



**Mapping the
commercial
determinants of health
in countries of the WHO
South-East Asia Region:
conceptualizations,
impacts and actions**



World Health
Organization
REGIONAL OFFICE FOR South-East Asia

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Foreword

Public Health exists as a part of the intricate socio-economic ecosystems of our lives and livelihoods.

WHO recognizes the importance of economic and commercial determinants of health, that generate both positive and negative impacts, while enabling political economic systems and norms for working conditions and other related activities. Commercial determinants of health are recognised as industrial driven commercial activities - including all the products and services impacting public health (health care delivery systems and cost) - that influence healthy and unhealthy lifestyle choices, and global health inequities. This includes the occupational health of workers in different commercial systems. The production and consumption of 'unhealthy' products, such as tobacco, alcohol, ultra-processed foods, and sugary beverages, impacts the earth, degrades the environment, and negatively impacts the health of communities, families and people, and adds to pollution.



This report documents a wide range of commercial products, activities, and market systems that influence people choices, and consequently the health conditions of SE Asia. Through a systematic review of secondary sources and interviews with key informants, the report contains significant recommendations derived from agreed points made in multisectoral regional consultations.

Commercial-driven noncommunicable diseases are most prominent in the SEA region. It was found that nine million deaths in SEAR countries in 2019 alone are from NCDs, which is 22% of global NCD mortality. The NCD mortality is attributed to lifestyle related risk factors, such as increasing emission of pollutants, and burning of biomass for industrial development.

The nutrition transition, from home-grown organic food to mass industrial processed food products, has been evident in SEAR countries. This has led to an increase in consumption of high sugar, salt, and trans-fat, and has contributed to obesity and metabolic disorders. The sales of sugar-sweetened beverages has increased. Availability of cheap unhealthy items in the region, such as loose cigarettes, cheap liquor, uncertified contaminated food and vegetables, and cheap unhealthy imitated food products is driving up noncommunicable diseases among the poor, rural, and less informed population.

The commercial systems of pharmaceutical products, medical technologies, vaccinations, and health supplements can divide health care services benefiting the rich and the poor differently. Commercial determinants of health pose a complex juxtaposition to health equities. They can increase health care costs, including out-of-pocket expenditure, and widen the gaps of health inequities.

It is important for Member States of the SE Asia Region to work together using a whole of government approach to regulate and mitigate some of the commercial products and marketing systems, and to strengthen consumer protections and human rights to health and wellbeing for the people. We also need to understand the imbalance of powers in regional and global commercial systems where transnational drivers may influence decision makers in economic, social and political policies. Collaboration by countries, through multilateral agreements or mechanisms, can bring

solidarity in the region, reduce negative impacts and increase positive economic drivers that promote health and wellbeing. Sustainable safeguards for people can be provided by public participations in all levels to increase the understanding of commercial determinants of health and the importance of health literacy.

This first regional mapping of the conceptualizations, impacts, and actions on the commercial determinants of health is an important milestone as we begin our journey of investigating the commercial determinants of health in the region.

A handwritten signature in black ink, appearing to read 'Saima Wazed', written in a cursive style.

Saima Wazed
Regional Director
WHO South-East Asia

Abbreviations and acronyms

ASEAN	Association of Southeast Asian Nations
BMS	breastmilk substitutes
CDH	commercial determinants of health
CMF	commercial milk formula
COP	Conference of Parties
CSO	civil society organization
CSR	corporate social responsibility
CSR	corporate social responsibility
DALY	disability-adjusted life year
FAO	Food and Agriculture Organization
FCTC	WHO Framework Convention on Tobacco Control
FSSAI	Food Safety and Standards Authority of India
GDP	gross domestic product
GST	Goods and Services Tax
HIC	high-income country
ILO	International Labour Organization
LMICs	low- and middle-income countries
NCD	noncommunicable disease
OECD	Organization for Economic Co-operation and Development
PHW	pictorial health warning
R&D	research and development
SE	South-East
SSB	sugar-sweetened beverage
TAPS	tobacco advertising, promotion and sponsorship
TRIPS	Agreement on Trade-Related Aspects of Intellectual Property Rights
UHC	universal health coverage
UNDP	United Nations Development Programme
WHO	World Health Organization
WTO	World Trade Organization

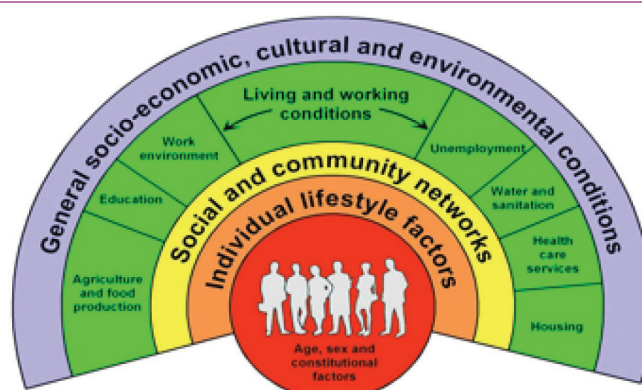
1. Introduction

1.1 What are the commercial determinants of health?

The health and well-being outcomes of an individual are determined by everyday living conditions, which are driven by the social, political and environmental surroundings in which individual lives or works. The famous Dahlgren and Whitehead “rainbow model” (Fig. 1) developed in 1991, maps the interaction between individuals and lifestyle factors, community influences, living and working conditions and social conditions that surround them (1). However, all these conditions are encapsulated within wider influences, namely: economics, social policies, politics and the commercial determinants of health (CDH) (2).

The activities and actions of business and commercial actors affect our social, physical and cultural environment. While commercial actors can have positive effects on health and society, there is now substantial evidence that commercial actors have increasingly negative effects on human and planetary health, and social and health inequities (3–16).

Fig. 1: The Rainbow Model by Dahlgren and Whitehead



The so-called unhealthy products industries (such as tobacco, alcohol, ultra-processed food, gambling and fossil fuels) have driven many of the world’s greatest health problems, including the rising burden of noncommunicable diseases (NCDs) and the climate emergency (14, 15, 17, 18). Other industries impacting health outcomes include social media’s effect on mental health (19) palm oil industry, cosmetics industry, and the pharmaceutical industry’s role in pricing and restricting access to essential medicines and vaccines, including during the recent COVID-19 pandemic.

It is not just the products of the commercial sector, but also their practices that harm health and widen inequities both within and between countries. This occurs through, for example, marketing of products, treatment of workers, methods of production and waste disposal, funding of research, lobbying for regulatory benefits, tax avoidance, and bribery. Commercial actors work to maintain the status quo that maximizes their profits, and influence policy and regulatory environments with the aim of making them conducive to their interests. They do so by exerting their structural power and influence via practices that include marketing, investment, production and employment. Indeed, they also exert influence through ideational power that shapes narratives, norms and ideologies (20). Power relations, and often the unequal balance of power, between governments, consumers and businesses is at the cornerstone of the commercial determinants (21).

Different forms of power are used effectively by commercial actors across industries – tobacco, alcohol, sugar, gambling, commercial milk formula, palm oil, fossil fuel, social media and pharmaceuticals – resulting in adverse public health outcomes. Modern commercial power is exercised in more subtle ways, including through shaping preferences by defining the dominant narrative and commodifying knowledge, and fostering a sociopolitical environment that permits favourable policies (22). While there are clear, evidence-based policy options available to reduce the burden of harm from various industries, such as those manufacturing or marketing unhealthy products, the adverse influence of these powerful industries continues to pose a significant barrier to progress in public health policy (23).

These products and practices negatively affect the health outcomes of the population, with particularly noteworthy attribution in the literature to the growing epidemics of NCDs and mental health conditions but are also attributable to communicable diseases and injuries as well as global risks such as climate change. Products of just four industries (tobacco, alcohol, ultra-processed food and fossil fuels) account for 19 million global deaths annually, a third of the global preventable deaths each year (24). While the negative direct effects of commercial practices are self-evident, the negative indirect effects include spread of pathogens and diseases along trading routes, harmful working conditions, environmental degradation and socioeconomic inequalities (22).

The commercial sector's influence on and exploitation of weaker regulatory frameworks in low- and middle-income countries (LMICs) contribute to inequities in access to quality health care, use of unhealthy products and workplace safety, to name a few (25,26). Given that people from lower socioeconomic backgrounds are both more exposed to the manipulation of their choice environments and physical environments by commercial practices and are less able to bear the subsequent costs of ill health, the distributional impacts of CDH have to be seen as a risk to health equity.

However, several commercial practices also contribute positively to the health and well-being of the population as an ordinary function of the commercial profit-seeking motive. Positive direct effects of commercial practices are often self-evident, like the trade in health-promoting products, technologies and services. Social demand for nutritious and healthier food options has, in certain settings, grown and along with it a profit incentive for commercial actors to lead on and support the development and distribution of healthier food products. More broadly, commercial practices aim to improve health when doing so is profitable, whether this be through promoting health within the workplace or supporting disease management and treatment as part of the health sector.

Countries in the WHO South-East Asia (SE Asia) Region, such as India, have seen growing investment in ventures offering holistic diet, physical activity products and mental health interventions. Similarly, paid-for apps have been developed which, through in-app purchases, offer tobacco cessation services, diet counselling, mental health solutions and virtual physical activity training. However, the reliance on paid services and products for health improvement raises concerns about equitable access, potentially widening the health equity divide by limiting these benefits primarily to those who already have the means to be healthier, while poor, marginalized and vulnerable populations are unable to benefit from these innovations and developments.

The commercial sector may also contribute positively to health equity. More recently, this is notable in commercial innovations aimed at developing accessible low-cost medical therapeutics. For example, the Grameen Health Care Services in Bangladesh focuses on providing affordable health solutions to the underprivileged as a social business enterprise (27).

This shows the potential of the commercial sector to both benefit and harm health and health equity. These interactions and links between the commercial sector and health are referred to as

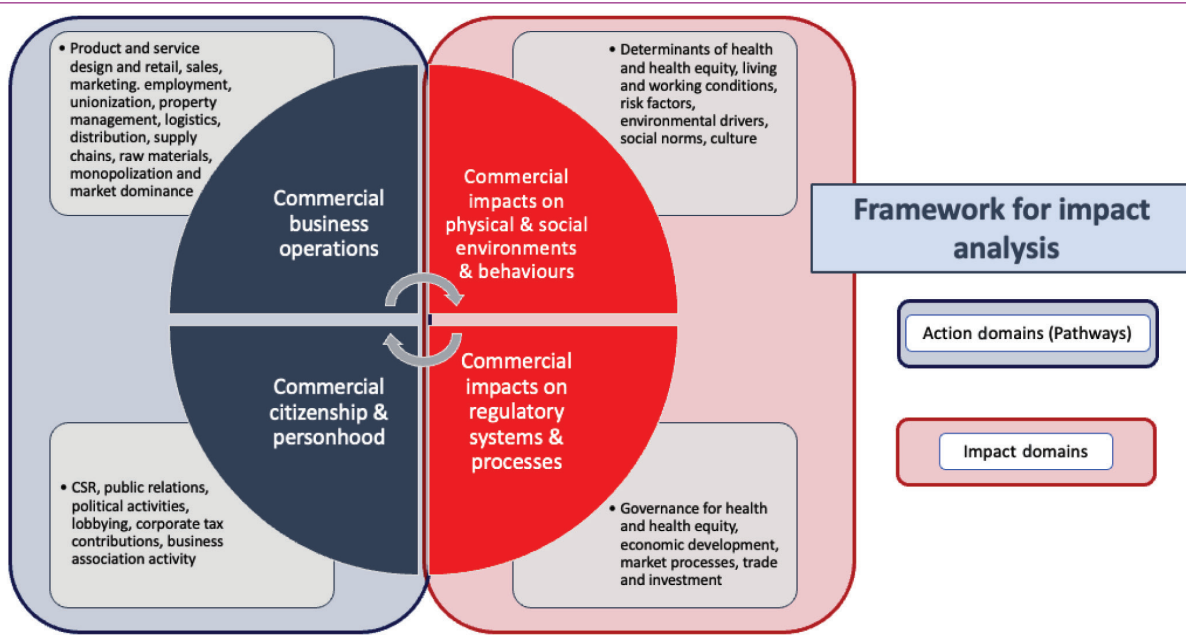
CDH. Harms caused by CDH are completely preventable and appropriate regulations and policies can ensure that people are not misled or adversely impacted. Studying and analysing the impact of CDH on population health is the need of the hour. The concept aims to redress markets that adversely affect public health. Several definitions of CDH are found in the literature. Some of these definitions have been listed in Table 1 (28).

The review and understanding of CDH in this report are based on the definition by Gilmore et al. in the 2023 Lancet Series on Commercial Determinants of Health and informed by the WHO SE Asia Regional Consultations (October 2023), WHO’s draft intervention framework model for the commercial determinants of health (2021) and the zero draft outline of the WHO’s *Global report on commercial determinants of health* (28). Gilmore et al. define CDH as “systems, practices, and pathways through which commercial actors drive health and equity”.

This definition encompasses all commercial actors, recognizes both positive and negative contributions of commercial actors, and focuses on both health (both human and planetary health) and equity as the primary outcomes of concerns. Lacy-Nichols et al. adopt a broad conceptualization of commercial actors, defined in the Lancet Series as actors that are engaged in buying and selling of goods or services (i.e. commerce), or both, primarily for profit or return on investment (5). This encompasses a range of hybrid, quasi-commercial actors because often, commercial actors possess qualities that overlap with the public sector or the so-called third sector of civil society organizations (CSOs).

More recent literature on CDH has expanded beyond addressing NCDs and more towards diagnosing the role of larger forces such as commercial practices, commercial power and global governance (5,20,22,28–30).

Fig. 2: Draft intervention framework model for commercial determinants of health (WHO, 2021)



In 2021, following a review of the existing models and literature, WHO proposed a *draft* intervention framework for CDH (see Fig. 2) (31). Each domain in the framework is related but conceptually distinct in terms of the actors involved; the skills and capacities required within the health sector and wider governmental capacities; and the various governance considerations.

