Spring 2016

A Precarious Paradigm: Seeking Alternatives to Public-Private Partnerships in Health, a Case for the Code

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Spring 2016

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Abstract

Background: Breastfeeding is an unparalleled source of nutrition for infants and young children and is recommended as the best practice universally by the World Health Organization (WHO). The benefits in human health and development that result from exclusive and sustained breastfeeding have enormous economic development potential. Because of the non-legally binding nature of the *International Code of Marketing of Breastmilk Substitutes (the Code)*, and shifting socio-cultural norms, breastfeeding rates are at an alarming low. In order to progress towards the Sustainable Development Goals, breastfeeding practices must be protected, promoted, and supported worldwide.

Objective: This research paper explores implementing strong measures of accountability to the *International Code of Marketing of Breastmilk Substitutes* as an alternative framework to the public private partnership model in achieving the Sustainable Development Goals (SDGs), using the example of infant feeding as a case study in the detrimental effects of industry involvement in policy decisions.

Method: An interactive research approach was used. Research was done through a literature and policy review, followed by the collection of primary data through interviews with experts in the field.

Results/findings: This paper finds that the intimate involvement of corporations with the private sector is detrimental from the point of view of public health, and that Goal 17 in the SDGs has the potential to undermine the entire Sustainable Development Agenda for 2030.

Conclusions: In progressing toward the Sustainable Development Goals, it is essential that alternative models to public-private partnerships be considered. Opting for more cost effective interventions, such as the implementation of the Code as national laws and the creation of a universal accountability mechanism have the potential to advance the Sustainable Development Agenda without compromising public interests. Further research must be done so as to establish a financing framework on a country-by-country basis.

Acknowledgements

Vital to the realization of this research were the SIT: Switzerland Global Health and Development Policy Faculty, Academic Director Alexandre Lambert, and Academic Coordinator Francoise Flourens. Thank you for all of your guidance throughout this semester, both before and during the ISP. In addition, I would like to thank my advisor, Dr. Lida Lhotska, who's work I deeply admire, for her support and feedback throughout the research process, and Dr. Judith Richter, for offering her time to discuss my topic with me and review my materials. I would also like to thank all of the experts with whom I spoke who offered some of their valuable time to discuss their work with me and give me guidance.

I would also like to thank my incredible support system at Connecticut College, notably my advisor, Professor Joseph Schroeder, without whom I would not be where I am today. I would also like to thank Mary Devins, Marybeth Sydor, and Marc Forster of CISLA for giving me the opportunity to spend this semester abroad studying what I love.

Lastly, I would like to thank my host mom, Valentine de Preux, for opening her home to me this semster, being so kind and thoughtful, and being understanding of all the long nights I spent working on my project. I am very excited to spend some more time with you now that it is done!

Preface

As I have studied development policy and health, I have become increasingly interested in the interaction between respect for human rights and the drive for social and economic growth. I have chosen to explore this topic through the lens of infant and young child feeding because it is one of the paramount examples of attempted mitigation between public interests and corporate expansion in the past decades.

Public Health is a key stepping stone to development, and child nutrition is one of the most pressing issues in public health today. As we enter the era of the Sustainable Development Agenda, the time has come to end the compromise. Through my topic, I hope to shed light on how the current structure of global public private partnerships for health has been doing a tremendous disservice to the public interest. By highlighting the works of several prominent advocates for the revision of the model and introducing an alternative, I hope to provoke policy makers and industry to rethink their priorities and perhaps see that what is best for the good of the public is, in the long term, good for everybody.

Literature Review

The frame of this paper is built upon the United Nation's Sustainable Development Goals. As the goals are rather new (having only come into force at the beginning of this year), I utilized the UN's own definitions and literature on the subject, as can be seen in "*UN Sustainable Development Agenda",* found on the UN website.

As my paper takes the form of a case study on the protection, promotion, and support of breastfeeding and infant nutrition, I consulted the World Health Organization's guidelines for industry in several documents, including the original *International Code of Marketing of Breast-milk Substitutes*, published by the World Health Organization in 1981. Article 11.3 of the Code explicitly states that it is meant to be followed universally, "independently of any other measures taken for implementation."[1] A key threat to breastfeeding today is the infant feeding industry's loose interpretation of these words, and my argument is based around the need to legally ensure compliance.

In order to quantify the benefits of breastfeeding and formulate a framework by which the goals could be achieved without heavy reliance on public private partnerships, I referred to several articles published in *The Lancet*, including *The Lancet's* Breastfeeding Series. Specifically *Breastfeeding in the 21st Century: Epidemiology, Mechanisms, and Lifelong Effect* and *Why Invest, and What It Will Take to Improve Breastfeeding Practices?* The calculations in these articles using the Lives Saved Tool and other theoretical models, paired with the projected costs of breastfeeding interventions calculated by the World Bank in *Investing in Nutrition The Foundation for*

[1] *International Code of Marketing of Breast-milk Substitutes*. World Health Organization, 1981 (14)

Development: an investment framework to reach the Global Nutrition Targets provided an instrument by which to measure the feasibility of my proposal without having any current, country-specific data.

Dr. Judith Richter, one of the experts I interviewed, referred me to one of her publications, *Public-Private Partnerships and International Health Policy-Making: How can public interests be safeguarded?* This document gave me a historical background as well as several working definitions for the often times abstract concept of public private partnerships. Through this article and other publications examining public-private partnerships' effectiveness, I was able to conceptualize a high cost of engagement, although no data has specifically been quantify the exact losses that come from engaging in these partnerships.

Research Methodology

Secondary Sources

In order to gain a deeper understanding of the field, I began my research by reviewing secondary sources. Peer reviewed scholarly articles were retrieved online using Google Scholar, the UNOG's Library's Research Guides, and Connecticut College's online database using keywords: *breastfeeding; infant nutrition; breastfeeding economics; public private partnerships; sustainable development goals; global governance; corporate accountability; International Code of Marketing for Breast-milk Substitutes.* Additionally, I referred publicly available documents by organizations such as the WHO, UNICEF, IBFAN/GIFA, WEF, Save the Children and corporations such as Nestlé.

