



World Health
Organization

Economic and commercial determinants of health in Small Island Developing States

Noncommunicable diseases, mental health
conditions, injuries and violence

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health conditions, injuries and violence**



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Front Matter

Foreword

There is a growing understanding of the critical role played by economic and commercial determinants of health in driving the burden of disease, violence and injuries in Small Island Developing States (SIDS). In order to support effective action to improve health and health equity in SIDS, it is essential that we strengthen our understanding of these determinants and their contribution to the multifaceted challenges faced by SIDS.

Geographical isolation, small populations, and economic dependencies on external resources and limited industries create unique economic vulnerabilities that impact not only on healthcare accessibility and quality, but also on the physical and social environments where SIDS populations live, work and play and that determine the distribution of health outcomes. These vulnerabilities are too often exacerbated by the power imbalances between SIDS and larger commercial entities, with negative outcomes arising from these commercial determinants of health.

Tackling the commercial determinants of health in SIDS includes action to support shifting businesses from health-harming to health-promoting practices, addressing power imbalances between public sectors and commercial actors, regulating harmful commercial practices, and improving underlying systems, such as for food and transport.

However, the unique context of SIDS creates unique strengths and opportunities, and lessons for not only small countries but also the global community. This includes SIDS to SIDS cooperation and 'whole of Island'

approaches that leverage the strong regional ties and unique characteristics of SIDS to implement cross-sectoral and integrated health strategies. Successful action will require international support in various forms, including through exploring debt relief and developmental financing, to bolster SIDS's efforts in combating harmful health impacts of the commercial determinants.

This Technical Paper explores the challenges, actions and opportunities available to SIDS with respect to the economic and commercial determinants of noncommunicable diseases, mental health, and injuries and violence. This paper not only sheds light on the complex interplay of economic and commercial determinants in SIDS but is a call for immediate action by all stakeholders in addressing these challenges, to help catalyse the potential for meaningful and enduring change.

The time for action is now. The 2023 Bridgetown Declaration on NCDs and Mental Health adopted at the SIDS Ministerial Conference on noncommunicable diseases and mental health, held in Bridgetown, Barbados on 14-16 June 2023, provides a critical roadmap for improving the commercial determinants across SIDS. This paper aims to support efforts to implement this roadmap and contribute to efforts to explore innovative economic approaches that prioritize well-being, incorporate Indigenous knowledge, and support health-aligned businesses, particularly those at the local level.



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Abbreviations used in the Technical Paper

CARICOM	The Caribbean Community
CDoH	Commercial determinants of health
CPR	Cardiopulmonary resuscitation
FAO	Food and Agricultural Organization of the United Nations
GDP	Gross Domestic Product
HFSS	Food High in Fat, Salt, and Sugar i.e., that are high in saturated fats, trans fats, free sugars and/or sodium and are typically heavily processed.
IFAD	International Fund for Agricultural Development
IP-TFAs	Industrially produced trans fatty acids
LMICs	Low- and-middle income countries
MVI	Multidimensional Vulnerability Index
NCDs	Noncommunicable diseases
OECD	Organisation for Economic Co-operation and Development
ODA	Overseas Development Assistance
PAHO	Pan-American Health Organization
PICs	Pacific Island Countries and Territories
SAMOA Pathway	SIDS Accelerated Modalities of Action Pathway (2005) Adopted at 3rd International Conference on Small SIDS, reaffirmed in UNGA Resolution, A/RES/69/15
SDGs	The Sustainable Development Goals
SDRs	IMF Special Drawing Rights
SIDS	Small Island Developing States
SSBs	Sugar-sweetened beverages
Rio Declaration	Rio Political Declaration on Social Determinants of Health (2011) Adopted during the World Conference on Social Determinants of Health
UN	United Nations
UNICEF	United Nations Children’s Fund
WFP	United Nations World Food Programme
WHO	World Health Organization
WHO FCTC	WHO Framework Convention on Tobacco Control
WTO	World Trade Organization

List of terminology used in the Technical Paper

Commercial determinants of health	The commercial determinants of health are those conditions, actions and omissions that affect health. Commercial determinants arise in the context of the provision of goods or services for payment and include commercial activities, as well as the environment in which commerce takes place. Commercial determinants can have beneficial and/or detrimental impacts on health. ¹ Commercial determinants are, therefore, considered the commercial dimension of the social determinants of health and comprise behaviours of and actions taken by commercial actors that cut across industries and health impacts, as well as the pathways and structures that incentivise and regulate these behaviours and actions. ²
Economic determinants of health	Economic factors that determine opportunities for health as a wider set of forces and systems shaping the conditions of daily life. For example, these include central bank policy, tax policy, trade policy, debt, and other economic and development approaches. ³
Environmental determinants of health	Environmental factors that influence human health, including physical, chemical, and biological factors external to a person. ⁴
Health equity	Health equity is the absence of unfair, avoidable, or remediable health differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation). ⁵
Negative externalities	Externalities are benefits or losses that affect people other than those directly involved in making the relevant economic decision. For products and practices that are harmful to health, negative externalities translate into side effects that were not accounted for by producers, consumers and others involved in a given transaction. Health-related negative externalities include

¹ World Health Organisation. Preparation for the third High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, to be held in 2018: Report by the Director-General. World Health Organization: Geneva, 2017 (EB142/15).

² World Health Organization. Scoping Paper on Considerations for a Global Report on the Commercial Determinants of Health [unpublished]. World Health Organization: Geneva; 2024.

³ World Health Organization. Scoping Paper on Considerations for a Global Report on the Commercial Determinants of Health [unpublished]. World Health Organization: Geneva; 2024.

⁴ World Health Organization. Health promotion glossary of terms. Geneva: World Health Organization; 2021 <https://www.who.int/publications/i/item/9789240038349>.

⁵ World Health Organization. Health promotion glossary of terms. Geneva: World Health Organization; 2021 <https://www.who.int/publications/i/item/9789240038349>.

damage to the health or well-being of others. Some examples are exposure to second-hand tobacco smoke, and accidents or violence related to alcohol consumption. Externalities also include the public health care and welfare costs of treating and caring for those who suffer injuries, illnesses and disabilities, as well as lost productivity caused by such premature mortality and morbidity.^{6,7,8}

Salutogenic action	Salutogenesis describes how social and individual resources, including the sense of coherence, help people to manage stress and to thrive. Salutogenic action focuses on the origins (genesis) of health (salus) and of positive health outcomes – moving towards the positive end of an ease/dis-ease continuum – in contrast to the more usual study of the origins of disease and risk factors (pathogenesis). ⁹
Social Determinants of Health	The social determinants of health are the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life. ¹⁰
Triangular cooperation	Triangular cooperation involves partnerships between two or more Low- or Middle-Income countries supported by a High Income country(ies)/or multilateral organization(s) to implement development cooperation programmes and projects. ¹¹

⁶ World Health Organization. WHO technical manual on alcohol tax policy and administration. Geneva: World Health Organization, 2023 (<https://www.who.int/publications/i/item/9789240082793>).

⁷ World Health Organization. WHO manual on sugar-sweetened beverage taxation policies to promote healthy diets. Geneva: World Health Organization, 2022 (<https://www.who.int/publications/i/item/9789240056299>).

⁸ US National Cancer Institute and World Health Organization. NCI Tobacco Control Monograph Series 21 - The Economics of Tobacco and Tobacco Control. Bethesda: US National Cancer Institute, 2017 (<https://www.who.int/publications/m/item/nci-tobacco-control-monograph-series-21-the-economics-of-tobacco-and-tobacco-control>).

⁹ World Health Organization. Health promotion glossary of terms. Geneva: World Health Organization; 2021 <https://www.who.int/publications/i/item/9789240038349>.

¹⁰ World Health Organization. Health promotion glossary of terms. Geneva: World Health Organization; 2021 <https://www.who.int/publications/i/item/9789240038349>.

¹¹ UN Office for South-South Cooperation. About South-South and Triangular Cooperation. New York: UN Office for South-South Cooperation, 2024 (<https://unsouthsouth.org/about/about-sstc/>).

List of Small Island Developing States (as of May 2023)

Antigua and Barbuda	Micronesia (Federated States of)
Bahamas	Nauru
Barbados	Niue
Belize	Palau
Cabo Verde	Papua New Guinea
Comoros	Saint. Kitts and Nevis
Cook Islands	Saint Lucia
Cuba	Saint Vincent and the Grenadines
Dominica	Samoa
Dominican Republic	São Tome and Príncipe
Fiji	Seychelles
Grenada	Singapore
Guinea-Bissau	Solomon Islands
Guyana	Suriname
Haiti	Timor-Leste
Jamaica	Tonga
Kiribati	Trinidad and Tobago
Maldives	Tuvalu
Marshall Islands	Vanuatu
Mauritius	

List of Caribbean Community Member States¹² and Associate Members (as of May 2023) (1)

Member States	Saint Kitts and Nevis
Antigua and Barbuda	Saint Vincent and the Grenadines
Bahamas	Suriname
Barbados	Trinidad and Tobago
Belize	
Dominica	Associate Members
Guyana	Anguilla
Haiti	Bermuda
Jamaica	British Virgin Islands
Montserrat	Cayman Islands
Saint Lucia	Turks and Caicos Islands

List of Pacific Community Member Island Countries and Territories¹³ (as of September 2022) (2)

American Samoa	Palau
Cook Islands	Papua New Guinea
Federated States of Micronesia	Pitcairn
Fiji	Samoa
French Polynesia	Salomon Islands
Guam	Tokelau
Kiribati	Tonga
Marshall Islands	Tuvalu
Nauru	Vanuatu
New Caledonia	Wallis and Futuna
Niue	
Northern Marianna Islands	

¹² Use of the term “Member State” in this publication may include reference to territories.

¹³ Excludes the four remaining members, which are not SIDS.

**Economic and commercial determinants of health considerations in Small Island Developing States:
Noncommunicable diseases, mental health conditions, injuries and violence**



Executive Summary

This Technical Paper is the first in a series of Technical Papers on economic and commercial determinants of health in Small Island Developing States (SIDS). It was prepared and first presented as a draft discussion paper ahead of the SIDS ministerial conference on the prevention and control of NCDs and mental health held in Barbados in June 2023. This revised version reflects comment and review provided subsequently. It focuses on how commercial determinants contribute to negative health outcomes in SIDS and gives recommendations for action to address them. Specifically, it outlines the economic and commercial determinants of noncommunicable diseases (NCDs), mental health conditions, injuries, and violence. It does not explore the full scope and potential of commercial actors as health partners.