Table 1: Definition of commercial determinants of health

Author	Definition of commercial determinants of health
Gilmore et al. (28)	Systems, practices and pathways through which commercial actors drive health and equity
West and Marteau (32)	Factors that influence health, which stem from the profit motive
Kickbusch et al. (33)	Strategies and approaches used by the private sector to promote products and choices that are detrimental to health
Kosinska and Ostlin (34)	A good or a service where there is an inherent tension between the commercial and the public health objective
Lee et al. (35)	The ways in which actors (through market and nonmarket strategies) and structures (stratification, systems, organization, culture, and regulatory frameworks and governance) operate to generate profit, and thereby influence patterns of health, disease, injury, disability, and death within and across populations
World Health Organization (2)	Conditions, actions and omissions by corporate actors that affect health

1.2 Commercial landscape of the SE Asia Region

The impacts of CDH are underlined by the unique social, cultural and economic context in the SE Asia Region, which invariably shape the political landscape, when it comes to many of the unhealthy products. For instance, tobacco presents a unique challenge in the Region. Even though *tobacco production* did not originate in the Region, countries such as India and Indonesia remain among the top five producers of tobacco in the world. India is the second-largest consumer and producer of tobacco globally and 81% of the world's smokeless tobacco consumers live in the Region (36,37). Tobacco is consumed in multiple smoked and smokeless forms in the Region, especially in India. The *bidi* industry and the smokeless tobacco industry largely constitute an unorganized sector and hence do not face strict tax and legislation implications.

Global *alcohol* consumption is expanding rapidly and expected to increase by more than 10% by 2030. This rise is anticipated to be driven by market expansion in key regions, including WHO's SE Asia Region (46.8% market growth by 2030) (38). While the consumption of alcohol may not be as common as in high-income countries, yet easy availability of home-grown, cheap-quality alcohol poses a serious threat to public health in the Region.

Moreover, to boost the economy, governments often offer various schemes and tax incentives for the commercial sector to invest in their countries, including CDH and other sectors. This Region is largely characterized by heavy investments by businesses overall of the global north, but also the economic development in the Region has been characterized by the growth of several home-grown businesses and industries.

Other than the alcohol and tobacco industries, the Region is dominated by the palm oil, cosmetics, garment, tourism and the pharmaceutical industries, to name a few. Indonesia and Malaysia are the world's top producers of palm oil. Both these countries have used government policies, including subsidies and land incentives, to assist industry expansion and facilitate greater investment (39). While large-scale commercial plantations have historically dominated the Region, small holders are on the rise (40). Palm oil is one of the world's most commonly used vegetable oils. It contains a much higher percentage of saturated fats compared to other vegetable oils.

A multicountry analysis of palm oil consumption and cardiovascular disease across 23 countries revealed a significant correlation with higher mortality from ischaemic heart disease (41). A systematic review revealed that the intake of palm oil was associated with elevated blood levels of atherogenic low-density lipoprotein cholesterol (0.24 mmol/L) (42). As far back as 2003, the World Health Organization (WHO) and the Food and Agriculture Organization (FAO) characterized the evidence connecting saturated fat intake with heightened cardiovascular disease risk as compelling (43).

Indonesia's cosmetic market amounted to almost US\$ 7 billion in 2020 (44). Cosmetic products in the country have increased, doubling from 44 398 items in 2016 to 75 530 items in 2020. The main harmful chemical compounds that are used as preservatives, surfactants, fragrances and dyes in cosmetic products are associated with potential health issues.

While these chemicals enhance the quality, attributes and longevity of cosmetics, many are toxic to humans, leading to health risks ranging from mild hypersensitivity reactions to severe anaphylactic shock or fatality (45). A study conducted in Nigeria analysed the presence of trace metals such as lead, cadmium, zinc and iron in eye pencils, eyeliners and mascara and its continuous use could potentially lead to elevated levels of trace metals in the human body, surpassing acceptable thresholds (46). Thus, the cosmetics industry can also be reviewed through the CDH lens.

Lead poisoning resulting from lead paint continues to be a significant concern in various regions worldwide, including several Asian countries (47). Exposure to lead can adversely affect various bodily systems, especially posing risks to young children and women of childbearing age (48). There is no known safe level of lead exposure. Nonetheless, lead-based paints remain prevalent in numerous low- and middle-income developing nations, with the production and trade of such paints still widespread globally.

Collectively, Asian countries contribute 50–55% of the world's total paint production (49). In India and many SE Asian countries, lead concentrations in paint frequently surpass 10 000 mg/kg (50). Despite India's voluntary standards for lead content in paints, lead-based paints continue to be readily accessible. In Indonesia, close to 70% of paints available on the market surpass the regulatory safety threshold of 600 parts per million (ppm) for lead content (51). Bangladesh faces challenges with elevated blood lead levels among its children (52,53).

The SE Asia Region offers cheap labour and land as well as easy availability of *textile raw material*, which has attracted many businesses in the apparel industry to set up production in the Region. The readymade garment industry of Bangladesh started in the sixties and has grown as an export-oriented sector. The industry attracts the highest foreign currency in Bangladesh and has the highest employment rate. In 2022, it accounted for 81.16% of total exports valued at US\$ 31 456.73 million (54). In order to maximize their profits, the garment manufacturing industry employs labour and offers low wages and dilapidated work conditions to the workers in their factories. This has an adverse impact on workers' health.

The tourism industry is a significant contributor to the economy of the SE Asia Region, particularly in India, Indonesia, Maldives and Thailand. The economy of Maldives is largely dependent on tourism and export of fresh and processed tuna (55). Tourism is also a major contributor to Sri Lanka's gross domestic product (GDP) and a significant source of foreign currency in the country (56). In Thailand, tourism receipts from foreign visitors amounted to over 26 billion Thai baht in June 2022 and brings about significant employment opportunities (57). Tourism contributes to over 2% of Indonesia's GDP (58). The negative health impacts of tourism include social, cultural and environmental issues (59).

The pharmaceutical industry in the SE Asia Region is expected to grow by 13% annually from 2021 to 2027, achieving a total market size of \$29.1 billion (60). The pharmaceutical industry in India is expected to reach \$130 billion by 2030 (61). The pharmaceutical industry in India is valued at \$50 billion in 2024 (62). India is a major exporter of pharmaceuticals, with over 200+ countries served by Indian pharma exports. In Bangladesh, the industry contributes 1% of the GDP of the country (63). Reports have predicted that the pharmaceutical market in Sri Lanka will reach a value of \$625 million and will cross \$710 million by 2029, observing a 10-year CAGR of 2.2% (64).

Trade liberalization, market trades and investments

The SE Asia Region has witnessed an unprecedented rate of economic development over the past few decades. The developments in these countries have been underlined by liberalization of trade and capital (reduction in barriers to cross-border trade and investment) among other reasons. In the past few decades, many multinational companies have moved their operations to and expanded their markets in LMICs, including SE Asia. India has doubled its economic output per capita in less than 20 years, which is twice the rate achieved during the industrial revolution in the West (65).

The large population and unchartered territories have provided an unprecedented opportunity for the commercial sectors, especially those manufacturing and marketing unhealthy products, to expand their profit margins. These trade practices have also contributed to the increasing incidence of poor health outcomes due to diseases such as NCDs such as respiratory illnesses, metabolic diseases, and cancers (33). The liberalization of trade has also proven to be beneficial for countries in the Region. Trade liberalization has improved access to goods and services, superior technology, and increase in employment rates.

The ill-effects of trade liberalization have been witnessed across industries, including the pharmaceutical industry. Patents for pharmaceutical formulations largely belong with businesses in the United States of America, European Union or Japan (46% of the global market share) (34). Since these industries own the patents, control to access to essential medicines lies with these commercial actors in high-income countries (HICs). This can severely affect the access to medicines and their affordability by people living in LMICs. Several bilateral trade agreements in the Region also preclude the health priorities for the Region. International trade agreements prioritize the rights of companies over health and human rights. For example, Pakistan and Indonesia signed a bilateral preferential trade agreement in 2012, which was later expanded to a free trade agreement.

Under the agreement, Indonesia agreed to give unilateral concession on major exports from Pakistan, including a zero per cent tariff on tobacco (66). Trade negotiations provide an opportunity for the tobacco industry to assert its interest without public scrutiny. Several trade agreements with the World Trade Organization (WTO) posed serious implications for tobacco control (2). For example, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) required milder labelling and product/content disclosure policies. Health warnings in countries of the Region could be challenged under such agreements. Trade agreements have also enabled subsidies on tobacco and food items. It has been reported that in India 52 different subsidies help the tobacco industry directly or indirectly. Heavy subsidies have also been reported for the sugar industry in the SE Asia Region. Several countries in the Region, such as India, Indonesia and Thailand are major producers and exporters of sugar. Sugar is considered an essential item in many of these countries and hence the cost of sugar is generally heavily subsidized (67).

Developing countries have witnessed nutrition transition due to trade liberalization and globalization. Countries in the Region have undergone a transition wherein the consumption of processed food and food high in fats and sweeteners increased substantially, while fruit and vegetable consumption decreased or remained inadequate (68). This nutrition transition has led to an increase in NCDs in most countries of the Region. Earlier, NCDs were more prevalent in high socioeconomic populations and in urban areas. The reversal in social gradient is now visible with NCD risk factors being more prevalent among the vulnerable poor, especially in countries like India where the poor living in urban slums are most impacted adversely by NCDs.

1.3 Framing of the commercial determinants of health in the literature of the Region

With the rapid rise in the number of unhealthy lifestyle-associated diseases in the Region, there is a growing need to understand the role of the commercial actors and their practices, with regard to their impact on population health and equity. Understanding CDH and their short- and long-term impacts, especially due to industry interference in policy-making, should be prioritized. This study is one of the first in the Region focused at understanding and conceptualizing CDH in the Region.

There is a lack of literature conceptualizing CDH as it relates to the Region. Our literature review, interviews with key stakeholders and WHO's regional consultations concluded that there is limited research done on defining and framing CDH in the Region and there is a heavy focus on the risk factors of NCDs. Different terminology is found in the literature to explain or address CDH, including: "corporate political activity" and practices of "unhealthy commodity industries".

However, limited search results are available. On the contrary, numerous results are available when searching for specific NCDs and planetary health risk factors, such as tobacco, alcohol, ultra-processed food industry, and breastmilk substitutes as well as specific industries such as palm oil, pharmaceutical and cosmetic industries. Within these risk factors, multiple results are shown for specific domains like industry interference, marketing strategies, and corporate social responsibility (CSR) practices. There is, however, lack of focus on these industries from a CDH perspective and the impact of these commercial actors on health and equity.

The focus of this report is to understand the diverse set of commercial practices across various commercial products manufactured and marketed in the SE Asia Region, which may impact health and health equity.

2. Methodology of the report

Over the period August to October 2023, we used five complementary methods to develop this report: (i) desk review; (ii) brief interviews (both in-person and virtual); (iii) expert co-author knowledge and recommended papers (iv) earlier SE Asia regional report on CDH and commissioned by WHO headquarters; and (v) WHO SE Asia Regional Consultation, October 2023.

The review and understanding of CDH in this report is based on the definition by Gilmore et al. in the 2023 Lancet Series on Commercial Determinants of Health, informed by the WHO SE Asia Regional Consultations (October 2023), WHO's draft intervention framework model for commercial determinants of health (2021), and the zero draft outline of the WHO's Global Report on commercial determinants of health.

Through our desk review, interviews and discussions at the WHO regional consultation, we identified diverse commercial sector practices in the Region, across varied products, which are characterized in a set of seven practices: political, labour and employment, reputational management, marketing practices impacting health-enabling legal environments, supply chain, waste management and environment degradation practices, and scientific practices.

- (i) *Desk review*: the rapid review of the literature was broadly conducted in two parts – first for analysing scientific publications, followed by a search for the grey literature.
 - **Scientific literature search**: the PubMed search engine was used to conduct in-depth searches of the scientific literature using a combination of search strings. Search terms included: “commercial determinants” of health; industry interference in SE Asia; corporate political activity in SE Asia; marketing tactics in SE Asia. Search strings included the set of seven practices specified above across a wide range of industries. During our research, our focus on industries went beyond just NCD risk factors such as tobacco, alcohol, food, and included gambling, commercial milk formulas, health care, pharmaceuticals, cosmetics, social media and palm oil. The desk review aimed to explore (i) definitions and conceptualizations of CDH both globally and in the SE Asia Region; (ii) impact of commercial practices on health and equity in the Region; and (iii) identify different sets of commercial practices across industries in the Region. Search results were scoped to identify the literature from the Region. The reference list of included studies was also reviewed to identify further literature on CDH specific to the SE Asia Region.
 - **Grey literature search**: the grey literature search was conducted via two strategies: (i) using search strings on the Google search engine; (ii) review of targeted websites identified through past research and recommendations from key informants:
 - Google search engine: a search for the grey literature was conducted on the Google search engine using the same terms as those used for the scientific literature search. Title and abstract screening was restricted to results appearing in the first three pages. The search results included reports, workshop proceedings, conference summaries, news articles and government policy documents.
 - Targeted website search: websites of known research consortiums such as SPECTRUM (University of Edinburgh), GEPI Public Health Network were searched

to identify literature specific to the SE Asia Region. Other websites included those of the World Health Organization, Campaign for Tobacco Free Kids, STOP (tobacco industry watchdog), Movendi International, NCD Alliance and South East Asia Tobacco Control Alliance (SEATCA).

- (ii) *Key stakeholder interviews*: a total of 14 interviews was conducted. In 2023, two researchers conducted eight interviews, six in-person in Bangkok, Thailand in October 2023, and two virtually in November 2023. Six separate interviews were conducted in 2021. An interview guide was developed in consultation with WHO colleagues. Each interview was transcribed, anonymized, and the findings were incorporated in this report. These interviews were conducted with government representatives and experts with work profiles in CDH or specific related areas within CDH such as tobacco or alcohol control, or food and nutrition. The key stakeholders were identified through past work experiences, through published work and referrals and included participants to the WHO Regional Consultation on Economic and Commercial Determinant of Health. Stakeholders from different countries in the Region were approached for the interviews. The interview questions are annexed to this document.
- (iii) *Expert co-authors*: the research team had expertise in public health as well as law, with knowledge across industries, both regionally and globally. Selected and known published papers and the grey literature were chosen and referred for this report. The draft outline of the global report was referred to as well to align the regional report along the same lines.
- (iv) *SE Asia regional report 2022*: an earlier report on *Mapping the understanding of, priorities for and domains of action on the commercial determinants of health in the WHO SE Asia Region* was developed by Dr Monika Arora in 2022. This report was the starting point for developing an outline for current report. This was aligned with the WHO Global report to finalize the format and framework for updating the SE Asia regional report.
- (v) *WHO regional consultation*: the WHO SE Asia Regional Office organized a Regional Consultation on Economic and Commercial Determinants of Health in SE Asia from 17 to 19 October in Bangkok, Thailand. The consultation had the following objectives:
 - (1) to inform Member States of the concept and potential impacts of the economic and commercial determinants of health;
 - (2) to share country experiences on the economic and commercial determinants of health and common challenges faced by countries;
 - (3) to solicit inputs for the Global report on CDH from Member States;
 - (4) to consult on priority actions and ways forward to strengthen understanding of CDH in SE Asia.

