CHAPTER 2

The objects of global health policy

Turning knowledge into evidence at the World Health Organization

Rachel Irwin

In December 2012, I received a box with a picture of a mother and baby. It was a 'Nourishing newborns feeding kit', which, according to the text on the outside, included an 'easy-to-follow guide to breast and bottle feeding, valuable savings on infant formula and Similac savings for your baby.' The box also had the slogan, 'Newborns don't come with a feeding manual. But Similac® StrongMoms® does'. In addition to this box, between July 2011 and December 2012 Abbott Laboratories, the makers of Similac, sent me five direct mailings advertising Similac Infant Formula and each including a $5 coupon.

At the time, I was researching the UNICEF/WHO International Code of Marketing of Breastmilk Substitutes. The Code was adopted in 1981 in response to the unethical marketing of infant formula, especially in low-income settings. The direct mailings I received thirty years later were a violation of the Code, specifically Article 5 which prohibits both the direct advertising to mothers and coupons. I reported this to the International Baby Food Action Network (IBFAN), an international non-governmental organization (NGO). IBFAN relies on a grassroots network to supply it with examples of Code violations or inappropriate private sector involvement. As

part of their work, they run the International Code Documentation Centre in Penang, Malaysia, to which people can report violations. The Centre responded, letting me know that they had received similar reports from mothers in Canada and the US. My complaint, and those of the mothers referenced in the letter, eventually fed into IBFAN reports, including updated versions of *Breaking the Rules, Stretching the Rules*, a biannual report produced by IBFAN that presents evidence on violations of the Code. IBFAN uses the report as an advocacy tool, for example using excerpts in flyers to hand out at WHO meetings with the aim of influencing policymakers.

This vignette describes how an object—or a photographic representation of it—can be transformed from a promotional tool, manufactured at an Abbott factory, into a piece of evidence which is then used in advocacy at the WHO in Geneva, Switzerland. In a broader sense, public health knowledge and experience are embedded in an object which is then used as evidence to inform policy.

Empirical and theoretical approaches

The transformation of public health knowledge and experience into evidence is fundamental to the work of the World Health Organization (WHO). As the United Nations' (UN) specialized agency for health, the WHO constitution mandates it to 'propose conventions, agreements and regulations, and make recommendations with respect to international health matters' and to 'develop, establish and promote international standards' in the health sector. In order to fulfil these core functions of 'setting norms and standards' in public health and 'articulating ethical and evidence-based policy options' (WHO 2019), the WHO also calls on experts to prepare independent and evidence-based reports. However, as a member state organization, the process of making recommendations and regulations also formally involves representatives from 194 countries, and often includes other UN bodies, civil society, and the private

sector. A key question is how (or if) the WHO produces policies that are globally relevant through this process. How are public health knowledge, evidence, and experience from 194 member states and a wide range of other stakeholders incorporated into policies that are meant to be universally applicable?

I examine this question by comparing the production of two WHO policies: the *International Code of Marketing of Breastmilk Substitutes* (1981) and the *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* (2010). The latter, developed in response to concern at increasing rates of childhood obesity, sets out ways for member states to 'reduce the impact on children of marketing of foods high in saturated fats, trans/fatty acids, free sugars, or salt.' In drafting both the Set of Recommendations and the Code, the WHO involved member states, experts, civil society, and the private sector in the shape of the food and pharmaceutical industries. Both documents were formally adopted and endorsed by WHO member states at the World Health Assembly (WHA), the WHO's main governing body.

Empirically, my comparison is based on interviews with key stakeholders behind both documents, ethnographic fieldwork at WHO headquarters in Geneva, archival material, and documentation from WHO governing body meetings. I interviewed 46 individuals, spanning WHO staff, staff from other relevant UN bodies, representatives from member states (including the WHA delegations), NGOs, and private industry (including advertising and the food and beverage sectors), and researchers involved in the case studies as experts. After the Set of Recommendations was endorsed by the WHA, the WHO was tasked with producing an implementation guide. This document sets out policy options and suggestions for incorporating the Set of Recommendations into national contexts. I carried out six months of participant observations at WHO headquarters, working in the team responsible for the Set of Recommendations and contributing to the writing of the implementation guide, which was finalized in 2012. In the course of the fieldwork, I came across information and experience

embedded in many physical and digital objects—reports, flyers, peer-reviewed articles, systematic reviews, logos, products, and brands—which are the subjects of this chapter.

The policy process at the WHO revolves around the transformation of public health experience and knowledge into evidence. Such knowledge and experience often come in the form of systematic reviews of peer-reviewed literature, official recommendations by expert committees, and data on disease trends and burdens. In the case of the Code and the Set of Recommendations, evidence also includes documented violations of the Code or other marketing techniques considered inappropriate by the various actors in the case studies. Formal decisions, or resolutions, taken by the WHA, not only cite evidence, they also become evidence in that they can be cited in future resolutions. In fact, any object can become evidence when it is used to prove a point. In the policy context, evidence only exists in relation to a question (Engelke 2008). That is, knowledge and experience of the marketing of food or infant formula is organized into evidence depending on who is using it and for what purpose, and evidence must be *for* something (Engelke 2008). In other words, the Similac® kit was 'just' an object, but became evidence when used by breastfeeding advocates to prove that Abbott was violating the Code. In other words, as Åsa Alftberg notes in this volume, knowledge is mediated through material objects.