SIDS are a distinct group of countries facing shared commercial and economic determinants of health due to their geography, remoteness, small populations, narrow resource bases, low production capacity, dependence on external supply of essential products, undiversified economies and low gross domestic product (GDP). Commercial and economic determinants are dimensions of the broader social determinants of health that describe how economic factors and commercial practices structure varied conditions of daily life that are, in turn, intermediary determinants of health and health equity. These are determinants of what healthcare is available, to whom it is available and at what cost, whether housing and broader physical environments are safe and health-promoting, the workplace health protections and compliance with them, and the legal right and capacity of States to regulate for health. They also underpin global health challenges such as biodiversity loss and climate change, which are each consequences of unsustainable commercial practices and exceedingly detrimental to well-being and livelihoods in SIDS.

Understanding these determinants—including the power imbalances between regulators and commercial actors that underpin them and the ways in which global governance shapes them—is a necessary step towards better and more equitable health outcomes in SIDS. It is crucial to recognize that as countries often dependent on single industries and imports of food, medicines, vehicles and other products, SIDS are especially vulnerable to harm from the negative impacts of economic and commercial determinants of health – their negative externalities. For example, the asymmetry between their economic weight

and that of both multinational commercial actors and their major trading partners may leave SIDS exposed to greater pressure from industry and disadvantageous terms in trade agreements.

Prevailing economic and development approaches have not only failed to avert a growing burden of NCDs, mental health conditions and injuries in SIDS, but also fostered economic and policy conditions—particularly with respect to trade—that have empowered commercial actors, particular transnational businesses, relative to the public sector. This power asymmetry has exposed SIDS to negative externalities from the commercial determinants of health. This includes the actions of some commercial actors to exert influence over health outcomes in SIDS via direct means, such as marketing and lobbying, and indirect means, such as shaping knowledge and societal norms.

At the national level given the small size and close-knit social fabric of SIDS, local commercial actors play critical roles in the health of their communities. In order to fulfil the potential of these commercial actors to be partners for health and well-being of SIDS populations it is essential to shift their practices from health-harming to health-promoting. This will be possible when there is potential for alignment between health and their business model, products and services. When their interests are misaligned, they risk negatively affecting local health and well-being—a problem exacerbated by their often-privileged positions in local communities and national political processes. These circumstances make shifting local commercial actors away from health-harming and toward health-promoting practices a priority.

It is essential that SIDS and partners address health harming commercial practices and the underlying power asymmetry between commercial actors and the public sector. This will enable SIDS to take regulatory and other action to correct negative externalities by, for example, reducing exposure to health-harming products and their marketing, improving diets, developing safer infrastructure and lived environments, and curbing air pollution. Salutogenic action is also needed including incentivising commercial actors to promote physical activity, improve food environments and other environments, and support communities affected by climate-related events and disasters.

The same characteristics that underpin their shared challenges also provide SIDS unique opportunities for

using “whole of Island” approaches that leverage their small sizes and close-knit social fabrics to act across sectors and levels to address population health and ecosystem impacts with integrated policies and interventions based on adaptive governance structures and community leadership. Such approaches are particularly needed for addressing the inherently cross-sectoral and structural challenges of addressing the economic and commercial determinants of health. Moreover, as regionally and globally united networks of countries facing common challenges, SIDS also hold immense potential for collaborating in creating and implementing these solutions.

A comprehensive response requires action to explore alternative economic approaches that prioritize well-being, embrace Indigenous knowledge and participation, and support health-aligned businesses and, in particular, health-aligned local businesses. It also requires action across sectors, such as taxes on harmful products that also raise needed revenue, as well as policy coherence, such as the alignment of trade and broader fiscal policies with health goals. Conflict-of-interest tools for safeguarding public health policies from commercial interests should be developed and community participation for decision-making and accountability should be promoted to protect and accelerate other efforts to address the commercial determinants.

At the same time, SIDS need international support, including debt relief and greater development finance, to allow for investments in improved social determinants including action to improve outcomes from the commercial determinants of health. This includes investment in action on specific harmful commercial practices and products, strengthening capacities for governing commercial actors, and specific initiatives for climate change mitigation and risk insurance, and protections against biodiversity loss. These also include investments in universal health coverage, early years, social protection, safe infrastructure and communities. These upfront investments will unlock long-term, sustainable and equitable development and well-being across the life course. Given that children are the ones who bear the longest periods of exposure and consequence and offer the greatest opportunity to impact for life and are the ones least able to influence the environment in which they grow up and make decisions for their lifelong health and well-being, specific interventions

should be considered to promote and protect the health of children.

Opportunities for SIDS to address economic and commercial determinants of health with improved outcomes for NCDs, mental health conditions, and injuries and violence could include the following:

Creating policy environments that enable health.

Addressing commercial practices at the demand and supply side of risk factors by supporting health promoting products and practices and regulating health-harming products and commercial practices. Actions could include:

- 1.1. Comprehensive best practice health taxation to raise the prices of health-harming products as well as trade rules and excise duties that support health-promoting products including safe vehicles;
- 1.2. Regulation of the availability and use of health-harming products (e.g., regulate alcohol outlets; smoke-free laws);
- 1.3. Bans or restrictions on health-harming advertising and marketing, including the advertising and marketing of health-harming products;
- 1.4. Bans on the promotion of health-harming products in schools, including bans on nominally educational programmes which promote health-harming product use;
- 1.5. Policies for sustainable local food production and processing to support improvements in the food environment and strengthen climate-resiliency;
- 1.6. Urban and rural planning and development policies that provide safe and inclusive urban and rural environments, including safe green and blue space for physical activity, and prevention of pollution and health-harming waste;
- 1.7. Integration of commercial determinants considerations into procurement policies;
- 1.8. Using health and health equity impact assessments as part of strengthening policy coherence between health and other policies with economic and commercial relevance to NCDs, injuries and violence, and mental health, such as trade, education, labour policy, social protection, urban planning, energy, fisheries and agriculture;
- 1.9. Improving data and surveillance on the commercial determinants of health including commercial influence

over public policy and national, regional and international regulatory authorities;

- 1.10. Whole-of-government accountability for sentinel child health outcomes and behaviours as part of future proofing policy.

Safeguarding against conflicts of interest.

Safeguarding against conflicts of interest is critical in the development, adoption, implementation, and monitoring of public health interventions, policies, strategies and approaches as recommended by WHO. This also includes ensuring conflicts of interest are fully addressed in the implementation of WHO technical packages (Annex 2).

Actions could include:

- 2.1. Whole-of-government policies to prevent and manage conflicts of interests for commercial actors, especially those whose products and services are health-harming;
- 2.2. Access-to-information legislation to facilitate transparency, monitoring and accountability including implementation of health impact assessments.

Empowering community participation in governance for health and the commercial determinants of health.

Investing in institutionalised and empowered community participation in governance for the commercial determinants of health, as part of a whole-of-society approach, is needed to deliver effective, equitable, long-term and health-enabling environments across the life course. This involves working with community-based organisations, Indigenous people and communities, civil society, the media and health-aligned local commercial actors, youth, people living with NCDs, and academics.

Actions could include:

- 3.1. Institutionalising community participation as part of action on the economic and commercial determinants of health;
- 3.2. Strengthening commercial determinants considerations in existing health-in-all-policies approaches including Healthy Islands, healthy cities, and other settings-based approaches.

Strengthening governance for the commercial determinants of health in development approaches.

Building public sector capabilities to integrate economic

and commercial determinants of health considerations within development strategies is essential for advancing the UN Sustainable Development Goals (SDGs). This includes development finance, debt relief, tax agreements, trade mechanisms, and the governance of global public goods, such as essential medicines and key health sector inputs. Actions could include:

- 4.1. Exploring the adoption of innovative economic and development approaches that create enabling markets for health and reduce harm from the negative externalities of commercial products and practices;
- 4.2. Integrating redress for NCDs, mental health, injuries and violence related to climate change within relevant finance discussions;
- 4.3. Integrating economic and commercial determinants of health considerations within discussions on development financing including debt;
- 4.4. As part of addressing the commercial determinants of health, implementing rules that prevent profit-shifting.

Investing in SIDS-SIDS and triangular cooperation for action on the commercial determinants of health.

Collective political leadership and action among SIDS, with the support of international partners, is critical to the addressing the commercial determinants. It enables the development of regional and SIDS-level norms, protection against industry interference, and capacity building.

Actions could include:

- 5.1. Integrating commercial determinants of health considerations within the implementation of SAMOA pathway commitments;¹⁴
- 5.2. Exploring a ONE UN approach to the commercial determinants of health;
- 5.3. Considering the establishment of a SIDS Technical Network on economic and commercial determinants of health, with support from WHO and partners.

¹⁴ The Small Island Developing States Accelerated Modalities of Action Pathway (2014) on the sustainable development of SIDS.

Adopted at 3rd International Conference on Small SIDS, reaffirmed by the UN General Assembly.



Approach to Development

The technical paper was developed through an integrative review approach that used diverse methods to contextualise and explore processes that influence concepts, issues, and outcomes (4). This entailed an iterative approach in which rapid reviews and early drafts were undertaken, produced, and shared for comment. Emerging themes were analysed iteratively among the authors using inductive coding. Initially, this coding began with a rapid review of the commercial determinants of major risk factors for NCDs and mental health, such as tobacco products, alcohol and foods high in fat, sugar and salt before broadening out to acknowledge the systemic impacts of business practices, corporate governance and multisectoral policy-making with potential to shape health outcomes for NCDs, mental health, injuries and violence. Data sources for analysis included: English-language or English-translated peer-reviewed research from public health and other relevant disciplines; publications by UN agencies, international organizations and WHO Member States; and grey literature including publications by civil society and media organizations. The review prioritized research on countries listed as SIDS, and/or as Associate Members of United Nations Regional Commissions. Descriptive statistics are used throughout where appropriate. The nearly 300 bibliographic references included were also carefully selected to reflect the depth and breadth of knowledge on commercial practices in SIDS, in line with their systemic impacts discussed above, and provide a resource for readers.