The consultations included representatives of Member States from ministries of health, ministries of finance/commerce heading the work on commercial regulations, trade investments or taxation of products, or market systems affecting the health of the population. It also included representatives from academia/CSOs working on consumer protection, civic and community's right to health, NCD Alliance, FAO, United Nations Development Programme (UNDP) and International Labour Organization (ILO).

The three-day proceedings were recorded, transcribed and a consultation report was developed and the findings incorporated in this report.

3. Impact of the commercial determinants on health and health equity in the SE Asia Region

The commercial determinants of health impact a wide range of risk factors, including smoking, air pollution, alcohol use, obesity and physical inactivity (2). It also impacts health outcomes such as NCDs, injuries on the roads and from weapons, communicable diseases and epidemics, violence and mental health conditions. CDH affects people across demographics, but young people are at greater risk. Certain countries and regions, such as LMICs, face unequal and greater pressure from transnational actors.

The products made and marketed by a commercial actor helps to understand whether the actor will have more health-harming effects or health-promoting effects, be it a direct or a more remote effect (5). Commercial actors producing and offering unhealthy products such as tobacco, alcohol, gambling, ultra-processed foods, fossil fuels, often have a more direct (negative) impact on population health, as mentioned earlier in this report. Products and services with the potential for a more positive effect on human health may adversely affect health equity if their access is not ensured. This includes health care and access to medical countermeasures such as vaccines and medicines. The practices of commercial actors, especially those that include essential products and services in their portfolio, control and impact affordability, quality and accessibility of their products.

The practices adopted by the commercial sector can affect everything, from consumption patterns of products to the social norms surrounding the use of these products, to how normal and desirable children perceive such products to be, to the tax and regulatory frameworks, and how policy-makers perceive public health concerns. Commercial actors affect the health of populations either directly, such as through marketing of unhealthy products, or more indirectly, like industry lobbying against duty increases, donating to political campaigns, funding dubious research, and generating doubt around product harms.

While there can be substantial overlap in the practices and tactics of industries manufacturing unhealthy products and other industries, the actual health impact of each individual business differs, often determined by their business strategies, employment practices, operations, regulatory compliances and political engagement (21). The subsequent sections of this report discuss, with examples, the different practices of the commercial sector actors in the SE Asia Region that may impact health and equity outcomes.

The impact of commercial practices on health and health equity in the South and SE Asia Region goes way back to the establishment of the Dutch East India Company in 1602, which led to the formation of the British East India Company. Indeed, these corporations pursued profit maximization with devastating impacts on human health with little or no thought of the human cost (21).

The WHO SE Asia Region is home to a quarter of the world's population. This population is affected by an epidemiological transition whereby a significant prevalence of infectious diseases coexists with the ever-rising prevalence of NCDs such as cardiovascular diseases, cancers, diabetes and chronic respiratory illnesses.

Breastmilk substitutes (commercial milk formula [CMF])

Inadequate breastfeeding is one of the largest contributors to the global burden of childhood disease due to the higher relative risk of frequent infections and mortality from diarrhoea and pneumonia (69,70).

The recent Lancet series on breastfeeding brings to the fore an extensive network of lobbying and marketing by formula milk companies to derail the progress on breastfeeding education (71–73). The world sales volume of milk formula per child (0–36 months) more than doubled from 3.5 kg to 7.4 kg from 2005 to 2019. This growth occurred mostly in the industrializing and highly populated middle-income countries of East and SE Asia and, to a lesser extent, Eastern Europe and Central Asia, Middle East and North Africa, and Latin America (74). A major reason for early cessation of breastfeeding is a pervasive belief in SE Asia that formula milk is superior to breastmilk (75). The commercial milk formula (CMF) industry exploits the concerns of parents about misinterpreted typical, unsettled baby behaviours as signs of milk insufficiency or inadequacy, with unfounded product claims and advertising messages (71,73,74).

The baby food industry has increased the marketing of breastmilk substitutes (BMS) for children under 2 years of age, particularly in emerging economies, where potential markets have grown due to increases in disposable incomes and the large child populations (76).

A study conducted in 2016 estimated the cost of suboptimal breastfeeding in seven countries in the SE Asia Region (Cambodia, Indonesia, Lao People's Democratic Republic, Myanmar, Thailand, Timor-Leste, and Viet Nam) (77). The human costs of inadequate breastfeeding include premature mortality both for children under the age of 2 years as well as mothers.

Economic costs include reduced cognition, health system treatment costs for selected illnesses in children under the age of 2 years (diarrhoea and pneumonia), and the costs of BMS. The study concluded that the health and economic consequences of inadequate breastfeeding are substantial, not only for children and their families but also for governments and the economy. It found that up to 50% of child deaths from diarrhoea and pneumonia and 10% of breast cancer deaths are due to inadequate breastfeeding – over 12 400 preventable child and maternal deaths occur annually in seven countries in the SE Asia Region.

Tourism – Maldives

The impact of the tourism sector on health and health equity is also observed in the Region, particularly in Maldives which is largely dependent on revenue generated from tourism. The country is struggling to make growth more socially inclusive and regionally balanced (55). Economic disparities between Malé and the other islands have widened. Increased human activity such as land reclamation, dredging and garbage dumping results in degradation of the coral reef and natural vegetation in the region (78).

Palm oil – Indonesia

The palm oil industry impacts both human and planetary health in the Region, particularly in Indonesia. While the industry actively engages in marketing and political practices with a profit-making objective, palm oil consumption is linked to increasing mortality from ischaemic heart disease and increased risk of cardiovascular diseases (39). Land-clearing practices for palm oil cultivation leading to increased level of air pollution has major public health consequences. Child labour practices are also common in this industry across the Region. The palm oil industry also leads to inequality among communities –

agroclimatic zones and regions where oil palm does not grow attracts lower government expenditure and investments in public infrastructure (40).

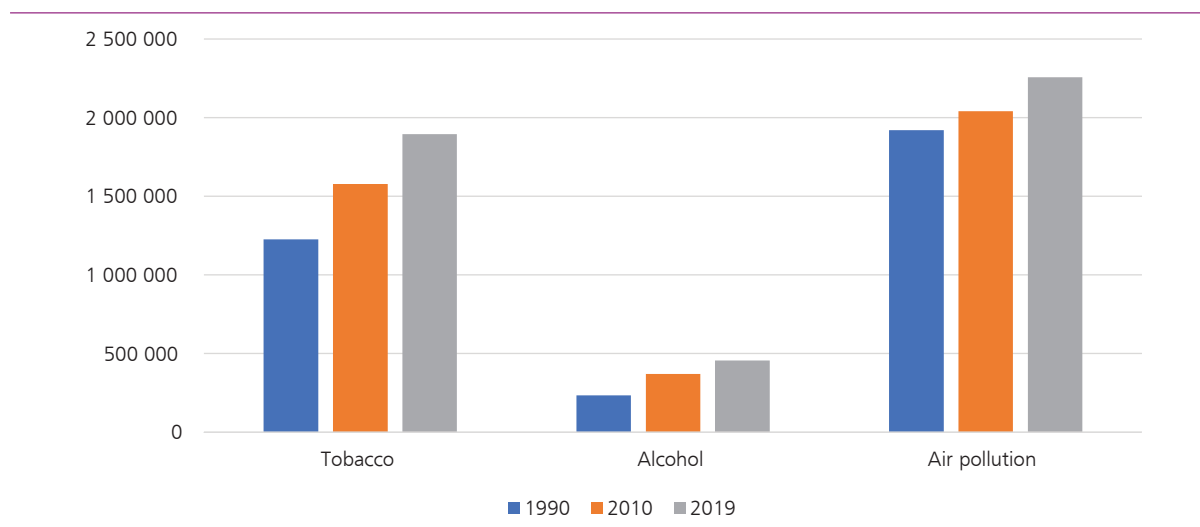
Gaming

Video gaming has a high addictive potential and the objective of game developers and publishers is to create attractive games that draw wide audiences for as long as possible. Their profit-making model is dependent on repetitive play. For this, the industry uses game design elements based on psychological mechanisms (79). East and SE Asia are among the most dynamic regions in producing games and some of these countries are also major users (80). Thailand was listed as the number one market in SE Asia by one of the developers. More than half of the global “sudden gamer death” has originated from SE Asia (Taiwan, China, South Korea, Thailand) and most of them happened in Internet cafes, which are easily accessible to the youth and are cheap (81).

NCDs risk factors

The mortality from NCDs in the SE Asia Region has nearly doubled since 1990, with over 9 million deaths in 2019 alone (24). Twenty-two per cent of global NCD mortality occurs in the Region. In 2019, NCDs accounted for 27.3% of total deaths and 49.8% of total disability-adjusted life years (DALYs) in SE Asia (82). The change in mortality attributable to several lifestyle-related risk factors between 1990, 2010 and 2019 is given in Fig. 3.

Fig. 3. All-cause mortality attributable to tobacco use, alcohol use and air pollution in SE Asia



Consumption of tobacco, alcohol and unhealthy foods are causes of NCDs and drivers of health inequities in the SE Asia Region. Consumption is often driven by complex systems of production, distribution and promotion dominated by transnational commercial actors. In considering the spread of NCDs and their commercial risk factors, it can also be helpful to consider affordability, accessibility and cultural acceptability as prerequisite conditions for spread and consumption. For instance, tobacco prevalence rates are low in Bhutan which, up until recently, had banned tobacco, but they are high in Indonesia, which is not a party to the WHO Framework Convention on Tobacco Control (FCTC) and where tobacco is loosely regulated.

A chronic and severe haze in the atmosphere has become far too common in recent years in the Region. There has been a steady rise in energy demand in the SE Asia Region due to increasing

population and growing economies (83). The increase in energy demand has led to an increase in fossil fuel burning, leading to emission of pollutants causing poor air quality and negative health outcomes (84). Widespread burning of biomass, including forest burning due to industrial practices, are also contributing significantly to the growing air pollution in the Region. All-cause mortality attributable to air pollution has significantly increased since 1990.

Tobacco is an example of a highly profitable yet deadly product that has been globally promoted by the tobacco industry to the financial benefit of a few at the cost of millions. A study done with the SE Asian population showed that prevalence of smoking and smokeless tobacco was highest among the poorest social class and lowest among the richest (85). Another study from Nepal found that educated individuals and individuals with skilled jobs were less likely to consume alcohol (86).

Harmful consumption of *alcohol* has been attributed to many NCDs, majorly cardiovascular diseases, but it is also a significant contributor to motor vehicle accidents (87). Alcohol use is limited in countries such as Indonesia due to religious factors; however, it is increasing in countries such as India, Thailand and the Democratic People's Republic of Korea (88). Even though the prevalence of alcohol in these countries is lower than other HICs, the data could be largely underreported due to the consumption of local alcohol products or illicit products, which are not captured in many reports.

While WHO recommends restricting marketing of foods and non-alcoholic beverages to children, food marketing remains prevalent across the globe, including the SE Asia Region. Evidence confirms that food marketing continues to be dominated by the promotion of foods that contribute to unhealthy diets (89). There is strong evidence to demonstrate that large numbers of young children in SE Asia are unable to consume a diet that meets their full nutrient requirements as a result of poor knowledge and behaviours, availability, and/or affordability, and widespread marketing of unhealthy foods (75).

Unhealthy product industries have promoted the consumption of foods high in sugar, salt and trans-fats. The prevalence of obesity and metabolic disorders such as diabetes has grown considerably in the Region (90). While the Region has the lowest prevalence of overweight and obesity worldwide, a staggering growth in the number of overweight and obese individuals, particularly children, is being witnessed in the Region. The sale of sugar-sweetened beverages (SSBs) has increased everywhere in the Region, with particular increase in countries such as Indonesia and Thailand, where the consumption is almost comparable to the numbers in HICs (91).

As per analysis of prices of healthy and unhealthy food items across the globe, it was found that potato chips were particularly very cheap in the SE Asia Region and prices of vitamin A-rich fruits and vegetables were the most expensive in the Region (92). Increasing the availability of cheap unhealthy food items in the Region is driving up obesity rates, especially among those belonging to high socioeconomic groups and now even among the low socioeconomic group.

Additionally, countries in the Region are currently undergoing a food retail transition – a decline in traditional markets and increase in supermarkets and online/digital stores (93). This impacts the choice of food consumed. In Thailand, for example, this has resulted in a loss of fresh, healthy, affordable food for lower-income Thais, and a dilution of regional variation in culinary culture. Modern food retail formats are rapidly becoming the main community food source for many populations in the Region.

Easy availability of cheap unhealthy food items, loose cigarettes, inexpensive tobacco products (smokeless tobacco) and cheap liquor along with the lack of resources/access to healthier food and lifestyle options, such as fresh fruits and vegetables, ample open spaces, facilities for physical activity, and health education drive the inequalities in health outcomes in the Region.

4. Commercial drivers within the health system impacting on health equity outcomes

There are several commercial drivers within the health system that impact health equity outcomes. This section briefly explores the wide range of such drivers in the WHO SE Asia Region.

Drivers influencing health care and designing health systems

The SE Asia Region has a very complex health-care landscape, involving numerous stakeholders, competing priorities, entrenched incentive system and institutional cultures. Although health care is considered a public good and human right, its commercialization has made it one of the largest and fastest-growing industries. Governments are increasingly struggling to deliver high-quality public services to the Region's urban middle class largely due to inadequate public health-care funding.

For-profit health-care provision is deeply entrenched in the Region, with nearly 53% of the \$420 billion health-care market in member countries of the Association of Southeast Asian Nations (ASEAN). The privatization of health care has substantial implications for equitable, ethical and comprehensive health care in LMICs (94). Access to health-care services is also adversely affected by the dominance of strategies partly based on the power of the pharmaceutical sector (95).

India, for example, has one of the lowest public GDP expenditure allocations to health care across the world (96). This gap in funding explains why many patients are turning to commercial sector health care, which is often costly, leading to catastrophic health expenditures for households (97). Other than the deficiency in public funding, pro-commercial policies (including tax incentives) have created opportunities for provider and regulatory capture by the commercial sector (98–100). With the introduction of publicly funded health insurance schemes in the country, public resources are increasingly being diverted to the commercial sector, since over 75% of funds from public health insurance flow to commercial hospitals (101,102). Commercial hospitals often adopt unethical revenue targets that incentivize doctors to offer unnecessary and costly drugs, diagnostics and procedures (98,103,104).

Private health insurance in India is a booming business with an increasing number of actors. However, private health insurance targets middle-class families and contributes to greater health disparity (105). The rising health costs for the poor because of limited coverage (inpatient) undermines national health equity goals.

