Framings of and priorities for action on the commercial determinants of health in Sub-Saharan Africa

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Table of contents

Executive summary ... 1

1. Background and purpose ... 3

2. Methods ... 3

3. Framings and priorities in commercial determinants of health ... 4
   3.1 Overall findings on the discourse and conceptual framings ... 4
      3.1.1. Discourse of International and global agencies engaging in SSA ... 4
      3.1.2. Discourse of SSA continental and regional organisations ... 5
      3.1.3. SSA government discourse ... 7
      3.1.4. Discourse of investors and funders operating in SSA ... 8
      3.1.5. Discourse of corporates operating in SSA ... 8
      3.1.6. SSA civil society discourse ... 9
      3.1.7. SSA academic discourse ... 11
   3.2 Overall findings on priorities and actions ... 15

4. Similarities and differences across actors and ideas ... 16
   4.1 In the framings and priorities by different actors in SSA ... 16
   4.2 Tensions/synergies between commercial and public health objectives ... 19

5. Discussion ... 21
   5.1 Overall analysis ... 21
   5.2 Implications for SSA ... 22
   5.3 Implications for WHO and exchanges across countries globally ... 25

6. References ... 26

Appendix 1 ... 39

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Cover photos: Top left: Conflict minerals in Congo, Ronibd, 2018 Top right: Migrant Sugarcane cutter South Africa, H Hugo, 2013 Bottom: Branded Kiosks in Ndolo, iSeeAfrica, 2013. All under creative commons licensing

Executive summary

This document produced by Training and Research Support Centre for the World Health Organisation (WHO) and the Alliance for Health Policy and Health Systems Research (AHPSR) explores in Sub-Saharan Africa (SSA), from the lens of International/ global; continental/sub regional organisations, governments, business, investors, civil society and academia in SSA how commercial determinants of health (CDoH) are being framed, prioritised and acted on. The evidence was sourced from 300 papers published post-2010 and reviewed for validation by 9 purposively selected key informants from these constituencies. The findings on the discourse and framings (in *Section 3.1*), and on the priorities and actions (in *Section 3.2*) are presented by actor. *Section 4* discusses the synergies and differences across these lenses, and the tensions / synergies between commercial and public health interests. *Section 5* presents a summary analysis and the implications for SSA, for WHO, and for exchanges between regions globally.

There is no widely accepted definition of CDoH in SSA. Beyond the usual focus on for-profit private activities that affect health, the findings highlight a spectrum of large to small, formal and informal commercial actors. The findings also point to influence of global actors, interests and policies as a key lens in SSA, given corporate roles in colonial and post-colonial systems, and the current impact of global rule systems, including on policy latitude and local power to address issues in the continent. Beyond national action, this raises the role of sub-regional co-operation and engagement on these dimensions of CDoH.

The most polarised views found in the analysis of discourse are between civil society and most academia on the one hand (very focused on harms) and private business/investors on the other (almost exclusively focused on benefits). Continental and international agencies have more mixed messaging. This mixed messaging has implications on state practice: One the one hand states taking action on CDoH have reported benefiting from clear international standards and assertive civil society evidence and support. However mixed messaging also means that SSA states may more commonly choose less conflictual paths with powerful translational corporates (TNCs) and their own economic sectors, despite the distrust and conflict this generates with their civil society.

There were many specific priorities, but three domains stood out. They reflect the most divergent views and present as key tensions between commercial and public health objectives in SSA. These are the role of human rights (as fundamental for or obstacle to engaging commercial practice in health); the economic and development paradigm informing discourse, policy and action (the role of a neoliberal political economy generating harms or opportunities for health, often with different views also between economic and social sectors in government) and in relation to the health sector itself (with commercial activity in health services seen as threat to or opportunity for UHC and health security).

Within the SSA business community and investors, there is also divergence. Domestic producers raise concerns about TNCs and liberalised trade undermining local producers, and there is growing engagement from SSA actors on global rules that undermine tax revenues, local production of health promoting technologies and regulation of harmful practices. COVID-19 has amplified debate and divergent views, generating new demand for public sectors to ‘de-risk’ and incentivise commercial activity to ‘modernise’ and digitise biomedical health services, to meet funding gaps for UHC and health security, but also new momentum in global engagement and new thinking on more strengthening distributed inclusive production capacities in SSA.

Beyond simply listing actions, as found by the WHO Commission on the Social Determinants of Health (CSDH), power plays a critical role in moving knowledge and interests to action. Commercial actors operating in SSA increase their own power through advancing ideas, narratives and discursive power (eg private is best), using mechanisms of agential power (eg sponsorships, putting public officials on corporate boards or sitting in policy bodies) and taking advantage of the structural power of free markets and for profit commerce being viewed as essential for wellbeing.

We thus explored the counterfactual in the various ways these same three forms of power are being used to proactively advance public health objectives and leadership on CDoH. The findings highlight a range of examples of this. SSA actors are challenging narratives that weaken public

health and building their own *discursive power,* such as in exposing health impacts of harmful practices or showing benefit from local food production systems for health and biodiversity. They are engaging on *agential power,* such as in regulating harmful commercial practices, implementing health impact assessments or taking visible public health action in areas that matter to the public, like controlling pollution, and engaging at the level of the *structural power*, such as in harmonising regional standards, protecting smallholder food producers; or engaging on the TRIPS Waiver.

The expansion of commercial interest and activity with health impact in SSA highlights a clear need for a more comprehensive, proactive focus on CDoH. Tobacco and alcohol as harmful products; the health impact of extractive activities and urbanization; health services and health commodities as areas of increasing commercialization; and the commercial drivers of NCDs are commonly noted as areas for policy attention in SSA. The CDoH impacting on food systems emerge as a key area needing particular policy attention in both urban and rural areas. Shared concerns suggest opportunities for more inclusive dialogue, understanding and action on CDoH.

For this, the findings point to particular areas for action:

- *As foundational and to influence discourse:* Improving the evidence from cross-disciplinary and citizen science research, institutionalizing strategic health impact assessment, strengthening monitoring, surveillance and information systems, with measures for private sector disclosure duties, public domain reporting and inclusive, transparent decision making.
- *To strengthen agency:* Updating or supporting public health laws and their inspection and enforcement mechanisms; domesticating relevant international standards; harmonising standards in sub-regions; and engaging/litigating on TNC duties in source countries.
- Building SSA leadership in areas of commercial benefit to health, particularly for public health prevention in communities and frontline services, through investment in development, R&D, proof of concept and production in SSA of health-related technologies, and challenging IP/ trade rules that limit this.
- Strengthening coherence, capacities and action across sectors, through HiAP and embedding CDoH in further development and wider implementation of 'One Health' actions and systems.
- *To engage on structural power,* through tracking of financial and tax flows within and between countries; engaging on health consequences of global trade, tax, biodiversity rules and financial flows and on health impacts of trade, debt, financing and IP measures, including at Africa continental level; and monitoring delivery and promoting accountability on claims and commitments, including for their impact on equity, national and international goals. Sub-regional and continental level organisations are identified as playing a key role in such actions.

These actions would benefit from exchanges within WHO regions and between WHO regions globally on evidence, standards and strategies, including on how challenges are being met and in joint engagement on global policies affecting CDoH. WHO can play a role in many of the strategic actions raised, to provide technical and normative guidance, capacity support, facilitate multi-actor co-operation and regional exchanges on practices, and support domestication and harmonisation of standards within sub-regions of SSA. WHO itself can enhance policy coherence on CDoH between key UN agencies engaging with health determinants; engage with multilateral finance, trade and economic institutions on the protection of public health in commercial activity; and ensure completion of a genuinely multilateral international instrument on business and health rights in the OCHR. Including CDoH as a standing agenda item at WHO regional and global assemblies will strengthen evidence and accountability on strategies and actions. With international public health standards influential in SSA negotiations, WHO needs to unequivocally and consistently articulate the central role of public sector health systems in UHC, and assert public health standards and values where for-profit interests conflict with public health goals, to protect the right to health and to articulate where public health values and norms take precedence.

The diversity and expansion of commercial impacts found in SSA suggest that piecemeal interventions on CDoH, while necessary, may be insufficient to address the scale of threat or the loss of potential opportunity in this area. The context and situation in SSA call for 'upstream action'. The report identifies key current economic, biodiversity, tax, trade debates and platforms within SSA and globally, where engaging on CDoH will be critical to ensure public interest voice on policies that better support synergies between social, ecological and economic wellbeing.

1. Background and purpose

WHO are developing a new portfolio of work on economic and commercial determinants of health. Given the still developing framing of this field, the WHO and the AHPSR commissioned a series of reviews from different regions, to better understand how the commercial determinants of health (CDoH) are understood, conceptualized and addressed, to inform and shape future WHO work on these issues. This document covers the WHO Africa region, specifically Sub-Saharan Africa (SSA), covering from the lens of policy/political, technical/ academic and social/civil society actors:

a. How CDoH are being framed / conceptualized/ understood and articulated, generally, and with attention to key features that generate tensions or synergies between commercial and public health objectives.
b. What domains of CDoH are being prioritised by the different actors.
c. The forms of action on CDoH being articulated, particularly for the identified priorities.

2. Methods

Searches were implemented in October 2021 by RL, SG and PCK, subdividing the actors, and using common search terms relevant for CDoH, Africa and specific search terms for the different categories of actors shown in *Table 2.1*. The searches were made in online libraries, databases and institutional websites of journal papers, reports, briefs, blogs and other media post 2010 in English. Searches were implemented separately for each category of actor, covering papers by or about these actors. The number of papers found is shown in *Table 2.1.* The voice being expressed was then used to allocate papers to the category of actor in the extraction of data, to compile tables for each paper on the discourse, priorities and actions. In extracting the data to reflect the 'voice' of each actor, some papers were reallocated to other categories. Further papers found in references or raised in KI interviews or review feedback were also included. A total of 300 papers were finally included, shown by category of actor in *Table 2.1* and similarly in the reference list. Six papers were included in more than one category for reflecting more than one voice.

Table 2.1: Papers sourced by actor

ACTOR	#papers from searches	# papers included finally in category
International/ global institutions (multilateral, bilateral, south-south foundation, philanthro-capitalist, commercial) operating in SSA	88	52*
SSA continental and regional organisations	21	54
SSA governments[1]	25	14
Banks, Investors, funders operating / investing in SSA	48	32**
Corporate, private for profit and business associations	43	21
Civil society/ social	27	43*
Academia	48	90*
Total	300	306

(*) one paper in this category appears also in another. (**) three papers in this category appear also in another

Given the wide nature of the field and the time and resource limitations, notwithstanding the range of literature sourced, a number of limitations need to be noted. Some relevant discourse and work may not be in the public domain, and published literature poorly captures the views of mid-level implementers, local government, informal and small and medium enterprise, or local level civil society. We were not implementing a systematic review. The evidence was limited by what is available online in English post-2010, unless reference was made in these documents to earlier policies or actions relevant to current framings. Searches were not continued where a saturation of key ideas was obtained. As the literature sourced was in English, views in francophone and lusophone countries are likely to be under-represented. Beyond searches using 'Africa', searches by country name were limited to a sample of countries from all sub-regions of SSA due to time and resource limits. While some gaps were addressed in the key informant review process, these limitations would also need to be addressed in follow up work using other methods. However, the

[1] General search implemented using 'Africa' in the search term, and also specific searches for government websites from a sample of countries from different regions and different economic and language groups (given time and resource limitations) ie South Africa, Mozambique, Zambia; Kenya, Tanzania, Uganda; Ghana, Nigeria, Sierra Leone and DRC

searches were extensive, cover all SSA sub-regions and actors and exposed common and different views. The nine key informant (KI) interviews provided a means to review the primary evidence gathered. The KIs, anonymised and categorized by type and level are listed in *Section 6* after the references. As their number was limited by time and resources, KIs were purposively selected, consent obtained and interviews carried out after the document review to review and provide insight on contrasting views and on implications of the findings from the document review. The KIs covered national, sub-regional, continental and international levels; state, non-state and technical actors, different regions and areas of work.

3. Framings and priorities in commercial determinants of health

The findings on the discourse and framings (in *Section 3.1*), and on the priorities and actions (in *Section 3.2*) are presented by actor in this section. *Section 4* discusses the synergies and differences across them, and tensions between commercial and public health interests.

3.1 Overall findings on the discourse and conceptual framings

As this subsection presents the primary evidence on which the analysis is based, with a focus on the *direct* discourse of the different actors, rather than what is said *about* them, the actors are differentiated, a reasonable level of detail is provided for each (even where several actors have similar areas of discourse) and direct quotes are provided in blue font.

3.1.1. Discourse of International and global agencies engaging in SSA

Various UN institutions have set rights to health and state duties to protect these rights, such as in the preamble to the WHO constitution, in the 1996 International Covenant on Economic, Social and Cultural Rights, or the International Labour Organisation (ILO) Multinational Enterprise (MNE) Declaration. The ILO has raised deficits in 'decent work' when businesses generate precarious employment, or states inadequately provide for social protection, especially for those with highest need in SSA. The ILO notes that the COVID-19 pandemic has widened deficits in key health determinants, identifying universal social security as essential to "…address the fragility and unevenness of social and economic conditions and bring about a human-centred recovery" [18;19; 20]. UN Habitat uses the 'right to the city' to promote urban inclusion, while FAO engages with corporate practices around food security.

The UN Office of the Commission on Human Rights highlights that while "businesses are considered to have some responsibilities with respect to human rights…the exact nature and scope of these are unclear" [26]. A UN Human Rights Council Intergovernmental Working Group is currently framing a legally binding instrument to regulate, in international human rights law, the activities of transnational corporations (TNCs) and other business enterprises with respect to human rights, including in SSA, but this process is incomplete. This gives TNCs operating in SSA a leeway to voluntarily apply standards such as the OECD Guidance for MNEs, the International Finance Corporation's (IFC) Performance Standards on Social and Environmental Sustainability, or the International Council on Mining and Metal Sustainable Development Principles [266]. While a growing field, there is still limited focus on health rights in these international documents with "…concerns that human rights due diligence was an expectation not an obligation, positioning the State in the neoliberal mode of facilitating business and setting expectations, but not actively regulating business and lack of political will to develop the treaty text" [35].

More commonly in the discourse, UN and international agencies project the private sector in a positive manner as partners, some as 'essential', in delivering on global commitments to Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC), contributing financing, technology innovation, green technology and health commodities for health-related and climate goals. Private sector partnership is referred to as bringing financing options like development impact bonds to frontload social sector investments to meet infrastructure needs and UHC funding gaps. This discourse situates the private sector as a 'technology innovator' for 'quality' health care, including through market systems, low cost technology and using digital technologies to bring medical services and commodities to low income communities [2; 9; 22; 27; 29; 36; 40; 43]. UHC aspirations, the pandemic, and '21st century challenges in Africa' are argued by global and multilateral agencies and investors to raise opportunities for investment in vaccines and other health products [16; 44; 45].