Themes of the technical paper were further iterated and expanded through four stages of review, in order: invited review by members of the High-level Policy Expert Group formed to advise the SIDS High-level Technical Meeting and Ministerial Conference on NCDs and mental health in December 2022; expert discussions at a deep-dive session on the commercial determinants of health at the SIDS High-level technical meeting on NCDs and mental health on 17-18 January 2023; invited review of the post-meeting draft paper by WHO technical units and external experts on the commercial and economic determinants of NCDs, mental health, injuries and violence from March-June 2023; and expert discussions at both a plenary session on multisectoral collaboration to address

NCD risk factors and commercial determinants, and a breakout session on the commercial determinants of health, at the SIDS Ministerial Conference on NCDs and mental health on 14-16 June 2023. The list of countries and organisations represented during the deep-dive session on the commercial determinants of health at the SIDS High-level technical meeting on NCDs and mental health and the plenary and breakout sessions at the SIDS Ministerial Conference on NCDs and mental health are available in Annex 1.

Approach for developing resource annexes

As part of the development of the technical paper, Annex 2 was prepared as a collection of relevant implementation guides, technical and policy packages while Annex 3 was prepared as a collection of relevant milestones and commitments. Resources were identified progressively based on prior technical work, the iterative review of literature, and review of the resources that emerged and predominated in inputs and feedback from both WHO and external contributors and reviewers. Inclusion was based on both the perceived significance and relevance of resources on the SIDS context for readers, signposting to a non-exhaustive list of helpful resources for providing further context.

Approach for identifying, preventing, and managing conflicts of interest

A rigorous and process was employed to identify, prevent, and manage potential, apparent, and actual conflicts of interest among external experts in line with the requirements of the WHO Framework of Engagement with non-State Actors (FENSA) and related policies. All external experts were required to submit declarations of interest ahead of contributing to or reviewing the Technical Paper. The responsible technical unit undertook a careful assessment of all declarations of interest in accordance with FENSA. All participants in the WHO-convened SIDS meetings noted above also submitted declarations of interest and were assessed for conflicts of interest as a condition of their attendance. This approach safeguarded the normative integrity and scientific accuracy of the technical paper's development and review from conflicts of interest.



Chapter One

The case for an economic and commercial determinants lens on SIDS

Key Messages

SIDS share challenges due to remoteness, small populations, narrow resources bases, low production capacity, dependence on external supply, undiversified economies and low GDPs.

As a result, SIDS grapple with a uniquely severe and intractable set of health challenges which result in drastic health inequities, high NCD prevalence, and negative health outcomes arising from and exacerbated by external shocks, such as climate-related events and disasters.

The economic vulnerabilities and dependencies of SIDS create choices between servicing debt, investment in health and health determinants, or investing in disaster-preparedness.

The impact of commercial practices in SIDS is shaped by structural determinants, including economic and contextual factors, which can lead to power asymmetries, market failures and unaddressed negative externalities.

Commercial practices, especially those of powerful foreign commercial actors, can undermine government action to tackle NCDs, injuries and violence, and mental health conditions.

Multisectoral approaches to improve health should include action on commercial determinants through strengthened governance for health, particularly safeguarding against conflicts of interest.

This Paper reviews the commercial determinants of health in SIDS and provides recommendations for action to improve health in SIDS in relation to NCDs, mental health conditions, injuries and road safety (a summary of these can be found in Annex 4). It outlines how commercial and economic determinants are among the key social determinants of these health issues. It also explores the pathways by which commercial practices affect health and the opportunities for SIDS to improve the economic and commercial determinants of NCDs, mental health conditions, injuries and road safety (a summary of existing WHO technical packages can be found in Annex 2). The opportunities for improvement run along political commitment to health and health equity, improved governance for health, innovative policy responses, and leadership in exploring economic approaches that protect health and the planet (existing political commitments can be found in Annex 3).

1.1 SIDS face economic and health challenges characterised by avoidable health inequities

Significant health challenges remain for SIDS. Of those who die from a major NCD, over half die prematurely between the ages of 30 and 70 years old (5). Further action is needed to support SIDS in achieving SDG target 3.4 by 2030—reducing by one third premature mortality from NCDs through prevention and treatment and promotion of mental health and well-being. Premature mortality negatively impacts development through lost human potential and productivity, and increased health system costs. Action to improve these health outcomes directly affects and is affected by factors captured in other SDGs as they target the distribution of the social determinants of health: those social, economic, commercial, political and environmental conditions in which people live and that impact health and well-being. These determinants include:

- i) Access to nutritional and safe food, safe water, education, job opportunities and housing.
- ii) The quality of schools, workplaces, the built environment, and community settings.
- iii) The composition of social networks and nature of social relations and the wider set of systems shaping the conditions of daily life (6).
- iv) Having sufficient governance capabilities to govern for health, including regulating in the

public interest, fostering commercial innovation for health, tackling corruption, addressing policy incoherence and conflicts of interest.

It has been estimated that social determinants of health account for 30-55% of all health outcomes globally, exceeding the contribution of the healthcare sector (7). Therefore, improving health outcomes necessitates acting on the social determinants. For example, different dimensions of social identity and location, including race and ethnicity, gender, sexuality, employment socioeconomic status, disability, immigration status, a history of migration and forced displacement, population ageing, geography, and more, have an impact on differential access to opportunities for health (8).

The distribution of health outcomes between different social groups is also impacted by structural inequities in the distribution of power and resources between groups. In SIDS these are produced and reproduced through the social determinants and contribute to growing health inequities, including in both physical and mental health. The unequal distribution of power and resources within and between different social groups creates inequities in the immediate, visible circumstances of peoples' lives—their access to healthcare, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities—and their chances of leading a safe and healthy life. These differences in circumstances affect the opportunities of individuals and communities and accumulate over the life course of individuals to lead to health inequities, within and between countries (9).

1.1.1 Although SIDS are very diverse, they face a common set of health and development challenges, and economic vulnerabilities

SIDS are a distinct group of countries that despite their differences, face common economic and development challenges arising from their small populations and small landmasses, their spatial dispersion and remoteness from major markets, narrow resource base and low production capacity, and colonial history. The low levels of internal resources and domestic production capacity that results from these common challenges, is implicated in their high exposure to external shocks, not only economic shocks but also including severe climate-related events and natural disasters. The combined economic and development

challenges lead to a common set of health challenges across most SIDS including:

- i) A high prevalence of NCD risk factors and disease burden.
- ii) A higher burden of disease related to maternal, neonatal, and nutritional conditions.¹⁵
- iii) Lower human, financial and medical resources and higher costs health services impacting the capacity of the health system to respond to NCDs and other diseases.
- iv) Increased risk and severity of health emergencies, including for those living with NCDs and from outbreaks of communicable disease, stemming from greater exposure and vulnerability to the effects of climate change, sea level rise and extreme weather events.
- v) Interactions of present and future threats from climate change with pre-existing circumstances and trends of food insecurity caused by the displacement of traditional diets with imported high in saturated fat, salt and sugar (HFSS) foods and beverages.
- vi) Urban populations particularly vulnerable to the impact of health emergencies and health security threats, due to high urban density coupled with increasing and unplanned urbanisation.
- vii) Legacies of colonialism that create, in some instances, vulnerabilities to the negative externalities of economic and commercial determinants of health. These legacies include

economic dependency on the production of single often health-harming commodities, reduced economic self-sufficiency, and increased dependency on imported capital and material.

- viii) Lack of access to development financing including Overseas Development Assistance (ODA), which is critical for addressing the acute health challenges and broader development needs that are essential for healthier populations.

The COVID-19 pandemic accentuated the interlinked nature of these challenges. SIDS populations were identified as being at heightened vulnerability to and risk of severe COVID-19 as a result of high a prevalence of NCDs caused by, among other risk factors, obesity, tobacco use, and alcohol consumption. Health systems already under strain from increasing rates in diseases linked to health-harming products had reduced capacity and resources for responding to the pandemic. The risk to people living with NCDs was exacerbated as the urgency of the response to COVID-19 diverted both human and financial resources from the continuous care and treatment inherent to the management of chronic disease.

Moreover, the heightened risk to SIDS population was not reflected in their prioritization for vaccine distribution: along with other low- and middle-income countries, many SIDS were forced to wait while high-income countries secured sufficient vaccines (10). By one



Sugar cane factory on New River in Orange Walk County, Belize. © Adobe

¹⁵ This is despite improvements in the Caribbean in particular.

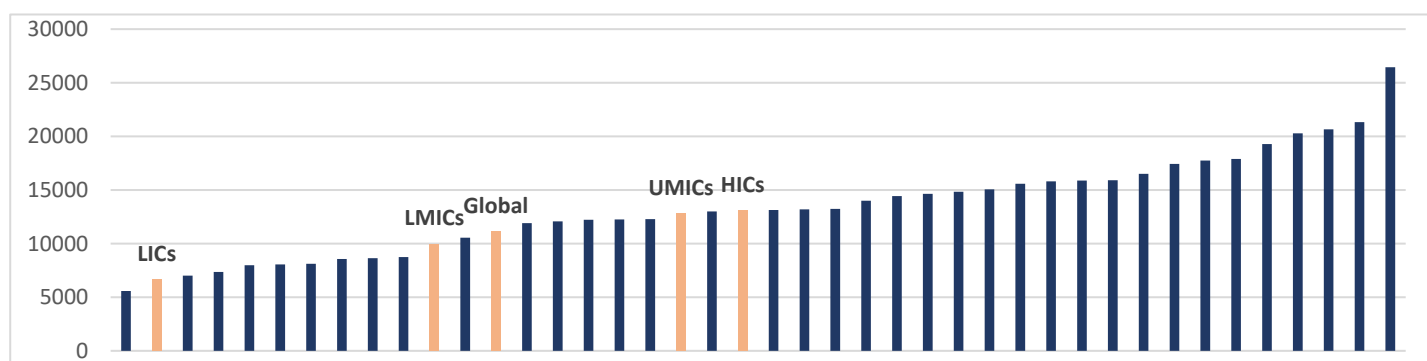


Fig. 1: Rates of DALYs per 100 000 population; all SIDS and averages by World Bank income groups and globally

year into vaccine availability, over half of SIDS had vaccine coverage of less than 40% (11). At the same point in the pandemic, coverage across high-income and upper-middle-income countries averaged at around 70% (11). This meant a majority of SIDS had vaccine coverage profiles similar to the 30% of lower-middle income countries despite having rates of disability adjusted life years per 100 000 population more similar to those of upper middle- and high-income countries (Figure 1) (11, 12).