Corruption in the frontline health-care service is also threatening the global goal of achieving universal health coverage (UHC) by 2030. There is a rising trend of corruption in LMICs in South and SE Asia. In these countries, the intersection between a pluralistic health system, a largely informal health market, and a poor regulatory regime have provided conditions favourable for corruption (106). Corruption impacts access to health-care facilities. For example, in Bangladesh, while only 10% of households visit government health-care facilities, even they felt forced to make payments (bribery) to access health care. Often informal payments are viewed as a necessary source of financing health care.

Drivers influencing pharma industries and medical countermeasures

Vaccines against communicable diseases are one of the most powerful public health tools and a classic example of a public good that provides positive externalities to the population (107,108). Given the global market dynamics, contemporary vaccine research and development (R&D) and manufacturing have become increasingly reliant on commercial sector actors (109). The commercial sector is most often accused of profiting from taxpayer-funded research and hoarding intellectual property rights. The COVID-19 pandemic was no exception. During the recent COVID-19 pandemic, the pharmaceutical industry was called out for selling publicly funded vaccines, treatments and tests to the highest bidder in inequities that cost more than a million lives, while businesses made billions of dollars (36).

Often, weak pharmaceutical sector regulation and governance in the SE Asia Region leads to poor access and inappropriate use of essential health products and inflated prices (110). Essential medicines are more easily available in private health facilities than in public facilities, leaving individuals with no choice but to purchase medicines from the commercial sector or forgo the expense of buying necessary medicines. This inequity has long-term social and economic consequences for the countries of the Region.

The high level of out-of-pocket spending on health care in many SE Asia Region countries is well-documented. Evidence from seven SE Asia Region countries shows that spending on medicines accounts for the main share of out-of-pocket payment (111). Medicines continue to be the main driver of impoverishment due to health-care costs, with the poorer households spending up to 18% more on medicines than their richer counterparts.

Governance barriers to access include a lack of manufacturing capacity for vital medical supplies or equipment, impediments to the movement of such supplies and equipment across borders, import duties, lack of internal transportation and delivery mechanisms and the lack of adequate technological infrastructure (112).

The ASEAN bloc is a huge health-care market, with Indonesia being the largest market, followed by Viet Nam and Thailand. Pharmaceutical companies see the region as a highly attractive commercial growth opportunity. Counterfeit medical countermeasures are widespread in the Region and a threat to the health of vulnerable persons (113). India leads in the production of counterfeit medicines with approximately 35–75% of fake medicines being produced in India. In September 2022, WHO flagged four substandard cough syrup brands from Maiden Pharma, India, as they were reportedly linked to the deaths of 66 children in Gambia in western Africa.

During the COVID-19 pandemic, counterfeit vaccines and medicines posed a serious concern. Several cases in India were registered for the falsification and selling of remdesivir where empty remdesivir vials were filled with liquid paracetamol or even saline (114). Dexamethasone was another drug of which counterfeits were reported by the Indian regulatory agencies. A report stated that the prevalence of substandard dexamethasone ranged between 3.14% and 32.2% in LMICs. A study by the United Nations Office on Drugs and Crime (UNODC) has found that up to 47% of antimalarial medicines in SE Asia were fraudulent in some way (113).

Corruption practices by the pharmaceutical industry are also documented in the SE Asia Region. The industry rampantly resorts to unethical practices to push sales, impacting the choice environment of patients. A study conducted by an Indian CSO Support for Advocacy and Training to Health Initiative (SATHI) had reported that the industry lures doctors through high-value bribes through medical representatives, such as smartphones, credit cards, e-vouchers, etc. (115). In 2016,

twenty pharmaceutical firms in India were charged with “bribing doctors, medical shopkeepers and unauthorised medical practitioners to sell their pharmaceutical products” (116).

Other practices by the pharmaceutical industry impacting health equity outcomes include marketing and promotion, and evergreening of patents, which are discussed in subsequent sections of this report.

Impact of medical tourism on health equity outcomes

Health tourism is increasingly seen as a revenue generator in SE Asia (contributing \$8 billion in revenue from nearly 4 million people who travelled abroad to seek treatment in 2018 alone) (117). Regional governments provide many incentives for commercial investment in health tourism and play a strong marketing and promotional role (118).

The commercial sector in the Region has capitalized on their comparative advantage to promote medical tourism and travel, catering to wealthy foreigners with recreational packages to boost the consumption of health services (119). Patients from the global north travel for medical treatment, which is often perceived to be of high quality and value for money.

There are apparent advantages to promoting medical tourism in a country. It not only encourages direct investment in health-care infrastructure, but it also contributes to wider economic developments in a country (110). However, there are growing concerns about the impact of medical tourism on health systems. Equity issues surface concerning the negative effects of international trade in health services and workforce migration. Medical tourism often fuels brain drain to the commercial sector, causing a lack of quality health-care personnel in the public sector. It further adds to access issues.

For example, the rise of medical tourism in Thailand has attracted concerns. While the government is attracting high numbers of overseas patients, there are concerns that access to health care for its own population may suffer and cause growing disparity (120). In the past decade, Thailand’s public-to-commercial health worker brain drain had strained public health provision, especially in rural areas.

In mid-2020, India’s medical tourism sector was estimated to be worth US\$ 5–6 billion (98). While medical tourism is a key growth sector for India, it has led to a growing divide between the public and commercial health-care sectors. There is a sharp contrast between the health-care facilities available at private hospitals for medical tourists and those in public hospitals that cater to mostly rural patients (95). It has also lured professionals to jobs in private hospitals in urban settings, leading to an acute shortage of qualified doctors in the public sector and rural areas.

Drivers counter health information: dis/misinformation infodemic

Misinformation, or false and inaccurate information, has been a major public health challenge during the COVID-19 pandemic. WHO even went on to identify the information situation as an “infodemic” – an overabundance of COVID-19-related information, including attempts to foment misinformation. During the COVID-19 pandemic, misinformation in the South Asian community (Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka) spread erroneous ideas regarding disease transmission, prevention and treatment (121).

Online fake news poses a threat to public health communication as more people now depend on the Internet to get health-related information (122). Misinformation is harmful for public health in several ways. For example, misinformation related to the COVID-19 vaccine (vaccine conspiracy

theories) is associated with vaccine hesitancy (123). Evidence suggests that areas with a higher exposure to news denying the severity of COVID-19 are associated with a larger number of COVID-19-related cases and deaths (124). Therefore, misinformation has potentially driven COVID-19 morbidity and mortality. This is a matter of concern, given the disproportionate burden of COVID-19 hospitalization and death experienced by South Asians globally (125, 126).

In India, during the COVID-19 pandemic, media reports suggest that information related to fake prescriptions and medicines circulated in the social media led to an increase in the sale of medicinal products (127). A significant amount of COVID-19 fake news was related to vaccines and medical facilities (128). This is often driven by economic benefits, suggesting that Indian health-related fake news could be intended to generate profits by increasing the sale of fake medical products (129).

Since social media is a major platform for distribution of misinformation, social media companies can play an active role in combating misinformation during a public health emergency. Limits to the number of message forwards slows the spread of misinformation and clear counter-messaging to correct misinformation can be effective (130).

5. Commercial sector practices

As mentioned in the previous sections of this report, the commercial sector engages in practices that prioritize their operational needs and profit-making goals, with little attention to protecting population health and the environment. These commercial sector practices are aimed at improving their legitimacy, which is key for accessing politicians, gaining access to the policy-making table, and even to ensure that audiences believe and trust their messages (131). It is important to identify these key commercial practices because when left unregulated or inadequately regulated, they can harm health and impact health equity in both direct and indirect ways.

Gilmore et al. in their Lancet Series on CDH identify seven overlapping mutually reinforcing commercial sector practices – political, scientific, marketing, supply chain and waste, labour and employment, financial and reputational management. Our desk review, interviews and the WHO regional consultation have identified diverse commercial sector practices in the SE Asia Region, across products and services, which can be characterized in seven sets of practices: political; labour and employment; reputational management; marketing; practices impacting health-enabling legal environments; supply chain, waste management and environment degradation practices; and scientific practices.

5.1 Political practices

Political practices are practices aimed at influencing laws and public policies at all levels of governance to further commercial interests. These include practices to secure preferential treatment from those in power and ameliorate regulatory obstacles. It is often done through direct involvement and lobbying and disseminating misleading information to undermine policies as ineffective (132–135). Indeed, businesses exert undue influence by investing enormous amounts of money in lobbying practices and sharing “expert” information with government officials, which may be biased or incomplete (21, 136).

In many instances, lobbying takes the form of investment by industry, particularly the tobacco industry, into respective countries. For example, there have been documented instances of high-level government officials meeting industry representatives to guide policy prior to joining the WHO FCTC (137). The US Securities and Exchange Commission, in 2010, charged two tobacco companies for bribing Thai public officials under the name of “Alliance One International Inc” (21). These two tobacco companies paid around US\$ 1.2 million in bribes to secure over US\$ 18 million of sales contracts. In another bribery case, Anheuser-Busch InBev was charged under the Foreign Corrupt Practices Act for bribing Indian public officials to boost beer sales and then threatening to silence a whistle-blower.

A 2018 report by the the Organization for Economic Co-operation and Development (OECD) found that corruption is disproportionately higher in the oil and gas, mining, postal, energy, and transportation and logistics sectors worldwide, including State-owned enterprises (SOEs) (138). Countries in the SE Asia Region score below the global average (less than 50 out of 100) in Transparency International’s Corruption Perceptions Index (139). High compliance costs and lucrative profits create strong incentives for industry to evade government rules.

Commercial political activity of the commercial milk formula (CMF) industry is also well documented and, more recently, in the 2023 Lancet Series on Breastfeeding. To enable and sustain

its aggressive marketing practices, the industry has engaged in diverse political practices to foster favourable policy, regulatory and knowledge environments – this has included lobbying international and national policy-makers and adopting commercial policies to counter regulatory actions by governments (71). A prominent example emerges from Thailand as explained in Box 1.

Government policies in Indonesia, including subsidies and land incentives, has assisted expansion of the palm oil industry and facilitated greater investment (39). Palm oil production is a controversial political issue; attempts to regulate palm oil cultivation has been met with industry leaders highlighting the threat to smallholders' livelihoods.

Box 1: Political practices of the commercial milk formula industry in Thailand (71, 140)

Thailand began drafting a revised version of its own Milk Code in 2015. The proposed law introduced new provisions restricting educational, promotional and marketing activities, including the use of trademarked brand names, packaging and symbols, established criminal penalties for violators, and expanded product coverage from 0–12 months to 0–36 months. Between 2015 and 2018, the Thai Government had repeated interventions in the WTO from the USA, New Zealand, the EU, Australia and Canada, mainly in the Technical Barriers to Trade Committee. In 2017, the US Trade Representative reported “seeking to ensure that Thailand’s final measure takes into account appropriate scientific and technical information”, and that it had engaged the Thai Government throughout the period “bilaterally and at the WTO and continues to monitor developments, particularly any potential regulations relating to restrictions on products for young children”.

Evidence suggests that CMF industry lobbyists met with senior government officials in the National Legislative Assembly and National Economic and Social Development Council, members of the press, and health professional associations. Lobbyists stressed the industry’s supposed economic importance, including the jobs and livelihoods of dairy farmers. In 2017, the Thai National Legislative Assembly passed the revised Milk Code; however, the extended product coverage for ages 12–36 months and criminal penalties had been removed.

Source: Lancet Breastfeeding 3 (2023)

Another aspect of the political practices of the commercial sector is the “revolving doors” phenomenon (136). The flow between public and commercial sector employment may contribute to advancing commercial interests by guaranteeing a voice in the policy-making process. For example, in Myanmar, there are reports that retired senior officials as well as current government officials or their relatives held positions in the tobacco industry (141). To offset the poor environmental and labour practices, several palm oil companies have jointly created industry associations, such as the Roundtable on Sustainable Palm Oil, to showcase their sustainability efforts (39). The Roundtable has partnerships with the United Nations Economic and Social Council (UNESCO), United Nations Environment Programme (UNEP) and United Nations Children’s Fund (UNICEF) aimed at improving its members’ business practices. Twelve of the 16 Roundtable board members are representatives of palm oil processors, manufacturers, retailers, banks, investors or international food processing companies.

Table 2: Additional examples of the political practices of the commercial sector

Realm of industry practices for promoting unhealthy products	Country	Type of industry	Example of industry interference
Influencing decision-makers	Thailand	SSB industry	When the SSB tax was introduced in Thailand in 2017, the SSB industry posed serious resistance to the government policy. The Thai Beverage Industry Association questioned the link between obesity and SSB (30).
Influencing decision-makers	Thailand	Tobacco industry	The industry attempted to meet high-ranking authorities prior to the passage of the new tobacco control law in March 2017 (142). Thailand's Excise Department received technical assistance from the International Tax and Investment Center (ITIC) on excise tax reform (143).
Lobbying	India	SSB industry	The US Senate's India Caucus was established to strengthen US–India relations. Through 2012 and 2013, a leading SSB producer, with vested interest in the Indian market, made significant financial contribution to the Caucus, to the extent of US\$ 104 000, which also includes direct contributions to the cofounder and co-chair of the Caucus (144).
Lobbying	Myanmar	Tobacco industry	In February 2016, Myanmar approved legislation for pictorial health warnings (PHW) on cigarette packs to come into effect on 1 September 2016. In March, Japan Tobacco International (JTI) Myanmar, along with British American Tobacco (BAT), met with the Myanmar Investment Commission about delaying the PHW.
Creating alliances and front groups	India, Bangladesh, Bhutan, Maldives, Nepal, Sri Lanka	Unhealthy food industry, including SSB industry	Leading food and drinks industries have created an alliance, The International Life Sciences Institute (ILSI). The Institute, listed as a not-for-profit organization, was restricted by WHO in 2006 from taking part in activities related to setting food standards; however, it still has a presence in many countries of the Region. The front organizes workshops, symposia, conferences, training programmes, research projects and publications on areas pertaining to public health, including nutrition and health. The website also lists many ministries of India as its partners (145, 146).

Realm of industry practices for promoting unhealthy products	Country	Type of industry	Example of industry interference
Creating alliances and front groups	Indonesia	Tobacco industry	The International Tobacco Growers' Association (ITGA) is a global organization funded and directed by tobacco companies to influence policy-makers and the public in favour of the tobacco industry. In 2010, the ITGA partnered with another industry-supported association in Indonesia (the Aliansi Masyarakat Tembakau Indonesia) to co-host a meeting in Jakarta of tobacco growers in SE Asia. The meeting resulted in a call for governments to reject the recommendations by WHO to ban tobacco flavourings (147).
Creating alliances and front groups	India	Tobacco industry	During the Conference of Parties (COP7) meeting in India in 2016, 500 members of the Farmer's Association (backed by the tobacco industry) protested outside the conference venue, demanding their participation as a stakeholder.
Creating alliances and front groups	Thailand	Tobacco industry	The industry established front groups such as the Thai Tobacco Trade Association (TTTA) and the Thai Tobacco Growers, Curers and Dealers Association (TTA), both to exaggerate the economic consequences of the 2017 new Tobacco Control Law (142).