The proposition by these actors is that there is a 'win-win' outcome between health and economic returns, relieving the pressure on 'cash strapped public systems': "The primary reason for investing in UHC is a moral one…: However, UHC is also a good investment" [41]. The IMF notes that "Projects that generate high private returns are generally financed and implemented by the private sector, whereas the government is usually better positioned to carry out projects with high social returns but low private returns" [21], even while observing the different interests to make 'private sector participation intrinsically complicated' [9]. On the one hand, from a 'moral' lens, corporates are encouraged to strengthen their voluntary corporate social responsibility (CSR) in SSA, including by channelling CSR spending directly towards state-led social protection programmes [28], or, as argued by UNICEF, for 'smart debt relief' that links debt relief to social protection funding [8]. However a more common focus appears to be on what states need to do to support 'market creation' in SSA' [21], with IMF reported to observe that "governments may have to provide extra incentives [e.g. subsidies and guarantees] to make infrastructure projects attractive to private investors. … the truth is, many projects in development sectors won't happen without them" [9]. Attracting private investors to health goals is thus perceived to call for states to 'de-risk' private investments, such as by providing blended concessional financing and a 'conducive' regulatory environment [17; 44].

The social protection deficits and intensifying inequalities arising from the COVID-19 pandemic have opened new discourse on motivations and demands around CDoH. Some international agencies see new opportunities for commercial activity in SSA, as colourfully noted by one global private sector stakeholder "The politics is still like treacle, but the regulatory and economic blender is finally whirring" [31]. Others note that what form this takes is now debated, with the socio-economic consequences of the pandemic opening opportunities for economic policy shifts in SSA from 'trading to a production based economy' [38].

3.1.2. Discourse of SSA continental and regional organisations

The rights language noted earlier is even more explicitly expressed at continental level in the African Commission on Human and Peoples' Rights (ACHPR) statement "that the growth of private actors' involvement in health and education services delivery often happens without the consideration of human rights resulting in growing discrimination in access to these services, a decrease in transparency and accountability, which negatively impact the enjoyment of the rights to health and education" [55]. The ACHPR positions states as duty bearers in protecting social, economic and cultural rights in relation to private actors' roles in health [55; 56]. Other continental actors note the pertinence of the UN Declaration of the Rights of Peasants and Other People Working in Rural Areas and the International Treaty on Plant and Genetic Resources for Food and Agriculture, both of which explicitly refer to health rights, given the economic importance of agriculture in SSA [KI3, 2021]. Equally the Convention on Biological Diversity (CBD) and its provisions on biodiversity and the equitable sharing of benefits from genetic resources are seen to be critical for health rights in SSA, and deeply affected by commercial practice. For example, commodified, financialized and technology driven approaches to achieving targets set under the CBD are seen to have accelerated rather than reduced biodiversity losses in SSA. This is argued to call for new strategies, including building power outside formal negotiating processes, to integrate CDoH and health gains for SSA in the post 2020 Global biodiversity framework currently under negotiation [KI3, 2021].

Continental organisations, including WHO AFRO, see rising non communicable diseases (NCDs) and future climate-related risk as calling for more attention on CDoH. They observe the need for legal, tax, and multi-sectoral actions to reduce risk factors, such as those related to alcohol, tobacco, food safety and quality and public infrastructures [57; 58; 101; 103; 105; KI7, 2021], particularly given "the impacts of water scarcity and climate change on food and water insecurity", and of poverty, hunger and women's empowerment as determinants of health [58; 59].

Some note that health benefits could be embedded in commercial products, such as in vitamin fortification of locally produced maize meal, with early adopters encouraging others to integrate such practices [KI1; KI7, 2021]. Others, however, note the wider impact of colonial and neocolonial extractive commercial systems on ecological degradation, fragile food systems, loss of dietary diversity and negative health outcomes, with financial institutions seen as key drivers of the policies that underlie these harms [KI3, 2021]. Mining activities, both formal and informal, are

economically influential but also generate multiple risks for health (KI2; KI7; KI8, 2021). The UN Economic Commission for Africa (ECA) note, however, that SSA's "enormous mineral resource endowment" has not made significant contributions to poverty eradication, calling for accelerated "efforts by governments, the private sector, local communities and individuals to improve social and environmental accountability of production and consumption processes" [89]. Trade-related mobility is seen to be leading to cross border infectious disease transmission and trade across porous borders to import or smuggling of substandard, counterfeit or illicit medical, tobacco, pesticide products and contaminated foods, with harmful products often sold in informal markets that are difficult to regulate [71; KI7; KI8, 2021). Pesticide use in agriculture has been associated with toxic exposures, pollution of water and resistance of malaria mosquitoes to public health controls [KI7, 2021]. The intersect between liberalised trade and rising urbanisation is seen to be shifting consumption to imported cereals and poorer quality foods at the expense of traditional grains and crops. FAO West Africa observed this to be a key cause of food insecurity and malnutrition in that sub-region [78]. Such health consequences of liberalised trade have led regional health and equity actors to raise concerns over the potential health impact of the African Continental Free Trade agreement (AfCFTA), particularly given weak capacities to test the quality and safety of goods crossing borders in many parts of SSA [80; KI7, 2021].

The COVID-19 pandemic has amplified policy debate on these issues. The AU has, for example, identified the intellectual property (IP) regime in the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement as a critical commercial barrier in an unfair global trade regime to universal, equitable and timely access to affordable diagnostics, vaccines, medicines and other health technologies to respond to COVID-19, giving continental support to a proposal for a TRIPS Waiver [62]. In contrast, the UN ECA sees the damage from COVID to require an even deeper engagement with "the major players of the global economy, public and private", to reinject growth momentum into economies "and build the foundations for recovery" including for investment in the health sector [93; 94; 95; 97]. Without note of TRIPS barriers, the UN ECA argues that the AfCFTA-anchored Pharma Initiative presents "lucrative private sector investment and innovation opportunities that will change lives, reduce poverty and contribute to Africa's inclusive and sustainable economic development" [95]. Amongst the sub-regional institutions, ECOWAS appeared to most strongly encourage a liberalised "transparent and attractive investment milieu to enhance private-sector-led development in West Africa" although also "accompanied by improving regional healthcare services, worker health, and worker productivity" and with law and supervision to "bring benefits of liberalization to ECOWAS people and businesses" [77; 88]. While the AfCFTA as a 'free trade' agreement is observed to potentially enable the production and distribution of health technologies and products in SSA, a caution is raised that its benefits may concentrate in wealthier corporates and countries and that reduced tariffs will reduce the very public sector revenues needed for measures to mitigate this [80].

Much continental and sub-regional discourse refers to the contribution of private actors in meeting health sector resource, capital, technology, IT, expertise and service gaps, and a funding gap of US$66bn annually for SSA to deliver UHC [79; 86; 92] and to modernizing and improving quality in the sector [68; 83; 87]. The ECSA HC, West African Health Organisation (WAHO) and East African Community (EAC) all note private sector involvement to be key to supplementing public services in their sub-regions [66; 74; 99]. The African Business Coalition for Health (ABCHealth) co founder Aigboje Aig-Imoukhuede, said, "Only partnerships will help solve the health challenges the continent faces" [25], while the AU Special Envoy to mobilize the private sector response to COVID-19 noted: "We need a Marshall Plan for Africa's public health system…that should be jobs and enterprise driven" [82]. Others are more cautious: WHO AFRO raises "a clear need for the private sector to expand its role, but, to bear in mind the low effective purchasing power of people in the region", given the harmful effect on equity of "higher out of pocket spending within private expenditures" [102; 104].

Regional economic forums profile the health sector as a key target for commercial investment [74; 81; 86], with the Africa Health Business Forum calling for "win-win options…to be identified and fostered" [84]. However, others, such as the ACHPR, WHO AFRO and ECSA HC have raised concerns over funder pressures to privatize key public services and called for effective state regulation and mutual accountability of both states and private actors [73; 79; 83]. Concern is raised that liberalised trade in the AfCFTA could lead to health worker outmigration towards

wealthier countries and falling tariff revenues could reduce public health budgets, unless measures are put in place to address this [80]. Others raise caution over the type of technology commercial actors bring [KI3; KI5, 2021]. A commercial focus on technologies for use in high level services is argued to poorly service the population health needs of SSA. The use of genetic engineering to eradicate malaria, as in the 'Target Malaria' project, funded by US philanthro-capitalist actors, and of genetically modified seed and food products, is criticised for carrying untested population level and ecological risk, threatening local farmer managed seed systems and productive diversity, with consequences for zoonotic- and environmental-related disease and epidemics [KI3, 2021]. Ensuring the relevance of and benefit from innovation is argued to call for regional co-operation on standards, digital registration and information systems and better sharing of information and capacities within SSA sub-regions, and for active engagement in treaty negotiations that affect the policy latitude to adopt or reject technologies and to protect biodiversity [KI3; KI7, 2021].

3.1.3. SSA government discourse

The documents by SSA governments were mainly national level strategic and policy reports, given that this is the level at which policy discourse is commonly found in official literature. These documents articulate an even stronger discourse on direct negative health impacts of commercial activity linked to food, unhealthy diets, alcohol and substance abuse, tobacco use, with concern over rising levels of NCDs and the associated burden on health services [111; 120; KI8, 2021]. Tanzania's health ministry links these risks to globalized trade bringing imported hazardous goods [119]. Mozambique's ministry of health raises concern over irrigation and agricultural projects contaminating food [115]. Others note climate emergencies and the ecological and social consequences of large extractive and agribusiness projects reducing health, food and income security of local communities, particularly given the weak enforcement of laws, rights and duties where powerful TNC actors are involved [KI2; KI3; KI8, 2021]. Zambia's health ministry observed that industries selling tobacco, alcohol, fast foods and other products leading to NCDs are resistant to regulation [120]. Such concerns over health risks from liberalized trade suggest a need to systematically assess the health impact of the AfCFTA for different SSA countries. We did not find a systematic analysis of this (yet) in the literature.

A focus on commercial systems, while not necessarily labelled CDoH, is found in proposals for cross sectoral strategies to improve health. Ghana's health ministry calls for public policy on trade, urban planning, transport, agriculture, education, finance, tax and social services to tackle NCDs [110]. Kenya's health ministry uses taxes and subsidies to promote healthy food and beverages [111]. Uganda'd health ministry outlines how the multi-sectoral nature of health risks necessitates "a departure from traditional, vertical public health responses" towards mainstreaming human, animal and environmental protection in 'One Health' plans that cover commercial actors [118]. A One health approach is also articulated in strategies of the Federal Republic of Nigeria [108; 109]. One health is raised as a platform in current use that can be further strengthened to coordinate health, agriculture, environment and trade sectors, to integrate evidence on local realities from civil society and communities and to engage other actors [KI7; KI8, 2021]. Co-operation between health ministries and inspectorates of commercial activities is noted to play a key role in putting law into practice [KI8, 2021].COVID-19 has raised the profile of public health with political actors, and is noted to have opened opportunities to strengthen public health law, inspection systems and actions to address social determinants (KI8, 2021). Further, while businesses generally pressure for voluntary regulation, those companies that see the value of mandatory standards for fair business practice are seen as possible allies in getting other business on board for mandatory regulation, and that early country adopters can enable regional standards [KI1, 2021].

The general tone of SSA government discourse thus associates commercial actors with negative health impacts to be managed. Some voices do vary. Rwanda's ministry of health identifies poverty as the most important social determinant of ill-health [116]. Noting that "the private sector has been the backbone of the creation of Rwanda's impressive economic growth over the last ten years" they link health benefits from poverty reduction to "engaging with the private sector across all sectors to fast-track economic growth and development". Harmful products such as tobacco are also noted to exist in a wider system. Existing law controlling tobacco consumption and advertising is often weakly enforced, given the role of tobacco production in economies and employment, and with smuggled tobacco products sold through middlemen in informal markets distributing these economic interests across multiple actors. Tobacco company sponsorship of decision makers,

such as parliamentary infrastructures, adds to this in links between company and high level political actors that are not always transparent [KI8, 2021].

As noted earlier, the health sector is itself a key focus of commercial activity and private sector engagement, with the argument that it expands access to care for UHC [107; 119]. However, here too the tone is perhaps more cautious than for other actors, with concerns voiced over "questions of equitable access and quality assurance", "the implications for health service staff, and oversight and regulation of private providers", the perceived urban concentration of private actors, and, in Mozambique, private health services primarily benefiting "people working in large companies, diplomatic missions and those with medical insurance policies" [107; 115]. Adding to these concerns is the lack of information and data on the functioning of their private sectors, and the limited capacities in some countries for negotiation with powerful commercial actors [117; KI8, 2021], given that "very little data is available on use of services or the resources used due to the poor control of this sector and a lack of clarity regarding its regulation" [115].

3.1.4. Discourse of investors and funders operating in SSA

There is some note by investors of commercial risks to health: The African Development Bank (ADB) observed this in relation to sub-standard housing, water and sewage systems, air pollution, industrial waste, poverty and unemployment in SSA, calling for sustainable policies for household energy, agricultural productivity, nutrition, transportation, water and sanitation [122].

Private investor discourse is, however, more focused on opportunities for commercial investment. These opportunities are observed in commodities for personal health care, "high-volume / low-margin products", such as vaccines [134]; green production and information technologies that are "Triple A… affordable, appropriate, adaptable" (IFHA, 2021); and in health service infrastructures and digital remote care [127; 132]. While some raise ways of addressing equity, such as through blending commercial and domestic public financing [133; 136], the more common private investor focus is on "favourable rates of returns and exit opportunities" [151] and on services for "the emerging middle classes, overseas business and tourists" in African "boutique-hospital development" [125].

A number of funders voice opportunities to contribute to UHC in SSA, pointing to the funding gap also noted by other actors [132; 136; 137; 138], but also to the projected economic growth and improving "economic, investment and political environment" in SSA, and its already rapidly growing private sector [124; 137; 147; 148]. COVID-19 has intensified discourse on private-public partnership to address 'health security' in SSA [123; 131]; to invest in industries which have been "most resilient in the wake of the crisis" [151]; and in "sectors that have performed well during the pandemic, such as those in technology, healthcare and Fintech technology-focused healthcare delivery models" [152].

Investors from within the continent add a somewhat different lens: The ADB argues that COVID-19 presents a unique opportunity for Africa to re-think its development policies, towards more inclusive, equitable and sustainable economies post-pandemic [150], particularly to strengthen local production capacity: "Africa cannot, and Africa must not, outsource the health security of its 1.3 billion people to the generosity and the benevolence of others" [142]. Transnational investors in the region note opportunities for 'co-creation' of business innovation if states can make their sectors attractive for private investors [144; 145]. ADB in contrast places high focus on "how effectively resources can be deployed to respond to equitable care for the poorest segments of society", measuring private investor success not only by performance "but also by its ability to cultivate businesses serving the poor" [122; 124], a concern also voiced by KIs [KI5, 2021). One funder, in self critique, raises concern that their "support for health operations has been skewed towards hospital construction and equipment supplies, despite the dire need for PHC services in low-income countries" [140]. The ADB suggest that different interests call for a "clear policy direction and framework for public-private collaboration" within national heath strategies [148].