The pandemic also shone a spotlight on the impact of interconnected challenges beyond the health sector on SIDS. For example, it revealed how food insecurity must feature as an important consideration within models of social protection. It also intensified existing vulnerabilities related to gender-based violence, mental health issues, and childhood obesity. These impact on health status and health systems were also exacerbated by the shock suffered by the vulnerable economies of SIDS—the OECD reports that in 2020 the GDP of SIDS nations dropped by 6.9%, versus 4.8% across other LMICs (13).

1.1.2 Achieving health and development goals requires addressing the commercial determinants of health

In the outcome statement of the 2021 SIDS Summit for Health, the representatives of SIDS Member States recognized that their nations face “acute and existential health and development threats” (14). They also recognized the need for multisectoral and whole-of-government approaches to address these threats, including action on the environmental, economic and social determinants of health (14). Among the critical influences of these factors are commercial determinants of health, defined as the activities by commercial actors that affect people’s health positively or negatively and the

environments in which commerce takes place. For example, it has been estimated that at least a third of preventable global mortality is due to commercial practices in just four industries (12, 15).

Underpinning economic and commercial determinants of health is an understanding that commercial actors, including large multinational companies and small- and medium enterprises, exercise broad influence on the physical, social and culture environments in which people live (16). As such, commercial actors impact the right of every person to achieve their highest attainable level of health and well-being. This is particularly true in SIDS, where government resources and budgets are exceeded by the size, scale and revenue of multinational companies, state-owned companies, and foreign commercial actors. This creates a power asymmetry between SIDS and commercial actors, which is in turn exacerbated by the international trade system in the case of foreign commercial actors, and interconnectedness of small populations in the case of local commercial actors.

Commercial actors have a critical role in ensuring positive outcomes from the commercial determinants of health. The role can be made more positive by SIDS governments leveraging co-benefits and partnerships to prevent NCDs and injuries and promote mental health. This cooperative approach is particularly needed because the remoteness of many SIDS results in a high transaction and transport costs, few economies of scale, and a lack of price transparency and quality assurance within health systems. As a result, commercial actors have the potential to support improved access to essential, high-quality, safe, effective and affordable medicines and health technologies, including for NCDs. For example, engagement between WHO and the pharmaceutical industry has included supporting SIDS to access prequalified medicines and health technologies (17). However, exploring the full

potential of commercial actors to be health partners is beyond the scope of this Technical Paper, which instead focuses on the commercial determinants of NCD risk factors, injuries and violence, and mental health and how these negative health outcomes and related externalities may be addressed.

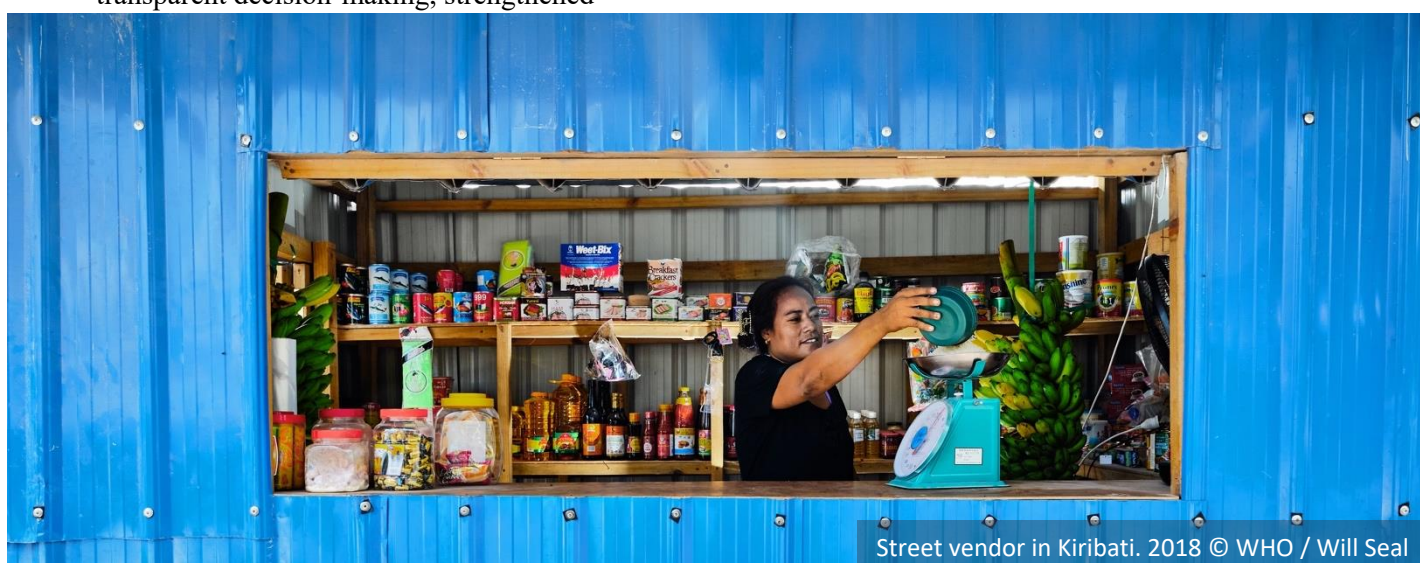
1.2 SIDS face specific challenges relating to conflicts of interest and negative health externalities from economic activity

In the Rio Declaration¹⁶ SIDS and the international community committed to safeguarding against conflicts of interest as part of strengthening governance for health and development while also increasing the involvement and accountability of commercial actors in these processes (18). This included:

- (i) Adopting better governance for health and development, including working across different sectors, strengthening health in development strategies and the leading role for health ministries, fostering collaborating with commercial actors while safeguarding conflicts of interest, and strengthening collaboration between countries on these topics.
- (ii) Promoting participation in policymaking and implementation, including inclusive and transparent decision-making, strengthened

accountability, empowering communities, governance approaches which span sectors and involve civil society and commercial actors, while safeguarding conflicts of interest.

- (iii) Further reorienting the health sector towards reducing health inequities, including developing public health policies that address the social, economic, environmental and behavioural determinants of health, building public health capacity, promoting health impact assessment.
- (iv) Strengthening global governance and collaboration, including adopting coherent policy approaches, striving to ensure mutually supportive international development goals and objectives to improve health equity, implement the FCTC, implement political commitments on NCDs ensuring a focus on reducing health inequities, and fostering North-South and South-South cooperation.
- (v) Monitoring progress and increasing accountability, including assessing the impacts of policies on health and societal goals to take these into account in policymaking, using intersectoral mechanisms such as Health-in-all-Policies, and promoting monitoring systems that take into consideration civil society and commercial actors, with appropriate safeguarding against conflict of interest.



Street vendor in Kiribati. 2018 © WHO / Will Seal

¹⁶ Rio Political Declaration on Social Determinants of Health (2011) Adopted during the World Conference on Social Determinants of Health, endorsed in WHA Resolution 65.8

These commitments stress the importance of safeguarding against conflicts of interest not only in health policy development, but also in the multistakeholder and multisectoral approaches needed for strengthening health in development approaches.

Safeguarding against conflict of interest is of critical importance in SIDS and all countries to ensure that health and health equity outcomes are not undermined by commercial practices. For example, a 2022 study on the implementation of a subset of WHO Best Buys related to risk factors found that commercial actor influence is negatively associated with their implementation (16).

1.2.1 Economic vulnerabilities in SIDS impact public health outcomes

Small, dispersed populations constrain labour supply, domestic production, and market size, therefore limiting the potential of economies of scale and macroeconomic diversification. This means that many SIDS are import dependent and have concentrated economic activity around a few sectors. While a handful of SIDS rely on exploiting their natural resources, including the production of tobacco, alcohol, sugar and fossil fuels, most are service economies reliant on tourism and finance. This economic concentration amplifies the macroeconomic impact of sectoral shocks (19). This vulnerability poses a risk to key social determinants of health, such as financial stability, household income, and job opportunities.

The lack of diversification can also foster close-knit relations between political and commercial leadership

(20) which can give rise to conflicts of interests of relevance for health in SIDS. This is particularly true where there is economic dependency on health-harming products such as tobacco or alcohol. SIDS may also face greater pressure from commercial actors due to the interconnectedness of their small populations, or the asymmetry in their economic weight relative to that of multinational commercial actors (20, 21). For example, small markets with heterogenous commercial actors dominated by single shareholders may simultaneously connect both health-harming and health-promoting goods and services—such as the use of the same manufacturing and bottling facilities for water, milk, sugar-sweetened beverages (SSBs) and alcohol. This creates a context where policymakers are more likely to be directly and indirectly connected to health harming commercial actors through personal relationships, political contributions or ownership (22, 23).

Due to their small size, SIDS economies are necessarily open to trade and reliant on a handful of trading partners. This leaves SIDS more exposed to market fluctuations with implications for economic vulnerability as well as the associated health outcomes. Moreover, trade and investment agreements do not consistently enable SIDS to promote and protect health. In some cases, the timing, extent and manner of their opening to global trade, particularly accession to and implementation of the WTO Agreement, has been shaped by pressure from high-income countries and intergovernmental organisations—with this pressure underpinned by pre-existing power imbalances,



Tobacco warehouse in Cuba. © Adobe Stock / Firman

relationships of dependency, and commercial interests (24-28). Commercial practices also shape markets and financial flows in ways that may disregard or undermine the public health interest, often enabled by economic approaches that put commercial interests before health (29, 30). For instance, inadequacies in supply chains may impede the importation of cost-effective medicines and health technologies undermining their affordability for SIDS. This means that trade agreements may simultaneously increase access to unaffordable pharmaceuticals and affordable health-harming products (31-33).

SIDS that are also geographically remote face additional challenges in accessing international markets. When taken together with their small size, this remoteness leads to high production and trading costs, which limits investment, competitiveness, and the integration within global value chains. This has implications for food and food sovereignty, as well as access to medicines and other essential goods and services provision.

Many SIDS are also highly dependent on tourism, which constitutes more than 30% of their total GDP (34). This sector is dominated by a small number of transnational commercial actors (35). Its importance is longstanding and has both direct and indirect impacts on health (36). For example, tourism is a driver of a shift toward increased and increasingly unhealthy food and beverage imports that meet the tastes of tourists, including sugar sweetened beverages and alcohol (37, 38). The

construction, waste and pollution it requires also results in environmental impacts detrimental to health (39).