Primary Sources

My review of primary written documents included both public and corporate policies, standards and international guidelines regarding the protection, promotion and support of infant feeding. I was also able to gather up-to-date quantitative data on breastfeeding rates and projected costs of project implementation through documents published by the World Bank. Additionally, I maintained myself up to date on news surrounding challenges to breastfeeding through publications and broadcasts on the BBC. All of these sources were publicly accessible online.

Knowledge on the subject was supplemented by relevant lectures by the SIT program. I also attended conferences and panels in the Geneva area.

After relevant background information was gathered, I conducted formal interviews with experts in the field. Interview candidates were selected and recruited based on their knowledge of and involvement in the field of infant feeding, policy advising, and/or economic cooperation. Selected candidates were initially contacted via email and phone, if necessary. I met candidates either at their offices or at a location of their choice. Formal interviews typically lasted between 40 minutes to one hour. Informal interview candidates were identified through their attendance at or participation in relevant conferences/ panels and were approached for questions after the events. These interviews lasted no longer than 20 minutes. Other experts I corresponded with over email or Skype were identified using the same criteria as formal interview candidates, but indirect interaction was necessary due to their availability.

Ethical Considerations

All interviewees were given the choice to remain anonymous and not have the interviews recorded if they wished. They were informed of their right to not answer questions, and discontinue the interview at any time. All interviewees quoted in this paper gave informed consent. Questions were asked in a non-leading fashion, and interviewees were given the opportunity to add any additional information they desired at the end of each meeting. In order to ensure objectivity, careful consideration was given to every source used in this project.

Limitations

Limitations to this research include issues of non-response from identified interview candidates. Several organizations and individuals whose opinions would have been of great value to this research project were unable to be reached or interviewed.

Research Questions

The purpose of this study is to call into question the widely accepted public-private partnership paradigm in the field of global health and sustainable development. Using the example of universal implementation of the *International Code of Marketing of Breast-milk Substitutes* and subsequent World Health Assembly resolutions, I explore an alternative pathway to reaching the Sustainable Development Goals at a lower social and economic cost.

Important questions in shaping my research include:

- What can be done to ensure that public interests remain at the center of all financial interactions?
- Is the voluntary and loosely defined public-private partnership paradigm sufficient to ensure industry accountability?
- Will the UN's reliance on this paradigm for development (as expressed in Sustainable Development Goal 17) undermine its efforts in health and development in the long run?

This study, as well as those that follow it, will contribute to the current discussion on how to best approach the new Sustainable Development Goals and perhaps call into question the potentially harmful paradigms that organizations have grown comfortable with in the past decades.

Introduction

On the first of January, 2016, the set of 17 Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development officially came into action; giving world leaders a lot to think about in terms of developing frameworks to mobilize their countries toward each of the goals and their 169 targets.

The ambitious Sustainable Development Agenda seeks to build upon the progress made toward the Millennium Development Goals (which lasted from 2000 to 2015) by addressing social, economic and environmental priorities in an integrated manor in all countries. The United Nations has identified "multi-stakeholder partnerships… as an important component of strategies that seek to mobilize all stakeholders around the new agenda."[2] through Sustainable Goal number 17: Revitalize the global partnership for sustainable development.

While co-ordination of global actors around the Sustainable Development Agenda is critical to making progress towards the Goals, the United Nations must not continue to rely on transnational corporations and other private actors for as they have been for the past several decades. These public-private partnerships (PPPs) pose a substantial threat to the achievement of the agenda as a whole, and are especially problematic in the sphere of health and human development, where partnerships with corporations often lead to unacceptable compromises on human rights.

Public-private partnerships in health have historically been laden with internal competing interests that undermine greater public gains and compromise the very

[2] "United Nations Sustainable Development Agenda."

constitution upon which the World Health Organization (WHO) was founded, which states "The objective of the World Health Organization shall be the attainment by all peoples of the highest possible level of health."[3] In addition to being a fundamental human right, health has been identified as a central input to economic development and poverty reduction. As such, urgent action is needed to ensure the realization of the highest attainable standard of health in order to propel the Sustainable Development Agenda forward in time to meet its 2030 target date.

In this paper, I will examine how selected SDG targets for health and beyond can be achieved without the need to engage in potentially compromising partnerships with private sector actors by using the example of infant feeding as a case study. As governments and intergovernmental organizations plan their next steps on achieving the health related SDG targets, I propose they focus on strengthening national legislation supporting the complete implementation and enforcement of all provisions of the *International Code of Marketing for Breast-milk Substitutes* and subsequent relevant WHA resolutions (heretofore referred to as the Code) as well as establishing a universal framework of Code monitoring and accountability.

[3] *Constitution of the World Health Organization*. WHO, 2006.

Section 1: The Code, Breastfeeding and the SDGs

Despite the fact that there has been evidence since as early as 1910[4] that breastfeeding is the superior way to provide infants with the nutrients they need for proper growth and development[5], breastfeeding rates have not improved, with rates of exclusive breastfeeding for infants six months or younger are only at 37% worldwide[6]. This number, along with rates of child survival, could easily see an increase in the upcoming years if implementation of the Code into national legislation were to become a priority in every country.

The World Health Assembly adopted the Code[7] in its entirety in 1981 as a minimum requirement to protect healthy practices in infant and young child feeding. While the Code is not legally binding, it is a strong set of policy recommendations, intended to be respected by infant food manufacturers universally, whether or not a government took any action in implementing them -- as they are in the direct interest of the realization of human rights and preserving dignity.[8] This notion has been strongly reinforced in the Convention on the Rights of the Child, which states that parties "shall take appropriate measures to (a) diminish infant and young child mortality… (c) combat

[4] Richter, Judith. *Codes in Context: TNC Regulation in an Era of Dialogues and Partnerships*. Sturminster Newton, 2002 (1)

[5] "Breastfeeding." WHO.