3.1.5. Discourse of corporates operating in SSA

There was no direct corporate voice on negative health consequences from products or processes in the papers found. In contrast, many papers pointed to SSA as fertile ground for business to innovate and apply their own models and technologies. Concerns were rather raised that public

health measures can act as a barrier to economic activity and free trade, whether due to regulation, or lockdowns and border closures during pandemics [168]. The papers allude to positive commercial opportunities in the potentially high consumer numbers covered using 'door to door ' sales models for "486 million people with less than $3,000 per year [that] represent 70% of all local purchases" in Africa [161]. The SSA context of weak existing infrastructure is posed as an opportunity for commercial activity in infrastructure, power, medical equipment, services, community outreach and monitoring/referral [164]. One corporate actor observes "One of the great advantages Africa has over other continents ….is that there's far less legacy to get in the way than in other regions, creating a clean sheet on which companies can develop their own distinctive business models" [167]. The language of some bristles with excitement: Referring to healthcare inequalities in Africa, Imoukhuede, GBC Health claims: "These inequalities are a reflection of the weak healthcare system… I believe that GBCHealth will be key to shifting the needle towards universal health care for Africans….By fixing health, we fix Africa!" [159].

Many business voices raise the health care sector as a key area for corporate activity and returns [153; 154; 159; 161; 166]. The risks to investment are seen to be falling due to a growing middle class and a rapid pace of urbanisation, implying that "demand has widened and is no longer restricted to just basic, affordable healthcare" [161]. The potential investment returns are profiled in low cost health commodities [162]; online services [160]; and medical tourism "Combining Africa's natural beauty with medical wellness retreats will help develop the domestic medical tourism market in the short term and get it ready to welcome international medical wellness tourists in the medium to long term" [161]. Corporate voices call for more vigorous state support to overcome risks for businesses, including an observation that "political risks and instability also tend to affect the healthcare sector more disproportionately compared to other sectors due to healthcare provision being perceived as a right, not an option, by most African countries" [128]. Further risks demanding state intervention include "government resistance to reforms, an inadequate and discriminatory regulatory structure, continued threats of strike action by healthcare professionals, and the reluctance to privatize public systems", with commercial actors noting "the availability of cheap money in the form of aid is also a massive put off for potential for-profit investors" [128].

Here too there is some diversity of lens, at least as publicly expressed. For example, Philips expresses a commitment to think beyond short term commercial interests to build "local ownership and responsibility as key prerequisites for enduring success", albeit still aligned around their own healthcare model [166]. In part, for large corporate actors, the contribution to health services or interventions is framed as a corporate social responsibility, rather than duty, as helping 'a weak healthcare system' to deliver on UHC [159; 166; 167], or to support pandemic control [172]. Across the discourse the focus is, however, largely on biomedical care models, services and commodities, including at primary care level.

Local enterprises in SSA raise somewhat different concerns. TNCs in health-related sectors, including agriculture and manufacture are seen to inadequately link to local small and medium enterprise (SME) or to consider local contexts [173]. African telecoms billionaire Strive Masiyiwa commenting on inequity in markets in the purchase of key health commodities to manage COVID-19 control said that "those with the resources pushed their way to the front of the queue and took control of their production assets" [164]. Rather than seeing regulation as a barrier, the IFP Manufacturers Association propose that a strong unified regulatory system helps to combat falsified and substandard medicinal products in SSA, improving the opportunities for producers of safe and innovative products [158]. They thus welcomed the establishment of the African Medicines Agency as a boost to local manufacturing.

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3.1.6. SSA civil society discourse

The published work by civil society came from membership based movements organizing labour, gender, farming and health; civil society coalitions of professional and social activists working on issues, such as tax justice, food systems, health, and civil society projects, with some organically based in SSA, others in wider civil society networks also working in SSA. The published literature clearly loses some voices, such as that of local communities.

In contrast to the corporate discourse, civil society raises multiple areas of harm to health from commercial practices, including from commodities, such as ultra-processed food, alcohol and

tobacco; and processes, such as from extractive industries, genetic modification of foods, agribusiness links to food insecurity and loss of quality diets, amongst others [176; 187; 204; 206; 212; KI2, 2021].

Civil society voice points to the deeper drivers of these risks. For example the Bretton Woods Project links corrupt power relations; extractive activities and land grabs in SSA to environmental and disease threats, further exacerbated by global volatility, conflict, aid declines and extractive business practices [177; 182]. World Bank policies in Sierra Leone and Mali are critiqued for, "favouring the interests of financial markets over food security and environmental protection" [182]. Casual, low-skilled, low-paid informal jobs generated by commercial entities are seen to undermine social incomes. Tax waivers or holidays and loopholes in tax laws are argued to enable profit-shifting outside the region, adding to a range of illicit financial flows [KI4, 2021]. In Nigeria, for example, the potential loss to public revenue from these outflows is said to be "equal to about three times the country's total health budget in 2015", with "elite capture of public sector policies and resources undermining the productivity of the most important sectors of the economy and preventing the fair distribution of the benefits of growth" [204]. Civil society warns that the options promoted by commercial actors are diverting resources away from more locally appropriate solutions, such as in food systems. For example, despite abundant foods such as sweet potatoes rich in Vitamin A, commercial promotion of genetically modified foods to enrich Vitamin A content is said to "risk perpetuating monolithic diets, the very causes of Vitamin A deficiency in the first place" [176]. IP regimes are said to fail to recognise indigenous customary law and western legal principles, ignoring that traditional knowledge is also "usually held by the owners and their descendants in perpetuity" [188].

Civil society is more strongly critical of efforts to mask the structural roots of commercial harms to health. World Bank reference to structural determinants as 'contingencies to be managed' are said to be masking "core features of North-South political economy from which Africa should be seeking protection" [177], and the Kampala Initiative (2020) observed that "these social, commercial, economic and political determinants of health have been tolerated or ignored by aid, thereby reinforcing the health inequities that aid is meant to resolve" [191].

Similar concerns around commercial practices are raised in relation to the health sector, where rather than supporting UHC, the discourse refers to private sector financing and services as undermining equity and universalism [201; 178; 190; 205]. Commercial investment in the health sector is observed by civil society to have predominantly gone to expensive, high-end urban hospitals offering tertiary care to wealthy groups [178], with fee charges that undermine access [205] and drawing formally employed workers out of public sector services [194]. Commercial markets in health are argued by civil society to undermine the view held unequivocally by WHO that "universal healthcare services funded through taxation and free at the point of access are the most effective, equitable ways of funding and delivering public health services and delivering on health care rights and state duties" [190; 194; 201; 205]. A commercial focus on personal care and biomedical approaches is argued to be inadequate for health, stating that "…without a robust public and community health infrastructure owned and managed by the state, it becomes next to impossible to implement interventions effectively to keep the population adequately healthy. There can be no healthy populations without access to safe water and hygiene, adequate nutrition, access to vaccines and so on" [211].

Civil society discourse commonly raises social rights and state duties around these issues, with concerns over states "relinquishing their obligations" and corporations "expanding their role and power" [174; 191; 211]. Expanding commercial roles in the health sector are traced to failures to deliver on state duties, to adhere to commitments made, such as the Abuja commitment of 15% government funding to the health sector, with declining public health services said to be providing an opening for private actors and inequity [196; 210; KI9, 2021]. As raised in South Africa, for example, "unfair practices, catastrophic understaffing, stagnating salaries and jobs stripped of security" imply that frontline and community health workers bear the brunt of under-resourced public sectors and expanding private services and profits in large health corporates [202].

A market framework based partnership with the private sector on health is argued to undermine rights, as "it is people and community interventions, not financialisation, that must be at the heart

of policy-making" [211]. Rights violations are enabled by lack of information to and involvement of affected communities in investments, combined with weak transparency and accountability in state engagement with commercial actors. Given these concerns, civil society see a role in acting as a watchdog of these interactions [179; 181; 187; 192; 212; KI9, 2021], while also asserting that the health policy space has become dominated by powerful interests, "while the voices of those most affected by health inequity are regularly tokenised or excluded from the conversation" [191]. This situation is seen to be reinforced by use of corporate research and a corporate narrative warning that regulation of commercial interests will lead to "a dysfunctional future of policy failure and widely dispersed adverse social and economic consequences" [187; 208].

Many civil society voices point to deeper drivers of these CDoH and corporate power in SSA. Neoliberal, market policies are observed to have led to deregulation and state withdrawal from key services, to ecological damage and social deficits, and to be undermining public resources and capacities to contest narratives and trends [195; 200; 208; 206; KI2; KI4, 2021). The PSI Public Services yearbook notes, for example: "Neoliberal analysts have argued that privatisation occurs because states fail: state officials are rent-seeking, inefficient, unaccountable, inflexible and unimaginative. Privatisation is seen as a rational and pro-poor policy choice, obvious to anyone willing to look at the track record of public versus private sector delivery" [195]. In contrast, it is argued that "privatisation of public services has not been inspired by some renewed enthusiasm for the market, but has become a necessity imposed on the state by economic circumstances: reduced public borrowing; cuts in state spending; liberalisation; and the opening up of new economic fields for intensified capital accumulation" [195].

The possibilities for public leadership in managing commercial challenges is also seen to be affected by the balance in public funding between capital investment in R&D and innovation vs the recurrent spending to react to disease and emergencies [KI9, 2021]. A range of civil society networks dealing with tax justice in SSA all connect extractive commercial practices, profit shifting, loopholes in tax systems and registration in tax havens to net outflows from the continent. With few countries yet meeting the 2021 Abuja commitment to allocate 15% government budgets to health, and punitive interest on debt, these tax-related practices are argued to be undermining both public resources and public sector power, even in fast growing SSA economies [186; 189; 197; 198; 203; 216; KI4, 2021]. Debt financing is further exposing countries in SSA to commercial conditionalities that limit public spending on social services, promoting deregulation and taking key public assets as security, with negative health impacts [KI4, 2021]. While this is seen to call for global engagement on tax rules set outside SSA, discussed later, continental civil society also argues for stronger domestic credit markets in SSA to resist debt instruments such as the UN ECA Sustainability Fund being used to intensify commercial finance and interests in key areas of policy [KI9, 2021]. This interface between states and commercial forces is seen to be taking place in "the context of colonialism and imperialism" , "designed within a set of power relations not dissimilar to today, and therefore developed to the benefit of these nations" and "today still dominated by corporations headquartered in the former colonial powers" [198]. Meaningful health, environmental and social protection is thus argued to demand action on these deeper drivers, particularly in the face of the debt generated by the pandemic and the inequitable share of health, social and economic burdens in SSA faces from climate change, despite its limited contribution to global emissions [KI4, 2021].

While there appears to be convergent interest between civil society and states in protecting public sectors in health and tackling rising disease from CDoH, civil society reject "the currently dominant neo-liberal paradigm" and see decisions that lead to loss of income, living standards and social protection in SSA communities as undermining trust between the people and the political class, and public interest alliances between civil society and states [200; 206]..

3.1.7. SSA academic discourse

Academic voices had the largest share of papers. CDoH were identified as health promoting or harming determinants relating to commodities, goods or services that generate tensions or synergies between commercial and public health objectives; the business, market and political practices that advance these commodities, goods and services; that "stem from the profit motive" and "are used by the private sector" [237; 272; 274]. Academic papers also raise the roots of

CDoH in market-driven economies, globalization and in power imbalances between commercial and public actors.

Academic discourse has perhaps the widest discussion of direct adverse and inequitable effects of CDoH, albeit also noting that they are poorly monitored. The risks observed from commercial activities arising, not always explicitly labelled as CDoH, include urban transport and air pollution; occupational hazards and tobacco, alcohol, fast food, firearms; gambling, with consequences in rising NCDs, "poverty and loss of opportunities, undermining the UN Sustainable Development Goals" [219; 157; 234; 239; 245; 253; 256; 266; 271; 292; 297; 306]. In addition to inadequate monitoring, lack of empirical research is also said to be leading to inadequate evidence on exposures, such as in children and communities surrounding mines. This is further exacerbated by harmful practices such as alcohol use being 'normalised" by cultures and marketing (217; 234; 266; 300].

Commercial practices are also seen to be escalating risk. For example, Hyder et al. highlight how market competition within the firearms market has made weapons more lethal over the years [157]. Igumbor et al. observe that "Big Food" corporate strategies have increased the availability, affordability, and acceptability of "nutrient-poor products such as biscuits, margarine, and oil-heavy snacks… as a cheap means [to] consume energy while nutrient-dense foods such as lean meat, fish, fruit, and vegetables generally cost more than processed foods" [253]. Spires et al. observe how this has enabled a commercially-driven transition from traditional foods to a 'western' diet, and rising NCDs [292]. Trade liberalization is thus noted to be creating obesogenic environments, even if it also brings new commodities [224; 288]. CDoH are also noted to become more pronounced in conditions of hyper-urbanization, rapid economic growth, rising levels of disposable income, and other economic and socio-cultural changes associated with globalization [285]. Rising NCDs from this market expansion has been referred to as "industrial epidemics" [238], and processed food, alcohol, and tobacco TNCs as "vectors of the NCD epidemic" [285].

Academic discourse thus poses a conflict between commercial, market for-profit interests and public health goals. For example, this conflict was raised in the Global Fund to Fight AIDS, Tuberculosis and Malaria funding of a (South African brewing company) SABMiller education intervention on alcohol-related harm and HIV prevention among men in drinking establishments as reflecting a "successful attempt of a highly profitable industry to position itself as committed to public health objectives", when "in reality, the liquor industry's aggressive marketing of its products is irrevocably linked with major health harms" [269]. Government economic sectors are observed to also align to commercial interests in this conflict: Mukanu et al. noted that while "the Zambian government [in 1998] maintained a 25% excise tax on soft drinks, amidst threats that Coca-Cola would pull out from the country" it later "repealed this excise tax in 2015, ostensibly for economic reasons" [275]. In more explicit expression of this, Democratic Republic of Congo's mining minister was reported to warn that mine shutdowns to address public health risks from COVID-19 risked "moving from a health crisis to an economic crisis, which would in turn lead to a social crisis" [286]. Academic discourse thus suggests challenges in the internal consistency of the SDGs, when "attempting to achieve one may result in another being negatively affected" [248].

There is frequent articulation of the inadequate attention to local contexts, local production systems and cultures in framing healthier policy alternatives [267; 277; 305]. The chairman of Tanzania's parliamentary public accounts committee MP Kabwe is cited as contesting policies that enable investors to acquire land rather than investing in small farmers: "With large-scale farming, you are turning small farmers into mere labourers," "Yes there will be huge investment in the country. There may be improvements in rural infrastructure. But this will not liberate people from poverty" [283]. Academic papers call for greater integration and protection of health in economic and trade paradigms negotiations and agreements, including in the AfCFTA [244]; in development aid and commercial agreements [241; 252]; in South-South platforms such as BRICS [259]; in discussions on new technologies [220], and in setting health duties of extractives [266; 298; 299].