Despite being an important sector for government revenue and, therefore, a promising source of financing for health-critical public expenditure (35, 40), this potential increase in financing for public services from tourism does not always fully materialise. Similarly, the potential for improvements in the social determinants of health from economic growth and greater local employment is not always fully met. This is in part due to economic leakages, including the consumption of imported products by tourists, the repatriation of tourism profits and land-rent incomes to non-domiciled commercial actors (34, 36). This is particular true for certain sectors, such as enclave tourism development (land-based or cruise), which offer only restricted opportunities for local communities to benefit from tourism and sometimes no opportunities at all (35, 36).

Economic opportunities relating to tourism are not gender neutral and this has implications for the social determinants of health. Women are more often working in precarious, lower-paid employment, including subsistence farming, which do not meet the demand created by the tourist industry. In the Caribbean, for example, women are generally not the producers of the specialist foods demanded for tourism (35). In the Pacific, subsistence farming in rural communities is also dominated by women, despite owning little agricultural land and facing lack of access to seed, technologies and essential financial services



Landscape in Suva, Fiji, of the coast, harbour and a cruise ship. 2017 © WHO / Yoshi Shimizu

necessary for agricultural productivity (41). Research in the Seychelles indicates that most jobs directly or indirectly related to commercial tourism were held by men and expatriate workers (42).

As shown, SIDS are ensnared in a complex web of economic and health challenges, characterized by limited labor supply, lack of diversification, and a reliance on a handful of vulnerable sectors like tourism. These constraints not only create dependencies on imported, health-harming products but also can foster conflicts of interest between political and commercial entities, complicating public health initiatives. Trade agreements may exacerbate these issues by inadequately addressing health concerns and increasing market vulnerabilities. The significant role of tourism in these economies comes with its own set of drawbacks, such as economic leakages and gender-specific employment challenges, which further strain the social determinants of health. Overall, the unique structural and economic factors facing SIDS have wide-ranging implications for public health, creating a landscape where systemic vulnerabilities are not just economic but profoundly affect the well-being of their populations.

1.2.1 Gaps in human and institutional capital create challenges for governance for health

Small, dispersed populations mean high per capita costs in delivering essential public services (19). This makes it challenging to build health system capacity for delivering care and implementing health policies and interventions—including on NCDs, injuries and violence and mental health conditions. For the same reason, it is also challenging to make broader government investments in social determinants of health such as education, social security, water and sanitation, safe and sustainable infrastructure and the governance capabilities needed to manage conflicts of interest (19). Without the pooling of resources, SIDS are also unlikely to be able to generate significant economies of scale (36), limiting the scope both for investment from commercial actors and for effective regulation and standards-setting to support health.

These characteristics also make human and institutional capital hard to develop and maintain (19). Resulting gaps in institutional and human capital can cause gaps in capacity that otherwise would allow SIDS to improve the commercial determinants of NCDs, mental ill-

health, injuries and violence while safeguarding against harmful commercial practices. Examples include gaps in the capacities needed for the full implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) (43) or for safeguarding against conflicts of interest as part of the development and the implementation of WHO-supported NCD policies, including those related to health-harming commercial products and practices (16).

Health harming commercial practices in SIDS occur in part because of economic environments that cause disproportionate benefit—including human capital—to accrue to foreign commercial actors (44). This occurs most of all when commercial actors decrease their tax burden and increase profits while also socialising the financial burdens and social harms that result from their business operations. This means they are increasing their profits by paying less tax while leaving local governments and communities to pay for the costs that result. The latter include rising NCD burdens, stalled living standards, biodiversity loss, environmental degradation, and climate change. These uncompensated for costs and harms, known as negative externalities (45), fall on the public sector, communities and individuals. Negative externalities related to health outcomes can be exacerbated by harmful commercial practices that undermine tax revenue, shift



profits overseas and fail to develop local human capital (46).

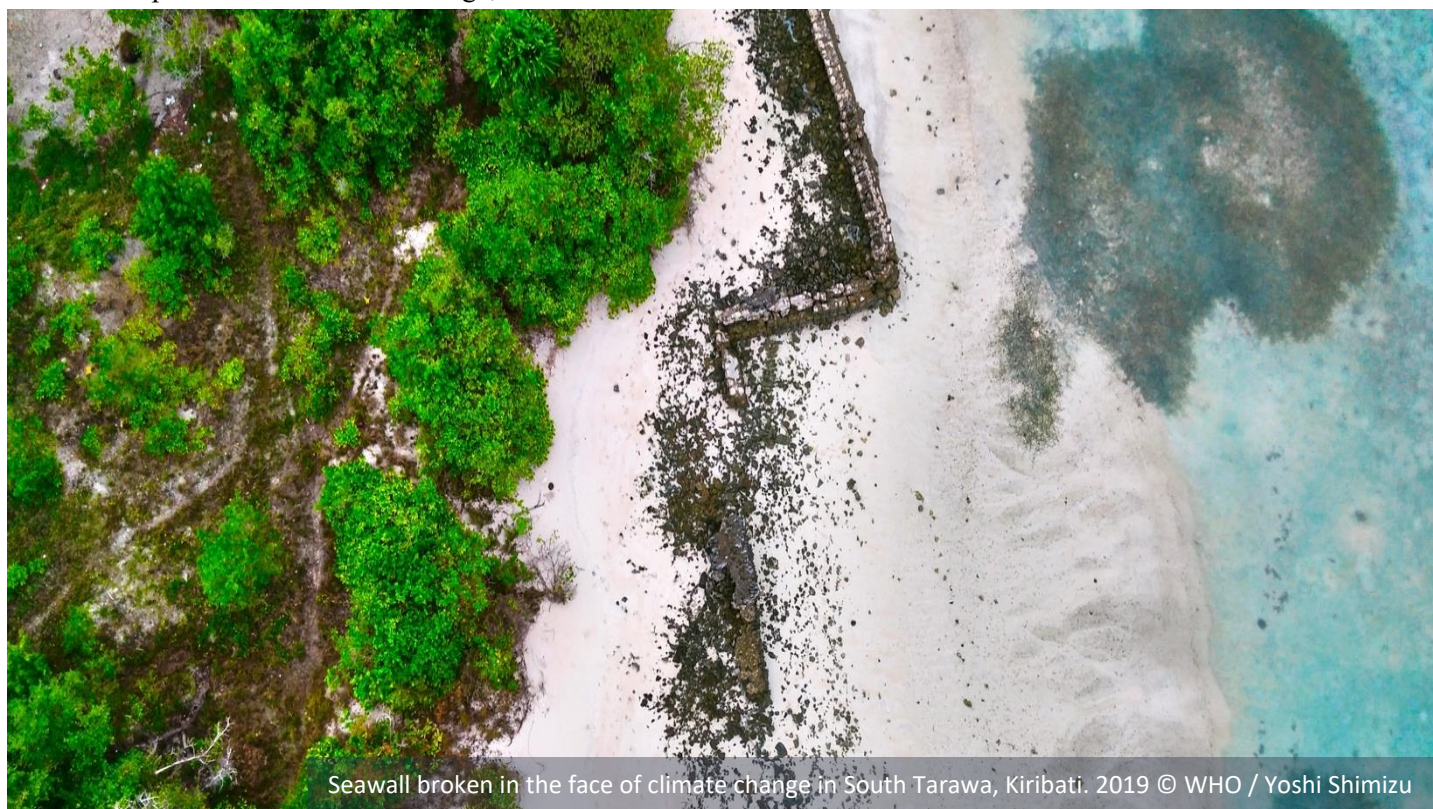
1.2.2 The vulnerability of SIDS to the negative externalities of commercial practices damaging to the environment

Commercial practices cause negative externalities in the form of environmental damage and this damage also causes and contributes to NCDs, mental ill-health, injuries and violence. Despite making minimal contributions to and deriving almost no financial benefits from these practices, SIDS now face existential risks from climate change and unfair health burdens from NCDs, injuries and violence, and mental health conditions. For example, rising temperatures, increased frequency of extreme weather events, and sea-level rise lead to a higher incidence of climate-related diseases, malnutrition due to compromised food security, and injuries from natural disasters. These changes in environmental conditions are direct threats to the physical well-being of SIDS populations (47).

Accounting for the economic and commercial determinants is, accordingly, indispensable to the multisectoral and multi-stakeholder policies and approaches needed for improving these health burdens in SIDSs. For example, biodiversity loss is an enduring and sometimes irreversible consequence of unsustainable commercial practices and climate change, which is itself

commercially driven. Biodiversity loss is extremely detrimental to the livelihoods of many in SIDS since many of the sectors, such as fishing and tourism, which are central to their economies are dependent on biodiversity (48). The resulting harms are more than economic: natural resources have aesthetic and spiritual value for many communities in SIDS while also contributing to their food supply, water safety and protection from storm surges, beach erosion and floods (49).

Accordingly, climate change is a pronounced risk for the physical, mental, social and economic well-being of SIDS. It is, as a result, already displacing entire small island communities both through immediate forced displacement due to sudden climate disaster and by slower outward migration provoked by deteriorating living conditions (50, 51). Both threaten socioeconomic and human security with consequences including the physical and mental stress associated with the loss of ancestral homelands and the cultural, economic and social impacts of internal migration (49, 52, 53). Forced migration comes, however, with particularly acute challenges for emergency response and resettlement while more gradual migration comes with different challenges in maintaining health and social services during such a transition (51). It is also important to recognize that some people are displaced multiple times with cumulative impacts on health and well-



Seawall broken in the face of climate change in South Tarawa, Kiribati. 2019 © WHO / Yoshi Shimizu

being, employment and education, and availability and access to care.

1.3 SIDS face common challenges in mobilizing the resources needed to strengthen governance for health

In addition to exacerbating existing health and economic challenges, the COVID-19 pandemic and its consequences also exposed and continues to amplify the interlinked challenges that SIDS face in mobilizing the public and private resources needed to invest in enhanced state capabilities, improved commercial determinants of health and sustainable development.