5.2 Labour and employment practices

Labour and employment practices of the commercial sector are determined by the regulatory environment in a country. LMICs often have weak labour market regulation, which has led to a range of challenging working conditions and practices that disproportionately affect the health of low-income workers (16).

In India and Myanmar, during the COVID-19 pandemic, while clothing retailers received bail-out funds from their governments, they offset losses onto their suppliers and workers, often leading to an increase in forced labour (148). The pandemic pushed many garment workers further into debt – the pandemic revealed how directly commercial sector practices shaped living and working conditions for workers. In India, the lockdown measures imposed in response to the COVID-19 pandemic stranded millions of migrant workers.

While the commercial sector employing these workers were compensated and benefited from government economic measures, the loss in earnings, sufferings and death of migrant workers received meagre to no compensation (149). Amid the pandemic, workers did not receive sufficient pay to meet even basic needs and struggled to access financial support from the government and CSOs. Average levels of debt per household increased by 34% in Myanmar, and 21% in India from the pre-pandemic to the post-pandemic period.

The SE Asia Region has also witnessed an increase in child labour in mines, exposing children to extreme physical, psychological and social dangers (150). Mining activities in India are unpopular globally for using child labour. A popular global cosmetics brand Fenty Beauty has been criticized for allegedly using mica from the mines in Jharkhand that use child labour (151). A report from an NGO estimated that about 22 000 children are scavenging for mica in Jharkhand and the neighbouring state of Bihar and a 2018 report also found that 45 children had died in the mica mines between 2013 and 2018.

SE Asia countries have become a hub for the export of textile and readymade garments to global businesses. More than 70% of imports of textile and clothing in the West come from Asian countries (152). Very low wages and trade deals have increased inequity in the SE Asia Region. However, most of the factories in these countries offer very harsh conditions to the workers. Factory workers are forced to work long hours every day and are often not paid for overtime. In these factories, millions of people, most of whom are women and children, are exposed to unsafe work environments with a high incidence of work-related accidents and deaths, as well as occupational diseases. Many of these buildings do not meet the legal requirements of construction.

Several deadly accidents have occurred in Bangladesh in 2012 and 2013 due to unsafe building conditions, killing nearly 2000 workers over several tragedies, the most disastrous of which was the Rana Plaza accident (152). The Rana Plaza building in Dhaka, Bangladesh housed the production unit for some of the leading fashion brands in the world. The building collapsed in 2013, killing at least 1132 factory workers. Since then, no fewer than 109 accidents have occurred in the country, where 491 workers were injured and 27 workers lost their lives. Around the time the Rana Plaza tragedy occurred in Bangladesh, the labour laws in Bangladesh did not require the employers to insure themselves against liability. Hence, no compensation was required to be paid to the victims.

Issues of safety, occupational stress and health risks of the labour force engaged in the garment industry have come up frequently after Bangladesh's Rana Plaza building incident. Common health issues faced by garment workers are occupational stress, due to low wages, long working hours, reduced leave, crowded work conditions, and the lack of safe health facilities (54). Workers are exposed to excessive sound and temperature, undue vibration and dust, poor ventilation and a lack of disposal of waste and effluents.

A number of goods exported from Myanmar have been tied to labour abuses, including child and forced labour (138). Evidence suggests that, to date, 14 goods from Myanmar are produced by either child labour or forced labour (153). In particular, teak, rubies and jade have been identified as goods with forced labour and child labour.

Investigations by NGOs have also found child labour and human rights violations at many of the palm oil plantations in Indonesia (154).

5.3 Reputational management practices

These practices are aimed at enhancing the commercial actor's legitimacy and credibility, reduce risk and shape the brand image of the business (133, 134, 155, 156). Most often, reputational management practices take the form of corporate social responsibility (CSR) activities. CSR often takes the form of an ostensible focus on social, environmental or public health benefits and often involve voluntary commitments from commercial actors that they claim offset the damage caused by their core

business (21,28). CSR practices are an entry point for the commercial sector to build public–private partnerships with various health and non-health actors in the Region.

While some of these practices may have a net-positive impact on the society and population health, in many instances, they contribute to reputation building and are aimed at distracting consumers from the harm caused by their products and practices. Countries such as India, Thailand, Indonesia – all have some form of CSR mandate in their national laws. However, commercial actors attempt to utilize the CSR mandates to also maximize profits and improve legitimacy.

Accordingly, when businesses derive their profit from undermining health, CSR will often conflict with public health objectives and policies. In the SE Asia Region, unhealthy product industries often heavily engage in CSR. For example, after the 2004 tsunami, an international alcohol company provided relief to persuade governments to change their alcohol tax policies in the particular company's favour (157).

While substantial political and reputational management practices of the tobacco industry are evidenced globally, it is particularly high in the Region, as not all countries are signatories to the WHO FCTC (158).

In India, the Cigarette and Other Tobacco Products Act (COTPA) prohibits advertisement, sponsorship and promotion of tobacco products (Article 5, COTPA) (159). However, in 2014, section 135 of the Companies Act made it mandatory for every company with a net worth of at least INR 500 crore (~\$65 million), or turnover of INR 1000 crore (~\$131 million) or more, to spend 2% of the average net profits on CSR practices.

This allows major tobacco companies in India to promote their brand under seemingly socially responsible practices and partner with government and other important stakeholders to improve their public image and project themselves as a responsible industry. India has witnessed an increase in CSR practices by the tobacco industry in the past few years (160). This is a case of conflicting policies within the government and requires intersectoral coordination to align policies with the goal of promoting public health.

Similarly, various alcohol and unhealthy food industries across the SE Asia Region have associated their unhealthy products with a positive image by using CSR and showcasing themselves as ethical (161, 162). In addition to being in direct conflict with public health objectives and policies, these CSR practices undermine public sector scrutiny of the commercial actors involved through influence over the perceptions of officials. This can lead to strong conflicts of interest within the public sector, as officials may be unduly influenced by this ostensible philanthropy.

5.4 Marketing practices

Marketing increases the demand and consumption of products by focusing on enhancing the desirability and acceptability of products manufactured and marketed by the commercial sector (28,33). As with other practices, some of the most successful marketing campaigns belong to the unhealthy product industries (21).

There is overwhelming and irrefutable evidence that marketing of unhealthy products, such as tobacco, alcohol and unhealthy foods/drinks, to children and adolescents is associated with the increased consumption of these products. Because it is effective, the commercial sector invests heavily in marketing. An analysis of advertisements on Indian television showed that marketing of unhealthy

Table 3: Additional examples of CSR practices of the commercial sector

Realm of industry activities for promoting unhealthy products	Country	Type of industry	Example of industry interference
Building public relations	India, Bangladesh, Sri Lanka	Tobacco industry	A study conducted in 8 LMICs, including India, Bangladesh and Sri Lanka, found that the tobacco industry engaged in corporate social responsibility (CSR) practices in areas of the health, education and the environment, in addition to also sponsoring local sports teams and providing support to farmers. The study reported that more often than not, these CSR practices would benefit their own tobacco farmers (163).
Building public relations and improving public image	India	Tobacco industry	A leading tobacco producer in India has plans to introduce an anti-COVID nasal spray. The tobacco brand plans to market the product under its other entity, known to produce antiseptic liquid (164).
Intimidation and litigation	Thailand	Food industry	When the Thai government was trying to launch nutrition labelling, the food industry threatened to litigate against potential government policy through legal channels provided by the World Trade Organization. The industry aimed to intimidate policy-makers by citing potential barriers to free trade if such a policy was introduced (165).
Donations	Myanmar	Tobacco industry	In September 2015, Japan Tobacco International (JTI) Myanmar met with the Secretary of the Myanmar Investment Commission and made a small donation towards helping flood victims (143).

food items (chocolates, biscuits, potato chips) were mostly placed on children’s channels as compared to mainstream channels (166). Businesses selling “fast foods” use schemes such as unlimited refills on sugar-sweetened beverages (SSBs), inclusion of cartoon characters and toys in meal packages, and offering combo meals to drive sales. Using these and other tactics of affordability, attraction and availability, these businesses have quickly garnered a dedicated customer base in the SE Asia Region, with children and youth particularly drawn into consumption patterns by these marketing tactics.

Marketing shapes new cultures and norms to drive consumption. Examples include marketing practices of e-cigarettes (ENDS, HTPS) and commercial milk formula (breastmilk substitutes) industries. Global sales of CMF were US\$ 44 billion in 2014 and have increased by nearly 10% each year (76). This enormous expansion has been possible due to sophisticated marketing techniques especially in the global South, including marketing through health systems, mass media and digital advertising, and novel product innovations backed by commercial science (74). Such marketing effectively undermines breastfeeding; exposure is associated with reduced initiation, exclusivity and duration in all country contexts (167–169).

Much of the growth in the CMF industry has occurred mostly in the industrializing and highly populated middle-income countries of East and SE Asia, and to a lesser extent Eastern Europe and

Central Asia, Middle East and North Africa, and Latin America. Rapid economic growth and a large child population make SE Asia an important market for baby foods, including CMF (170). To expand market size, CMF companies aggressively market their products in this Region (76). Advertising expenditure by the industry from 2010 to 2020 increased by 280% in Indonesia and 77% in Thailand, while sales increased by 15% in Indonesia and 38% in Thailand (73).

A 2017 study in the SE Asia Region identified various tactics used by the CMF industry to market their products and use marketing content (e.g. stages of milk formula, messages about the benefit, and pictures of a child) that confuses audiences (171). The industry cross-promotes their products by using similar branding, pictures and logos on a range of products from milk for pregnant and lactating women to Growing Up Milk (GUM) for children up to 36 months and beyond, which reduces the effectiveness of national restrictions on infant formula advertising (172).

They also claim unsubstantiated health benefits such as optimal development or contributing to stronger, taller and more intelligent children. They use social media and networking sites – often unregulated platforms – to promote BMS, give advice and expand exposure to their products. They also sponsor health events that position BMS manufacturers and distributors as reliable sources of health information. This study further found that the market size and growth of milk formula were positively associated with the number of newborns and the number of advertisements, and were not affected by the current level of implementation of BMS laws and regulations.

Often different industries mutually benefit from marketing practices; for example, the palm oil and processed food industry. The palm oil industry benefits from the increase in sales of foods containing palm oil, often driven by targeted advertisements by the processed food industry (173–175).

Market tactics are often tailored to interfere with people's ability of make good/healthy choices. For example, in India, consumers are subjected to aggressive marketing that alters their behaviour to want to consume ultra-processed foods (176,177). Food marketing is typically presented by the industry as an issue of "choice".

Digital marketing, including through social media, is rampant among commercial sectors across the Region. Digital marketing is rapidly becoming the dominant form of CMF promotion (178). It is highly prevalent in Bangladesh, India, Indonesia and Thailand. The most frequently identified sources of advertisement for CMF in Indonesia and Thailand were the Internet and especially Facebook. Exposure to tobacco-related content on social media has a significant impact of the patterns of ENDS and tobacco use by adolescents (179).

The pharmaceutical industry also actively engages in marketing practices in the Region. CSO reports in India reported that the Indian pharma industry spent INR 34 187 crore on marketing between 2008–2009 and 2016–2017 (180). In Bangladesh, reports claim that promotional practices of the pharmaceutical industries constitute a considerable part in their total budget (15–25%) (181). As mentioned earlier in this report, freebies are often offered by the industry to promote sales of their products.

Another prominent marketing tactic unique to the SE Asia Region has been the setting of "unreal beauty standards" by cosmetics businesses producing "fairness" creams or skin lightening products. This industry is one of the fastest-growing segments of the global beauty industry, particularly in Asia and Africa (190). By 2024, the industry will be worth an estimated US\$ 31.2 billion. Advertisements and packaging of these products claim skin fairness for users. There is also widespread use of models and actors in the advertisements of these products (191, 192). The increasing availability in the market

and use of skin fairness products is recognized as a public health, environmental and social justice issue due to its health side-effects and for harbouring racial injustice and social inequalities by promoting the belief that fair skins are socially more desirable (193). India is one of the fastest-growing markets with an annual spend of US\$ 450 million on skin fairness products as reported in 2016 (194). The nature and extent of potential health risks depend on the concentration and ingredients of these products. Some include potentially dangerous ingredients such as hydroquinone, mercury, bleaching agents such as hydrogen peroxide, and steroids that can be harmful to the skin (190,195,196).

Table 4: Additional examples of marketing practices of the commercial sector

Realm of industry practices for promoting unhealthy products	Country	Type of industry	Example of industry interference
Tactical marketing strategies	Indonesia	Tobacco	In Indonesia, due to the weak nature of laws that restrict tobacco marketing, a leading transnational tobacco company was able to launch a wide campaign wherein posters were put up across the country, promoting their brand (182).
Tactical marketing strategies	Republic of Korea	Ultra-processed food industry	Eating broadcasts or food shows have gained popularity in the Republic of Korea. The broadcasts, known as Mukbang, have a strong presence in the social media and they portray close-up images of food cooking, strategically presenting foods that are high in fat, salt and sugar as well as sugar-sweetened beverages and alcohol. Marketing professionals now use this platform for advertising unhealthy food products in the country (183).
Tactical marketing strategies	Nepal	Ultra-processed food industry	The marketing environment in Nepal includes a mix of online and offline marketing techniques, including social media and advertisements during television shows. Studies have found that multinational companies in Nepal use free toys, cartoon characters and famous people to promote unhealthy food to children. A study found that 85% of mothers in Kathmandu Valley with children below 2 years of age had seen promotions for commercial snack foods (184).
Tactical marketing strategies	India	Ultra-processed food industry	A study found that a higher proportion of food advertisements were seen on children's channels than youth channels. It found that the advertisements targeted towards children and youth had specific timings and were majorly high in fat, salt and sugar (185).
Tactical marketing strategies	India	Tobacco and alcohol industry	In India, surrogate advertisement of alcohol and tobacco products developed following the implementation of a ban on direct advertisements (186). The commercial sector, in response, began producing and promoting a range of products, including merchandise, soft drinks, and sports accessories with the same branding and logo as their alcohol/tobacco products.