These challenges are particularly noted in relation to commercialization in the health service sector. As for other actors, a number of academic voices propose benefits from private sector engagement in terms of funding, technology, training, R&D, innovation and expertise, directly or in public–private-partnerships PPPs) [114; 218; 240; 245; 250; 260; 261; 279; 301; 302]. The same

voices also raise cautions, such as in higher-than-anticipated costs from PPPs to health ministries, and weak state capacities to manage and pay for contracted services and to fund public-interest driven innovation. Investment in the processes, capacities and infrastructures to move from idea to use is argued to be inadequate [KI5, 2021]. For example, while Tanzania has multiple institutions and a strong research base for health innovation, it is observed to lack "investment in scientific infrastructure and its maintenance, lack of early stage proof of concept funding and venture capital, and incentives for investments in R&D and its translation for the private sector" [289].

Academic discourse also cautions that commercial/market activity and influence in the health sector impacts negatively on health inequalities and the right to health, with evidence that while a profit-driven model may broaden access for middle and upper classes, it undermines access in lower income groups, and raises financial barriers for poor women and children [236; 252; 254; 296]. There is debate in Mozambique on the "public-private balance" [282] and concerns in East Africa of "… our best public health infrastructure (being) foreign owned" [225] and of an active state promotion of PPPs providing a "cash bonanza for the private sector" [236].

The COVID-19 pandemic is argued to have exacerbated negative impacts, such food stress in West Africa [222], but also to have opened new thinking, such as on greater local trade in food, on the use of digital health technologies, and on "rewriting monetary policy to protect their citizens", as high income countries have done [222; 257; 304]. The challenges posed by CDoH are seen to call for more policy coherence and accountability through multi-sectoral action and effective scrutiny before investments are made, including by civil society (Hellowell, 2019; Buse and Waxman, 2001; Delobelle, 2019). Academic voices note that a robust civil society can reframe issues and "produce compelling moral arguments for action, build coalitions beyond the health sector, introduce novel policy alternatives and enhance accountability systems in mitigating the commercial determinants of health and ensuring rights-based approaches", particularly as states become more aware of the demand to respond to electorate needs and involve more informed societies [247; 290]. For example, in Kenya, Mureithi describes how over 230 000 Kenyans have signed a petition for IMF to cancel a debt financing arrangement that they perceive as inequitable [276].

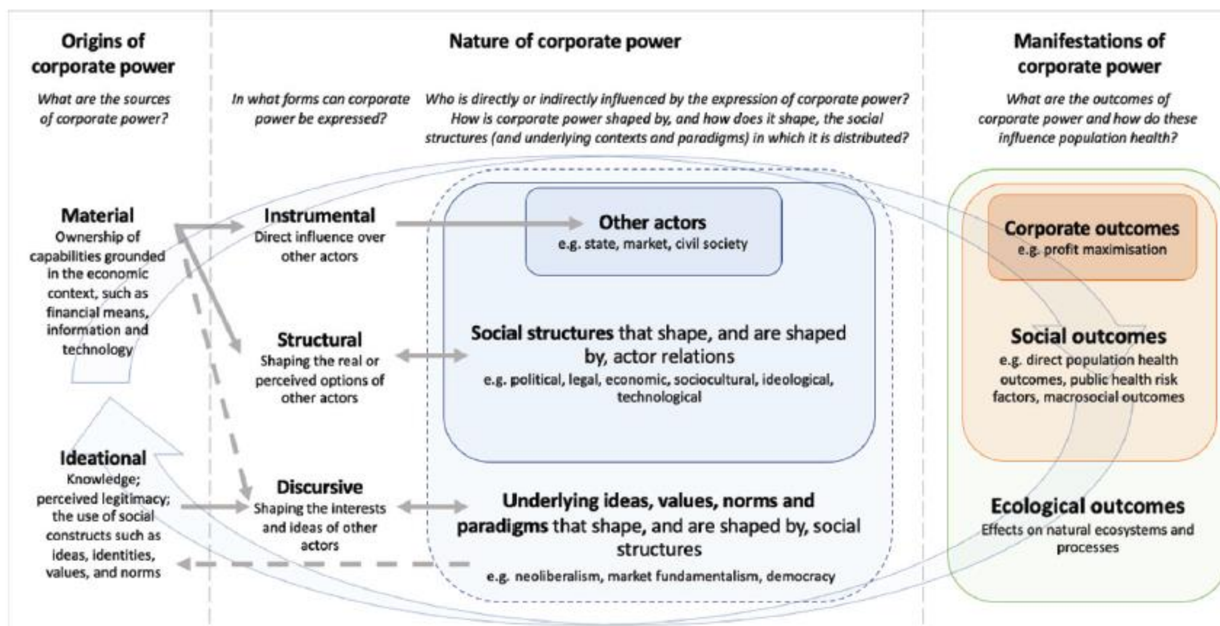
Within these different debates, and with examples that space doesn't permit elaborating, academic papers describe how corporate marketing, policy lobbying and framing of narratives powerfully influence norms, narratives and policies. Beyond advertising, commercial actors are noted to make policy-makers shareholders of companies; sponsor sports events and conferences; use messages on packaging that imply untested health benefits; provide scholarships, facilities for extra-curricular activities and stationery gifts to connect to school personnel and young people; hold public relations campaigns; bribe officials, and to raise trade disputes or litigate against regulatory controls [217; 226; 242; 253; 263; 270; 273; 293; 294; 303]. Lee et al. observe in relation to sponsorship and targeted marketing of tobacco that "many of these strategies are now illegal or severely restricted in high-income countries" [263]. The commercial influence acquired in these strategies is observed to divert attention from CDoH and their deeper causes, and thus undermine effective action. Obeng-Odoom, comments, for example, that "an emphasis on weak health systems hides all the health consequences of activities of transnational companies", including on decent work, public housing, land, nature and sovereignty [278]. Such 'policy capture' is argued to divert resources from essential public services towards corporations, to undermine local business and SMEs in a TNC dominated market, with land 'grabs' that undermine indigenous territorial rights raising a risk of zoonotic spillover, and an undervaluing of work, caring, and education roles played by women widening gender inequalities [222; 229; 245; 251; 253; 271; 281; 306].

A number of academic voices point to neocolonial and neoliberal drivers of these features of commercial practice and policy influence in SSA. Some note that beyond specific risks and practices noted in earlier paragraphs, "it is the dominant neoliberal policy paradigm that continues to enable the ability of these interests to influence public policy" [264],and that this undermines government efforts to regulate harmful practice [238; 288; 294; 303]. A 'rollback' regime of cuts to public services, wages and regulation in the 1980s' and 1990s' and a 'roll-out' regime of private investment in commercialized services as a response to the gaps resulting from the rollback are both associated with a neoliberal globalisation [291], leading to a "detrimental relationship between structural adjustment and child health outcomes" [296], and a situation that led Dr. Ivo Garrido, former Mozambique Minister of Health, in a comment on funding for the health sector to

note: "There are no Ministries of Finance in Africa, there is just the IMF" [282]. Liberalized trade and investment and deregulation at global level are linked to the corporate consolidation over global and domestic food chains and market expansion of powerful monopolies that underlie the processed food, tobacco, alcohol, pandemic and other risks noted earlier [235; 255; 271; 288; 294], and to environmental degradation and climate emergencies, that Obeng-Odoom states are "not so much of the Anthropocene, but of the capitalocene and its grotesque growthism" [278].

International commitments are seen to help SSA states and societies to confront these pressures. However, they face opposing action from TNCs, from global marketing, and from private consultants in bilateral agencies, within "asymmetries of power" between corporate and public sector influence, and between north and south in global policy [214; 232; 265; 288; 303]. Mwacalimba and Green observe that the underlying trade and economic causes of disease outbreaks are marginalized in international debates, "exacerbated by western anxieties around globalization" [258]. This results in "a dichotomous containment strategy casting the global North as being 'at-risk' from 'at-source' outbreak areas, including in Africa". Milsom et al. identify that corporates use the international trade regime to prevent policy action, or "promote policy non-decisions" on NCDs, to ensure that the "dominant understanding of NCD causation is kept congruent with neoliberal assumptions" [274]. Notwithstanding recognition of the upstream determinants by authoritative political and scientific institutions, policy decisions thus still " 'drift' downstream to those safely within these narrow boundaries". There is an expectation that WHO stand for health rights in these debates, and a concern that its reforms and funding challenges have weakened its role in doing so [232].

More so than other actors, academic voices analyse the power asymmetries between public and commercial actors that affect democracy, transparency and the protection of public interests in health and that enable commercial influence [227; 280; 301; 306]. Wood et al. observe that "there is increasing recognition that power imbalances that favour corporations, especially those active in unhealthy commodity industries, over other actors are central to the ways in which corporations influence population health" [306]. They suggest that greater attention be given to an analysis of power, presenting a framework (reproduced below) that explores the origins / sources of corporate power, including material and ideational sources; its instrumental, structural and discursive nature, and range of corporate, social and ecological manifestations, whether firm-specific, such as in costs externalized, to wider gains in market concentration, prices, wages and working conditions.



Source: [306:7]

Transforming existing power relations that drive health policy is argued to require "the development and adoption of a new [development] paradigm with public interest and sustainability values and goals" [274]. The COVID-19 pandemic and climate crisis are suggested to offer a rare window of opportunity for this.

3.2 Overall findings on priorities and actions

Table 3.2.1 briefly summarises the common priorities and areas of action on CDoH identified by the different actors. This table is drawn from detailed information on priorities and actions drawn from content analysis of the publications sourced, presented with relevant citations in *Appendix 1*. Both tables reflect voice of the category of actor indicated. These tables do not repeat what has already been raised by actors as key areas and concerns in *Section 3.1*. The findings on the discourses, priorities and actions raised in *Section 3* are discussed in *Section 4.*

Table 3.2.1: Key / prioritised key domains and forms of action of CDoH identified by actor

Actor	Key priorities	Areas for action
International/ global actors involved in SSA	Health rights and standards, zoonoses, antimicrobials, social protection, health services, pollution, water and climate, linked to UHC and SDGs	*Internationally:* UN rights, multilateral agreements and voluntary standards on rights and corporate duties. Supporting fiscal space, debt financing; IP sharing, technology transfer *By states:* Regulation and financing of public capacities. Setting incentives, guarantees to encourage private investment *South-south* multilateral engagement
SSA continental and regional organisations	Health rights in commercial activity (food, WASH, public sector services); harmful commodities, alcohol, tobacco; processed food, linked also to urbanization agribusiness; extractives and ecological degradation. As beneficial areas: technology, ICT, R&D, supply chain resilience. TRIPS flexibilities and Waiver.	*Regionally:* Trade, debt and investment agreements/ relief; Support for SMEs, diversified production, local food systems, sustainable use of water and natural resources. Regional integration for regulatory harmonization. Curbing illicit financial outflows. In the health sector- support for standard setting, R&D, infrastructure funding and regulatory reforms. *By states:* Domesticating international standards in national law; regulating controls, strengthened law enforcement, health impact assessment (HIA), health promotion, monitoring and information systems; negotiation capacities and measures to secure land rights of local communities. Tax and pricing measures to control harms, incentives for desired practices.
SSA govern-ments	Control of NCDs from commercial activity (food, WASH, alcohol, tobacco, public sector services), linked to urbanization, agribusiness; extractives, ecological degradation and biosecurity. Private actor roles in PHC	*By states:* Regulation, standard and policy setting, controlling production, manufacture, sale, advertising, promotion, and use of harmful products. Registering, accrediting and ensuring quality control of private and public health services. Aligning sectors in One Health, overcoming information/evidence gaps on health impacts, with integrated information systems, monitoring of private actors. Exerting influence through tax, pricing measures and using these funds for health promotion.
Banks and Investors, operating in SSA	Mainly positive (eg health technology), a few negative (eg pollution), and health benefit post COVID in health commodities, essential equipment; facilities, services (low-cost models). and health security	*By investors:* Tapping market opportunities in health sector tech-enabled services, skilled personnel, distribution and retail systems, medical supply production, R&D, digital systems and climate adaptation. Bridging businesses with investment funds. *By states*: Setting conditions, fiscal/financial measures to enable investments - IPR protection, procurement transparency, cost efficiency. Support for medical research, supply chains. Linking public and private finance; Ensuring that regulation does not dis-incentivise foreign investment.
Private-for-profit business in SSA	Areas of beneficial impact, ie vitamin-fortified food, IT, medical equipment, health service/ technology innovation, business skills	*By businesses:* Assessing opportunities, risk profiles, models. Building alliances with domestic business and policy actors. *By states:* Laws, infrastructures to enable ease of business, innovation, private financing, PPPs, and trust with business. *By investors:* Credit and catalytic funding for proof of concept. Credit funds to help private health facilities, pooling with pension /public funds for concessional funding
Civil society in SSA	Harmful ultra-processed foods , agribusiness, extractives; commodified essential services, especially health services undermining right to health	*By civil society:* Coalition action exposing, tracking, driving accountability on harms, information disclosure, reporting rights violations, ecology/health damage; and on economic, corporate, tax, debt, ODA/investment policies/ practices underlying harms. Monitoring, litigation, accountability reporting on state duties and corporate influence in policy, *By states*: Regulation, resourcing public health sectors, information disclosure; meeting rights, legal commitments

Actor	Key priorities	Areas for action
Academia	Harmful processed food; alcohol, tobacco, production hazards/pollution; agri-business, extractives externalizing risks to local economies, ecologies. Benefits in R&D, expertise, technology, IT	*By investors*: Investment in local scientific infrastructure, proof of concept funding. Integration of PHC in UHC funding *By states*: Binding regulation; monitoring, negotiating on risks, labour and product standards; fiscal, tax measures on risks; co-financing to encourage investment in benefits; integrating health in trade, investment agreements *By academia, states, civil society*: Organizing evidence, monitoring, information systems, ensuring disclosure.

4. Similarities and differences across actors and ideas

4.1 In the framings and priorities by different actors in SSA

While specific areas of commonality or difference between the different actors are indicated in *Section 3*, three major domains of discourse and priorities emerge that are discussed in this section, viz, the role of human rights, the economic and development paradigm informing discourse and in relation to the health sector itself.

The first area is in relation to the **discourse on human rights in relation to CDOH**. The rights discourse is most strongly articulated by civil society in SSA, linking social rights to issues of state duties and socio-economic justice within countries and internationally, including rights to protection of traditional knowledge and biodiversity; to information, prior informed consent in economic activities and to participation in decisions. Civil society links the expanding power of commercial entities in areas harmful to health to states relinquishing their obligations, such as by offering TNCs exemptions on laws or taxes, allowing profit shifting or ignoring breaches of environmental, labour and social rights. In contrast, many businesses and funders see – and some explicitly state - rights claims to be a barrier to their economic activity. They prefer voluntary or 'responsibility' approaches, even while using liberal freedom of choice rights, in marketing practices.