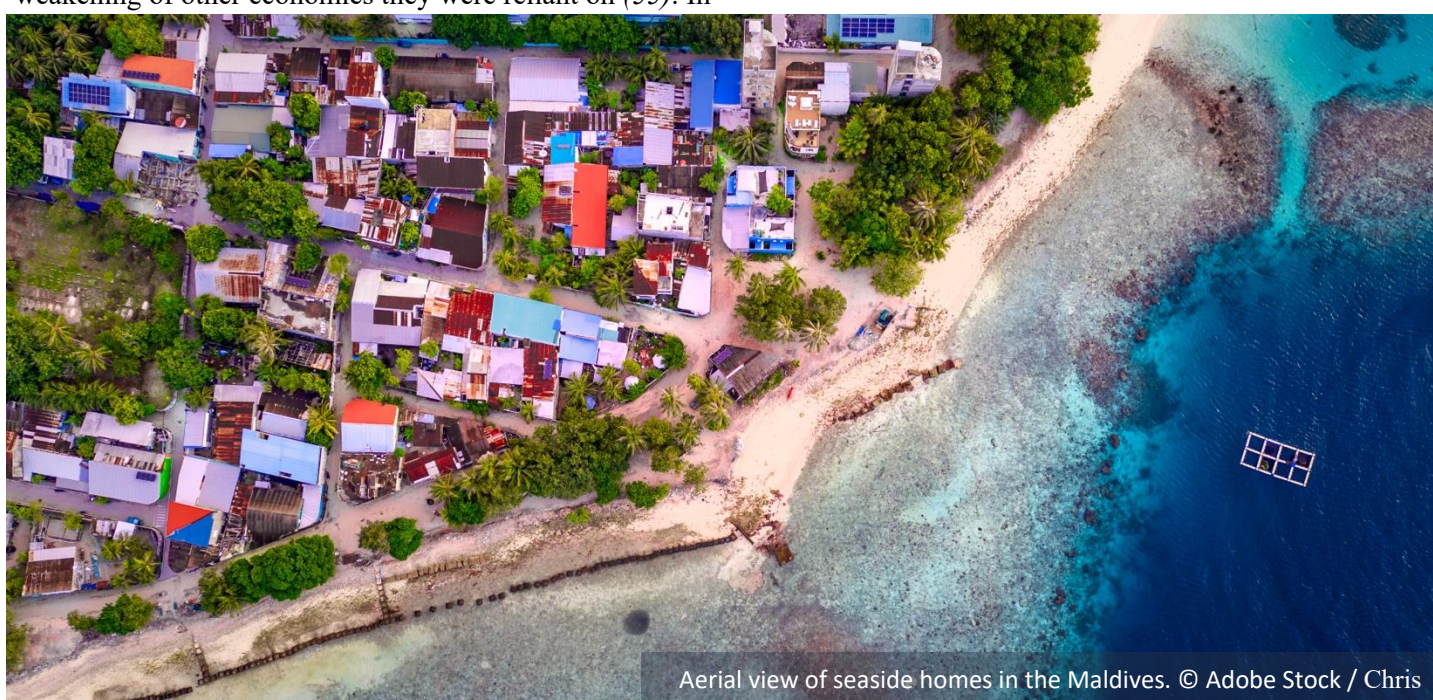
Unlike in most other LMICs, the unique resource mobilization challenges of SIDS mean external finance is dominated by remittances and ODA, while private finance flows remain small and volatile (54). This contributes to high fiscal deficits and public debt which, in turn, creates barriers to increasing public expenditures and investing improving the determinants of health, including governance capacities needed for addressing commercial determinants (54). The vulnerability of revenue to external shocks also hinders the maintenance of essential government spending and access to development finance.

This was the experience of many SIDS during the pandemic as revenue collapsed due to a combination of low tourism rates, remittances reductions and the weakening of other economies they were reliant on (55). In

this case, one consequence of this collapse in revenue and lack of alternative external financing meant that resources, including staff and government funds intended, for NCDs had to be redirected toward support the COVID-19 response (56). Such disruptions are particularly problematic for those living with NCDs who need regular care and were also more at risk of severe COVID-19 (56, 57). They also show the risks to health that come with the combination of the challenges SIDS face in mobilizing resources and their particular vulnerability to external shocks. In some SIDS, however, the COVID-19 response triggered greater expenditure on the management and treatment of NCD due to the greater risk and severity of COVID-19 among this group—for example, Mauritius increased public health financing, including for NCD prevention, management and care (58, 59).

1.3.1 Debt, debt obligations and remittances are key determinants of health in SIDS

The common characteristics of SIDS mean that they face high debt levels and debt distress (13). Prior to the pandemic, 11 out of 22 SIDS faced solvency issues and qualified as either high risk or in debt distress—with mutually reinforcing debt servicing burdens, current account deficits and elevated public debt levels that mean more fiscal space must service debt and less is available to invest in development (60). These features combine to make SIDS uniquely vulnerable to economic shocks and global financial shifts (19). This can be seen in the



Aerial view of seaside homes in the Maldives. © Adobe Stock / Chris

economic fallout from the COVID-19, which has exacerbated the risk of sovereign debt crises and potential defaults.

More broadly this means that many SIDS are forced to make hard choices between servicing external debt and attending to critical social determinants of health by paying salaries, providing benefits to citizens, and investing in key infrastructure—such as that needed in advance of potential catastrophic future weather events (61).¹⁷ Although the international community reacted quickly to the liquidity problems faced by SIDS as a consequence of the pandemic, this has not been sufficient for many SIDS and those with the highest debt burden have remained outside of recent global debt processes (60).

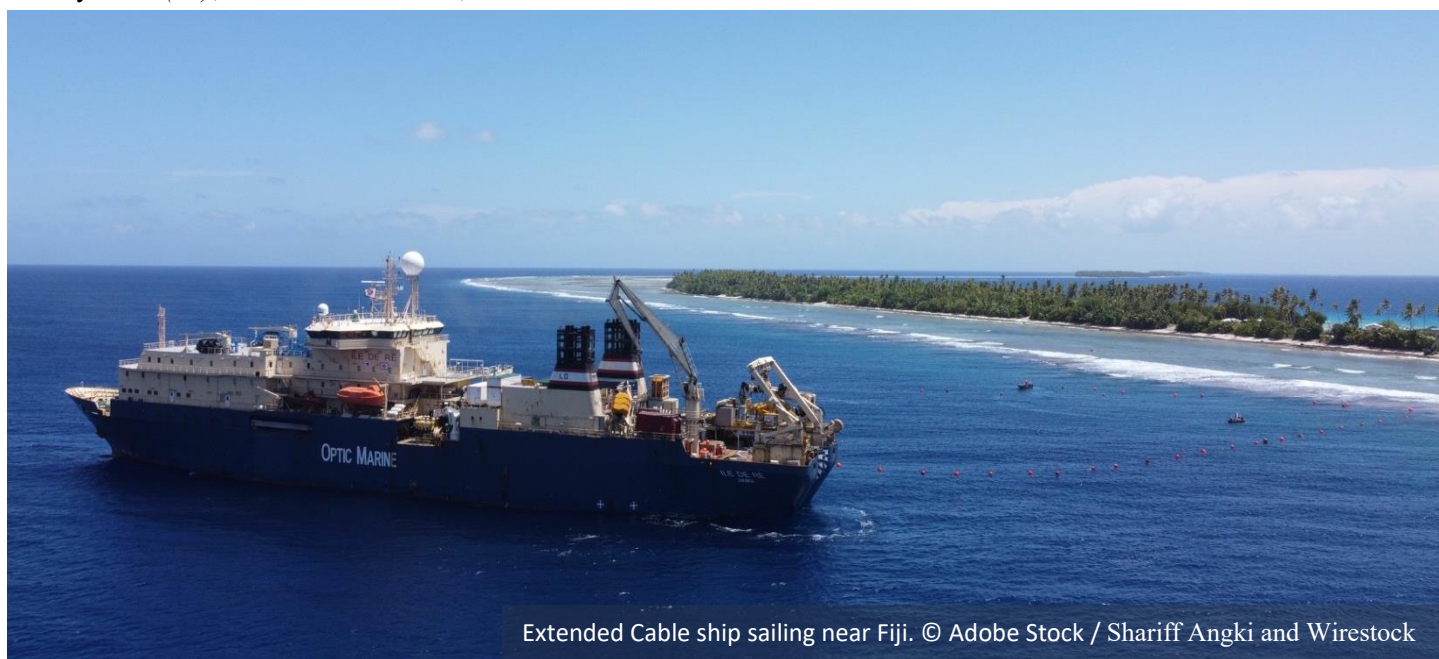
Despite the challenges outlined above, SIDS have been remarkably resilient in preserving and promoting social inclusion and well-being while resisting external dependency (62). Despite high and often increasing transaction costs, remittance transfers have contributed to this resilience as they are predictable, sustainable, and often targeted to vulnerable and hard-to-reach households (63).

Despite SDG target 10.C to reduce to less than 3 per cent the transaction costs of migrant remittances and eliminate remittance corridors with costs higher than 5 per cent by 2030 (64), remittance transfers, to SIDS countries

continue to face cost barriers. For example, SIDS in the Pacific experience remittance costs above 10% (65). Unlike other natural disasters during which remittance transfers remain a vital financial lifeline for those receiving them, and in many cases increase, during COVID-19, migrant and low-wage workers bore the brunt of income losses and health risks associated with the pandemic (66). This meant these migrant populations were not in a position to maintain, let alone increase, remittances to meet the need of those in SIDS. This could be seen in 2020, where remittance inflows were mixed with increases relative to the previous year in Latin America and the Caribbean (by 6.5%) and South Asia (5.2%), but decreases in East Asia and the Pacific (by 7.9%) (67).

1.3.2 Development approaches that deliver for health in SIDS need to integrate economic and commercial considerations

The specific needs of SIDS are not well addressed in the global governance architecture or development agendas (68). Resulting global economic systems leave SIDS vulnerable to harmful commercial practices that are governed by policy decisions taken elsewhere. This can be seen in the displacement of traditional diets by the financialisation and commercial consolidation of land for tourism or agriculture, shifts in demand in international



Extended Cable ship sailing near Fiji. © Adobe Stock / Shariff Angki and Wirestock

¹⁷ As noted by the UN office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States.

markets, market speculation, and the commercially driven global shift toward the production and consumption of cheaper HFSS products (69-71). Similarly, the need to protect the tourism and hospitality sectors from financial loss has been used to oppose tobacco control policies. This is despite research from four CARICOM countries concluding that implementing smoke-free environments did not affect the arrival of tourists, tourism expenditure or the average length of stay (72). This inattention to the specificities of SIDS has also meant that economic approaches have fail to account for their susceptibility to how external shocks, whether domestic and global, can cause or exacerbate this type of tension between the public health interest and commercial interests (73).