The narratives of these two case studies demonstrate how policymaking at the WHO is the result of the interaction among public health knowledge, evidence, emotion, and a range of situational, social, and environmental factors that influence political feasibility (Walt 1994, 29–33; Hodžić 2013). We also see that the global health community continues to struggle and experiment with ranking and using different types of evidence in creating policy. On the one hand, the superiority of evidence can be fetishized and used to create the illusion that policy stakeholders are morally superior and acting impartially according to what the evidence 'says'. In this way, the use of evidence can be a way to assert power. On the other hand, evidence is a social product whose truth can be challenged. Indeed,

treating evidence as truth can obscure the subjective, ideological, and political nature of the production of evidence (Goldenberg 2006). For example, criticisms of randomized controlled trials (RCT) and evidence-based medicine focus on how these movements and tools have inappropriately quantified the social and political processes that interact with health, or have ignored them completely (Lambert 2006; Lambert et al. 2006; Goldenberg 2006; Ecks 2008). In another example in this volume, Kristofer Hansson, Gabriella Nilsson, and Irén Tiberg look at the challenges of implementing evidence-based care practices in real-life settings. Evidence can also be challenged on the basis that those who produce it are biased—as in both of the cases I mentioned at the start of this chapter.

Beyond this, the policy process at the WHO is characterized by both politics and aesthetics. Major policies, such as the Code or the Set of Recommendations, must be agreed upon by 194 member states. Each of these countries has their own social, cultural, and political contexts which influence how they vote or push for certain policy choices in Geneva. This also creates a situation in which powerful lobbies or advocacy groups at the national level can influence member states to make certain decisions at the WHO, and pressure other countries to do the same. At the same time, WHO documents represent a certain type of genre, and knowledge and evidence must be massaged so that it fits the aesthetic constraints of international policy documents (Hodžić 2013; for press releases, see Lindh in this volume).

In what follows I look at how public health knowledge and experience were transformed into evidence, which in turn was used to produce both the Code and the Set of Recommendations. In doing so, I consider the use of evidence for agenda-setting and as a rationale for action, controversies about evidence, and how the 'best available evidence' promotes or limits certain policy options.

Evidence as a rationale for action

I begin with breastmilk substitutes: at the 27th WHA in 1974, fifteen WHO member states sponsored a draft resolution that was adopted as Resolution WHA27.43. Its preamble stated:

> Reaffirming that breast-feeding has proved to be the most appropriate and successful nutritional solution for the harmonious development of the child; … Noting the general decline in breast-feeding, related to sociocultural and environmental factors, including the mistaken idea caused by misleading sales promotion that breast-feeding is inferior to feeding with manufactured breast-milk substitute. (WHO 1974, 1)

This was the first mention in the WHO record of the issue of marketing of breastmilk substitutes, and it noted evidence and experiences of the decline in breastfeeding.[1] Less than ten years later, the WHO would adopt the International Code of Marketing of Breastmilk Substitutes. Here I will trace the history leading up to the adoption of the Code.

The decline of breastfeeding rates and the rise of commercial feeding had their origins in the industrial era and shifts in women's roles (Palmer 2009). Broadly, industrialization led to increased female employment outside the home in settings that were not conducive to breastfeeding. 'Scientific products' such as infant formula were promoted as 'modern' and 'better'. In the first half of the twentieth century, the increasing Westernization of medicine continued this trend, so that by the Second World War artificial feeding was promoted as the norm in much of the US and Europe (Post & Baer 1980; Palmer 2009; Allain 2005, 8). Other reasons cited for the decline in the mid twentieth century included a lack of education in general, lack of education about breastfeeding, family influences, working conditions, and healthcare practices (WHO 1981, 7, 14–24).

In the post-war period, companies also began to market their products heavily in low- and middle-income countries. According

to the WHO, this marketing of breastmilk formula was a factor in the decline of breastfeeding:

> Another factor is the infant food industry. While it has met certain needs it has also diffused new and inappropriate ideas on infant feeding and has often created an unnecessary demand. The advertising and promotion of breast-milk substitutes, particularly in health facilities, may have contributed to the decline in breastfeeding. Promotion of breast-milk substitutes by commercial concerns has been more extensive and pervasive than provision of information about the advantages of breast-milk and breastfeeding. (WHO 1981, 17)

Companies marketed their products in ways that many NGOs and others working in health considered to be unethical. For instance, companies gave medical workers misleading literature and free samples, and, dressed in white coats, gave starter packs of formula to new mothers while still in hospital (Jelliffe 1971; Werner & Saunders 1997). This was not limited to low- and middle-income countries, but health workers and activists were particularly concerned about the promotion in poor resource settings.