While some private actors within the region argue for harmonized laws, standards and for infrastructures for ease of business practice, civil society and private business/investors largely represent polar opposite views on the role of rights in managing CDoH. Within this, the position of international and regional agencies and states on rights is both important, and variable.
On the one hand there is common support internationally (particularly in the UNCHR, ILO, WHO, UN Habitat, FAO) and even more strongly at continental level through the ACHPR, on duties to control commercial activity that is harmful to health and that generates inequity in access to health care, food, water, safe cities, decent work and other conditions for health. SSA governments do not make specific reference to 'rights' language, but implicitly recognize this in common reference to regulating hazardous products, work, and market practices and to ensure quality and safety of services. Enabling this, international and regional institutions and academia refer to domestication of relevant international rights treaties and standards in domestic law, and setting harmonized, mutually recognized standards within SSA regional economic communities.

However, some states, international and regional agencies, and particularly those in economic spheres, hold a contrasting view, seeking rather to promote voluntary codes and state measures to persuade or incentivize 'good business practice', rather than enforcing it by law. They argue that the private sector contribution is essential for achieving SDGs and UHC, and focus more on leveraging beneficial impacts for health from corporates. Contrasting messages from international and continental actors around protection of health rights create uncertainty, and potentially give TNCs and corporates latitude to block regulation, within countries, regionally and at global level.

In a context of mixed messaging, the evidence suggests that SSA states navigating negotiations and regulation with powerful TNCs, and weakened by trade rules and global dispute settlement procedures, may choose less conflictual paths with corporates and economic sectors. Academic voices identify this as a deficit in policy coherence from local to global level. The findings suggest that these choices are generating distrust between civil society and states, with more common reference to conflictual than alliance action between them, and of civil society protest, litigation and

shadow reporting to claim rights and question the legitimacy of commercial *and* state practices. However, these tensions are seen as counterproductive when the continent needs to mobilise processes within and outside formal negotiations to advance positions grounded in equity, collective responsibility and community wellbeing in global platforms, such as in the CBD negotiations noted earlier [KI3, 2021].

A second area where views and priorities differ between actors is in **how CDoH relate to overall economic and development paradigms**. Here too, the widest divergence in expressed views is between civil society and corporates or investors. Corporates express no harms at all in their activities, and in contrast, identify the benefit from their products, such as vitamin-fortified food or medical technology, and their economic activity, such as on digital connectivity or health service models. Where harms arise, investors note these to be due to wider underdevelopment, not corporate activities. Civil society, a number of continental/sub-regional organisations and much academic literature, in contrast, raise multiple areas of harm to health from commercial commodities, practices and market policies in SSA, in often interconnected extractive, agri-business practices and systems and in urbanisation, in the depletion and diversion of natural and public resources away from sustainable environments and locally appropriate solutions, in the primary focus given to profit-making over social and ecological wellbeing and in distortions to public services. Much civil society effort thus focuses on making harms visible and raising advocacy on their drivers, to challenge the externalisation of these harms in corporate practice.

All actors see wider development conditions as relevant, but differently. Corporates and investors largely see under-development and the infrastructure, communication and related development conditions as important to enable commercial practice in health. A view of SSA as under-developed positions the continent as fertile ground for market opportunities and commercial operations, with primary concerns being to increase 'penetration efficiency and decrease risk'. Civil society in contrast identifies neoliberalism and market deregulation as setting the foundation for monopoly business practices, resource depletion, financial outflows, loss of tax revenue, legal deficits and state weaknesses that they associate with many CDoH. While some academics point to potential benefits from commercial activity in investments, R&D, technology and business services, these actors too more commonly raise the liberalized trade and investment, deregulation, global corporate consolidation and expansion of powerful monopolies associated with a neoliberal globalization as generating risks associated with commercial practice. From within SSA, there has thus been a call for greater investment in local R&D and production of health-related technologies, and also for harmonisation of tax policies in the region to avoid a 'race to the bottom' in attracting investment [KI4; KI5; KI9, 2021]. There has been a more critical discourse, including at high political level and from finance ministers of a global architecture that does not serve or is accountable to SSA policy goals, including in areas that affect health [KI9, 2021]. These pressures attributed to neoliberalism, point to modes of production and consumption, or commercial ecosystems, that preference capital accumulation over social and ecological wellbeing.

Here too there is a mixed discourse between other actors: International / global agencies raise challenges to global sustainable development and climate goals in SSA that commercial activities are contributing to, including zoonotic diseases, pollution, microbial resistance and deficits in social protection. However, they also see markets playing a key role in infrastructure, investment, technology and other inputs to these same goals. SSA continental and regional actors similarly link commercial and extractive activities to pollution, obesogenic environments, food insecurity and ecological degradation. However, they too point to opportunities to lever beneficial synergies for health from corporates, particularly in terms of technology innovations, ICT, and R&D. SSA governments, particularly health ministries, articulate stronger concerns than international and continental actors on risks from commercial activity, particularly in terms of the consequences in an increasing burden of NCDs that their health services have to deal with. They propose multi-sectoral, One Health approaches, participatory HIAs, financial and regulatory measures and more comprehensive, updated public health laws and strengthened inspectorates to tackle these risks and NCDs. Some SSA governments, however, argue that poverty is the greatest risk to health, and that these direct health risks from commercial activity are over-shadowed by the positive impact of business and investment activity on poverty reduction, and thus on ill-health.

Food systems exemplify of these different lenses on commercial interests. One example is in relation to sugar as food and biofuel. On the one hand, TNC mono-cropping of sugar cane for biofuels has been encouraged from highest political levels in some SSA countries, with corporate land acquisition ('grabs') displacing or shifting food producers towards contract sugar farming for TNCs. For many small farmers, this has led to precarious incomes, indebtedness, and loss of land and access to health services [268]. While some farmers have pursued land rights in court action [199] others have migrated to urban areas, swelling numbers exposed to urban fast-food markets [KI1, 2021]. In relation to sugar consumption, business influence, limited policy recognition of over-consumption of sugar as a factor in NCDs and policy inconsistency between economic and health objectives have led to few or limited taxes targeting sugar content [219; 275]. In a contrasting engagement on sugar, Mauritius, despite being a sugar producer, has applied excise taxes on sugar content of sugar sweetened non-alcoholic beverages, given the impact on NCDs, doubling this tax in 2020 and extending it to imported, non-staple sweetened products [113; KI1, 2021].

More broadly on food systems, African technical actors, highlighting biosafety risks and failures in genetically modified (GM) seed and the biodiversity losses and pandemic risks from mono-cropping, have warned against succumbing to pressures to adopt novel GM techniques in food systems and to undermining local seed and food production [53; 54; KI3, 2021]. Even more explicitly, at the 2021 UN Food Systems Summit, African civil society rejected a 'Green Revolution' model, extractive mono-cropping and 'corporate hegemony of food systems', citing their destructive health, ecological and socio-economic impacts [175].

These divergent positions reflect significant differences in the political economy paradigm driving policy. Some see liberalised trade, capital accumulation and enhanced global integration as essential for multiple areas of economic activity, with indirect but ultimate benefit for health and ecological wellbeing, notwithstanding transitional harms. Others critique this model as generating poverty, inequality, public sector decline and degradation of natural resources, undermining health, both in the immediate and in the long term. They call for health (and ecology) issues to be internalised in standards, investments, and practices at all levels. This critique is not limited to civil society or academia. Some SSA continental and business voices also raise concern over how liberalised trade and TNC monopolies are crowding out SMEs, local benefit and local production, and see investing in domestic enterprise and small scale farmers as more critical for improved health and poverty –reduction. A focus on CDoH inherently opens a deeper debate on these political economy paradigms, evident in this divergence of discourse. It implies choices on whether to focus on health protections within current economic policies or whether health, together with other socio-economic and ecological challenges, motivates more radical thinking on development. Commercial interests and power are influential CDoH in these policy debates, as discussed later.

A third major area of converging or conflicting discourse is in the **contribution of (or harms from) commercial activity in the health sector itself**. All actors state commitments to UHC, but with different understandings of what this implies. For civil society, numerous academic voices and as stated by WHO, UHC depends on quality, accessible *public sector* health services, and there is caution that commercial involvement will undermine equity and universalism in health systems. These actors point to the manner in which market demands weaken financial protection and drive inequity in access to services; segmenting risk and income pools and services and diverting personnel and resources. Private-for-profit services are observed to focus on more profitable personal care, biomedical, hospital services, leaving deficits in comprehensive PHC, population and public health approaches, despite these being rights and essential for health improvement.

These concerns are raised explicitly by the ACHPR, and more conditionally by SSA governments and some continental actors, who express a role for private sectors to 'complement' and not substitute public sectors to achieve UHC. These SSA actors raise similar concerns to those above, and particularly the implications for a maldistribution of health personnel, services and funding towards richer, urban communities, leaving poor majorities underserved. Continental, sub-regional and state actors view state regulation, oversight, information and mutual accountability between states and private actors as necessary to avoid negative consequences or to leverage beneficial impact from private actors in health services, but also note challenges in power, resource, capacity imbalances and information flows between states and large private actors. A divergence of policy views within state sectors also affects efforts to manage these risks in practice.

In this regard, there is a growing and countervailing discourse, particularly from business and investors, but also from some international and continental actors, proposing that private sector engagement and involvement is essential to attain UHC and to 'modernise' the health sector, particularly to meet funding gaps for UHC. This is reinforced by global actors such as the World Bank, whose 'Maximizing Finance for Development strategy', launched with the SDGs "… insists that nothing should be publicly financed if it can be commercially financed in a sustainable way" [221]. Commercial actors are argued to bring technology and digital innovation, investment in production of health technologies, expertise and business models that improve quality and extend service outreach. In what is argued to be a 'win-win', this is argued to yield economic return for both countries and enterprises. The COVID-19 pandemic, the under-resourcing and weakness of health services it has exposed and demands for improved health security appear to have intensified this discourse, with an expectation that states will lever private contributions by incentivizing private sectors and facilitating PPPs.

Diverse SSA actors raise cautions, however, on inequities in the distribution of costs and benefits and challenges in expanding private markets in health services, including as PPPs. As noted earlier, SSA investors, such as the ADB, raise a need to identify "how effectively resources can be deployed to respond to equitable care for the poorest segments of society", with private investor success measured not only by performance "but also by its ability to cultivate businesses serving the poor". In health technology development, SSA businesses have raised concerns about being 'crowded out' and 'put at the back of the queue' in the current global economy. There appears to be a potential convergence of interests between SSA domestic actors, including local producers, to build shared approaches and policy demands arounds health services and technologies to manage these tensions, and to engage from an African lens in global processes. This has already been visible in the coalition across domestic business, governments, academia and civil society in SSA around the TRIPS Waiver and local production of medicines, vaccines and diagnostics.

4.2 Tensions/synergies between commercial and public health objectives

The findings in *Section 3* suggest some areas of tension and potential synergy between commercial and public health objectives in SSA, due to their different value systems, impact on health, healthcare models, governance and power.

There are **different values applying in commercial markets and public health activities**. The collective, social and economic rights framings in public health, the expectation of equity, redistributive justice, transparency, informed participation; the duties to do no harm to health that apply to all, including corporate entities, and the precautionary principle that implies protection of public health in the face of uncertainty, are all raised in various ways in the discourses. So too is the protection of health as a public good [KI9, 2021]. These values contrast with the liberal, individual freedoms and demand for economic return, profit and value for money goals in commercial market activity. While some discourse refers to these as different 'motives', they are in fact deeper than motivations, and relate to the different value systems and principles that govern these different fields. In a market lens, for example, health risks can be financialized and externalized or built into profit-loss equations, such as in 'polluter pays' options, while from a public health lens, risks that undermine the right to life and health must be controlled.

There is an **apparent synergy noted in the production of commodities that contribute to health**, particularly when produced in a manner that does not externalise health costs or generate ecological damage and unhealthy forms of consumption. This makes food and health technologies a focus of attention for many actors, for example, and one that exposes the **tensions even in the production of potentially health promoting commodities**. For example, as earlier noted, commercial actors see opportunity in urban demands for fast and processed foods, and in genetically modified foods. Public health actors raise the risks of these practices for NCDs and malnutrition, and the loss of locally produced food crops and seed stocks, smallholder incomes and local markets, all of which undermine health and biodiversity, connecting these outcomes to labour, tax, trade, marketing and pricing policies that favour commercial over health objectives. There are also **tensions between commercial and public health goals in the model of health care adopted.** Private sector health services and PPPs are noted to favour biomedical, personal and hospital care, and to avoid ('risk-skim' away) less financially cost-effective population health, PHC and cross-sectoral interventions that reach lower-income communities. These are left for

public sector and not-for-profit actors to invest in. Yet public health actors note integrated PHC systems, prevention and health promotion, and 'One health' approaches as essential to manage key health burdens and for equity and universalism.

Hence while commitments to health are stated across all actors, on the one hand, and private sector roles in SSA encouraged on the other, the interaction of these two domains reveal their contrasting value systems. This has been raised earlier in whether rights to health are viewed as obligations or expectations, what legal systems take precedence when there is conflict between public health and commercial interests, such as in IP debates, or in the risk of regulatory controls TNC practices that are harmful to health unleashing disputes over trade rules. It is evident in business perceptions of risks to profits from demands for decent work or land rights, or indeed in the adoption by states of health care as a right. While many actors observe potential for synergies of interest in commercial practices that promote health, such as in the production of health technologies or IT, these competing values still exist and need to be explicitly addressed in negotiations between health and commercial interests, while also recognizing the influence of paradigm, power and politics in the outcomes of such negotiations.

The paradigmatic tensions between commercial and public health objectives are also reflected in **governance and implementation issues** [284]. SSA actors note that the multi-sectoral action needed to manage CDoH calls for alignment of priorities and co-ordination across government for, as for example articulated in comprehensive PHC and in 'health in all policy' (HiAP) approaches. However, there is also an observation of weak policy coherence across government sectors in areas relating to CDoH, and in regulation and tax measures. How differences are resolved in policy decisions and their implementation is seen to be affected in part by evidence, and more by the relative power of public health and commercial actors and the exclusion of key public-interest civil society actors from policy platforms [KI2, 2021]. The relative power depends also on the rules and procedural systems governing policy processes, such as in the duties for information sharing and disclosure, as well as on the level of public capacities and prevention and disclosure of conflicts of interest in state/government involvement with industry. Policy setting on CDoH is thus a fluid space that merits attention, particularly given concerns raised earlier by SSA civil society that policy decision-making has become dominated by powerful interests, "while the voices of those most affected…are regularly tokenised or excluded from the conversation".

