legitimacy as partners in global health policy-making and governance
b) An application of the concept of the corporate playbook to the strategies and tactics undertaken by corporations and their associations to influence the WHO as the global lead body on health. This focus is especially interesting because although the WHO lacks enforcement mechanisms, it remains a significant site for political activity by corporations to influence both policy recommendations and paradigms relating to health, industry products, and corporations and their associations as governance actors.

A more nuanced understanding the strategies in the corporate playbook as they are deployed to influence global health policy-making and governance at the WHO and how the strategies are accessible to the corporate sector. The analysis demonstrates how, in pursuing these strategies and tactics, the corporate sector is able to draw upon different types of power – notably instrumental, structural and discursive power. Moreover, the exercise of one type of power often increases or reinforces access to another type of power. In this way, the analysis shows that the strategies and tactics and the different dimensions of power underpinning them are iterative and mutually reinforcing. For example, by using discursive power to represent itself as a "partner" and legitimate governance actor, the private sector increases its instrumental and structural power by shaping paradigms that determine which policies are pursued and what role private actors are able to play in developing them.

Together, these empirical and theoretical contributions inform the development of policy-making processes and mechanisms that safeguard the public interest. My analysis presents a critical evaluation of private sector influence on global health policy and governance, demonstrating that

corporate activities and influences have both governance and public health implications. Such a critical analysis is particularly necessary at a time when the agency is increasingly seeking partnerships with the private sector and philanthropies to bridge its budgetary shortfalls an evolving global health architecture. This shift is taking place against a backdrop of a similar trend toward multistakeholder initiatives and public private partnership and an emphasis and entrenchment of the role of private sector in efforts across the UN system and the development sector more broadly (see, for example the Sustainable Development Goals (UNGA, 2015)).

8.2 Direction for future research

As discussed in Chapter 1, it can be difficult to access firsthand information about companies and industries associations. However, after the research for this dissertation was completed a new resource has become available for exploring food and beverage industry activities to influence global health governance. The Food Industry Documents Archive was launched by the University of California, San Francisco Industry Documents Library on November 15, 2018 (UCSF, 2018). The Industry Documents Library is already home to archives about the tobacco, drug, and chemical industries that have made it possible to investigate corporate tactics for influencing public health policy. Future research delving into this new industry documents archive can shed additional light on the tactics that the food industry uses.

FENSA itself also warrants further research. While this dissertation has focused on the Framework in relation to the growing political influence of corporate actors, FENSA addresses the WHO's engagement with NGOs, philanthropic foundations, and academic institutions. Each of these types of actors warrants detailed consideration of its political influence on the WHO and global health governance more generally. Research into the WHO's engagement with NGOs is of particular interest. NGOs often draw their political legitimacy – and distinction from the corporate sector – from their claim that they represent the public interest. However, NGOs lack accountability to the public, and there is also growing corporate involvement in the civil society sector. These two factors may muddy the water for the WHO's engagement with this type of NSA.

Further examination is also necessary of the unfolding operationalization of FENSA, analysing its effectiveness with respect to conflicts of interest and undue influence by corporate actors and the implications of its institutionalization of the WHO's multistakeholder activities. Of particular interest is the initial evaluation conducted in December 2019 for presentation at the Executive Board meeting in February 2020 (WHO, 2019h). Chapter 7 raised several significant

concerns about the operationalization and implementation of FENSA. For example, the department responsible for implementing FENSA is also tasked with entering into partnerships with NSAs. These two functions create potential risk of conflict of interest for the department. The effectiveness of FENSA's ability to safeguard against conflicts of interest should also be assessed. The January 2017 admission of the Bill and Melinda Gates Foundation, a top financial contributor to the WHO, into Official Relations status with the WHO with no disclosure of its ties to the profit-making sector suggests that safeguarding against conflicts of interest have been sidelined in favour of fundraising objectives.

8.3 Conclusion

Taking the baby food and soda industries as examples, this dissertation outlined why it is important for the WHO to take seriously the need for caution when engaging with the private sector in light of the track-record of these industries. This caution is especially important given the WHO's embrace of a multistakeholder approach as it tries to address its financial challenges.

In evaluating potential engagement with NSAs, besides the risk of potential conflicts of interest (which, again, would exist *within* the institution), the analysis in the dissertation why WHO must also consider *conflicting interests*, namely the extent to which each NSA's interests align with public health interests, how much with profit-making interests, and how much with maintaining the independence, integrity and credibility of the WHO as a global health leader. Public health interests, and not profit-making interests, should determine global health policy, and also the legitimacy and influence of NSAs in the policy-making process.

The analysis in this dissertation has shown that corporations will go to great lengths to protect and expand their ability to make a profit. Although they may provide an essential product or service to advance public health, and they may be happy to see this positive outcome, fundamentally their main interest is turning a profit. That is the corporation's *raison d'être*. Corporations can be necessary and even important global health *actors,* but, based on the analysis in this dissertation, they should not be part of policy-making. They may contribute to the common good, but, as Marks (2019, p. 51) notes, "they cannot and should not be considered [its] guardians," which is the responsibility of public officials, government bodies, and intergovernmental organizations. Based on the analysis in this dissertation, therefore, the WHO must take measures to protect global health policy and policy-making against profit-driven influence and safeguard its own independence,

integrity and credibility as a global health leader, including by responding appropriately to both "conflicts of interest" and "conflicting interests".

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