Realm of industry practices for promoting unhealthy products	Country	Type of industry	Example of industry interference
Tactical marketing strategies	Myanmar	Tobacco industry	In October 2016, JTI ran a half-page coloured advertisement of its prominent brands in a local newspaper supposedly meant to be a “public notice” to inform its customers about the new graphic PHW on cigarette packets. JTI claimed it had approached the Department of Health and obtained permission to publish the “public notice”, that the announcement as it appeared in the newspaper “was formally approved by the Deputy Director-General of the Public Health Department” (143).
Marketing strategies	Timor-Leste	Tobacco industry	Businesses, for example, LA, sponsor social events such as sports and musical concerts. During these events, cigarette products are on display through billboards (187).
Marketing strategies	Thailand	CMF industry	CMF marketing did not comply with either the national legislation or the WHO Code, despite several years since the enactment of the Thai law (188). Most mothers were exposed to at least one type of CMF marketing, with the most frequent marketing channel being the electronic media.
Marketing strategies	Indonesia	Tobacco industry – e-cigarettes	E-cigarettes have been available in several flavours and packed and promoted by taking advantage of new media. Promotional content on Instagram has been mostly made in Indonesia, the US and UK and were designed to attract the youth (189). Celebrity endorsement on Instagram has increased the intention to use e-cigarettes.

Case study: Ban and re-entry of common instant noodle brand in India

A company monopolized the Indian and other SE Asia markets with its leading brand of instant noodles, which were particularly popular among children and the youth. During a surprise inspection by the Food Safety and Standards Authority of India (FSSAI), this brand of instant noodles was found to have very high levels of lead and the monosodium glutamate (MSG), both of which were not permissible, given their harmful impact on health.

As a result, the noodle brand was banned in India and the government filed charges against the parent company. Criminal cases were also filed against several popular Indian actors and actresses who had endorsed the brand. However, even though the product was banned, the brand continued to keep its social media pages active and promised that the “customers’ favourite food” would be safe to consume very soon. They launched a campaign to show that they missed their customers. Helpline numbers and FAQ pages were created for any customer-related query. Eventually, after only five months, the ban on the product was lifted and a “Welcome Back” campaign was launched by the brand, with 15 new variations of the product being introduced. Within the next two years, the brand managed to recapture its leading position in India’s instant noodle market.

Case study: The political, reputational management and marketing practices of unhealthy product industries during the COVID-19 pandemic

The onset of the COVID-19 pandemic brought unprecedented challenges for the government and public alike. As on 1 December 2021, the Region witnessed 44.5 million cases of COVID-19 and 707 782 deaths, with India being worse hit with 34.6 million cases and 469 724 deaths (197). Due to the pandemic, various resource mobilization strategies were adopted by the government as well as non-State actors. However, it is imperative to understand the intended or unintended harms that may have occurred due to the involvement of the commercial sector in mitigating the socioeconomic harms of the pandemic. As per a global report (198), commercial actors promoted their brand during the COVID-19 pandemic via four broad strategies: (i) adapting marketing and promotion of products; (ii) commercial social responsibility and philanthropy; (iii) pursuing partnerships and collaborations; and (iv) shaping policy environments. In the report, industry practices during COVID-19 was found in 94 countries, with the activities in India being fourth highest. Although the methodology used in the report was strictly based on inputs gathered via crowdsourcing, nevertheless, 43 varied activities found in the country were verified and then included in the report.

For example, a prominent chocolate brand printed “thank you” on its wrappers in various local languages, a gesture they claimed honoured local workers during these trying times. Similarly, a leading potato chip brand launched the #Heartwork campaign to appreciate the workforce in their supply chain, even roping in social media influencers for wider reach.

India’s alcohol industry, too, adjusted its strategies in an attempt to protect against regulation and consumption declines related to the public health crisis. A beer brand, previously marketing facemasks for air pollution, pivoted to promoting them as protection against COVID-19. Further, seeing the lockdown as an opportunity, the Confederation of Indian Alcoholic Beverage Companies urged various government bodies to permit online alcohol sales, a move not previously allowed.

Meanwhile, in Myanmar, the alcohol industry demonstrated its ability to exploit a crisis with a leading company in the market setting up protective screens at off-trade outlets, to promote a sense of customer safety during transactions and, thereby, both gaining credit for protecting health and ensuring continued sales. During the pandemic, the Myanmar Ministry of Health accepted charitable contributions from the tobacco sector but, in an apparent quid pro quo, this came with tax exemptions for certain tobacco products.

A WHO policy brief in 2022 examined the policy response to alcohol and tobacco consumption during the COVID-19 pandemic in the SE Asia Region (199). It reported extensive industry participation by both the tobacco and alcohol industries. In Indonesia, Multi Bintang, the largest domestic brewery in the country, produced masks and donated hand sanitizers. In Myanmar, the alcohol-producing industry donated ventilators, patient monitors and oxygen concentrators.

In India, the alcohol industry made direct financial contributions to citizen assistance and relief funds while simultaneously pushing for resumed alcohol sales to assist states in providing the minimum subsistence allowance. Their participation in the pandemic response helped to legitimize the industry’s role in the policy process, positively impacting their public image. With regard to tobacco, of the 11 SE Asia Region countries, six showed evidence of industry participation both by way of CSR activities to support government pandemic efforts and also direct interference in policy-making such as in Bangladesh.

All these examples show how the profit-generating imperative of commercial actors engaged in harmful product markets means that they will never miss an opportunity to further gain advantage over our choice environments, knowledge and politics. They did not hesitate in doing so during a pandemic, which was exacerbated by the burden of NCDs and other pre-existing morbidity that their products cause.

5.5 Practices impacting health-enabling legal environments

Law is undoubtedly an essential and an effective tool in regulating the commercial sector with a public health objective. Regulations, such as those related to advertisements, packaging and labelling, age limits, licensing, taxation and intellectual property rights affect the accessibility, availability and affordability of products in the market. This includes unhealthy products and access to health care, medicines and vaccines.

The commercial sector engages in practices that impact health-enabling legal environments, particularly those laws and regulations that go against commercial profit-making objectives. Law is an effective tool to reduce market demand for and consumption of unhealthy products, and this is precisely the motivation behind commercial actors in challenging these legal frameworks.

One of the most well-documented practices of the commercial sector impacting health-enabling legal environments in the Region is of the tobacco industry. The tobacco industry routinely threatens, and sometimes legally challenges, legislation, using its power to exert a chilling effect – although the industry is almost always unsuccessful, the legal costs can be prohibitive (200).

The tobacco industry has used litigation to open up new markets. For example, in Thailand the industry responded with litigation and lobbying through an industry alliance (US Cigarette Export Association) along with US trade representatives to open up the tobacco market (201). In 1989, the US Trade Representative referred its dispute to the World Trade Organization and in 1990, forced Thailand to lift its tobacco import restrictions.

There has been extensive litigation in Nepal by the tobacco industry against laws mandating 90% pictorial health warnings (PHWs) (202). Similar litigation was initiated by the industry in Sri Lanka in 2012–2013 against an 80% PHW requirement (203). There has also been extensive litigation in India by the tobacco industry across regulations, including PHWs, regulation of content, ban on minors' access to tobacco, tobacco advertising, promotion and sponsorship (TAPS) ban, ban on the sale of smokeless tobacco in plastic sachets, and the ban on *gutka* (204). In India, the industry attempted to lobby against the implementation of the Goods and Services Tax (GST) regime on tobacco leaves and *bidi* products (205). While the government went ahead in implementing the GST regime, the imposition of the additional cess on *bidi* was postponed to later years.

Commercial actors also often find ways to avoid and go around regulations. For example, in India despite a ban on *gutka* (smokeless tobacco) since 2012, *gutka* remains widely used and available (206). Businesses producing *gutka* have found ways to circumvent the ban by producing *pan masala* (a non-tobacco product) under the same brand name and selling tobacco separately in a packet for free, leaving it for users to prepare their own *gutka*.

Commercial actors often use international forums to challenge national sovereignty and open up new markets in the name of trade liberalization (21,207,208). The mere threat of litigation by the commercial sectors can lead to “regulatory chill” and influence government considerations on

introducing regulations that challenge profit-making objectives (209). In Thailand, when the Thai government was trying to launch nutrition labelling, the food industry threatened to litigate against potential government policy through legal channels provided by the World Trade Organization. The industry aimed to intimidate policy-makers by citing potential barriers to free trade if such a policy was introduced (165).

The commercial sector often uses framing and messaging techniques to amplify pro-industry voices and oppose policies that may impact its profit-making interests. The Coca-Cola Company, for instance, operationalized media platforms to voice their oppositions to a tax on sugar-sweetened beverages in Indonesia, arguing that such policies would damage the beverage industry (210). The Coca-Cola Company and several of its industry associations promoted alternative policies in East Asian LMICs.

The evergreening of patents by the pharmaceutical industry is another example of practices impacting health-enabling legal environments. Evergreening patent is a practice whereby the pharmaceutical industry extends the patent protection of a drug by obtaining additional year patents for minor modifications, without necessarily enhancing the therapeutic efficacy. Such patent practices have a negative affect across countries, especially LMICs that lack the resources for pharmaceutical research and development (R&D). Tactics employed in evergreening could include a new combination of drugs, a slightly different composition of drugs, or a different method of taking the drug.

Transnational pharmaceutical companies often use such strategies to monopolize the drug market, forcing people to buy vital drugs at expensive prices. It is a barrier for generic drug manufacturers to produce generic medicines for such patented drugs. Such practices unnecessarily raise health-care costs.

A study from Thailand claims that across a period of 11 years, 2000–2010, a staggering 84% of patent applications in Thailand were examples of evergreening, and 74% of patents granted also fell into that category (211). Thailand would have saved at least 8000 million baht (about US\$ 258 million) if those patents were not granted. The study also cites as an example of the effect on high prices by the evergreening of the drug atazanavir, which is recommended by WHO as a component of second-line antiretroviral treatment regimens for adults living with HIV.

In India, section 3(d) of The Patent Act protects against the evergreening of patents and this was upheld by the Supreme Court of India in a 2013 landmark decision, which was heralded by many as an example of India leading the charge on curbing evergreening, thereby safeguarding its access to public health. However, over the past years, the pharmaceutical industry has tried different tactics for evergreening of patents including misdirecting the attention of the Patent Office to other provisions of the Act (212).

More recently, in India, Janssen Pharmaceuticals, a subsidiary of Johnson & Johnson applied to renew its 20-year-old patent on the base compound of bedaquiline, which is one of the best treatments for drug-resistant TB (213). The Indian Government shot down an attempt by the company to renew the patent. The Patent Office concluded that Janssen Pharmaceuticals (the subsidiary of Johnson & Johnson that developed the drug) was engaged in patent evergreening.

5.6 Supply chain, waste practices and environmental degradation

The environmental impact of commercial sector operations is worse in LMICs due to less stringent regulations, often due to the political practices of commercial actors (28). Transnational businesses,

including tobacco, alcohol, unhealthy foods, pharmaceuticals, contribute large proportions to the economic wealth of the country and have extensive supply chains (21). They wield extensive power and it can be often challenging to hedge against them.

In Kerala (India), a Coca-Cola bottling plant that opened in 2000 led to groundwater contamination and toxic waste release. While eventually the plant was shut down, the local communities never received full compensation (214,215). The Coca-Cola Company has a strong supply chain control in the East Asia, including Myanmar, and ownership of controlling interests in local subsidiary bottling operations (210). In Indonesia, the Company sells concentrates and syrups to franchisees and also profits from licensing.

The SE Asia Region is known for rice and grain production. Industrial influence has changed healthy agricultural practices to improve harvest and profits. The introduction of excessive use of pesticides and steroids in agriculture has led to deterioration of crop quality and has posed a huge health threat to consumers of these products. Agriculture production and trade liberalizations have likely led to a regional shift in vegetable oil consumption in countries of the Region, with increased production and import/export of palm oil in particular (88). Indonesia is the top producer and exporter of palm oil. In 2020, the production of palm oil in the country grew to 48.3 million metric tons from 26 million metric tons in 2012 (216). Increased production of palm oil in the country is linked to mass deforestation, with Indonesia losing 13% of its tropical forests since 2000 (217). Studies have found economic and political incentives driving the palm oil industry and increased deforestation in the country (218). Front groups of the palm oil industry have published articles delinking the rates of deforestation and increase in palm oil production in Indonesia to undermine the growing concern of the unhealthy impact of the palm oil industry (219). Literature has also shown that the increasing rates of deforestation is driving the incidence of malaria in the country, which has disproportionately infected women during their first pregnancy, thus causing greater harm to newborns (220).

The countries of the Region have also witnessed a growth in meat consumption. Excessive consumption of meat can act as a double-edged sword with the risk of chronic diseases among consumers and adverse impact on the environment due to industrial animal production processes. Industrial methods of producing and processing meat are increasing and pose a significant public health challenge (221). The industry devotes considerable resources to feeding livestock in the meat industry, thereby reducing the quantity of resources such as grains available for ready consumption by individuals. Moreover, the meat industry has expanded their market by providing ready-to-eat and frozen meat products. As a result, in countries such as Thailand, the meat packaging subsegment is expected to generate US\$ 57 360.5 million by 2026 (222).

In Maldives, plastic waste has the most severe adverse effect on the environment. Around 21% of the total solid waste (855 metric tonnes) discarded daily in the Maldives comes from the tourism industry (78).

The land-clearing practices for oil palm cultivation in the Region has had significant public health consequences. Since the 1990s, air pollution from these land-clearing practices have affected the health of populations in the Region, especially the most vulnerable groups of the population, such as infants and children (223,224). Often crossing country borders, these burning incidents have been linked to premature deaths and increased respiratory illness as well as cardiovascular diseases.

The primary sources of ambient particulate matter pollution in India include commercial biomass burning, coal burning for energy generation, industrial emissions, construction, transport vehicles and diesel generators (225).

5.7 Scientific practices

Scientific practices aim at shaping the knowledge environment to secure favourable outcomes for industry. Consumer and market knowledge about commercial products, including their effects on health and equity, directly impact the perceived need for consumption (136). The commercial sector aims to influence every step of the scientific process with the intention of reaching a conclusion that supports industry regulatory or litigation objectives for the sector (226).

The tobacco industry engages in several tactics to undermine the importance of various scientific studies done to generate evidence regarding the harmful impact of tobacco (227). The industry uses counter research, alters media and public opinion to prevent the diffusion of studies and innovation that can lead to more significant restrictions on smoking (228,229).

As mentioned in previous sections, the commercial milk formula (CMF) sector has engaged in sophisticated marketing techniques as well as political practices. Their practices expand to include generating and deploying favourable science and introducing novel product innovations backed by industry-funded science (74). This commercial sector has engaged heavily in capturing the science and knowledge environments. They effectively use science to build brand credibility and influence health and other professionals (73).