Specifically, they were concerned by the misuse of infant formula, leading to higher infant mortality. This included mixing formula with contaminated water, diluting formula to make it last longer, or the use of non-appropriate foods as formula such as sweetened condensed milk (Werner & Saunders 1997). The difference in mortality between breastfed and formula-fed babies was noted as early as 1910 (Davis 1913). In the 1930s, Cecily Williams—later the first director of Maternal and Child Health at the WHO—warned of unsanitary, diluted breastmilk substitutes (Joseph 1981). In the 1950s and 1960s, doctors across Africa were 'dismayed by the numbers of younger infants suffering from the diarrhoea and malnutrition that came to be called "bottle-baby disease"' (Palmer 2009, 240). The issue here, as in Europe and the US at the turn of the century, was that much of the population

did not have access to clean drinking water. Also, on account of poverty, mothers were diluting the formula to make it last longer, further contributing to malnutrition. An additional concern in poor resource settings was the high costs of treatment for ill babies (Post & Baer 1980).

The concern expressed by healthcare providers gained attention in the popular press in the early 1970s. The New Internationalist magazine published an interview with two paediatricians who had worked in Africa. Then in 1974, the British charity War on Want published *The Baby Killer*, which was infamously translated into German as 'Nestlé kills babies' (Palmer 2009, 242). Perhaps what garnered more attention was not the publication itself, but Nestlé's libel suit against War on Want (Chetley 1988).

By this time, religious groups were also concerned about the promotion of infant formula. The World Council of Churches' Christian Medical Commission addressed the issue in several of its newsletters (Barrow 1976).[2] In the US context, the Interfaith Center on Corporate Responsibility, a coalition of national church bodies and Roman Catholic orders, investigated the issue and, finding that many of its constituent national church bodies and Roman Catholic orders held shares in companies that sold infant formula, decided to encourage its membership to file shareholder resolutions. At first these resolutions were simply requests for information and clarification about marketing practice, but as marketing practices were documented in ever-greater detail they began to take legal action. For example, in 1976 the Sisters of the Precious Blood, who held shares in Bristol Myers, filed a lawsuit against them for misleading sales promotion. The Infant Formula Action Coalition grew out of these grassroots efforts to launch a boycott of Nestlé in 1977, which attracted a growing number of breastfeeding groups, such as Baby Milk Action in the UK.

The result was that the issue entered the political arena, where it was picked up by US Senator Edward Kennedy. He pursued it at both the national and the international level, even insisting that the WHO send a representative to testify to Congress and later

requesting that the WHO organize a conference to consider the development of an international Code (McCoy 1995).[3] Prompted by Senator Kennedy's letter along with 'deep concern felt by many people, organizations and governments about the state of health and nutrition of the infant and young child' the WHO and UNICEF called a joint meeting in October 1979 (WHO 1981, 10). Experts and stakeholders discussed information about energy needs, normal weight gain, milk production and composition, anti-infective factors in human breastmilk, and mechanisms of prevention. They also considered information on trends in breastfeeding and its role in birth spacing (WHO 1981). The WHO had set up a collaborative study that ran between 1976 and 1978 to gather evidence on breastfeeding, specifically 'to define the current state of breastfeeding more clearly and to identify the factors contributing to change'. In it they studied 23,000 mother and child pairs from Chile, Ethiopia, Guatemala, Hungary, India, Nigeria, the Philippines, Sweden, and Zaire, countries chosen to represent broad regional, cultural, and socioeconomic differences across the WHO, with participants selected from a range of rural and urban locations and according to their socioeconomic status (WHO 1981, 130).

One recommendation to come out of this meeting was that 'there should be an international code of marketing of breast-milk substitutes' (WHO 1981, 10). Over the next two years, the WHO Secretariat consulted with member states, other UN agencies, NGOs and consumer groups, scientists, and the food industry. They went through several drafts of the International Code, which was revised following further consultation. The final version was endorsed by the 34th WHA in May 1981. It was widely seen as a success, with only the US voting against it and three other countries abstaining.

At the 34th WHA, delegates submitted interventions, citing evidence to argue for the Code. The Iranian delegate noted the health benefits of breastfeeding, stating that:

> Breastfeeding not only provided the child with a considerable amount of maternal antibodies, thus protecting it against communicable disease. It also created an emotional and psychological interdependence between mother and child which resulted in well-balanced physical and mental growth. (WHO 1982a, 11)

The delegates of Turkey and Canada, respectively, made similar points on the 'superiority' of breastmilk over infant formula, with Turkey arguing that 'no one questioned the superiority of breastmilk'.

> Indeed, the biological and psychological benefits of breastfeeding were so well established that it would be superfluous to elaborate on them, except perhaps to say that every year added more knowledge of breastmilk's unrivalled anti-infective and nutritive properties. (WHO 1982b, 3–4)

Canada said that 'the superiority of breastmilk—psychological, nutritionally, immunologically—was beyond dispute. Hence breastfeeding must be encouraged and produced as one of the measures essential to the vary [*sic*] survival of many infants and desirable for the health development of all the world's children' (WHO 1982b, 4).