In summary, the specific economic characteristics and vulnerabilities of SIDS that shape the commercial determinants of health include:

- i) Small, dispersed populations and narrow resource bases that constrain production capacity, domestic markets, economies of scale and economic diversification, meaning that SIDS' economic activity is predominantly focused on a small number of sectors, including those that are health-harming, such as tobacco, alcohol, sugar or in some cases fossil fuels.
- ii) Long distances, remoteness and small sizes reduce and diminish access to international markets leaving SIDS reliant on volatile and relatively expensive imports from a small number of commercial actors, based in an even smaller number of countries, while limiting scope for

integration within global value chains, which leads to higher production and trading costs, and limits investment and competitiveness.

- iii) Dependency on tourism with implications including employment disparities, environmental damage, and the shifting of imports to suit the preferences of tourists—often but not always in harmful ways.
- iv) An openness to trade and reliance on a handful of trading partners exposes SIDS to “trade fragilities”, tensions between public health interests and interests in maintaining trading relationships, and a concentration of economic activity in fewer sectors that increases the impacts of external shocks.
- v) Small populations, geographic size, and economic weight means greater social interconnectedness and asymmetries in power with respect to multinational commercial actors which can result in a greater number of conflicts of interest and particular challenges in managing conflict of interests.
- vi) Greater challenges in mobilizing the public and private finance needed to invest in health and health determinants including governance for health.
- vii) Debt, taxation and fiscal circumstances create challenges to increasing public expenditures and investing the determinants of health and in governance.
- viii) Development approaches where the specificities of SIDS are not always considered.



Avatiu Harbour in Avarua, Rarotonga, Cook Islands. © Adobe Stock / Tristanbnz

**Economic and commercial determinants of health considerations in Small Island Developing States:
Noncommunicable diseases, mental health conditions, injuries and violence**



Chapter Two

Impact of economic and commercial determinants on health and health equity in SIDS

Key Messages

Commercially determined exposure to risk factors contribute to the significant burden of NCDs, mental health conditions and injuries in SIDS.

Some commercial actors use their power – including their market concentration in SIDS – to interfere with and undermine public health policies and engage in practices harmful to human health and the environment.

There is a need to regulate health-harmful commercial practices—including by reducing the supply of and demand for harmful products as well as curbing air pollution—improve diets and develop safer infrastructure and lived environments.

At the same time, there is need for salutogenic, ameliorative and mitigative measures that incentivise commercial actors to improve food environments, promote physical activity, and support communities affected by climate-related events and disasters.

All measures need to be underpinned by action across government to protect public health objectives and prevent efforts to undermine them by commercial actors.

Economic diversification should be promoted to support this effort and overall resilience by reducing over-reliance on sectors centred on health-harming products and practices.

Addressing the commercial determinants of health requires an understanding of how harmful commercial practices in SIDS structure and are structured by broader power imbalances in global governance. Health and health equity in SIDS are determined by the distribution of commercial power and resources at national and global levels. The burden of NCDs, mental health conditions, road safety and injuries in SIDS is to a large degree determined by commercial products and practices along with other intermediary social determinants of health. The products and practices of commercial actors involved in the production and promotion of health-harming products, such as alcohol, tobacco and HFSS foods and beverages, are particularly detrimental in SIDS (33, 74).

Harmful commercial practices are, more broadly, also associated with negative externalities such as climate change, health-harming food environments, increased NCD incidence and an exacerbation of the social and economic pressures on already constrained budgets and fragile health systems of SIDS. They are also disproportionately negative among countries and populations that are benefiting the least from the harmful products and practices in question. In this way, they shape unfair and unjust health inequities within and between countries: the greatest health burden is too often concentrated in those communities that can afford it the least while the greatest profit is concentrated among those communities that suffer the least (75).

This section presents an overview of the economic and commercial determinants of NCDs, injuries and violence and mental health conditions. A summary of these can be found in Annex 4.

2.1 Economic and commercial determinants of tobacco use

Despite progress, current tobacco use rates remain high in SIDS. In 2022, 17% of adults aged 15+ in SIDS used tobacco, with a prevalence of 26% for men and of 8% for women. In some SIDS, more than half the adult male population (aged 15+) were currently using tobacco products in 2022 (such as Timor-Leste, 66%; Papua New Guinea, 54%; Solomon Islands, 53%; and Kiribati, 52%) (76). The countries with the top three highest rates of adult tobacco smoking in the world, in 2022, are in the Pacific region: Nauru with 45%, Kiribati and Papua New Guinea both with 40% of adults smoking (76). Generally, men in



SIDS smoke at approximately three times the rate of women (76). However, countries in the Pacific region have some of the highest rates of tobacco smoking among women in the world; estimated 45% of women (15+) in Nauru are current tobacco smokers, followed by 27% in Kiribati (76).

Despite relatively low overall rates of tobacco use in Caribbean SIDS, rates among young people (age group 13-15) in the Caribbean are amongst the highest in the WHO Region of the Americas (76). Novel and emerging products such as electronic nicotine and non-nicotine delivery systems, of which electronic cigarettes are the most common, and heated tobacco products are also becoming more widely available and accessible (76). For example, 30.9% of students aged 13-15 years in Timor-Leste were found to use tobacco products in 2019 (77). Similarly, in 2016, 33.3% of students in Papua New Guinea were found to use tobacco products and 19.6% of students used electronic cigarettes (78). While the major form of tobacco use is smoking, smokeless tobacco such as

snuff and betel nut with tobacco is also widespread in SIDS and especially in the northern Pacific with 38% of adults (18+) in Palau, in 2012 (79), and 22% of adults in the Marshall Islands (80) reported as using smokeless tobacco.

Tobacco use is one of the risk factors responsible for the high prevalence of NCD-related mortality and associated societal and health sector costs in SIDS (3). Tobacco use in SIDS is commercially determined with practices by the tobacco industry and its affiliates responsible for the product's penetration into these markets, its marketing within them, and the widespread availability of affordable tobacco products—including locally grown tobacco sold on the informal market. In some SIDS, tobacco cultivation and tobacco product manufacturing continue. The 2020 reports on the implementation of the WHO FCTC indicate that Kiribati, Marshall Islands, Micronesia (Federated States of), Palau, Singapore, and Tuvalu do not grow tobacco, while in Solomon Islands, Samoa, and Vanuatu, there is small-scale tobacco growing for personal use and sale (81-91). In 2017, the Niue Ministry of Social Services adopted legislation prohibiting the commercial growing and manufacturing of tobacco (92).

All but two SIDS have ratified the WHO FCTC and all Pacific Island SIDS were early ratifiers—this has proved a foundation for the adoption of successful measures on tobacco control (43). SIDS have used various measures to reduce demand for tobacco and, thereby, reduce tobacco-related death, disease and disability. For example, 13 SIDS have adopted legislation to make all indoor public places completely smoke-free (Antigua and Barbuda, Barbados, Guyana, Jamaica, Marshall Islands, Nauru, Niue, Papua New Guinea, Saint Lucia, Seychelles, Suriname, and Trinidad and Tobago) (93). In Kiribati, traditional community leaders have declared their maneabas (community halls and meeting places) tobacco-free, with over two-hundred such maneabas smoke-free as of 2018 (94). 14 SIDS mandate large graphic warning labels on tobacco products to warn the public about the dangers of tobacco use (Barbados, Fiji, Guyana, Jamaica, Mauritius, Saint Lucia, Samoa, Seychelles, Singapore, Solomon Islands, Suriname, Timor-Leste, Trinidad and Tobago, and Vanuatu) (93). Vanuatu and Niue have the largest graphic health warnings in the Pacific covering 90% of the display area (93, 95). Mauritius is the only country among the SIDS, other than Singapore, to have

implemented plain packaging (93, 96). 11 SIDS have put in place comprehensive bans on all forms of tobacco advertising, promotion and sponsorship (Antigua and Barbuda, Cabo Verde, Guyana, Kiribati, Maldives, Mauritius, Niue, Seychelles, Suriname, Tuvalu, and Vanuatu) (93). Only two SIDS, Mauritius and Vanuatu, levy a share of total taxes of at least 75% of the retail price of cigarettes, as recommended by WHO (93).

It is important that SIDS remain alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and stay informed of tobacco industry practices for undermining tobacco control. An example of these practices can be seen in how the tobacco industry exploited the COVID-19 pandemic to gain influence with decision-makers and interfere with public health policies. It undermined tobacco control by using government vulnerabilities such as heightened funding shortages, a susceptibility to corporate social responsibility organised around the pandemic response, and the diversion of political and legislative attention to grappling with pandemic (97, 98). By purporting to offer solutions for addressing the pandemic, the tobacco industry further impeded the development and implementation of tobacco control measures.

More broadly, the tobacco industry seeks to advance its interests with various commercial practices of interference including distorted misrepresentation of its economic contributions across employment, economic growth, tax revenue, and other indicators. These false figures are then used to overshadow the otherwise wholly negative economic story of the tobacco epidemic. The tobacco industry then seeks to leverage this false appearance of alignment between their interests and the public interest in job creation and broader economic goals into access to intergovernmental, national, and subnational policy fora and decision-makers and in particular those of the finance, customs, trade and agriculture sectors (99, 100).

2.2 Economic and commercial determinants of alcohol consumption

Alcohol consumption in SIDS causes and contributes to NCDs, injuries, and violence—including gender-based violence, suicide risk, crime and drowning (101, 102). As of 2019, alcohol consumption is generally lower in SIDS (4.35 litres of pure alcohol per capita in 2019 (15+)) than it

is globally (5.45), although the rates for the Caribbean region (5.43 litres of pure alcohol per capita) is closer to the global average. As is the case globally, alcohol consumption in SIDS is more prevalent among men (6.96 litres of pure alcohol) than women (1.74 litres of pure alcohol) (103). The global school-based student health survey found that alcohol use rates among students aged 13-17 was found to be 32.8% in Trinidad and Tobago and 48.9% in Jamaica in 2017, and 46.3% in Saint Vincent and the Grenadines in 2018 (104-106). By contrast, only a quarter of all adolescents between the ages of 15-19 years are current drinkers globally (107). Alcohol consumption among young people has a negative effect on brain development, decreased educational attainment, reduced mental well-being, greater alcohol consumption throughout the lifespan, higher likelihood of binge drinking and increased risk of alcohol use disorders and earlier development of liver cirrhosis.