[6] Branca, Francesco. interview by author. WHO Headquarters, April 25th, 2016.

[7] WHO defines optimal infant and young child feeding as early initiation of breastfeeding – within an hour after birth – followed by exclusive breastfeeding for the first 6 months and after that by continued breastfeeding for 2 years or beyond with adequate and safe complementary foods

[8] *Universal Declaration of Human Rights.* United Nations Dept. of Public Information,1949. (Article 25)

disease and malnutrition… through the provision of adequate nutritious foods and safe drinking water…(e) ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic child health and nutrition, the advantages of breastfeeding…"[9]

Breastfeeding: a practice in peril

According to the UN Guiding Principles on Business and Human Rights, states are obliged under international law to protect people against transgressions on human rights by corporations through "effective policies, legislation, regulation and adjudication." [10] While states may not be held directly responsible for violations of human rights inflicted by third parties, they can be held responsible for not having taken all the appropriate measures to impede human rights abuses. Still, as of 2011, only 37 of 199 countries have passed national laws reflecting the complete recommendations of the Code, and only 45 countries report having functional monitoring and implementation systems for Code compliance[11]. The update on the situation, to be released later in May, may in fact present an even poorer scenario.[12]As will be explored further on in this paper, this leaves substantial space for the infant feeding industry to violate the recommendations of the Code with no legal ramifications.

[9] *Convention on the Rights of the Child*. New York: United Nations, 1991.

[10] Mareș, Radu. *The UN Guiding Principles on Business and Human Rights: Foundations and Implementation*. 2012. (2)

[11] *Country Implementation of the International Code of Marketing of Breast-milk Substitutes: Status Report 2011*. World Health Organization, 2013

[12] Lida, Lhotska, interview by author. Skype interview, April 18th, 2016.

Another set of significant barriers to breastfeeding are connected to the sexualization of the female body, especially the breasts. Many people in society believe they have the right to tell women what to do with their bodies and how to care for their children. This ranges from a woman's intimate circle (her spouse or her family) to passers by on the street. When a woman is making the decision whether or not to breastfeed her child, it is possible that she will experience enormous psychological pressure from her family: older generations who may not be as well informed about the risks of artificial feeding may dissuade a woman from breastfeeding, claiming it won't make a large enough difference to be worth the trouble,[13] it is also not uncommon for a father to be jealous of the bond mothers create with their child through breastfeeding, and be opposed to sharing a body they previously saw as 'theirs'.[14] Outside their homes, women are often shamed or downright banned from breastfeeding in public spaces. Breastfeeding mothers in public or even in the workplace may attract a fair amount of negative attention: they are seen as obscene, vulgar, or even downright disgusting, whereas bottle feeding mothers do not even get a second look. Space then becomes a factor in the mother's decision to breastfeed. It is important that on top of enforceable legislation controlling the marketing practices of breast-milk substitutes, national laws, such as maternity protection provisions, and supportive practices in health care systems help to establish breastfeeding as a societal in all countries.

The widespread misconception that breastfeeding only benefits developing countries is partially responsible for the alarmingly low rates of optimal breastfeeding in

[13] Lida Lhotska, 2016.

[14] Lida Lhotska, 2016.

developed countries.[15] Globally, the prevalence of breastfeeding (measured at 12 months) is highest in Sub-Saharan Africa, South Asia, and Latin America, while in most high-income countries the prevalence is below 20%.[16] While in high-income countries, wealthier, more educated mothers tend to breastfeed more than their less well off counterparts, the opposite trend is true in LMICs. This is due to the perception that breast-milk substitutes are "modern and prestigious"[17] and the association of breast-feeding with being "poor and unsophisticated,"[18] resulting in poorer mothers switching to BMS as their incomes increase. In LMICs, studies of children between 6 and 23 months old showed that breastfeeding was associated with a 50% reduction in deaths;[19] in high-income countries breastfeeding is associated with a 36% decrease in sudden infant deaths.[20] Thus, while maintaining and increasing breastfeeding rates among all sectors of the population in LMICs, developed countries have significant room for improvement. The protection, promotion and support of breastfeeding should therefore be a priority on the policy agenda of every country, regardless of level of development.

[15] Gallagher, James. "UK 'world's Worst' at Breastfeeding." BBC News.

[16] Victoria, Cesar G., Rajiv Bahl, Alusísio JD Barros, Giovanny V A França, Susan Horton, Julia Krasevec, Simon Murch, Mari Jeeva Sankar, Neff Walker, and Nigel C. Rollins. "Breastfeeding in the 21st Century: Epidemiology, Mechanisms, and Lifelong Effect." 2016 (477)

[17] Rollins, Nigel C., Nita Bhandari, Nemat Hajeebhoy, Susan Horton, Chessa K. Lutter, Jose C. Martines, Ellen G. Piwoz, Linda M. Richter, and Cesar G. Victora. "Why Invest, and What It Will Take to Improve Breastfeeding Practices?" 2016 (491-504)

[18] Rollins, Nigel C., Nita Bhandari, Nemat Hajeebhoy, et al. "Why Invest, and What It Will Take to Improve Breastfeeding Practices?" 2016 (491)

[19] Victoria, Cesar G., Rajiv Bahl, Alusísio JD Barros, et al. 2016 (479)

[20] Victoria, Cesar G., Rajiv Bahl, Alusísio JD Barros, et al. 2016 (479)