The Code provides guidance on how companies may ethically market products to healthcare providers and to mothers, including, but not limited to, the following measures:

> All products should include clear labels with the benefits and superiority of breastmilk;
> Labels should also clearly state the hazards of improper preparation of breastmilk substitutes;
> No advertising of breast milk substitutes to the general public;
> No free samples to pregnant women, mothers or members of their families;
> No promotion in health care facilities, including no free supplies. (WHO & UNICEF 1981)

The WHO Code per se is non-enforceable, but many WHO member states have incorporated parts of it into their own national laws, which are in line with the Code (Allain 2005; Palmer 2009). Companies have subsequently been taken to court in several countries, either for false advertising or for breaking national law in member states. For example, in the mid-1990s a consumer group in India took Nestlé to court for violating the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 (Jindal 1996; Bouckley 2012). Primary monitoring of the Code is carried out by a global network of breastfeeding groups, under the wider umbrella of the International Baby Food Action Network, and the reporting on the Code's implementation is typically discussed every other year at the WHA.

In the next section, I turn to the marketing of food and non-alcoholic beverages to children. In high-income countries childhood overweight and obesity levels began to rise in the 1980s, alongside a rise in adult levels. Obesity and overweight are multifactorial, with a number of causes and suggested reasons for the increase. At a micro level, these include levels of physical activity, parental eating habits, breastfeeding, and early child nutrition; at a macro level, both the academic and popular discourses have focused on the nutrition transition, including the role of modernization and industrialization in the food and agriculture sectors, the growth of transnational companies, and trade liberalization (Zimmet 2000; Hawkes 2007), and specifically the role of fast-food companies, agricultural subsidies, high fructose corn syrup, and the marketing of unhealthy food (Schlosser 2001; Nestle 2002). These dietary changes are not limited to high-income settings (Kennedy 2005; WHO 2010). In fact, low- and middle-income countries bear the greatest burden of diet-related non-communicable diseases (NCDs) (WHO 2011).

Philip James of the International Obesity Task Force was one of the first researchers to raise concerns about the specific role of the marketing of food and non-alcoholic beverages to children as

a significant contributor to the rise in childhood obesity. The first milestone was his 1997 report to the UK government, *Healthy English schoolchildren: A new approach to physical activity and food* (James & McColl 1997), in which he discussed corporate promotion in schools. Two subsequent studies were also influential in setting out the evidence base, raising awareness of the issue, and contributing to national policy: the so-called 'Hastings Review', and an Institute of Medicine (US) study in 2006. Gerald Hastings and colleagues published the first systematic review of the effects of food promotion on children for the British Food Standards Authority (Hastings et al. 2003). Policy recommendations included restrictions on broadcast advertising and the sponsorship of products high in fat, salt, or sugar during and around programmes with a disproportionately high child audience. Three years later, the US Institute of Medicine produced the report, *Food Marketing to Children and Youth: Threat or Opportunity?* (IOM 2006).

During the first five decades of the WHO's existence, the organization, with a few notable exceptions, neglected non-communicable disease, focusing overwhelmingly on infectious disease. Those exceptions included a report by the WHO's Study Group on Diet, Nutrition and Prevention of Chronic Disease, published 1990. The WHO's first explicit recognition of the emerging obesity epidemic came in 2000 when it published a technical report on obesity, subtitled *Preventing and Managing the Global Epidemic* (WHO 2000). It was thus in the late 1990s that the WHO's work on food marketing began. 'Recognising the growing burden of NCDs and the fact that up to 80 per cent of heart disease, diabetes and stroke and over a third of cancers can be avoided by avoiding risk factors' (WHO 2008), in 2000 the 53rd WHA endorsed the Global Strategy for the Prevention and Control of Noncommunicable Diseases. The WHO's mandate for action on marketing food to children is ultimately derived from this document.

In a report prepared for the WHO, *Marketing Food to Children: The Global Regulatory Environment*, Corinna Hawkes (2004) focused on the processes that were very visible to the consumer,

namely advertising and promotion. The report considered food marketing and promotion to include (but not to be limited to) broadcast advertising (television and radio), in-school marketing, corporate sponsorship, product placement, online and digital marketing, sales promotions, and packaging, including everything from supermarket specials on certain items to product placements in television programmes (Hawkes 2004). In the period leading up to the Set of Recommendations, the bulk of marketing of food and non-alcoholic beverages to children was on television, but the Internet, films, music, games, viral marketing, events sponsorship, and cross-promotions (such as toys in fast-food meals) were also notable sources (Harris et al. 2009).

The 60th WHA saw the passing of Resolution 60.23 on the Prevention and Control of Noncommunicable Disease: Implementation of the Global Strategy (WHO 2007), which asked the Director-General to use the Global Strategy for the Prevention and Control of Noncommunicable diseases as a basis for developing an action plan (WHO 2008). As part of Resolution WHA 60.23, the Director-General was asked 'to promote responsible marketing of foods and non-alcoholic beverages to children, in order to reduce the impact of food high in saturated fats, trans-fatty acids, free sugars, or salt, in dialogue with all relevant stakeholders, including private-sector partiers, while ensuring avoidance of potential conflict of interest.' It also called upon the WHO Secretariat to develop a set of 'recommendations on marketing of foods and non-alcoholic beverages to children' (WHO 2007).