The COVID-19 pandemic appears to have had an impact on the interaction between public health and commercial objectives. On the one hand it has raised the profile of and co-operation with commercial actors as positive contributors to technologies and digital measures seen as critical for health security. On the other hand, liberalised commercial trade is argued to have exacerbated pandemic harms, such as food stress in West Africa during border closures. An emergency framing is seen to have enabled a bypassing of procedures and policy processes and to have driven more investment in biomedical health security approaches, overshadowing needs for wider public health promotion, prevention and social protection and action on the systemic roots of pandemics [53; KI5, 2021). The longer term impact of COVID-19 is still unfolding in SSA, including through conditions applied to debt relief and economic support. It has, however, also opened new dialogue on economic models, trade and IP rules and monetary policy and has raised the profile of public health for economic and political actors and the public. While this may open opportunities for a shift in values, rights, health approaches, and in economic thinking, it may also do the opposite, further deepening tensions between commercial and public health objectives.

A key aspect of how these tensions or potential synergies are resolved lies in the **power asymmetry between public health and commercial interests**. Many of the factors that affect the levels of power different actors bring to policy and practice are noted in this paper. They relate to the evidence, arguments and practices used to promote one lens or the other, and the level of public, social, political and policy uptake of the different narratives and ideas. The paper points to a range of instrumental and institutional measures used to influence policy that derive from or reinforce the power of different actors, as do the material resources and structural paradigms discussed earlier that are brought to bear in decisions. This is further discussed in the next section.

5. Discussion

5.1 Overall analysis

There appears to be no widely accepted definition of CDoH in SSA. The discourses refer to commercial products, processes and underlying policy conditions affecting health, competing or conflicting interests, inherent tensions and some synergies between commercial and public health objectives, and power asymmetries in the interaction. Within SSA there is a need to consider the spectrum of formal and SME/Informal economic actors. There is also an important additional lens of how global dimensions of these issues and interests relate to those within the continent and countries, particularly given corporate roles in colonial and post-colonial policies, in extractive activities and the impact of global rule systems and financing on CDoH and the policy latitude and local power to address them. There is common reference to engagement with global platforms and rules systems that are set beyond the continent, but have deep influence on CDoH in SSA.

The paper raises many driving factors and interventions in relation to these areas of CDoH. Resonant with the recommendation of the WHO Commission on the Social Determinants of Health [7], tackling inequitable distribution of power is identified as essential to address CDoH. As a dynamic analysis, Farnsworth and Holden propose a power analysis to help frame strategic thinking on this interaction of different interests, with power increased through mechanisms of agential power (active interventions) and structural power (actions undertaken by governments and advocated by influential bodies) [243]. Hathaway adds the element of discursive power (rarely questioned ideas and narratives)[249]. We use these categories of power to locate the debates and measures on CDoH raised in this paper. Lacy-Nichols and Marten in a similarly structured power analysis of CDoH point to how a power analysis can identify levers, such as reputational and legitimacy concerns, that can be used by public health advocates [262]. In this paper, beyond analysis of areas of commercial power, we draw on the evidence found to explore the countervailing power levers that can be and are used to advance public health objectives.

Corporate agential power is applied when businesses enter new or contested markets and need to shape debates and influence decision-making. This includes the political engagement, coalition building, information management, sponsorship and welfare-related interventions described in our findings, supported by investors and international agencies. Corporate discursive power manifests in narratives that ‘private is best’ and public sectors ‘failing, that private sector innovations result in better and more affordable health care, on individual freedom of choice on products or practices, or that controls on businesses can lead to wide adverse social and economic consequences. Commercial structural power centres on corporate freedoms to do business, unregulated, ‘derisked’ and in their own models and areas of preference. It is supported by state decisions that are “framed by the imperative to induce companies to invest” and by national and global processes that legitimise corporate roles and ensure enabling environments for commercial activity in health [243]. Structural power reduces commercial actors’ need to more actively seek and negotiate policy influence through discursive and agential effort.

All three forms of corporate power are being engaged with in SSA in health and commercial actors are viewed as more agile and proactive in doing so than states [KI1, 2021]. While labour markets have longstanding and legally defined tripartite procedures and capacities to reach binding agreements between actors, the platforms related to health are viewed as more ad hoc and the consultation as more tokenistic [KI2, 2021]. The health security demands of the COVID-19 pandemic, the reality of underfunded public sectors in health, declining public health infrastructures and poor social protection, and a dominant neoliberal global paradigm and practice setting the context for decision making all appear from the evidence to have strengthened the structural and discursive power of commercial interests, to the cost of key public health objectives and outcomes.

The question this raises, beyond an academic understanding of the different forms of power, is how to engage with these power levers to proactively advance public health objectives in engaging on CDoH, including to support proactive public leadership on CDoH?

There were numerous examples in SSA of actors challenging narratives that weaken public health and building their own *discursive power*. This was evident, for example, in evidence exposing

harmful practices, making clear the central role of public sector systems in UHC, or showing the benefit from local food production systems for both health and biodiversity. Putting pollution monitors in the hands of citizen scientists was noted by KIs, to build both awareness and demand around drivers of air pollution [KI2; KI6, 2021]. The demand for information systems that monitor and cover commercial actors, and implementation and public reporting of health impact assessments (HIAs) of commercial processes and projects are further examples of practice that is perceived to be important to institutionalise evidence for public health narratives. Proactive forms of health promotion, such as of healthy foods, and participatory, consultative public health approaches are raised as counter-measures to narratives promoting harmful practices, particularly when backed by relevant enforced controls on marketing, labelling and false messaging.

The findings showed a number of ways of exercising *agential power* for public health, such as in regulating alcohol and tobacco company sponsorships, or disclosing state official inclusion on corporate boards or other conflicts of interest. There are also more affirmative forms of agential power promoting public health in SSA. As envisioned in PHC approaches adopted in policy by many SSA countries, agential power is built by the active measures taken by the state to meet Abuja public funding commitments, to pool adequate funding and to provide accessible, affordable quality universal *public sector* health services accessible to communities. Public health agential power also results from investments in key areas of health that are visible to and matter to the public, like reliable safe water and waste management, penalties and actions on polluting industries that harm community wellbeing, and promotion of affordable healthy foods, urban transport systems, and schools. The findings point to the role of informed alliances and involvement of communities and civil society in processes involving corporates, such as in the prior informed consent demands and the monitoring and review of extractive industries and PPPs, or negotiations on internalizing social protection in corporate policies [KI2, 2021]. Indeed the disconnect and distrust between states and civil society and the marginalization voiced by local producers in the findings suggests a current loss in agential power by not bringing these groups together around shared public health goals.

For public health actors to intervene at the level of the *structural power* that underlies and moderates or enables these other forms of power implies engaging economic policies and rules systems (local to global) that weaken the policy coherence, policy spaces, and capacities to claim, protect and promote rights to health and public health within commercial practice, or to advance production and consumption alternatives that align better to health objectives. The findings showed the resistance from TNCs and some economic sectors to the regulation, tax, pricing and policy tools that lie within the power of states to promote public health, and the pressures imposed on states to adopt PPPs and other market practices, given weakened public sectors. However, a more affirmative use of structural power to promote public health is also apparent in the findings. It is evident in the use of international and continental rights and standards such as the FCTC, or the ACHPR and national constitutional and legal provisions to support national state action in these areas. It is expressed in locally negotiated agreements arounds decent work [KI2, 2021] through to the negotiation of harmonised standards in regional communities, and the role of alliances and co-operation in pooling capacities, evidence and experience. There is evidence in SSA of challenge to economic paradigms - many a continuation of colonial and neo-colonial policies - that undermine policy latitude, constrain local producers or generate inequalities, ecological damage and negative health outcomes. There is some evidence of a potential for stronger connections on these issues between states, domestic producers, civil society and academia. Continental and south-south alliances are argued to bring greater voice to low- and middle-income countries in global platforms, particularly as multiple centres of power emerge on these issues [5]. The AU CDC has for example played a key role in engaging commercial actors on health security, including on access to health technologies, and has brought capacities ‘closer to the field’ [KI8, 2021]. Continental co-operation has played a role in the actions on vaccine equity and the TRIPS Waiver, as well as in alliances across actors on extractives, food systems, biodiversity and other areas.

5.2 Implications for SSA

Expanding interest and activity in SSA of commercial activities that have health impact highlight the need for a more comprehensive focus on CDoH in the continent. While there appears to be no shared definition of CDoH in SSA, beyond a focus on different levels and forms of for-profit private

sector activities that impact on health, common attention to global commercial drivers and influences in SSA suggest this needs to be factored into frameworks.

Tobacco and alcohol as harmful products; the health impact of extractive activities and urbanization; health services and health commodities as areas of increasing commercialization; and the commercial drivers of NCDs are commonly noted as areas for policy attention in SSA. These and other CDoH all imply giving more focus to prevention, health promotion and public health literacy in SSA, including in areas of technology innovation and data systems [KI5; KI7, 2021]. The findings and KI interviews point to food systems as needing particular policy attention [KI1; KI5; KI8, 2021]. Commercial drivers of rising NCDs, undernutrition, food insecurity and poor quality diets need to be understood and acted on, whether in terms of urban obesogenic environments from ultra-processed foods, concerns around genetically modified seed and foods, or the liberalized food markets, land use for mono-cropping of biofuels or export crops and other processes displacing locally produced food and undermining rural food producers. A food systems lens could engage a number of actors in SSA on CDoH, including and going beyond individual products or processes, to address underlying policies and practices and the multiple actors, sectors, policies and rules systems needed, within countries, and at global level.

While the evidence suggests diverse, sometimes conflicting views on these issues in SSA, many actors had shared concerns about ensuring equity, protection of public interests and revenues, public and private duties, multi-sectoral co-ordination and the need to strengthen local production and wellbeing. This suggests opportunities to bring different actors together for dialogue, understanding and action on CDoH within countries, regionally and from the region and the Africa Group of diplomats in Geneva and New York, to bring a SSA lens in global engagement. This sub-section of the paper suggests some domains of action to support this.

The evidence to inform action on CDoH appeared to be largely ad hoc, with weaknesses and fragmentation in public monitoring and information systems and in the coverage and public reporting of private sector activity, including on financial flows and health impacts. Cross-disciplinary and citizen science participatory research on CDoH can provide useful evidence to build joint policy advocacy across health actors, particularly where policy objectives differ between economic and health actors. Information gaps point also to a need to strengthen surveillance and routine information systems across public sectors, to ensure private sector reporting, transparency and accountability on information, and to use monitoring to widen public, official and policy awareness of health impacts from CDOH [KI7; KI9, 2021]. One option is to institutionalise HIA in law and practice for licensing and monitoring of commercial activities and processes, with HIAs including of affected communities, covering equity and the full value chains of commercial activities and / or district-wide assessment of impacts. The evidence points also to the importance of improved evidence on international corporate tax flows and investment funding; and strengthened measures for information disclosure and public domain reporting of financial flows. Several KIs noted the importance of information reaching the public, to build health literacy, including through media, and of strengthened relations between civil society and states, given the key role civil society plays in bringing evidence, promoting public health demand, tracking public commitments such as the Abuja commitment and countering a narrative that those limiting commercial risks are 'enemies of development' [KI1; KI2; KI5; KI6; KI8; KI9, 2021].

Protecting rights and regulation were commonly viewed as key measures: to set standards related to CDoH, fiscal duties, excise tax measures on harmful products and duties to control harmful practice; to align investments and services to policy goals; to ensure information disclosure and so on. This is a contested area, but there is scope for action on regulation. This includes updating ageing public health laws to cover rights, duties and measures related to CDoH, to ensure the general role of all actors, including commercial actors, to prevent harm to health; and to domesticate relevant international rights and standards. It implies making better use of institutions with inspection powers to monitor commercial activities [KI8, 2021], and parliaments to monitor budgets and oversee the implementation of rights, laws and commitments such as the Abuja commitment [KI9, 2021]. Harmonising standards in sub-regions is seen to be an area for development, particularly working with 'early-adopter' countries [KI1; KI2; KI7, 2021]. Regulation is perceived to improve opportunities for local producers of safe products, or to ensure ethical practice related to the application of new technologies [KI2; KI7, 2021]. While there are

implementation challenges, it acts as a foundation for many measures and actions on CDoH, and as a lever to clarify and progressively realise the roles, resources and institutional mechanisms needed to implement standards. In areas of high TNC activity, such as extractives, it also opens pathways to SSA engagement on standards and duties in source countries [6].

Financial flows between public and commercial sectors, including through taxes, investments, pricing, and cross subsidies clearly play a significant role in CDoH. SSA countries are using excise taxes on harmful products that should be, but are not always directly reinvested in health promotion measures to address the harms. Better tracking of tax and investment flows, within and between countries and actors, helps to test and monitor delivery on claims and commitments, together with their impact on equity, poverty, national and global goals, including UHC and SDGs. With tax losses from corporate practices in low income countries estimated at equivalent to nearly 52% of health budgets, for example, AU, SSA finance ministries and civil society have already raised attention to losses from tax avoidance by TNCs and illicit financial flows, and called for national, regional and continental action to strengthen economic governance, address trade-related financial leakages and harmonise tax laws to avoid a 'race to the bottom' through the African Tax Administrative Forum. They have also called for reform of global rules enabling tax outflows, such as adoption of unitary taxation and for tax revenue to be assigned to where revenues are produced [63; 185; 197; KI4, 2021]. These initiatives are important in a context where debt is being used as a lever to promote commercial instruments and interests [KI9, 2021], where revenue streams are a key issue [KI1; KI4, 2021], and where domestic funding gaps are generating commercial involvement in health services. SSA actor perceptions that public sectors are central to UHC, together with concerns over risks in expanding private-for-profit health services and weak state capacities to manage these issues, raise the need for funders to direct investments to public sector health care in SSA.

Technology development and R&D is a key area of commercial demand and potential health benefit. However the findings, including from KIs, suggest that SSA needs to build its own leadership in health technology. COVID-19 has opened a potential for this. Expanding local production within SSA of health-related technologies calls for significantly greater venture capital/catalytic investment in scientific infrastructure, R&D, early proof of concept and its translation into production activities, together with challenges to IP and trade rules limiting distributed capacities in SSA to produce essential health technologies. It is proposed that investment needs to shift from supply- driven to needs-driven innovation; away from hospital-based curative technologies to prevention technologies accessible in communities and frontline services; with a 'mining' of IP and expired patents to support reverse engineering [KI5, 2021].