The Position of Breastfeeding in the Agenda

In addition to safeguarding human rights, universal implementation of the Code and the subsequent increased prevalence of breastfeeding could have significant impacts on social and economic progress, measurable by the Sustainable Development Goals. The relationship between increased rates of breastfeeding and human progress has been apparent since the MDG era, at which time the Director General of the WHO requested all member states "continue to promote breastfeeding and infant and young child nutrition as essential for achieving the Millennium Development Goals, in particular those relating to the eradication of extreme poverty and hunger and the reduction of child mortality."[21] Although breastfeeding was never explicitly included in the MDGs, analyses showed that breastfeeding protection, promotion, and support were essential in achieving every single one of the goals.[22] This relationship becomes even more relevant in the SDG era: unlike the MDGs, the SDGs are meant to be universally applicable. Breastfeeding is a practice in peril in developed and developing countries alike, and is in fact one of the few positive health-related behaviors that is more frequent in low and middle income countries (LMICs) than high income countries.[23] Supporting positive breastfeeding practices in LMICs while working to revitalize the practice in all countries could reduce inequalities and improve global health and development overall. Yet, when the UN Standing Committee on Nutrition specifically put together a paper explaining the

[21] WHA resolution 61.20 (61st WHA 2008)

[22] Lhotska, Lida. *Whatever Happened to Health for All? Ups and Downs of Protection of Breastfeeding, Regulation of Transnational Corporations and Health for All?* 2008 (26)

[23] Victora, Cesar G., Rajiv Bahl, Aluísio J D Barros, Giovanny V A França, Susan Horton, Julia Krasevec, Simon Murch, Mari Jeeva Sankar, Neff Walker, and Nigel C. Rollins. "Breastfeeding in the 21st Century: Epidemiology, Mechanisms, and Lifelong Effect."2016 (479)

value inclusion of the six Global Nutrition Targets,[24]which include increasing the rate of exclusive breastfeeding in the first six months of life to at least 50% in the first six months of life, the targets were not incorporated.[25] While breastfeeding may not have an official position within the Sustainable Development framework, it has the potential to create considerable, sustained advancement towards the Goals.

Breastfeeding's Development Potential

Almost all mother-baby pairs are able to safely and successfully breastfeed if provided complete, accurate information, protection from harmful advertising practices, and a breast-feeding supportive environment.[26] The decision to breastfeed a child, which is normally made by the third trimester, is arguably the most important health decision that can be made, both in terms of child health, nutrition and development, and maternal health.

Breastfeeding is potentially one of the "top interventions for reducing under 5 mortality",[27] and is a secure source of nutrition for infants in almost all situations, including emergencies.[28] Early and sustained breastfeeding strengthens the child's

[24] The Global Nutrition Targets (WHO) by the year 2025: 40% reduction in the number of children under 5 who are stunted; 50% reduction of anemia among women of reproductive age; 30% reduction in low birth weight; no increase in childhood overweight; Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%; Reduce and maintain childhood wasting (acute malnutrition) to less than 5%

[25] Francesco Branca, 2016.
[26] Lida Lhotska, 2016.

[27] Branca, Francesco, 2016

[28] Linnecar, Alsion, Arun Gupta, JP Dadhich, and Nupur Bidla. *Formula for Disaster: Weighing the Impact of Formula Feeding Vs Breastfeeding on Environment*. 2014 (10)

immune system in such a way that artificial feeding cannot, and as a result is able to protect against almost half of early childhood diarrheal and respiratory infections, two of the leading causes of child death in developing countries.[29] Further down the line, the protection provided by breastfeeding results in significant decreases in for non-communicable diseases such as childhood leukemia (19% decrease in incidence in breastfed children), type 2 diabetes in adolescence and adulthood (35% reduction) and a 26% decrease in the odds of overweight/obesity.[30] In mothers that breastfeed, inverse associations have been shown in length of breastfeeding and breast cancer and ovarian cancer deaths.[31] The worldwide increase of optimal breastfeeding practices to near universal levels has the potential to prevent 823, 000 annual deaths of children under 5, 87% of which would have occurred in babies under six months and, and an additional 13.8% correspond to deaths in children under 2 years of age. 20,000 annual maternal deaths from breast and ovarian cancers could also be averted.

Healthcare gains made by optimal and continued breastfeeding redound partly to the family, and partly to current and future health insurers.[32] Further down the line, breastfeeding is consistently associated with higher intelligence in children and adolescents,[33] and is therefore a likely factor to influence "school attendance and final educational attainment and thus lead to better job opportunities, higher wages, and a more

[29] Victora, Cesar G., Rajiv Bahl, et al 2016 (475-490)

[30] Victora, Cesar G., Rajiv Bahl, et al 2016 (475-490)

[31] Victora, Cesar G., Rajiv Bahl, et al 2016 (475-490)

[32] Phelps, Charles E. "Economic Issues of Breastfeeding." 2011 (307-311)

[33] As measured by intelligence quotient tests, Victoria, Cesar G., Rajiv Bahl, Alusísio JD Barros, et al. "Breastfeeding in the 21st Century: Epidemiology, Mechanisms, and Lifelong Effect." 2016 (477)

productive life as a citizen of our nation."[34] This increased productive potential can only contribute positively to the development and economic wellbeing of society.

In addition to the benefits in health and human development, when compared to the alternative (breastmilk substitutes -BMS), it is apparent that ameliorating breastfeeding practices can have a significant environmental impact. Unlike breast-milk substitutes, which tax the environment with a substantial demand for water resources, fuel, plastics and metals, "the demands placed by breastfeeding on the environment can be met without reducing the capacity of our planet to allow all people to live well and healthily, now and in the future."[35] The Natural Resources Defense Council estimates that, under a business-as-usual scenario, the costs of climate change will reach 1.84% of global GDP by 2100. As was recently discussed at the COP21 conference, and reiterated in the Paris Agreement, developing countries are disproportionately more vulnerable to the impacts of climate change,[36] further emphasizing the need to take action in defense of sustainable development and the reduction of inequalities.