As part of the process of drafting the Set of Recommendations, Hastings and his colleagues were asked to write two reports for the WHO on global data. In 2009, the WHO published their study, *The extent, nature, and effects of food promotion to children*, in which they reviewed studies from the 1970s up to 2008. Although the data was mixed, overall they found that food promotion did indeed influence food preferences, preferences for branded over unbranded products, and purchase-related behaviour (Cairns et al. 2009; Hastings et al. 2003; Livingstone 2005). The WHO

Secretariat convened an ad hoc expert group on food marketing for a week-long meeting to look at the evidence base for policy recommendations, including Hastings and his colleagues' reports. The WHO also consulted with member states and held two sets of stakeholder dialogues in Geneva with the private sector and NGOs respectively (WHO 2012).

At the 63rd WHA in 2010, the WHO Secretariat presented its recommendations on the marketing of food and beverages to children, as mandated by Resolution 60.23. They were duly passed as Resolution 63.14. The recommendations present a range of policy options for member states and, although much of the onus falls on them to implement the marketing policies—whether as government regulations, private sector voluntary pledges, or a combination—the WHO can offer assistance in developing policies if wished. One form this took was the 2012 implementation guide for the Set of Recommendations, a document that provides national and regional policymakers with concrete options for implementing the Set of Recommendations.

In the foreword to the Set of Recommendations, Dr Ala Alwan, then Assistant Director-General for Noncommunicable Disease and Mental Health, cites evidence of the global burden of obesity and overweight among children and its effects:

> Overweight and obesity now ranks as the fifth leading risk for death globally. It is estimated that in 2010 more than 42 million children under the age of five years are overweight or obese, of whom nearly 35 million are living in developing countries. Overweight during childhood and adolescence is associated not only with an increased risk of adult obesity and NCDs, but also with a number of immediate health-related problems, such as hypertension and insulin resistance. (WHO 2010, 4)

He then points to the role of marketing in childhood obesity:

> But at the same time, the wide availability and heavy marketing of many of these products, and especially those with a high content of fat, sugar or salt, challenge efforts to eat healthily and maintain a healthy weight, particularly in children. (WHO 2010, 4)

Although he does not cite any specific studies of marketing, this is inferred, and he does refer to the overall process, which included an analysis of such studies. With his statement that 'The recommendations were developed with substantial input from Member States and other stakeholders and endorsed by the Sixty-Third World Health Assembly in May 2010' (WHO 2010), he implies that member states' and other stakeholders' experiences were indeed incorporated into the final document.

In both case studies it is clear that evidence and experience were the precursors to serious international action. The ad hoc expert group and academics both noted that 'evidence was a given' and that the Set of Recommendations 'couldn't have happened without the evidence—like Gerald Hasting's work', pointing to the importance of research.

Once a health issue reaches the WHO, evidence provides the justification for action and confers on it the necessary 'moral authority'. By invoking evidence, actors give the impression they are acting rationally to improve health and well-being. Although policymaking at the WHO is situated in wider social, political, and economic contexts, the use of evidence in these interventions was a key depoliticizing strategy. This is seen in the statements by the Turkish, Canadian, and Iranian delegates at the 34th WHA: by invoking evidence, it makes diplomats seem as if they are 'above' politics and acting impartially, even as they gloss over the wider context of the situation and the political nature of evidence (Goldenberg 2006).

A key difference between the making of the Code and the Set of Recommendations was that the Code relied far more on expert opinion and stakeholder views, particularly at the 1979 Joint WHO/UNICEF meeting and in the drafting process. This was highlighted

by a report published by the WHO in 1981, based on the paper prepared for the 1979 Joint WHO/UNICEF meeting. While not meant to be a 'scientific treatise', it nevertheless set out to 'stimulate further thought and discussion' among 'national-level health workers and planners' (WHO 1981, 12); it did include such statements as 'several studies indicate that breastfed infants have fewer gastrointestinal infections than those not breastfed' (WHO 1981, 109), but provided no references.

Today, greater transparency in the way evidence is collected and analysed is expected, and this transition has been seen at the WHO. Before 2007, WHO recommendations were based largely on expert opinion and did not use 'systematic evidence-based methods'. Public criticism of this process led the WHO to develop a Guidelines Review Committee (GRC) to standardize the process and assert a level of quality control (Sinclair et al. 2013). In a study led by the clinical researcher David Sinclair, eighteen WHO staff were interviewed about their experience of the GRC. Overall, the interviewees felt that it was essential to the WHO that its guidelines met the highest standards; however, some had concerns about the way in which the GRC takes a single approach to ranking types of evidence, for instance prioritizing randomized controlled trials over observational studies. The concern is that this may work very well for clinical guidelines, but may be less appropriate for health systems or public health guidance.