The multi-sectoral nature of CDoH necessitates "a departure from traditional, vertical public health responses" and a demand, reiterated by KIs [KI5; KI7, 2021], for greater **coherence in policy and action across sectors**. While HiAP approaches offer entry points, SSA health ministries and others pointed to 'One Health' as an important entry point, building on experience of its use in areas such as managing zoonotic risks. It is seen as a useful platform for coordinating health, agriculture, environment, trade and other sectors on CDoH, to address the role of commercial actors and integrate input from affected communities. Sub-regional and continental platforms were noted to play a role in sharing practice and supporting diplomacy, policy framing and global engagement on CDoH [KI1; KI7, 2021]. In all these approaches, a more inclusive dialogue appears to be essential to address tensions between civil society and states in SSA over management of CDoH, to strengthen co-operation across public interest actors, without losing state mandates or the key role of civil society in ensuring accountability of public and commercial actors on duties related to CDoH, including to contest regulatory capture.

Addressing CDoH in SSA raises both **questions on and challenges to economic paradigms** - many a continuation of colonial and neo-colonial policies - that generate inequalities, ecological damage and negative health outcomes associated with commercial practices, that constrain local producers' contribution to areas of health benefit and that undermine policy latitude in SSA. While these issues and COVID-19 are raising commercial pressures, they are also promoting 'a rethink' on more inclusive, equitable economies that more sustainably use local resources and support local producers. This is debate opens opportunities to also assess the health and environment impact of investment and trade agreements, including the AfCFTA; of proposed economic

development zones and indeed of post-pandemic recovery plans in SSA, including to project the longer term impacts to inform policy negotiation [KI6, 2021]. It is inevitable that dialogue on CDoH raises debate on economic policies that better support synergies between social, ecological and economic wellbeing, within and across countries, and on the democratic processes needed for such debates. As stated by one civil society actor: "We can set our priorities right. We can hold our governments to account…But when you enter the private sector who are negotiating in closed rooms without any public participation...I think that's problematic" [246]. The diversity and expansion of commercial impacts in SSA suggest that piecemeal interventions on CDoH, while necessary, may insufficiently address the scale of threat or the loss of potential opportunity in this area. The context and situation in SSA call for 'upstream action' on the range of current economic, biodiversity, tax, trade debates and platforms within SSA and globally, where engaging on CDoH will be critical to prevent a deepening erosion of public policy space and to advocate policies that better support synergies between social, ecological and economic wellbeing.

5.3 Implications for WHO and exchanges across countries globally

The various areas of action raised in the previous subsection would benefit from exchanges within WHO regions and between WHO regions globally on evidence, standards and strategies, including on how challenges are being met and in joint engagement on global policies affecting CDoH. WHO can play a role in many of the strategic actions raised, to provide technical and normative guidance, including on health rights, to support the updating of public health law, provide guidance on procedures to prevent conflicts of interest and codes of practice on areas of CDoH, and to support domestication and harmonisation of standards within sub-regions of SSA, connecting in so doing with the AU and sub-regional organisations in SSA.

No one actor can address CDoH alone. The various areas of work on CDoH call for co-operation across multiple sectors, social groups and disciplines. WHO could usefully enable such multi-actor co-operation, building on existing 'One health' , HiAP and social determinants mechanisms and providing information, guidance, technical and capacity support for these interactions on areas of commercial activity, including to plan for future risks linked to climate emergencies [KI7; KI8; 2021]. Addressing the CDoH also calls for strengthened 'One health' at regional and global level [KI6: KI7, 2021]. Deficits in policy coherence at these levels affect coherence within countries. WHO could strengthen shared frameworks, rights-based approaches and policy coherence on CDoH between key UN agencies engaging with health determinants - such as UNCHR, ILO, FAO, UNEP, UN Habitat, UN Women and UNDP - and draw on this and its own direct interactions to engage with multilateral economic institutions to protect public health in commercial activity. WHO has a key role in ensuring completion of a genuinely multilateral international instrument on TNCs and business and health rights in the OCHR that reflects the perspectives of all global regions.

Such binding standards are important for negotiating measures in SSA, particularly where there are tensions between commercial and public health interests. WHO in the region and globally thus have a key role to reiterate clear unequivocal information and policy on the central role of public sector health systems in UHC, and the challenges that for-profit health services bring to equity and universalism, to avoid UHC being used as a springboard to pressure for an expanding commercialisation of health services in SSA. WHO in the region and globally has a key role in responding to policy concerns in SSA on rising NCDs, to ensure that the policies and strategies do not stop at proximal causes and address also the upstream commercial determinants, many of which are well elaborated in scientific literature, including in SSA.

Including CDoH as a standing agenda item at WHO regional and global assemblies will strengthen evidence and accountability on these strategies and actions, as well as on delivery on and violations of health rights, health-related treaties, and regional and global commitments.

A CDoH lens opens a deeper debate on development thinking and the interplay of discursive, agential and structural power that from a SSA lens, currently advantage TNCs and related commercial actors. In this terrain WHO is challenged to 'creatively flex its muscles without breaking its mandate' [KI9, 2021]. It is expected through its own discursive, agential and structural normative power to stand for health rights in debated areas on CDoH, and in relation to commercial determinants, to articulate where public health values and norms take precedence, in the face of risks that undermine the right to life and the highest attainable standard of health.

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Key informants

Key informant (KI)1 (2021) SSA Sub-regional intergovernmental agency lead
Key informant (KI)2 (2021) SSA Sub-regional trade union organisation lead
Key informant (KI)3 (2021) Africa Continental environment/ecology technical agency actor
Key informant (KI)4 (2021) Africa Regional tax/finance actor
Key informant (KI)5 (2021) National SSA expert in a health-related technology innovation hub
Key informant (KI)6 (2021) International technical expert with experience in SSA
Key informant (KI)7 (2021) Africa sub-regional public health actor
Key informant (KI)8 (2021) National governmental health technical actor
Key informant (KI)9 (2021) Africa continental finance actor

Appendix 1

Table A1: Key / prioritised key domains and forms of action of CDoH identified by actor

Actor	Brief findings
Interna-tional/ global actors involved in SSA	The United Nations, particularly through the UNCHR prioritises measures to protect health rights, placing a duty on states to ensure that private actors conform with human rights standards when providing health care and commodities, or in relation to economic activities that have health consequences, and in negotiating international or multilateral agreements [26]. UN and international agencies raise a diversity of diverse specific areas of concern, including zoonotic spread and antimicrobial resistance in animal production value chains; assessment and control of pollution, employment and income support, universal social protection strategies, healthcare and schooling [11; 18; 19; 20; 22; 26; 35; 39], referring to largely voluntary global standards noted in *Section 3.1.* The state is observed to have a range of tools at its disposal for this, including public incentives, subsidies, guarantees for private projects and technological innovations, prior plans and funds to address exit risks, regulation of negative impacts and to promote equity in access [9; 10]. Some global actors (such as World Bank, UNDP, European countries) focus more on overcoming barriers to investment (noted in *Section 3.1*), with proposals to strengthen innovative fund structures, impact measurement, funder guarantees with large financial institutions to enable SME and start-up investment and microfinancing for infrastructure, agribusiness, health and education [1; 12; 30; 36]. The COVID-19 pandemic has added a critical priority focus on vaccine acquisition, administration (infrastructure, training, data collection, PPE, laboratories), local production (sharing intellectual property, technology transfer and know-how), as well as creating fiscal space and 'derisking' private financing (through Special Drawing Rights, aid replenishment, debt rescheduling and concessional financing), not only for the health sector but for sectors that have impact on health, such as agriculture [8; 33; 34; 41; 43; 44; 46; 47; 48; 51]. The health service sector is a major area of focus, noting SGDs and UHC commitments as raised earlier, with diverse measures raised for private sector partnership/engagement in health services, including aid, investment, technical assistance, training in digital systems, corporate logistical systems and data platforms, asset management, and credit instruments. While mainly focused on health services, there is also a focus on water, on reproductive health commodities for adolescents and on digital platforms generally [4; 13; 14; 15; 17; 24; 45; 46; 49; 50]. While these are largely globally defined, there is also some South-South multilateral voice from BRICS summits raising a general priority on bringing mutual economic into global health [37; 52].
SSA conti-nental and regional organi-sations	As for the international actors engaging in SSA, some SSA regional and continental actors also raise as a priority protecting health rights in commercial activities, particularly safe and nutritious food, clean water and sanitation (WASH), and public sector health and education services [55; 78], including by domesticating rights in national constitutions and international human rights treaties in domestic law [100]. Regional actors prioritise action on specific harmful commodities, particularly alcohol, tobacco; food – high salt, sugar, transfats; access to improved water supply and sanitation; on harmful commercial processes, where urbanisation has been associated with processed foods and dietary shifts detailed in *Section 3.1*, agribusiness and reduced farm sizes affecting food security and ecological degradation (noted in West Africa), and the weak links to local development in extractive activities. A common priority for many is the impact of increasing acquisition of land for agrofuels by foreign governments and private investors on small-scale farmers, water and food security, with actions proposed to build negotiation capacities and measures to secure land rights of local communities [74; 78; 87; 89; 92; 99; 101; 102; 103]. Some continental actors give more focus in their priorities to levering beneficial impacts for health from corporates, particularly in terms of technology innovations, ICT, research and development, regional supply chain resilience, and investment in research and development to boost innovation. Informal cross-border trade in food is given attention for its employment impact, especially for women; with measures proposed to enlarge the within-region commercial and trade networks and points of sale, including in remote areas. Regional actors note as a

Actor	Brief findings
	priority ensuring that trade and investment agreements and debt-related agreements support job creation, especially for young people, and SMEs, diversify production, support adaptations in agriculture and food systems to ensure food and water security; enable optimal and sustainable use of natural resources; enhance resilience to global shocks; promote greater regional integration, provide debt relief and interest rate forbearance and take full advantage of the Addis Ababa Action Agenda on international tax cooperation and technology transfer, and curb illicit financial outflows. There is not always consistency across the priorities and measures of different regional institutions. For example, the West Africa countries in ECOWAS agree on ensuring that trade supports food and nutrition security, but with some conflicting positions amongst them. Some make national and regional self-sufficiency in basic food commodities a priority, while others support liberalised trade in food to ensure food security. This leads to different strategies, either to promote access to information, capital, land, and within country markets, storage systems and value chains for food stuffs to support production, distribution and affordable access, or to invest in cross border transport, standardized rules and regulations between countries and removing barriers to regional trade [60; 61; 78; 87; 88; 89; 90; 93; 95; 96; 101]. Specifically in relation to leveraging a beneficial impact from private actors for health services, the priorities and measures raised include building a network of experts/practitioners in SSA and local production and of essential medicines, vaccines and other health products; integrating private sector investment in multi-sectoral WASH initiatives, health workforce needs and PHC services. The measures to support this relate to standard setting, inspection, surveillance, research and development, quality management, infrastructure investments and regulatory reforms. As a result of the COVID-19 pandemic, continental actors have escalated their stated attention on TRIPS flexibilities and the Waiver noted in *Section 3.1*, and on mobilizing investment for domestic production of quality medicines, diagnostics and cold chain infrastructure, and on reducing prices for African buyers of health technologies. One example of this is the common information management system for medicines registration in the EAC, to ensure regulatory harmonization and mutual recognition of product registrations [59; 62; 66; 67; 68; 69; 70; 75; 75; 78; 87; 97; 99; 102; 104]. Across these above areas, the priorities for action raised by actors from the continent relate to: • Aligning priorities within government and co-ordination across government, to strengthen and generate mechanisms for coordinated, multi-sectoral action on key areas such as food security, social safety nets, control of harmful products like alcohol, illicit flows, and research and development of health products. • State regulation and policy, to domesticate WHO and other global standards and international treaties in national law, broadly in areas relating to harmful products and processes noted earlier, as well as to ensure target levels, such as of salt in food, and harmonising and mutual recognition of laws and standards across countries in common markets or economic unions; as well as legal and resource support for measures to close implementation gaps, such as in addressing right to food violations around land, labelling of food products, or violations of corporate health duties to workers and communities. • Addressing information and evidence gaps in public sectors on commercial actors, through strengthened public health information systems, measures to address low private sector compliance with reporting; public reporting of hazards and impact assessment, and monitoring and regional research on commercial determinants. • Fiscal, revenue and financing measures, both to increase revenue for public health services and to use excise and other taxes, minimum pricing measures to control harmful practices (eg tobacco, alcohol; high sugar foods etc) and to incentivise desired commercial practices. • Controls on the range of forms of advertising and marketing of harmful products noted in Section 3.1, particularly those targeting young people, and use of dedicated taxes, social media and information outreach for health promotion, including to promote intake of fruits and vegetables [58; 59; 60; 69; 72; 73; 74; 77; 78; 83; 85; 88; 99; 100; 101; 104; 105; 106].
SSA govern-ments	As for regional actors, SSA government actors prioritise action on specific harmful commodities - particularly alcohol, substance abuse, tobacco, unhealthy and poor quality food, as well as access to improved water supply and sanitation facilities - commercial processes - such as the rise in NCDs around rapid and unplanned urbanization; protection of workers from occupational health threats- and wider commercial risks for health, including malnutrition and obesity, zoonotic risks and biosecurity threats. A number of the state policies specifically raise equity issues in

Actor	Brief findings
	these commercial risks for health, to regulate health sector models that focus on selected diseases or undermine access for poorer groups, or to ensure that commercial practices invest on SMEs and small-holder farmers to reduce poverty [108; 110; 111; 118; 120]. More directly in the health sector, government documents prioritise and set specific measures in relation to local production of and supply chain management systems and quality standards for medicines and other health sector commodities; to build 'One health' capacities and systems, and in healthcare services. In the latter case while many of the actions relate to managing issues in the curative care services, there is also note of measures for private actors to be involved in disease prevention, occupational health and PHC [108; 116; 117; 118]. The primary focus of many of the government papers, and thus apparent priority, is on measures relating to state practice in • Regulation and policy, controlling the production, manufacture, sale, labelling, advertising, promotion, sponsorship and use harmful products, - tobacco, alcohol and breastmilk substitutes- setting standards for market practices- such as in food and medicine quality and safety- regulating hazardous work, and registering, accrediting and ensuring quality control of private and public health services. • Aligning across sectors in One Health Approaches and overcoming information and evidence gaps on health impacts, including through integrated information systems, monitoring of private actors. Including of implementation of control measures and compliance with contracts and regulation. • Exerting influence through excise taxes, pricing measures to control harmful products and processes, channelling funds raised from fines and taxes to health promotion and price subsidies to promote healthy products and practices [107; 108; 109; 110; 111; 119; 120].
Banks and Investors, operating in SSA	While some funders operating in and from SSA point to priorities in areas of both positive (eg health technology) and negative (eg pollution, industrial waste) health contribution, the focus on priorities is largely framed on the positive contribution of commercial actors, particularly post COVID in health commodities and essential equipment; support to private health facilities facing COVID related challenges; overcoming bottlenecks associated with vaccine manufacturing and distribution in the health sector preparedness and response [130; 131; 147]. The papers from funders thus point to priorities in: • Market opportunities in a range of health sector related areas - physical assets (beds, facilities); airport clinics, trauma centres and well-woman clinics; innovative, tech-enabled services skilled personnel; distribution and retail systems, pharmaceutical and medical supply production facilities and a range of investments in areas with beneficial health impact, including R&D on neglected diseases, digital systems and fibre-optic networks, and climate adaptation, and the conditions and that need to be in place and measures being applied for viability of investment in these areas discussed in *Section 3.1*, noting for example that strict IPR protection frameworks, comparable to the TRIPS plus conditions, "could act as an obstacle to setting up domestic generic-drug manufacturing bases" [143]. • Overcoming investment and market barriers, including procurement transparency, cost efficiency; bridging healthcare businesses seeking medical equipment and financial institutions and equipment manufacturers; facilitating long-term financing and business-state contacts to scale up investment in medical research, local healthcare supply chains and innovative low-cost healthcare models. One investor explicitly raises "targeting the "last mile" to reach vulnerable, population groups as a priority, suggesting options for this as implementing impact investment and "health in all sectors" delivery mechanisms [140]. • Implementing due diligence for investments in health technology; integration of smallholder farmers into larger value chains and measures that address air pollution, industrial waste, motor vehicle traffic, and stress associated with poverty and unemployment in urban areas. • Proposing and using fiscal/ and financial measures to encourage market actors in health related investments and enable competitive, risk-adjusted financial returns. A number of these measures are raised, including blending concessional and commercial investment capital, mezzanine debt, convertible debt; equity and project financing for social impact goals; bringing together investors with different 'bottom lines' such as development finance institutions and foundations; supporting taxes on revenues harmful items such as beverages, tobacco, processed meats, fast foods and mobile phone use, encouraging