As mentioned earlier, an underlying factor contributing heavily to low rates of breastfeeding is the position of women in society and how their roles are valued and understood, which influence their nutrition, quality of healthcare, economic opportunity and the support they receive in their families, workplaces, and communities.[37] "If women are not empowered, and supported, how are they expected to make decisions that will

[34] Phelps, Charles E. 2011 (307)

[35] Linnecar, Alsion, Arun Gupta, JP Dadhich, and Nupur Bidla. *Formula for Disaster: Weighing the Impact of Formula Feeding Vs Breastfeeding on Environment*. 2014 (11)

[36] Not proportional to impacts suffered

[37] Lhotska, Lida, 2016

ultimately affect their health and that of their child so deeply?"[38] asks Dr. Lida Lhotska of IBFAN, emphasizing that access to complete and accurate information about infant and young child feeding plays an essential role in empowering women in these important health decisions "If women receive this information," Dr. Lhotska continues "they tend to breastfeed against all types of odds. For example lack of support in the workplace. In most instances a mother will do everything she can to protect her child and make sure (the child) develops well."[39] The Code recognizes that the health of infants and young children is intimately connected with the health and nutrition of women, their social and economic status and their roles as mothers.[40] Protecting mothers and children by full implementation of the Code will affirm the value of motherhood to society. Along with the adoption of the Code as legislation it is also important to address legislation concerning women in the workplace, mandating that employers and insurers do not penalize women for breastfeeding children by providing insufficient paid maternity leave[41], not covering essential health services for new mothers such as breastfeeding consultations, and not providing paid breaks and adequate space for women to feed or express breastmilk throughout the day if necessary. In his article "Economic Issues of Breastfeeding", Charles E. Phelps observes "many employers treat smokers better than breastfeeding mothers."[42]A large portion of employers and insurers, in both developed

[38] Lhotska, Lida, 2016

[39] Lhotska, Lida, 2016

[40] *International Code of Marketing of Breast-milk Substitutes*. World Health Organization, 1981 (6)

[41] ILO requires a minimum of 14 weeks paid maternity leave (only met by 53% of countries) and recommends 18 (only met by 23%)

[42] Phelps, Charles E. 2011 (308)

and developing countries, do not want to support mothers in these ways because they will not capture all of the economic benefits of breastfeeding (such as lower healthcare costs later on in the mother's and child's life due to the preventative power of breastfeeding against certain NCDs) due to the likelihood that mothers will switch jobs or insurers.[43] A breastfeeding-unfriendly environment in the workplace puts pressure on mothers to choose between economic opportunities and the wellbeing of their child, and unfortunately, society has prioritized the former. Mothers who do choose to breastfeed for the recommended length of time suffer in experience and participation in the labor force, making them potentially less attractive for promotions and reducing their job mobility in the future and the labor pool available to employers.[44]

Despite the fact that breastfeeding has not been included as an indicator for the Sustainable Development Goals, it is apparent that national legislation in line with the Code that protects, promotes, and supports breastfeeding has an essential role in achieving several of the targets[45] under Goal 2: By 2030 end hunger, achieve food security and improved nutrition and promote sustainable agriculture, Goal 3: Ensure healthy lives and promote wellbeing for all at all ages, Goal 5: Achieve gender equality and empower all women and girls, and Goal 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.[46]

[43] Phelps, Charles E. 2011 (308)

[44] Phelps, Charles E. 2011 (308)

[45] The Global Nutrition Targets by 2025(WHO) are: 40% reduction in the number of children under 5 who are stunted; 50% reduction in anemia among women of reproductive age; 30% reduction in low birth weight; No increase in childhood overweight; Increase the rate of exclusive breastfeeding in the first 6 months up to at least 50%; Reduce and maintain childhood wasting (acute malnutrition) to less than 5%

[46] These targets have been selected by the author as an example, many other goals/ target stand to gain from the universal adoption of the code as legislation.

Furthermore, and perhaps just as important, is the fact that implementing the Code as enforceable national policy is an action every country could take, if provided with the adequate information and support, creating a legally binding, measurable action towards the goals without the need for the often times inappropriately close relationships with industry that have become customary in the public policy arena. However, it has become customary that governments do not reach for the strategy to regulate the private sector practices, and instead often enter in the name of the much promoted model of public-private partnerships and multi-stakeholder initiatives into inappropriately close relationships with industry. While eliminating all interactions with the private sector is not feasible, or even desirable in many cases[47], in the arena of public health (among others) it is essential that government policy-making and actions remain unfettered by undue influence from the private sector that may subvert their mission to work in public interest. SDG 17 calls for the revitalization of global partnership for sustainable development, an action that could have dire consequences in public health around the world.

Section 2: Public Private Partnerships in Health, the Potential for a Problem

What are Public-Private Partnerships?

In the UN Secretary-General's report *Enhanced Cooperation Between the United Nations and All Relevant Partners, in Particular the Private Sector (2003)*, "Partnerships are commonly defined as voluntary and collaborative relationships between various

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[47] Alexandre Vautravers, interview by author, University of Geneva, April 14th, 2016.

parties, both State and non-State, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities, resources, competencies and benefits." In the arena of global public health a variation on this definition has been proposed by Kent Buse and Gill Walt, academics from the London School of Hygiene and Tropical Medicine. A global public private partnership for health (GPPPH) is "a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/ or industry association) and an intergovernmental organization, so as to achieve a shared health creating goal on the basis of a mutually agreed division of labor"[48]

These two definitions differ in that GPPPHs require a third actor, or central force, to govern the partnership due to the highly sensitive nature of these types of arrangements.[49] These definition are sufficiently vague that they encompass such diverse issues as fundraising, negotiations, consultations, agreements to implement voluntary (legally non-binding) codes of conduct, research collaborations, corporate social responsibility projects and contracting out of public services.[50] The use of the word 'partnership' (in both PPPs and GPPPHs) carries the implicit assumptions that public interactions with the private sector should be based on "'trust', should aim at 'mutual benefits'…(and) represent a win-win situation (or even 'win-win-win' in the case of tri-sector 'multi-stakeholder' interactions)."[51] While there do exist interactions between the

[48] Richter, Judith. *Public-private Partnerships and International Health Policy-making: How Can Public Interests Be Safeguarded?* 2004 (6)

[49] James Pennington, interview by author, Café des Arts, April 24th, 2016.