The Lancet Series on Breastfeeding (2023) elaborates on the selective and misleading use of science in CMF marketing and the use of self-generated evidence to reframe and undermine high-quality science-based policy frameworks, including the International Code of Marketing of Breast-milk Substitutes. Globally, much like the pharmaceutical sector, the CMF sector sponsors professional organizations, conferences and meetings, and publishes sponsored articles in scientific journals. In Indonesia, one CMF company – Danone, reported in 2012 that health-care professionals, especially midwives, were key endorsers/brand ambassadors of their products (230).

Research funded and generated by the CMF industry is focused on a biomedical and nutrient-centric interpretation of infant and young child nutrition typically focusing on the “fortification” of baby foods (e.g. micronutrient-fortified infant cereals), the “reformulation” of products to enhance their nutrient profile (e.g. reduced lactose formulas), or the development of novel product ingredients that “functionalize” their products (e.g. human-milk oligosaccharides) (231,232).

Using such research tactics, the CMF industry exercises discursive power and draws positive attention to its products. The CMF industry often academically partners with various professional associations, universities and research institutions to influence policy. For example, the industry partnered in the South East Asia Nutrition Survey, involving 16 744 children across Malaysia, Indonesia, Thailand and Viet Nam, resulting “in a better understanding of the diet, health, dietary needs and general dietary patterns of children in Southeast Asia”. The findings of this survey were used to develop and implement a “scientifically grounded nutrition policy” for children in SE Asia (233).

The scientific practices of the palm oil industry are also noteworthy. Reports of the health impact of palm oil consumption are mixed – some attributing the consumption to increased heart and cardiovascular related diseases (41,42) and some attributing no negative effects (234). Four of the nine studies in a literature review conducted in a 2019 study showed overwhelmingly positive health associations were authored by the Malaysian Palm Oil Board, drawing parallels with the tobacco and alcohol industries and calling into question the credibility of claims in favour of increased palm oil consumption (39).

6. Action on the commercial determinants of health in SE Asia

Government and nongovernment actors are showing some level of commitment to addressing CDH, especially, as evidence suggests, by addressing commercial practices that are contributing to the growing epidemics of NCDs and the degradation of planetary health across the SE Asia Region. Despite some promising progress, however, overall prioritization of these issues is low and multisectoral responses are only just beginning to emerge in the Region.

6.1 Action by governments

6.1.1 Political commitment

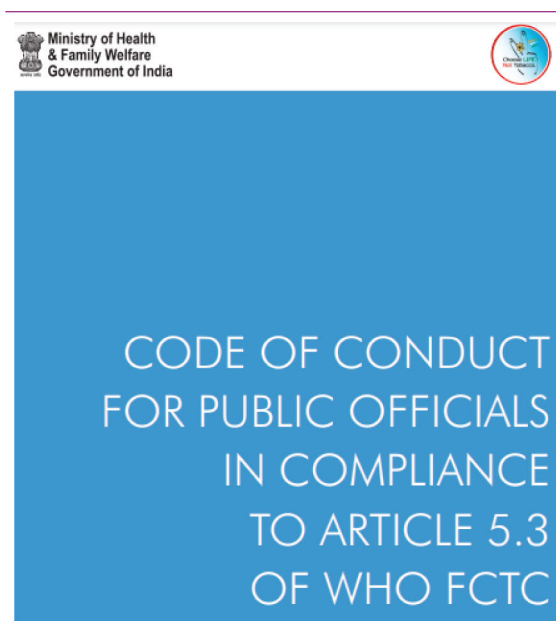
As an illustrative example, tobacco control has witnessed the maximum level of political support from governments in the Region. The WHO Framework Convention on Tobacco Control (WHO FCTC) has been ratified by all countries in the Region except Indonesia. One of the reasons for Indonesia's delay in ratifying the FCTC stems from the significant influence that tobacco industry has on policy decisions and public perception (235). Furthermore, for countries such as Indonesia, Myanmar and Thailand, governments have not set up disclosure procedures when working with the tobacco industry. On the other hand, the Ministry of Health and Family Welfare, Government of India has launched a code of conduct document for public officials under the Ministry of Health, to comply with Article 5.3 of the WHO FCTC. This document includes guidelines to protect tobacco control policies and programmes from commercial and other vested interests of the tobacco industry (236).

Indonesia has general guidelines to address conflicts of interest, which prohibit government officials from working with any type of industry/establishment outside government services (143). This restriction, however, does not extend to periods following their immediate retirement from service.

In Bangladesh, following a series of tragedies concerning factory workers of the apparel industry, a consultation meeting was conducted in Geneva in November 2017. The meeting was chaired by the Secretary in charge, Ministry of Labour and Employment (87). At that meeting, the forum suggested a tripartite policy-level committee on employee injury insurance to decide future steps for introducing insurance for Bangladeshi workers.

Considerable research and action is needed in the Region to understand CDH, their impact on health, development and planetary health and decide on restricting their interference in policy-making and/or their engagement in promoting health and welfare in countries.

Fig. 4: Code of conduct for public officials in compliance of WHO FCTC Article 5.3, as released by the Government of India



6.1.2 Policies, regulation and legislations

The role of governments in protecting, promoting, and assuring the health of their citizens is operationalized through national legislation, policies, and legally or morally binding international conventions. This section briefly illustrates the actions by governments with examples related to access to medicines, corruption, the gaming industry, commercial milk formula industry and NCD risk factors.

Since the adoption of the Doha Declaration – Declaration on the TRIPS Agreement and Public Health in 2001, there has been a rise in government-issued compulsory licensing in the SE Asia Region. Compulsory licensing (CL) has been issued in Asia to solve the health crisis relating to HIV/AIDS. Thailand and India have implemented compulsory licensing as a means to increase access to drugs while market prices are regarded as being too costly, such as those of cancer and cardiovascular drugs.

Indonesia, for example, issued its first government-use pharmaceutical compulsory license by way of a Presidential Decree in 2004, to address the urgent needs of the community in the effort to control the HIV/AIDS epidemic (237). Again, in 2007, the Indonesian government issued the second CL on another HIV/AIDS drug. Thailand's Ministry of Public Health issued its first batch of CLs on three patented drugs from December 2006 to January 2007 (238). These drugs were related to HIV/AIDS. Subsequently, licenses were also issued for medicines for NCDs, including a cardiovascular medicine, clopidogrel (Sanofi-Aventis' Plavix) and a range of cancer medicines (238).

In 2012, Natco Pharma was granted the first-ever compulsory license in India for the manufacture of a drug for liver and kidney cancer (239). The license was granted on the grounds that the drug was not manufactured in India, and was sold for €3200 for a month of treatment, which restricted access to the public.

Corruption

Over the past decade, governments in the SE Asia Region have developed policies to contain corruption (106). Bangladesh (2008), India (2005), Nepal (2007), Sri Lanka (2016) introduced the Right to Information Act. Both India (2014) and Bangladesh (2011) introduced the Whistle Blower Protection Act. Additionally, India also introduced the Lokpal and Lokayuktas Act, 2013. Six countries in the Region have signed and adopted the United Nations Convention against Corruption (UNCAC) and initiated actions to comply with the Convention (240).

Gaming industry

A few governments in the Region have adopted measures to restrict exposure to the gaming industry. For example, the Thai government in 2003 implemented a measure requiring all game servers (domestic and international) to be blocked between 10 pm and 6 am (241,242). The government further recommended restricting access to children to venues providing gaming from 10 pm to 6 am. A similar regulation was implemented in Viet Nam in 2011 (243).

Well-being, economy and wellness products

The momentum towards greater emphasis on well-being has steadily built over the past few decades in the Region. The Government of India has built on the indigenous understanding of health and well-being and long-standing traditional practices. It created the Ministry of Ayurveda, Yoga, Naturopathy, Unani, Siddha, Sowa-Rigpa and Homoeopathy (known as the Ministry of Ayush) in 2014 (244). The Ministry is dedicated to promoting health and well-being through education and the provision of

BOX 2: Government action in the SE Asia Region – commercial milk formula industry

Sri Lanka was one of the first countries to enact the implementation legislation of the International Code of Marketing of Breast-milk Substitutes shortly after the World Health Assembly called upon Member States to do so in 1981.

In 2014, Myanmar's Food and Drug Board of Authority issued the Order of Marketing of Formulated Food for Infant and Young Child under the National Food Law, which regulates the marketing and labelling of CMF, complementary foods, and bottles and teats intended for children under 2 years of age.

In 2017, the Thai National Legislative Assembly passed the Marketing Control on Food for Infants and Young Children Act to restrict the marketing of food for infants and young children. Under the revised legislation, the Government of Thailand prohibits all marketing of CMF for children under 12 months of age, with further regulations that apply to marketing of similar products to children under 3 years of age.

Source: Nguyen TT, Weissman A, Cashin J, Ha TT, Zambrano P, Mathisen R. Assessing the effectiveness of policies relating to breastfeeding promotion, protection, and support in Southeast Asia: protocol for a mixed methods study. *JMIR Res Protoc.* 2020 Sep 21;9(9):e21286.

services in the ancient traditions. Building on 5000 years of indigenous knowledge systems, the Ministry collaborates through states, provinces and rural communities to provide education and clinical services.

Bhutan has for long had a holistic approach to development with its Gross National Happiness (GNH) initiative (244). Thailand has introduced the concept of sufficiency economy philosophy (SEP) and integrated it into its National Economic and Social Development Plan and the current Constitution. For instance, the Government of Thailand has applied SEP in designing policies to address poverty and encourage community self-reliance. Additionally, there is an increasing interest in Thailand in integrative medicine, such as traditional Thai medicine, as an alternative to conventional medications. In 2024, the Ministry of Public Health will introduce a policy aligned with the Department of Health's objective to emphasize the promotion of a wellness-oriented lifestyle and development of the wellness economy.

The Wellness Economy Policy of 2024 in Thailand features a city model that encompasses aspects such as diet, exercise, lifestyle, satisfaction, health literacy and local resources. This city model is tailored to align with the regional context in Thailand. It encompasses elements like urban design, health-care infrastructure, development policies and comprehensive health packages. The goal of the wellness community extends beyond individual well-being to promote local income and capacity-building. This approach involves four key components, contributing to the broader wellness economy, including wellness hotels, wellness restaurants and wellness spas.

Noncommunicable diseases

WHO's Global Action Plan for prevention and control of non-communicable diseases 2013–2020 calls for countries to reduce their NCD burden (245). All 11 countries in the Region have developed their action plans that include specific indicators for reducing tobacco use, alcohol use, ensuring healthy diets with the right amount of salt and sugar and reduction of trans-fats.

In terms of legislation, countries such as India and Thailand have introduced health taxes on unhealthy products such as tobacco, alcohol and SSBs. In Thailand, the revenue collected from

excise taxes on tobacco and alcohol are used to address NCD risk factors through health promotion campaigns (246). It was the first country in Asia to introduce plain packaging for tobacco products in 2019.

The Thai government has also announced a ban on trans-fats in domestic and imported food products. The government has thus shown a strong commitment to addressing NCDs in the past decade through several national strategies and plans, including the national multisectoral NCD strategy, the national sodium reduction strategy, the national tobacco control plan, the national alcohol policy and the national strategy on physical activity.

Various policy measures for controlling industry activity related to NCD risk factors in the SE Asia Region are mapped in Fig. 5.

Fig. 5: Progress on prevention and control of NCDs in the SE Asia Region, 2021

Indicators	BAN	BHU	DPR Korea	IND	INO	MAL	MMR	NEP	SRL	THA	TLS	Fully achieved	Partially achieved	Not achieved
1 National NCD targets	●	●	●	●	○	●	●	●	●	●	●	10	0	1
2 Mortality data	○	○	○	○	○	○	○	○	○	○	○	0	4	7
3 Risk factor surveys	○	●	●	○	○	○	○	○	○	○	○	3	8	0
4 National integrated NCD policy/strategy/action plan	●	●	●	●	○	●	●	●	●	●	●	10	0	1
5 Tobacco demand reduction measures														
5.a. increased excise taxes & prices	○	○	○	○	○	○	○	○	●	●	○	2	4	5
5.b. smoke-free policies	○	○	○	○	○	○	○	○	○	○	○	2	9	0
5.c. large graphic health warnings/plain packaging	○	○	○	○	○	○	○	○	○	○	○	6	3	2
5.d. bans on advertising, promotion and sponsorship	○	○	○	○	○	○	○	○	○	○	○	2	7	2
5.e. mass media campaigns	○	○	○	○	○	○	○	○	○	○	○	4	3	4
6 Harmful use of alcohol reduction measures														
6.a. restrictions on physical availability	○	○	NR	○	○	○	○	○	○	○	○	4	6	0
6.b. advertising bans or comprehensive restrictions	○	○	NR	NR	○	○	NR	○	○	○	○	6	0	2
6.c. increased excise taxes	○	○	NR	NR	○	○	NR	○	○	○	○	3	4	1
7 Unhealthy diet reduction measures														
7.a. salt/sodium policies	○	○	○	○	○	○	○	○	○	○	○	2	2	7
7.b. saturated fatty acids and trans-fats policies	○	○	○	○	○	○	○	○	○	○	○	0	1	10
7.c. marketing to children-restrictions	○	○	○	○	○	○	○	○	○	○	○	3	0	8
7.d. marketing of breast milk substitutes restrictions	○	○	○	○	○	○	○	○	○	○	○	3	5	3
8 Public education and awareness campaign	○	○	○	○	○	○	○	○	○	○	○	6	0	5
9 Guidelines for management of cancer, CVD, diabetes and CRD	○	○	○	○	○	○	○	○	○	○	○	7	3	1
10 Drug therapy/counselling to prevent heart attacks and strokes	○	○	○	DK	○	○	○	○	○	○	○	3	0	7

6.2 Action by commercial actors

Commercial actors can also address CDH, although there is limited evidence from the Region. Such actions of the commercial sector often merge with their reputational management practices and it can be challenging to dissect such actions from their profit-making objectives. Commercial actors should adopt a balance of responsibility and profit-making, and consider their entire value chain, including the nature of the business and internal and external processes (21).

As mentioned in the initial sections of this report, commercial determinants also have a positive impact on health. For example, reports suggest that over the past two years, several unhealthy commodity industries (ultra-processed food industry, SSB industry) are diversifying their portfolio to include healthier and compliant beverages and snack items due to the strengthening of laws in countries such as India and Thailand (247). A leading potato chips producing brand in India has reported that they have reduced the amount of sodium and saturated fat across their various popular products. Furthermore, during the COP26, a Clean Air Fund was launched by a number of companies, including the Indian Mahindra Group (248). The members of the alliance have proposed measures and declared their commitment to reduce air pollution.