With the Set of Recommendations, the WHO spelt out very clearly how its systematic reviews were conducted, and gave references and summaries for all the studies reviewed, which are publicly available (Cairns et al. 2009). These reviews are also cited in the final Set of Recommendations. Overall, in line with the move towards evidence-based medicine, the WHO has increasingly taken a more systematic, evidence-based approach to policymaking. In this case, however, the evidence linking childhood obesity to food marketing is not conclusive. This has proved to be fertile ground for controversy.

Controversies about evidence

It is difficult to link the marketing of food directly to childhood obesity. In the systematic reviews commissioned by the WHO, 115 studies met the criteria for inclusion, of which only 46 were 'capable of demonstrating a potential causal relationship between food promotion and children's food knowledge, preference and behavior' (Cairns et al. 2009, 10). The remaining studies were content analyses of advertisements or other type of promotions, or they were surveys of food consumption or purchasing behaviour, or rather children's purchase requests to their parents. There are natural experiments as marketing aimed at children has been highly restricted in Norway, Sweden, and Quebec since the 1980s, but the evidence as to the usefulness of such bans is mixed (Kent et al. 2011). Still, marketing remains an 'easy' policy choice in that it is 'legislable'.

In interviews with private sector informants, representatives from the food industry discussed the mixed nature of the evidence. For instance, one stated that

> I would say in general, that there is no sure cause-effect relation between advertising and obesity … obesity is definitely a multifactorial phenomenon. For example, most families have two cars … causes range from transport to health to culture. Yes, advertising is a part. But a part.

Another complained about 'academic activists' publishing headline-grabbing studies that are based on 'bogus' evidence—or at the very least, evidence that had been manipulated or presented in what they saw as an anti-industry way. The same informant also felt that that NGOs have greater influence at the WHO. Specifically, he suggested that many academics have a political bias which 'taints' their work, yet because many of them work closely with the WHO—in expert groups, collaborating centres, and as consultants—their academic work is affected by their politics. He went on to explain the main obstacle to the food industry producing

evidence, namely that it is virtually impossible to publish any industry-funded research in academic journals, although he felt like this was beginning to change.

Almost all civil society informants, meanwhile, compared the food industry to the tobacco industry, citing the way that private sector actors 'deny, deflect or diffuse' public health evidence. One, who had worked closely with the WHO, discussed 'dismissal, denial, acceptance and pre-emption'. These strategies range from industry representatives who dismiss the quality of evidence to companies which, accepting the 'unhealthiness' of their food, introduce new 'healthy' ranges of popular products. It also includes companies that focus on multiple causes of obesity or on lack of physical activity as a cause (rather than diet).

Broadly speaking, the evidence as collected, analysed, and presented by academics working for the WHO is mixed. Many private sector actors use this to shift the focus away from their unhealthy products—a tactic that is part of the wider quest for legitimacy. By creating doubt, the private sector delegitimizes its critics; when the evidence is stronger, the private sector must participate in partnerships with government or other regulatory processes if it is to maintain its legitimacy (Benson & Kirsch 2010).

The controversies and dilution of the evidence about breastfeeding are similar. A representative from an infant formula company pointed out that the decline in breastfeeding was multifactorial, citing issues with maternity leave and ease of pumping that have nothing to do with her company's production of food. Indeed, although delegates at the WHA in 1981 asserted that the 'superiority of breastmilk was beyond dispute', the reality is that there were—and remain—conflicts about evidence. For example, in September 1981 the editor-in-chief of *Pediatrics* wrote:

> Picture yourself, a doctor living in a Third World country frustrated by the failure of your efforts to change poverty, malnutrition, and poor sanitation. Little wonder that you would choose to attack rich foreign companies if you thought they contributed

> to your problems. You would also feel great if the whole world joined you in condemning such companies. When the turmoil had settled, however, and you realized that you may have been wrong, or at least lacked proper evidence, you might not feel so self-righteous. (Lucey 1981, 431)

The evidence to limit the marketing of breastmilk substitutes was not strong in the way we expect evidence to be strong today. Much of the evidence for the Code was based on the experiences of health professionals working in low-income countries. If the Code were written today the evidence *for* it would be expected to come from systematic reviews and quantitative, replicable studies. And yet, despite all the research in the nearly forty years since the Code, the issue has not been settled. In the 1980s and 1990s, evidence on breastfeeding was called into question because of concerns about HIV transmission between mother and child (Newell 2001). Other researchers have questioned the WHO/UNICEF recommendations of exclusive breastfeeding for six months (rather than four months), suggesting that new systematic reviews were needed. This was in part due to concerns about the higher incidence of food allergies and risk of coeliac disease among breastfed children (Fewtrell 2011).

There is a performative aspect to evidence (Ecks 2008, S85). This means that an individual, say a clinician, may use the same study or statistic differently depending on the audience, patient, colleague, or academic journal. When scaled up to a global level, we see that policymaking at the WHO involves people who use the same body of evidence to forward the agendas of their country or organization. While the underlying knowledge and experiences may be the same, they are used to created different sets of evidence depending on the situation.