[50] Richter, Judith. 2004. (6)

[51] Richter, Judith. 2004 (44)

public and private sector where all actors involved stand to gain,[52] the risks for society that come from engaging in these 'partnerships' in health weigh too heavily to be redeemed, much less ignored.

When the corporate sector engages in PPPs and GPPPHs, it gains the power to exert political influence, whether it be by controlling where funds are allocated or exercising its new position as a 'partner' (read 'equal') with governments or intergovernmental organizations to participate in setting the policy agenda whether it be through expressing its interests in or being explicitly involved in policy discussions.[53] "When a state or organization collaborates with a private actor they shouldn't be partners" says Mirza Alas of the South Centre "The public actor should be in charge and they should set clear terms. It is the only way to ensure that the interests of the private actor are not put on the same level or above the best interests of the public."[54] Unfortunately, the establishment of a hierarchy in a PPP is often a deterrent to participation to the private sector[55], as much of the allure of a 'partnership' is indeed to be perceived as an equal.

Furthermore, corporations often get direct financial returns in the form of tax breaks and increased market penetration as well as direct financial benefits through the bluewashing[56] of their image. "Responding to demands for social responsibility in the

[52] "Carefully outlined and transparent agreements for contracting out projects or services for example" Mirza Alas, interview by author, The South Centre, April 22nd, 2016.

[53] Mirza Alas, 2016.

[54] Mirza Alas, 2016.

[55] James Pennington, 2016.

[56] 'bluewashing' is a term used to describe when a corporation is able to enhance its public image through association with UN agencies

industry, whether it be consumer pressure or pressure from international agendas such as the SDGs, is one of the large motivators pushing companies towards cooperation with the public sector" says Mr. James Pennington of the World Economic Forum.[57] Dr. Judith Richter says that the public should be weary of these campaigns for corporate social responsibility, referring to them as "sophisticated public relations exercises" that are aligned with the companies' "enlightened self interest"[58] at best.

The Rise of Public Private Partnerships in Health

Increasingly, the UN views the partnership paradigm as a strategy that has no alternative (TINA).[59] This is likely due to three key influences that have taken place over the past several decades: (1) the budget freezes of several UN agencies (the WHO, maked the standard norms and regulation setting to rely almost entirely on voluntary contributions from member states, philanthropic foundations and the private sector), which forces the agency to 'sell'[60] programs that appeal to large-scale donors in order to get funding (2) nomination of UN leaders who favored the neo-liberal restructuring of the UN[61] and (3) Major transnational corporations (TNCs) recognizing that collaboration with the UN could help them gain the necessary political and market influence to "ward

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[57] James Pennington, 2016.

[58] Judith Richter, interview by author, Skype interview. April 28th 2016.

[59] There is no alternative

[60] Alexandre Vautravers, 2016.

[61] Richter, Judith. 2004 (47)

off pressure from UN member states and social movements critical of an unfair globalization"[62] and thus use the transfer of positive social image to ameliorate business.

The definitive shift towards the institutionalization of the partnerships with industry model within the UN occurred in 1998 when then Director General Kofi Annan "recognized that peace and prosperity could not be achieved without 'partnerships' between various sectors in society, including business"[63] in a speech at the World Economic Forum in Davos, Switzerland. Two years later, then Director General of the WHO, Dr. Gro Harlen Brundtland, introduced a new *Corporate Strategy for the WHO Secretariat,* that was based on the principles of neo-corporatism and advocated for the use of partnerships as a new model to tackle health inequities while still reflecting the values and principles of Health for All.[64][65] At the time, there were concerns that this new strategy would cause the WHO to stray from its constitutional mandate, which is fundamentally informed by human rights, social justice and equity, to an approach that "advised governments to focus on cost effective interventions rather than on strengthening health care systems."[66]

Two years later, Dr. Brundtland made the following, rather worrisome statement, affirming the WHO's *dependence* on its private 'partners':

[62] Richter, Judith. 2004 (52)

[63] Richter, Judith. 2004 (77)

[64] Attainment of a level of health that would allow for productive participation in their lives and communities for all people by the year 2000

[65] Richter, Judith. 2004 (77)

[66] Richter, Judith. 2004 (78)

"In a world filled with complex health problems, WHO cannot solve them alone. Governments cannot solve them alone. Nongovernmental organizations, the private sector and foundations cannot solve them alone. Only through new and innovative partnerships can we make a difference. And the evidence shows we are. Whether we like it or not, we are dependent on the partners … to bridge the gap and achieve health for all."[67] (Brundtland 2002a)

In his paper *Sharing Responsibilities: Public, Private and Civil Society,* Bellamy warns of the dangers of assuming that the goals of the private sector align with those of the UN, stating that they "most emphatically… are not. Business and industry are driven by the profit motive… the work of the United Nations, on the other hand, is driven by a set of ethical principles that sustains its mission." [68] This contrast in goals is particularly evident in the case of the WHO's interactions with the infant feeding industry: as partnership policy has gained momentum, WHO support for implementation of the *International Code of Marketing of Breast-milk Substitutes* has weakened.[69] Recently, WHO has renewed its efforts to assist governments in monitoring the Code[70] and it will be critical for achieving sustainable improvement in breastfeeding rates that this resolve is of a long term.

[67] Bellamy, Carol. "Sharing Responsibilities: Public, Private and Civil Society." UNICEF. 1999.

[68] Bellamy, Carol.1999.

[69] Richter, Judith. 2002 (16)

[70] "Global Network on the Monitoring of the International Code of Marketing of Breast-milk Substitutes and Subsequent Relevant WHA Resolutions." WHO.