India has witnessed the success of involving the commercial sector in infectious disease control, particularly in the context of prevention and treatment of HIV/AIDS. This often occurs when CSR

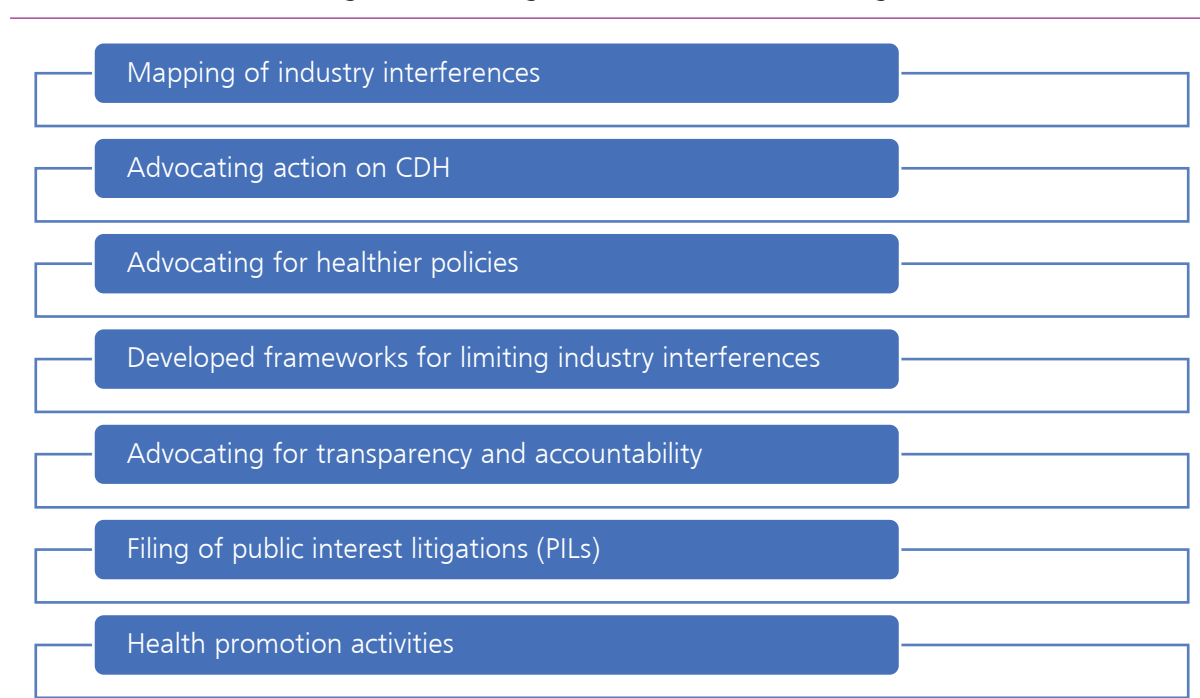
activities are conducted in tandem with both government organizations and NGOs (249). Some commercial actors have funded HIV education and awareness campaigns, while some have provided treatment support for employees with HIV infection (250).

6.3 Action by civil society organizations (CSOs), academics and non-profit organizations

All these actors play a role in directly or indirectly addressing CDH and the growing burden of disease in the Region due to commercial practices. Our research has found that despite the lack of a platform available to discuss CDH in the SE Asia Region, academic and knowledge environment participants in many of the countries of this Region have made progress in addressing these determinants. In January 2019, the Prince Mahidol Award Conference organized an international meeting on the “Political economy of noncommunicable diseases”. The meeting was held in Thailand, and it was a major public health gathering to incorporate the role of the political economy in prevention and control of NCDs. The Conference recommended that global health researchers need to direct more attention to the political economy of NCDs (251).

The role that advocacy-orientated actors have played to highlight and address CDH is both unprecedented and invaluable. Many organizations in the Region have produced targeted documents, highlighting the commercial practices in the Region. Various not-for-profit organizations have mapped and reported various practices of interference from unhealthy product industries, such as tobacco. Separate reports have also documented how, during the COVID-19 pandemic, these industries, directly or indirectly, marketed their brand through their CSR practices. Our review and data from key informant interviews also found that CSOs have advocated aggressively for policy changes to control the impact of CDH. Some of the key areas of work by CSOs and industry watchdogs are enumerated in Fig. 6.

Fig. 6: Areas of action by civil society organizations and nongovernment organizations in the SE Asia Region



Specific examples of work by not-for-profit sector actors have also been noted for specific domain areas, such as exploitation of workers by the fashion industry. Following several fatal accidents in Bangladesh, which killed thousands of factory workers, various national and international actors pursued the government and local authorities in Dhaka to strengthen occupational safety and health, conducted labour inspection services, skills training and rehabilitation services in the long term (252). These actors also campaigned to convince businesses sourcing from the factories in Bangladesh to contribute towards the compensation for affected families.

Health alliances in SE Asia and CDH: case studies (253)

National alcohol policy development in Nepal: role of civil society organizations

Nepal has one of the highest alcohol consumption rates in the Region. Since 2010, several meetings and workshops involving the Minister of Health were held to discuss the details of a national alcohol policy. In 2012, the Ministry of Health (MoH) set up a task force to develop a draft national alcohol policy and legislation. Various civil society organizations (CSOs) and health alliances in Nepal were involved in the drafting the policy. The CSOs organized media briefings and demonstrations to move the policy forward. In 2016, a second task force was formed by the MoH to incorporate the comments and suggestions received from earlier consultation and to prepare a final draft.

Members of the Nepal NCD Alliance and National Alcohol Policy Alliance were once again involved. This second task force finalized the national alcohol policy along with an act to implement it. In November 2016, the Nepal NCD Alliance organized a workshop on the need for an alcohol control policy in the country. The Secretary of health and representatives of the department of health services attended the event, as a consequence of which it was recommended that the Nepalese government urgently approve the previously finalized Nepalese alcohol policy. The ministerial cabinet finally approved the policy on 20 February 2017.

Standing up to industry to secure higher sugar-sweetened beverage taxes in India

The Indian government launched a new unified Goods and Service Tax (GST) regime on 1 July 2017. A GST council was set up to determine the GST rates for various products. As the GST proposal was undergoing several rounds of discussions, CSOs hailed suggestions to earmark SSBs as "sin goods" and bring them under the highest tax bracket. However, the food and beverage industry strongly urged the government and the GST council to reconsider this proposal and resist pressure from health advocates.

In response, Healthy India Alliance (HIA) members agreed on and submitted a joint representation in the form of a letter to different government departments, including the GST council, the MoH and the Food Safety and Standards Authority of India (FSSAI) to express support for the new tax regime and calling for its successful implementation. The letter strategically put on record the public health significance of the highest possible taxation under GST (43%) as a critical policy measure for NCD prevention and control in India. This was an important and strategic opportunity for the HIA to demonstrate strong civil society support for substantial taxation of SSBs and thwart attempts by the food and beverage industry. Ultimately, the GST council announced a 40% tax on SSBs (28% GST+12% cess) in line with the HIA's request.

7. Conclusions and recommendations

The following recommendations have been made to address CDH comprehensively in the SE Asia Region. These incorporate and synthesize the recommendations emanating from the analysis of key stakeholder interviews, 2022 Regional report on CDH the WHO regional consultation 2023, and the authors of this report.

- There is a lack of understanding and evidence on CDH specific to the Region. Most of the literature and evidence focuses primarily on the unhealthy product industry. Using the tobacco control narrative to frame and guide the construction of CDH is a limiting choice. The scholarship on CDH must look beyond a narrow focus on specific industries and their products such as tobacco, alcohol and ultra-processed foods, and should instead look at how a broad range of commercial and quasi-commercial actors influence health outcomes and equity.
- Reputational management practices other than that of the tobacco and alcohol industries are less documented in the Region.
- There is a need to unpack, disaggregate, interrogate and thoroughly scrutinize the myriad sources and forms of commercial power in the Region.
- Academic institutes and research organizations should prioritize research on CDH in the Region. Additionally, existing literature in the Region must be analysed from a CDH lens.
- CSOs, across sectors, must be trained in drawing attention to the right to health and government obligations to protect health.
- Public and plenary health and health equity should be priority goals for all sectors – governments, commercial sectors and non-State actors.
- Increase the level of health literacy in the Region by targeted educational campaigns. Increasing health literacy is the least restrictive option and allows populations to weigh information provided by commercial actors against their understanding of the health implications of consumption.
- Public participatory approaches should be adopted for CDH to create public awareness and community movement on CDH.

Government-specific recommendations

Governance

- The whole of government and not just the Ministry of Health should address industry interference and related practices, thus a whole-of-government and a multisectoral response is needed to adequately address the adverse impacts of CDH.
- Governments should avoid partnerships with unhealthy product industries, particularly in areas where they have no competence, such as developing health-related policies.
- Commercial actors should meet the true costs of the harm they cause. Governments should exercise their power in holding commercial actors accountable.
- Governments must divest from unhealthy product industries and not accept funds from these industries during emergency periods, such as the COVID-19 pandemic.

- A commercial determinants action plan should be developed and properly funded in the budget and with the assistance of donors.
- Existing health, development, and other government plans should be reviewed to incorporate a focus on CDH.
- Capacity should be built for multisectoral action on assessing, monitoring, and to capture CDH.
- Governments should include a focus on addressing the commercial determinants with the healthy cities agenda.

Research and scoping

- Country-level research and scoping should be carried out systematically on the commercial determinants.
- Gaps in existing laws and regulations should be analysed and plugged to strengthen action on addressing CDH.
- Governments should develop and implement a monitoring and evaluation mechanism on CDH with a protocol to hold harmful industries accountable.

Enact measures

- Policies and approaches should be adopted for identifying, preventing and managing conflicts of interest to prevent undue influence over policy-making. These policies and approaches need to be positioned within overarching frameworks for addressing and mitigating commercial practices that have influence over and interfere with public policy. Further, these frameworks can be used to monitor industry interference regularly to enhance transparency and ground the development of actions.
- Governments should prohibit unhealthy product industries from benefiting from any incentives and subsidies.
- The political and reputational management practices of industries should be monitored. Unhealthy product industries should be prohibited from conducting CSR practices related to promoting health and development.
- Much greater transparency should be encouraged about industry lobbying and funding across all levels of policy-making. Lobbying registers could be used to monitor who lobbies who and how much is spent. A number of countries do so – Canada, Denmark, France, Taiwan, the UK and the USA ⁽²¹⁾.
- For a green economy, governments should ensure reduction in emissions and an increase in the share of renewable energy.
- Governments should enact measures for marketing restrictions and excise taxation on unhealthy commercial products, and regulate product composition, labelling and packaging
- Governments should strictly enforce existing regulations to promote public health.
- Governments should focus on particular vulnerable populations such as women and youth, and marginalized communities.
- Programmes need to be implemented in settings such as schools and colleges on health literacy and association with CDH.

Adopting a public health approach to the commercial determinants of health (specific recommendations from the WHO Regional Consultations 2023)

Public health approach to CDH

Governance

- ◉ Multisectoral approaches under high-level leadership and through institutionalized multisectoral institutions to ensure coherence that aligns economic policy with public health goals.
- ◉ Ensure **incorporation of health** considerations in economic and trade policies.
- ◉ Address and mitigate **conflicts of interest** in the design and implementation of legislation and regulations on harmful products and practices.
- ◉ Ensure transparent and participatory **governance**.
- ◉ Build public sector and public health capacity, including funding.

Addressing harmful products and practices directly

- ◉ Introduce and implement the **principle of polluters pay**.
- ◉ Implement **health impact assessments** prior to licensing commercial activities.
- ◉ Regulate product composition.
- ◉ Impose **marketing restrictions** on harmful products – including cross-border and online.
- ◉ Ensure excise taxes on harmful products.
- ◉ **Regulate** the use and sale of harmful products.
- ◉ Introduce labelling and warnings.
- ◉ Increase health literacy.
- ◉ **Raise awareness** through public health campaigns.

Promote health products and practices

- ◉ **Introduce subsidies for healthy products** and practices with access to the public.

Need for measurement and monitoring of the commercial determinants

- ◉ Of market changes
- ◉ Of risk factor consumption
- ◉ Of health outcomes
- ◉ Of health inequities
- ◉ To determine the effectiveness of policies and interventions for addressing the commercial determinants.

Civil society

- ◉ Support and establish local organizations for advocacy against harmful products and practices.

Collaboration and coordination with commercial actors

- ◉ Collaborate and coordinate with businesses and industry associations on voluntary agreements.
- ◉ Coordinate with media to control the commercial determinants.

- ◉ Public health campaigns on social media and in communities should be conducted on unhealthy products and practices.
- ◉ Commercial health institutions should provide evidence-based services.

Strategic actions

- ◉ Develop a comprehensive list of CDH in countries of the SE Asia Region, focusing on myriad sources and forms of commercial power in the Region.
- ◉ Develop capacity-building opportunities on CDH: WHO to develop courses for government and related stakeholders as well as for public health students to conduct research, monitoring and assessment of CDH to build evidence in countries of the Region.
- ◉ Build the capacities of governments and civil society to conduct country-level review and mapping of CDH and assess their impact on health.
- ◉ Conduct multisectoral consultations in countries to propose and create conflict of interest policies, CSR restrictions and other CDH regulation policies to tackle CDH appropriately.
- ◉ In conjunction with governments, develop actions to address the identified CDH through a policy response.
- ◉ Support governments in developing monitoring and surveillance systems to track population, environmental and other impacts of CDH and for assessing the effectiveness of interventions.
- ◉ Support the development and implementation of legal measures to address CDH.
- ◉ Collaborate with other UN agencies to address CDH at regional and country levels.
- ◉ Develop a protocol to evaluate industries as emerging CDH.

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WHO recognizes the importance of the economic and commercial determinants of health that generate both positive and negative impacts, while enabling politico-economic systems and norms for working conditions. Commercial determinants of health are recognized as industry-driven commercial activities, including all products and services that impact public health such as health-care delivery systems and cost, and influence healthy lifestyle choices as well as global health inequities. This includes occupational health of workers. The production and consumption of 'unhealthy' products such as tobacco, alcohol, ultra-processed foods and sugary beverages degrades the environment, negatively impacts the health of communities, families and people, and adds to pollution.

This report is a collaborative effort of the WHO Regional Office for South-East Asia and headquarters. The Regional Office convened a consultation with Member States, bringing together officials from relevant sectors, academia, civil society groups and United Nations partners in the Region, to obtain inputs on the wide range of commercial determinants of health in countries. This first regional mapping of the impact of and action on commercial determinants of health documents a wide range of commercial products, activities and market systems that influence peoples' choices and consequently health conditions.