This is particularly the case with both the Code and the Set of Recommendations, in which the evidence base is mixed. Most global health actors would suggest that the move towards standardization and evidence-based policymaking is a positive step. There is also

the suggestion that it lends greater legitimacy and authority to guidelines, as in the case of the Sinclair et al. study (2013). However, it also raises the question of what policymakers should do when the evidence is not clear, as is often the case in situations of international concern. I discuss this in the next section.

Evidence and policy options

The way evidence is used both constricts and expands the possible policy options. With the Set of Recommendations, the WHO convened an ad hoc expert group who were asked to 'Provide technical advice in three areas':

> Policy objectives: What should be the objectives of Member States policies on marketing of food and non-alcoholic beverages to children;
> Policy options: What are the evidence-based or currently applied policy options available on marketing of foods and nonalcoholic beverages to children;
> Monitoring and evaluation: What are the feasibility and mechanisms required to monitor and evaluate recommended policy options. (WHO 2012, 1)

The groups focused on the responsibilities of the various stakeholders, the range of policy recommendations and options (statutory versus non-statutory), the age ranges of the children, and where protection from marketing pressure was needed.

A 2012 special issue of *The Economist* argued that food companies influenced the Set of Recommendations, which led to watered-down, general recommendations:

> Food companies are among those that present their view to the WHO … through the WHO's 'public dialogue' process. For example, companies encouraged the WHO to present a menu

> of possible policies on food marketing, rather than a single prescription. (*The Economist* 2012)

Another point of contention has been the role of voluntary measures, including self-regulation (Sharma et al. 2010). Since 2006, individual companies and industry-wide bodies have made a series of voluntary promises to restrict the types of foods marketed and the venues and modes of advertising. For example, this might include ceasing to use cartoon characters to promote foods, or not promoting foods with an 'unhealthy' nutritional profile to children. Critics argue that voluntary self-regulation is ineffective, in part because the ways in which companies define foods as healthy or not healthy is not transparent or uniform across countries or regions. Also, there are virtually no examples of self-regulation being effective (Moodie et al. 2013). The Set of Recommendations leave open the possibility of self-regulation, in part because at the time there was not the evidence to rule it out completely. Research has since been published indicating that self-regulation pledges are too limited and inconsistent to be effective, and that the private sector has not followed through on wider promises to self-regulate (Hawkes & Harris 2011; Kraak et al. 2016).

I find the criticisms that industry influenced the Set of Recommendations somewhat misleading. One problem is the lack of direct evidence. According to an informant from the expert group, they 'thought critically of the evidence and their duty and responsibility' to be independent. This same informant said that 'there was no evidence for the interventions, which is part of the reason we couldn't make concrete recommendations'. A second member of the expert group also noted that they 'knew the evidence base wasn't there to fully rule out self-regulation.' I also specifically asked informants from the ad hoc expert group whether the private sector had influenced the Set of Recommendations, to which one responded that 'I would not use the word influence, but there was the recognition that we needed to provide a range of options and recognize reality.' Similarly, another said there was 'indirect

influence because we knew the political reality, attitudes […] and this shaped the direction and frame of recommendations.' The same informant pointed out that they had consulted the reports from the private sector and civil society dialogues, and in that sense they were aware of the range of possibilities that were politically feasible. Another believed that the WHO Secretariat had suggested Corinna Hawkes as the chair of the ad hoc expert group because she 'knew the political possibilities.' Companies and the way they interact with governments and public health actors—through various types of partnerships and platforms—help determine the policymaking environment, and thus the options open to policymakers.

A concept that was often discussed during my participant observation at the WHO was the precautionary principle. Known from other civil society and member state fora, this is the idea that 'the introduction of a new product or process whose ultimate effects are disputed or unknown should be resisted' (OED 2013). Applied to food marketing, the precautionary principle would suggest that policymakers should restrict the marketing of foods high in fats, salt, and sugar to children unless food companies can prove it has no ill effect on child health. The food policy expert Amandine Garde, who has worked as a consultant to the WHO, writes that:

> while there is at present no conclusive scientific evidence that controls on food advertising directed at children alone are likely to lead to direct reductions in either consumption or harm, there is evidence that the promotion of food impacts on cultural attitudes and patterns of eating. An absence of conclusive evidence should not be interpreted as evidence of an absence of any adverse effect. (Garde 2006, 15)

The point here is that sometimes there is a justification—perhaps a moral justification—for making policy in the lack of direct and conclusive evidence.

Another challenge which impacted on the final Set of Recommendations was the reliance on studies from high-income countries. The WHO ad hoc expert group considered two systematic reviews of *The extent, nature, and effects of food promotion to children* (Cairns et al. 2009, Hastings et al. 2007), the more recent (led by Georgina Cairns) being an update of the first. A total of 115 studies met the inclusion criteria, of which only 10 studies had a component on countries outside Europe, the US, Canada, Australia, or New Zealand, 6 focused on a middle-income country, and only 2 were carried out in a low-income country (Nepal and Solomon Islands). This lack of input from low- and middle-income countries was also found in the countries and organizations represented in the stakeholder dialogues, few of whom had experience of low- or middle-income countries. The authors of the studies were well aware of the limitations and tried to mitigate them: in the first review, researchers conducted supplemental desk research using the business and marketing press, journals and responses from NGOs to map the marketing environment in low- and middle-income countries (Cairns et al. 2009,18); in the later review, there is an entire section devoted to 'food promotion and marketing in developing and middle-income countries' which teases out more detailed data from the 10 applicable studies. Additionally, there was geographic diversity in the ad hoc expert group.