The shortcomings of voluntary measures

Attempts at regulating the infant food industry's marketing practices is one of the longest-standing efforts at international regulation of an industry.[71] Yet, since the Code's adoption in 1981, has been left largely to independent actors such as NGO's to hold industry accountable towards this non legally binding standard. While the Code specifies that "manufacturers and distributors or breast-milk substitutes should, independently of any other measures taken ensure that their conduct conforms to the principles and aim of the code at every level,"[72] implementation of the Code in its entirety in every country interferes with the infant feeding industry's maximization of profit, presenting a direct conflict of interest that makes self-regulation impossible by definition.[73] An attempt to use self-regulatory measures in situations such as these results in what can be seen today with the Code: a fragmented and quasi-committal compliance by the leading actors in the industry.[74] For the children's rights to be truly protected, BMS producers should not have the freedom to pick and choose which provisions of the Code they will follow and where they will follow them. Even companies with the most developed 'corporate social responsibility' agenda are still profit-driven private actors whose primary accountability is to their shareholders, and therefore are not in the position to determine the acceptable "standards of risks for society".[75] In order to count on industry to act in agreement with

[71] Richter, Judith. 2002 (1)

[72] Richter, Judith. 2002 (5)

[73] James Pennington, 2016.

[74] Baby Milk Action. "Nestlé and FTSE4Good." Baby Milk Action. 2014.

[75] Richter, Judith. 2002 (19)

the public agenda, national legislations that accept nothing less must be created and enforced.

A correspondence with Mr. Alexandre Biella of Nestlé confirmed the company's willingness to comply with national legislations, if they were in place. Nestlé, the current industry leader in responsible marketing practices, according to their own statement, follows Code guidelines stringently in the 152 countries that have been determined to be high-risk[76] regardless of national legislation. In countries that are deemed to be "lower-risk," it is Nestlé's policy to abide by all national laws.[77] In many of these countries legislation is not up to date with current WHO Code recommendations, or is entirely absent. This policy presents a double standard. As was explained earlier, the Code is universal and to be applied as a minimum in all countries. Nestlé thus introduces unilaterally a significant loophole in following the provisions of the Code that undermine the intended universality of the Code's recommendations.

While these shortcomings in compliance can certainly be mitigated in part through implementation of policy at a national level, the need for effective and consistent laws and standards at an international level to hold TNCs accountable has become increasingly important, as TNCs grow larger and more politically influential. The current 'policing' approach, in which underfunded civil society groups and NGOs play a watchdog role is insufficiently structured and beyond 'naming and shaming',[78] little can be done to hold perpetrators accountable for their actions. Therefore, a standardized,

[76] Countries are considered to be "high-risk" based on a prevalence of under 5 year old mortality of more than 10 per 1000 and having a rate of acute malnutrition greater than 2%

[77] Public Affairs, Nestlé. *Nestlé Policy and Instructions for Implementation of the WHO International Code of Marketing of Breast-milk Substitutes*.

[78] Judith Richter, 2016.

universal tool to independently monitor the marketing practices of all BMS producers against the full standards set by the Code has been called for by multiple organizations[79], and has even been suggested as an improvement by companies in the infant feeding industry.[80] Such a tool would create a level playing field and foster buy-in from industry. The voluntary measures that are used today, such as the FTSE4Good index hold industry to a much looser set of standards than those of the Code. Nevertheless, only one company in the infant food sector meets these criteria.[81]

In order for legislation to be passed at both a national and international level, it is important to keep the decision-making processes free from undue influence, thus free from those who are to be regulated, i.e. the industry. Historically, ensuring that industry does not have a place at the table has presented a significant challenge to strengthening adherence to the Code.[82]

While there is no simple way to guarantee the decoupling of industry and the public sector at every level, there are two courses of action that if taken simultaneously, will allow for increased governmental autonomy and policy making with sustained progress with human rights to health, development, and dignity at its core. These actions are (1) strengthening governance, specifically in developing countries and

[79] Mason, Frances, Kathryn Rawe, and Simon Wright. *Superfood for Babies: How Overcoming Barriers to Breastfeeding Will save Children's Lives*. Save the Children, 2013.

[80] Alex Biella, email correspondence with author, April 29th 2016.

[81] Baby Milk Action. 2014.

[82] "Industry is often involved in policy discussions where it is not welcome. Even though we may know this, it is very difficult to prove" Mirza Alas, 2016.

smaller economies and (2) re-gaining an 'arms-length'[83] distance between the public and private sectors.

Strengthening Governance

The World Bank cites poorly functioning public sector institutions and weak governance as two of the foremost constraints to growth and equitable development.[84] In the absence of good government, development projects are extremely difficult to catalyze, and almost impossible to sustain. This is especially true when development projects are based off of large foreign donations or investments. Neither good policies nor good investments "are likely to emerge and be sustainable in an environment with dysfunctional institutions and poor governance" [85] Ensuring a high level of institutional capacities in national governments, especially in developing countries, is therefore of crucial importance for the implementation of the Code as national legislation.

While this is an extremely complex process, two steps should be highlighted as extremely important: 1.) Understanding the complete range of pressures and incentives that come from within and outside the government that affect the performance of the public sector. This entails a thorough assessment of all those involved in or exerting pressure on decision making at every level in both international organizations and national governments; 2.) Revitalizing or setting in place research and communication capacities in order to contextualize international policy recommendations and translate

[83] Judith Richter, 2016.

[84] World Bank. *Reforming Public Institutions and Strengthening Governance: A World Bank Strategy*. 2000. (xii)

[85] World Bank. 2000. (vii)

them into strong and effective local legislation, complete with follow up monitoring and accountability frameworks.[8687]

Re-gaining an arms-length distance

In order for national and international policies and regulations to truly keep public interests at their core, it is important to eliminate, at every level, the financial and political "middle man" that industry has become. It is especially important to remove industry's interests from the Sustainable Development Agenda by addressing the inherent contradictions that exist both between Goal 17 and the rest of the Sustainable Development Goals, and within Goal 17 itself.