Actor	Brief findings
	social and voluntary health insurance, social impact bonds, employer contributions and community financing; providing direct funding, long-term equity and quasi-equity to private healthcare companies to scale up successful business models, and bringing together institutional investors, bilateral and multilateral development finance institutions, pension funds, sovereign wealth funds, foundations, and high net worth individuals in blended funds for health investments and pairing concessional and commercial funding in a "capital stack" approach. • Specific priorities and actions in relation to health services, with particular interest in in provision of higher-quality services (clinics, hospitals, diagnostic centers, labs); risk pooling and financing vehicles (health management organizations, insurance companies); distribution and retail organizations (eye clinics, pharmaceutical chains, logistics companies); pharmaceutical and medical-related manufacturing companies and medical education. • Ensuring that state regulation does not become a disincentive to foreign investment, while also building South– South and domestic private–public partnerships for greater domestic ownership of health systems [121; 122; 124; 125; 130; 131; 133; 134; 135; 136; 137; 138; 139; 140; 143; 146; 148; 151; 152].
Private- for -profit business in SSA	Corporate actors prioritise a range of commodities and impacts of commercial markets that they identify as having beneficial impact on in health, particularly 'essential' and vitamin-fortified food, digital connectivity, medical equipment, health technology and business skills [144; 153; 154; 155; 162; 163; 167; 168; 171]. In health services, there are a mix of priorities, from low-cost accessible service provision in public private partnerships; proof of concept innovations for scaling up; to 'medical wellness' services and pandemic controls [153; 155; 166; 167; 168; 172]. In this group of actors, the prioritised concerns relate to: • Addressing business opportunities and barriers, doing research to 'choose the right country, the right risk profile, and the right model', building alliances with domestic African healthcare businesses to increase 'penetration efficiency and decrease risk', and investing in the physical, financial and telecoms infrastructure along which commerce flows [128; 161]. • Harmonising laws, standards and infrastructures for ease of business practice, coordination with state on logistics; creating "ecosystems of innovation" in SSA linking "tech hubs and technopreneurs'; to make products and services cheaper [153; 158; 163; 168]. • Having streamlined effective communication channels and databases and trust building measures, and • Accessing financing and credit options that enable value for money and catalytic funding for proof of concept; including through credit funds to help private health facilities access loans for quality improvement projects; and using pension funds and other savings pools as catalysts for private equity investment. [152; 154; 155; 163; 167].
Civil society in SSA	Civil society actors in the publications sourced give priority to a range of harmful products, particularly commercialized or ultra-processed foods, and to a lesser extent tobacco and alcohol, but refer more commonly to harmful processes and their impacts as priorities, particularly those relating to 'land grabs' and TNC-driven extractive activities in agribusiness, energy and mining undermining local food production and livelihoods, displacing communities and economic activities, diverting water resources to large projects and degrading and polluting natural resources and generating public health risk. These processes prioritised for attention are identified as not only leading to increased NCDs, poor nutrition and occupational disease, but also under-reported and poorly compensated long term diseases, and to health risks from climate change and environmental damage. Processes that are commercialising essential services (health, water, waste management) are also prioritised, particularly for their consequences in escalating charges, their negative impact on equity in public sectors, public procurement and social rights, and for 'creating cash bonanzas' for private sector while leaving deficits for many and widening social inequalities livelihoods. Particular areas of action are raised to address these priorities: trade unions are argued to have a role to protect workers interests and decent work, and in doing this to ally with other social organisations to make harms visible, including through involvement in prior informed consent and health impact assessment processes and report of rights violations, to protect wider public and ecological interests affected by corporates and to ensure that corporates contribute to revenues and services for public health during crises. More broadly, civil society action is identified in exposing economic policies,

Actor	Brief findings
	global supply chains and markets, trade and tax rules, land, water and other natural resource use and depleting practices, legal deficits, financial flows, corporate links to tax havens; debt conditions and investments and ODA flows that enable or support harmful processes [176; 181; 182; 184; 186; 187; 191; 194; 195; 198; 200; 202; 206; 207; 208; 209; 212; 213; 216]. The health sector is given its own attention in civil society priorities related to commercial determinants, particularly in relation to commercialized/privatised services leading to catastrophic spending from households, excluding key services, particularly PHC and community health systems, poorly protecting the labour rights and conditions of health workers, including community health workers, and poorly covering work-related services for formal and informal sector workers. Civil society note that the complexity of PPP contracts and privatization processes mean that only large companies are bidding for contracts, limiting competitiveness; and that these processes lack of transparency in contract negotiations and public accountability of projects. These health sector issues are identified to call for action on the political and state duty to protect the right to health equity and other social rights in the face of market pressures; including in global trade regulations that deny the right to health and in controlling costs of care, and action by civil society to expose the gap between stated commitments and realities and to demand accountability on health, labour and social rights [174; 178; 184; 194; 203; 209; 210; 211; 212; 213]. Significant priority is given to measures to ensure accountability on and protection of rights to health and equity. This is raised in relation to: • State duties and capture on regulation and policy, with civil society engagement, claims and litigation on the constitutionality and legitimacy of PPP contracts and exemptions for TNCs on compliance with local laws, tax agreements/ exemptions, profit shifting activities, land tenure laws and policies; protection of traditional knowledge and biodiversity; application of international human rights standards, including labour rights and rights to prior information and consultation on commercial-related agreements. Civil society has used shadow monitoring and complaints / objections procedures to international agencies (ILO, World Bank Inspection panel , IFC, G20; African Regional Intellectual Property Organization (ARIPO), ILO) on identified procedural breaches, harms and rights violations [181; 182; 184; 188; 189; 192; 198; 200; 207; 213; 215]. • Fiscal/financing measures and particularly tax (in)justice and underfunding of public sector services, with civil society tracking and making demands on political commitments on public funding and for commercial actors to pay 'fair shares' of costs and revenues, and by exposing and taking legal and social action on inequity in tax rebates for private actors; double tax agreements and tax avoidance/evasion; costs of liberalised trade, and escalating costs and public subsidies in PPPs [189; 191; 194; 196; 198; 202; 203; 207; 209; 210]. • Different aspects of democratic governance (detailed in *Section 3.1*), from demands for public information disclosure on corporate practices and agreements, to undue corporate influence in public policy and exclusion of affected communities in assessments and decisions related to corporate practices that affect them, through to (under-)representation of LMICs in global finance institution boards. Civil society has used petitions, campaigns, commentaries, alternative declarations, community opinion polls, media interviews, shadow and 'watch' research and reporting, including online, and litigation on this range of issues,. Civil society sources often note coalition building and organising into a range of associations, across unions, residents, ex-workers, patients, professionals, parents, communities, issue networks and in other collectives in these actions. Civil society has involved community opinion leaders, and in many countries, collaborates with local, national or supranational entities on actions taken [179; 181; 184; 187; 192; 200; 207; 208; 210; 212; 213].
Aca-demia	In relation to harmful products, academic papers have a major focus on food (high sugar/salt/transfat; processed); alcohol, tobacco, and production hazards (chemicals, dusts, radiation, noise, heat) and firearms, and as for civil society, a more common focus on commercial processes as priorities, including production processes emitting harmful air and water pollution, pesticide contamination; poor working conditions, agribusiness crowding out smallholder farming; unsafe and polluting urban transport systems, market drivers of processed foods and food insecurity (as detailed in *Section 3.1*). Academic sources also raise as priorities for action processes and policies that externalize these risks, that cause immediate child, community, worker disease and injury and long term, intergenerational damage to environments,

Actor	Brief findings
	workers health, community and social wellbeing [157; 217; 222; 229; 234; 237; 238; 239; 244; 248; 259; 260; 263; 264; 270; 271; 273; 274; 278; 285; 288; 296; 297; 298; 300; 303; 306]. There is also some note in academic literature sourced of prioritised areas of potential health benefit, including in technology innovation and transfer; for vaccine access, health technologies, responses to climate change; environmental measures; infrastructures; distribution networks, research and development (R&D), digital expertise and infrastructure, and biodiversity-related ecosystem services. There is also note of south-south alliances on priorities in reform of global institutions for public health and SSA voice, or in relation to market related inequities in vaccine rollout detailed in *Section 3.1.* Sectors prioritised for action on leveraging potential health benefit include pharmaceutical, food, mining, agribusiness and infrastructure. Academic authors propose investment in local scientific infrastructure, to move from basic research to proof of concept funding, product development and application, and investors, including from ODA to move towards funding models that provide longer commitments to R&D research and infrastructures and capacities, and support for proof of concept, knowledge translation in practice [32; 224; 228; 229; 237; 270; 282; 289; 306]. Within these economic sectors that impact on public health, academic sources call for measures such as participatory health impact assessment (HIA) to be used to expose risks and benefits and options for managing them, preferably prior to investments and licensing, including to design agreed options and internalize corporate liabilities. For example such HIA was used in urban transport planning in Mauritius, to identify the mix of measures for regulating private motorized vehicles and promoting active and public transport to support public health [234; 266; 297]. Numerous academic sources prioritise action on negative consequences of commercial determinants in the health sector itself, detailed in Section 3.1. particularly the specialized, ‘cream skimming’ (risk excluding) care models promoted, distortions of funding and personnel in away from primary care; risk and subsidy inequities, tax and profit repatriation revenue losses, escalating costs and weak financial protection in PPPs; overall negative equity impact and governance issues relating to transparency, including in off budget and intermediary financing, and short term targets understating long term consequences of sale of public sector enterprise. These actors see a priority for resolving technology, UHC financing inputs in ways that integrate public health and PHC promotion, prevention approaches; multi-sectoral collaboration and community engagement. The major action articulated beyond research, monitoring and exposure of evidence on these areas of concern is that of making clear the central role of public sector health systems in UHC and equity and advocating that public sector interactions with commercial entities ensure commitments to equity, equality, diversity and inclusion (EEDI) principles [219; 224; 230; 237; 245; 250; 252; 279; 280; 296; 297; 302]. Further areas of action raised by academia include: • Strengthening state regulation and policy, including state capacities for testing, standardising product safety, legislating binding regulations to protect and promote public health in an environment free of commercial influence, including through domesticating international standards, including on corporate obligations relating to advertising, labelling, information and conflict of interest disclosure, financing and investment disclosures; prior informed consent; labour standards; amongst other areas as raised in *Section 3.1.* In particular, academic sources note the need to move from voluntary codes to binding law, to strengthen state regulatory capacities and enforcement, to ensure coherence between health, environmental and economic measures and to provide clear information, including on cost-benefit, to support dialogue and decision making on law and policy. This strengthening of state capacities is particularly argued to be important in the face of arbitration, dispute and compensation remedies that may be used by foreign private investors and TNCs if they believe their investment has been expropriated or their business affected by public regulation, such as banning the sale of processed food items in school cafeterias. • Acting on fiscal/ revenue measures, particularly excise taxes on harmful products such as sugar-sweetened beverage, options for sustainable financing, including co-financing options across SDG goals; negotiating with investors and in capital markets on measures that explicitly address intersections between financial, public health and equity interests. • Acting on gaps in evidence on impacts of commercial determinants and the information and marketing systems that influence public and policy, including through strengthening

Actor	Brief findings
	monitoring and evaluation systems; obligations for corporate information sharing and disclosure; declaration of interest conflicts in research; diary disclosures and public disclosure regarding government official/politician interactions with/ involvement in industry; and controls on advertising and other forms of market promotion raised in *Section 3.1*. • Integrating public health more centrally within trade agreements and investments, demonstrating good practices in the AfCFTA, making health costs clear as an input to negotiations; strengthening financial, human and technical capacity as well as bargaining power to participate effectively in international trade and relevant health standard-setting spaces (e.g. WTO and Codex); using international agreements in negotiations (FCTC, EU recently agreed list of counter-measures against tax havens, Extractive Industry Transparency Initiative and others raised in Section 3.1), shifting decision-making to more favourable international trade legal venues; using continental, regional platforms and alliances to contest imbalances in global platforms, - such as use of “trade and investment disputes” through the Technical Barrier to Trade platform of the World Trade Organization- as well as for protection of intellectual property of traditional knowledge; promoting R&D, balanced industrialisation and harmonised standard setting on the continent; and unbundling monopolies, vertical and horizontal mergers in sectors affecting health (health sector; food) that lead to excessive control and power across all levels of a system [219; 220; 224; 226; 232; 238; 242; 244; 248; 251; 253; 256; 259; 260; 261; 263; 264; 273; 274; 275; 281; 285; 288; 294; 299; 303; 305; 306]. Academic writers raise the need in acting on CDoH to better understand and engage with the different forms of corporate power if strategies for protection and promotion of public health are to succeed. This is particularly raised in relation to material sources (eg corporate capture of global/international funding; externalising considerable social and environmental costs) and ideational sources of corporate power (eg framing alcohol harm as an individual responsibility; portraying market regulation as an infringement of personal choice). In part this is noted as conflicting priorities within government on necessity and impact of policy measures is expressed as a lack of coherence between national trade and investment policy and national health policy that weakens state power in negotiations with commercial interests, and weakens the necessary intersectoral action to implement policies, such as for One Health or pandemic prevention, preparedness and protection. This is noted in part to depend on the nature of economic policy adopted in the region, given the inherent bias towards commercial over public health interests in a neoliberal paradigm , as raised by these actors in *Section 3.1* [219; 223; 247; 258; 264; 270; 274; 275; 287; 290; 292; 306]