While global representation is a goal at the WHO, there are few health issues that are evenly distributed across the globe. Georgina Cairns and colleagues found that food companies in middle-income countries used marketing techniques similar to those in high-income countries at the time, but had very little data on low-income settings. This meant that in the final version of the Set of Recommendations there was greater focus on television and online advertising and less on advertising methods in low-income countries at the time, such as billboard, print, and point-of-sale.

One informant, an academic who had worked closely with the WHO, discussed the difference between evidence-based and evidence-informed policy, suggesting that 'good policy should not

be solely evidence-driven'—that is, sometimes the evidence is non-existent, not strong enough, or not in the right form to justify policy action, but that due consideration of the evidence which does exist and some common sense can justify policy action. Generally speaking, the quality or type of evidence can either constrict or expand policy options. A lack of clear evidence also decides the policy options. If the Code were developed today, it would need to be supported by more developed evidence than was available at the time. Evidence, however, interacts with emotion and political feasibility, which means that decisions can be pushed forward in the absence of evidence.

Where knowledge and experience become evidence

Both the Code and the Set of Recommendations embody a narrative of how groupings of actors—diplomats, WHO staff, academic experts, civil society and private sector actors—brought a range of ideas, beliefs, values, and experiences to the drafting process. In both cases, civil society actors and health professionals used their knowledge and experience, mediated through objects, to put inappropriate marketing on the WHO's agenda; they continue to work to keep it there, for example by collecting data on violations of the Code nearly 40 years later. The WHO's role in all this is to gather and then turn public health knowledge and experience into evidence, which, in turn, is used to determine policy. This often means assembling expert groups and commissioning systematic reviews. Stakeholders use evidence and moral arguments to justify to donors and other policymakers why action should be taken to address the underlying causes of various health problems. Addressing global inequities in health is a justification for global health action (Rosskam & Kickbusch 2012, 4).

Delegates to the WHA use persuasive language and descriptions of the health burdens in their countries. Words like 'urge' are used to propose action. Evidence is also used as a tool to assert moral legitimacy and as a depoliticizing strategy. If actors 'have the

evidence on their side' they can push for certain policy options over others. Yet some views are simply not taken into account. This is a source of contention for anthropologists such as Judith Justice, who have focused on the applicability of global norms to communities (Justice 1987). The national-level civil servants who sign up to agreements in Geneva are not the same people who survey supermarkets for inappropriate marketing practices. Although the Code and Set of Recommendations are ostensibly global documents, the impetus for the Code originated in the marketing situation faced by low- and middle-income countries, while the Set of Recommendations grew out of the situation in high- and upper-middle-income countries.

There have always been disagreements over the quality and interpretation of evidence. One change, however, is that in comparing the Code to the Set of Recommendations the global health community expects more methodologically robust evidence today. It also expects greater transparency about what kind of knowledge and experience is used as evidence in decision-making. The negotiation and scope of solutions are now more dependent on the robustness of the evidence than they were in the 1970s and 1980s. On the one hand, this is democratizing, for when evidence and decision-making is more transparent, a wider range of actors is informed about and can participate in the policy process. On the other hand, if the evidence is inconclusive and if actors are averse to the precautionary principle, then the interests of consumer industries may prevail and public health action may be constrained.

Writing of co-production, Sheila Jasanoff notes that 'what we know about the world is intimately linked to our sense of what we can do about it, as well as to the felt legitimacy of specific actors, instruments and course of action' (2004, 14). The case studies considered here highlight the wider context of policy-making and constraints on action, and the ways in which power is embedded in the sense of reality. For instance, in the case of the Set of Recommendations the expert committee took into account the 'reality' of

a global society in which transnational companies wield significant influence over regulators. There is also an aesthetic element to the process: knowledge and experience must be presented in certain ways to become evidence. Similarly, actors are expected to behave according to culture scripts in order to be 'successful' in legitimizing their experience and knowledge as evidence, and actors can be criticized for deviating from the script, for example by acting emotionally. These case studies challenge any notion that evidence is apolitical, demonstrating instead the flexible arrangements found in the transformation of experience and knowledge into evidence for policy-making.

Notes

1 Starting in the late 1960s, the UN Protein Advisory Group, which included the WHO, began to discuss concerns about bottle feeding.
2 The Christian Medical Commission was disbanded in the 1990s, but the World Council of Churches remains an active NGO in official relations with the WHO (Litsios 2004, 1892).
3 WHO Archives, Edward Kennedy to Halfdan Mahler, 20 July 1978.

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