Goal 17, "revitalize the global partnership for sustainable development,"[88] is broken down into 19 separate targets that fall into the categories of finance, technology, capacity building, trade, and systemic issues. The targets aimed towards addressing systemic issues are further broken down into three subcategories: policy and institutional coherence, multi-stakeholder partnerships, and data, monitoring and accountability.

While several of the provisions of Goal 17, such as capacity building, policy and institutional coherence, have already been pointed out as being fundamental to achieving the other goals (by way of their essential role in the successful implementation of the Code). However, Goal 17's emphasis on multi-stakeholder partnerships[89] has the potential to undermine ethical progress towards implementation of effective capacity

[86] Biersteker, Thomas, Katia Papagianni, David Haeri, and Sebastian Von Einsiedel. Proceedings of Strengthening the UN's Research Uptake, The Graduate Institute Geneva, 2016.

[87] Katia Papagianni, interview by author, Graduate Institute of Geneva, April 26th 2016.

[88] "Global Partnerships - United Nations Sustainable Development."

[89] stakeholders can be anyone who claims to have a "stake" in a certain issue. Corporations are often involved in multi-stakeholder partnerships because policy issues impact their profits. Judith Richter, 2016.

building plans by imposing on the policy space of countries and therefore weakening policy coherence towards the goals.

Unfortunately, the contradictions and compromises expressed in Goal 17 are reflective of a much deeper compromise being made in development. It is important to revisit one of the main reasons the UN is increasingly adamant on 'partnering' with industry: funding. In order for UN agencies to focus on programs that fulfill their mandates rather than on programs that will fill their coffers, the policies of UN economic austerity must be revisited.

Secondly, the notion of what comprises a public-private 'partnership' must also be clearly and explicitly defined. The strong connotations of intimacy, mutual benefits and trust as well as the broad range of activities that this term covers are unacceptable when dealing with the public sphere, especially in such sensitive[90] topics as health and development. IBFAN has suggested re-framing the concept as public-private 'interactions,'[91] a term that implies much more independence of actors as well as a defined time frame.

Concluding thoughts and future directions

The call for the strengthening of optimal breastfeeding practices worldwide through the universal implementation and systematic and independent monitoring of the *International Code of Marketing of Breast-milk Substitutes* and subsequent WHA resolutions is an excellent example of how removing private actors from their deeply entrenched and influential positions in public policy decisions has the capacity to

[90] In terms of human rights

[91] Richter, Judith.2004. (46)

drastically improve the state of global public health as well as make the much needed progress towards the Sustainable Development Goals. Without the reliance on private funding and good will to act on voluntary measures, interests that conflict with the good of the people are most effectively removed from consideration, causing the agenda to move forward more efficiently and with fewer externalities.

In order to increase exclusive breastfeeding rates for the first six months to 50% or above, the World Bank has estimated an investment of 5.7 billion U.S dollars,[92]including the implementation of creation of legislation and enforcement of policies related to the Code. While the increase in expenditure that would be required to finance this progress is significant, it is affordable in most countries without reliance on substantial international aid.[93] Based off of projections of the economic benefit potential of other infant health reforms heavily based on nutrition, the long-term benefit to cost ratio per dollar invested has the potential to increase to rates close to 30:7 by the year 2050 (and is projected to increase every generation).[94]

Future research is required to gage a more accurate estimate of the potential social and economic progress that could come from the universal implementation and

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[92] Shekar, M., J. Kakietek, M. D'Alimonte, D. Walters, H. Rogers, J. Dayton Eberwein, S. Soe-Lin, and R. Hecht. *Investing in Nutrition The Foundation For Development: An Investment Framework to Reach the Global Nutrition.* 2016. (6)

[93] Based off of similar reforms in women's and children's health as seen in: Stenberg, Karin, Henrik Axelson, Peter Sheehan, Ian Anderson, A. Metin Gülmezoglu, Marleen Temmerman, Elizabeth Mason, Howard S. Friedman, Zulfiqar A. Bhutta, Joy E. Lawn, Kim Sweeny, Jim Tulloch, Peter Hansen, Mickey Chopra, Anuradha Gupta, Joshua P. Vogel, Mikael Ostergren, Bruce Rasmussen, Carol Levin, Colin Boyle, Shyama Kuruvilla, Marjorie Koblinsky, Neff Walker, Andres De Francisco, Nebojsa Novcic, Carole Presern, Dean Jamison, and Flavia Bustreo. "Advancing Social and Economic Development by Investing in Women's and Children's Health: A New Global Investment Framework." 2014 (133-354)

[94] Stenberg, Karin, Henrik Axelson, Peter Sheehan, et al. "Advancing Social and 2014 (168)

monitoring of the Code. Based on the clear, evidence based, life improving and life saving potential of exclusive breastfeeding, I predict the figures to be significant. Additionally, research must also be done to quantify the social and economic losses the public suffers from governmental and intergovernmental engagement in public private partnerships. If the PPP paradigm does not shift soon, "inestimable public losses"[95]will continue to amass, locking the world into a cycle of public-private dependency.

Moving forward into the implementation of measures towards the Sustainable Development Goals, it is important for governments and intergovernmental organizations to know that alternatives to public private partnerships do exist, and can drive significant and lasting progress towards the Goals. While making compromises with industry and private donors has the allure of increased funding and a potentially farther reach, focusing on implementing strong, binding national and international policies around sensitive health issues, is the only way to preserve the integrity of the WHO's mandate and ensure that public interests are the only interests being served.

[95] Richter, Judith. 2004 (43)

Abbreviations List

The Code --- The International Code of Marketing of Breastmilk Substitutes (and subsequent WHA resolutions)

GPPPH --- Global Public Private Partnership for Health

IBFAN --- International Baby Food Action Network

MDG --- Millennium Development Goal

PPP --- Public Private Partnership

SDG --- Sustainable Development Goal

TINA --- There Is No Alternative

TNC – Transnational Corporation

UN – United Nations

WHA --- The World Health Assembly

WHO – World Health Organization

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