Although SIDS progress on alcohol policy implementation is comparable to global trends, alcohol sponsorship and advertising remains a policy challenge in SIDS (108). Sports sponsorships by alcohol producers are prominent in SIDS. This is a way to market alcoholic and SSB brands to younger audiences and increases their risk of alcohol use and dependency in adulthood (109). Sport activities sponsored by the alcohol and SSB industry in SIDS include those in primary and secondary schools, for elite athletes, as well as community-based sports (109).



Alcohol advertisement, Kiribati. 2018 © WHO / Will Seal

The results of a review of interventions undertaken between 2000 and 2019 (inclusive) to improve the nutrition of SIDS populations found restrictions on alcohol availability and increased alcohol taxation were the most commonly partially or fully achieved policies (110). Similarly, a recent review found that all Pacific Island countries tax alcohol and in some cases these taxes have been implemented in such a way as to reduce alcohol consumption (111). At the same time, tools are needed to assist governments in preventing the alcohol industry from exploiting times of extreme mental stress, such as during the COVID-19 pandemic, as market opportunities to increase alcohol sales and use (108, 112).

Some commercial actors from the alcohol industry have played a role undermining public health policy objectives and opposing effective alcohol policies (109). The industry's power relative to the public sector has the potential to be affected by the way in which markets are concentrated among a few transnational alcohol corporations. For example, in 2020 one company held 57.2% of the market share in Latin America and the Caribbean (109). The implementation of alcohol policy is also undertaken by some SIDS in the complex context of links between alcohol consumption and tourism, and the role of alcohol as an export product in their economies. Industry market analysis anticipates that 2019 total beverage alcohol volumes in the Caribbean will be surpassed in 2024, positioning alcoholic beverage production as a commercial opportunity for SIDS in the context of COVID-19 pandemic recovery (113).

2.3 Economic and commercial determinants of physical inactivity

Physical inactivity is modifiable risk factor for preventing NCDs (114). Data from 2016 showed that globally, one in four adults (27%) are insufficiently physically active (115). In SIDS, one in three (33%) do not, on average, meet the global recommended level of 150 mins of moderate-intensity activity per week or equivalent (Figure 2). Levels of physical inactivity are higher in women compared with men (globally 32% in women versus 23% in men) and these differences are wider in SIDS (38% in women versus 28% in men). Women often face multiple barriers to being regularly active including fewer gender sensitive opportunities for participation in physical activity, as well as social, cultural and economic constraints (115). As of

2016, levels of physical inactivity between SIDS countries vary and are highest in The Marshall Islands (47%), Nauru (46%), Palau (45%) and Barbados (45%) (115).

Levels of physical inactivity in adolescents are very high, 81% in 2016, and highest yet in some SIDS. For example, data from 2020 showed that 87% of students aged 11-17 were not meeting recommended levels of regular activity in Nauru, Samoa, Tuvalu and Vanuatu, and 86% in Saint Vincent and the Grenadines (116). Of particular concern is the increasing time adolescents spend using screen-based technologies for entertainment and communications. Across these five countries, for example, students spent three or more hours per day doing sedentary

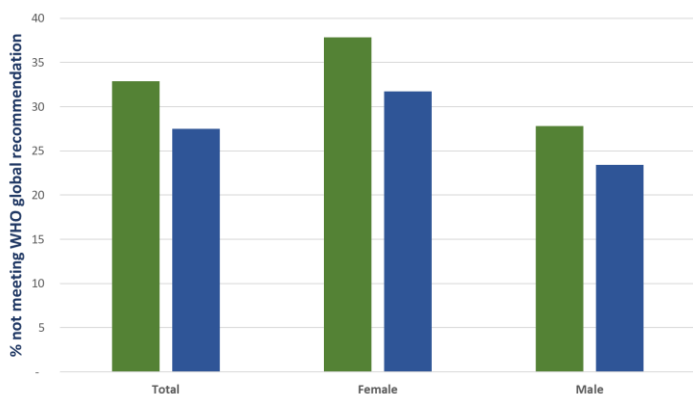


Fig. 2. Levels of physical inactivity in SIDS UN countries and globally in WHO Member States

activities, such as watching television, playing computer games or talking with friends online when not in school in 2022 (106, 117-120).

Physical inactivity creates a preventable burden on primary health care services and public health care costs. New estimates (Figure 3) reveal that in SIDS between 2020-2030, approximately 5.1 million new cases of NCDs and mental health conditions (such as heart disease, stroke, hypertension, diabetes, several cancers, depression and dementia) could be averted by increasing physical activity participation (121). The direct costs to the public health systems in SIDS associated with the first year of treatment of these 5.1 million cases is estimated at Int\$ 5.2 billion. Over half (53%) of these costs are due to new cases of depression (Int\$ 2.7 billion), and 30% due to hypertension (Int\$ 1.6 billion) followed by diabetes (Int\$ 0.3 billion) with the remaining costs across cancers, heart disease and stroke.

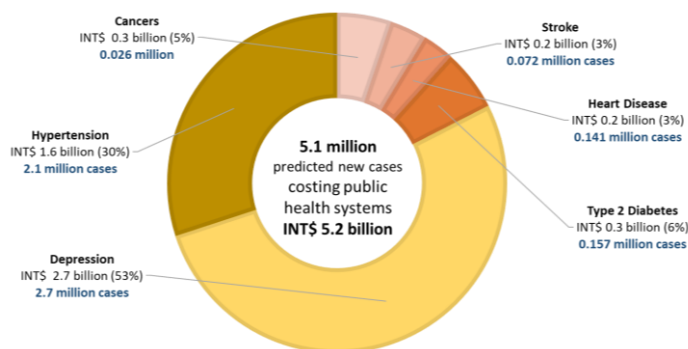


Fig. 3. Cost of predicted new cases of NCDs attributable to physical inactivity in SIDS between 2020-2030

Research shows participation in physical activity is strongly associated with various environmental as well as socio-cultural and economic factors in SIDS and globally (122). In general, more advantaged communities have better provisions of, and access to opportunities to be regularly active, whether through sport, exercise or safe walking and cycling for transport or recreation. In SIDS, only 16% of population reported in 2020 doing any physical activity in their discretionary (or “leisure”) time and this ranges from 20% in upper- and middle-income SIDS to 12% in low- and lower-income SIDS (122). At the country level, The Marshall Islands and Palau reported the highest level of discretionary-time physical activity (34% in each) and Timor-Leste with the lowest (2%). Addressing the inequities in access to affordable, safe opportunities to be physically active that are appropriate to age, sex and context must be addressed.

A recent review of the barriers to and facilitators of physical activity for children and adolescents living in Oceania with Non-European, Non-Asian Ancestry found that distance between the home and sporting facilities, safety concerns on the road and within communities, food insecurity and village curfews were all key barriers to regular engagement in physical activity. In some Caribbean SIDS, unsafe and poorly maintained public spaces, such as absent or improper infrastructure for walking and cycling, water hazards and the absence of drowning prevention for recreational and water sports, are key barriers. With seasonality and extreme weather identified as a barrier to participation in physical activity (123), the changing climate of SIDS may also further impact physical activity now and into the future (124). Additionally, rural communities are often not able to access or afford the

equipment and facilities to engage in physical activity during leisure time (125).

Physical activity can also be accrued through work and household-related tasks and in SIDS this domain accounts for just over half (52%) of the total reported physical activity—based on data collected between 2002 and 2019 (122). While traditional, subsistence-based work in SIDS and globally can be physically very demanding, as economies transition and with the adoption of new technologies employment is often more sedentary (125, 126). In SIDS, the declining levels of physical activity through work must be counteracted by increased physical activity opportunities in other domains and settings.

For women in particular, working long hours, and often in predominantly sedentary employment environments, as well as being responsible for household and childcare activities are barrier for engaging in physical activity. These challenges can be further compounded by poor access to safe, inclusive and affordable opportunities for physical activity. Improving the built environment, for example through creating more public open spaces (e.g., parks) and improving the walking and cycling networks and road safety, are likely to improve physical activity, particularly for disadvantaged communities. Ensuring provision of these environments requires robust policy, legislation and regulatory requirements and enforcement (127).

Physical activity through transport (such as walking and cycling) accounted for one third (32%) of total physical activity worldwide in 2020 (122). Access to safe roads with adequate provision for walking and cycling is essential to maintaining and increasing current levels of transport-related physical activity. It also requires management of the influence from the commercial sectors such as land developers and car industry. The industry marketing of motor cars and motorbikes is aimed at encouraging a transition from “active” transport to personalised transport with the associated increased requirements on land use for roads, street design to accommodate increased traffic, and increased parking. In SIDS this is further compounded by pressures to change land-use, for example, for tourism or other commercial and housing development, which can infringe on the local communities’ access to and mobility in previously open spaces (124, 128).

Perceptions of physical activity for specific population groups illustrates the barriers and enablers to physical activity in SIDS. This is particularly important in Indigenous communities where often traditional lifestyles were more active and intrinsically embedded with engagement with the environment (125, 129). This includes values, norms, ways of life, motivations, enjoyment, family commitments and social support underpinning physical activity, and the value of integration with cultural components such as traditional dance and music, prayer, community orientation and family inclusiveness (130). Considerations of gender and cultural contexts are also particularly important to engage women and girls in structured exercise, incidental exercise, and sports, providing them with environments in which they are safe and accepted in which to exercise and play (129). Addressing the social, economic and commercial barriers in SIDS is fundamental in national and subnational efforts to effectively increase participation in physical activity and thereby improve health and well-being.

2.4 Economic and commercial determinants of unhealthy diets

Obesity rates in SIDS continue to increase. This is in part due to the relatively high consumption of foods and non-alcoholic beverages that are high in saturated fatty acids, trans-fatty acids, free sugars and/or sodium, and typically highly processed (HFSS foods). This is, in turn, the result of economic and commercial determinants of health that result in these products being easily available, widely marketed, and predominant within the makeup of imports that SIDS are particularly reliant on. The widespread availability and accessibility of HFSS foods and beverages contributes to the global syndemic in which the threats of climate change, obesity and undernutrition and micronutrient deficiencies converge within the same populations (131, 132).

Five of the top 10 countries with the highest overweight and obesity rates in the world in 2016, and seven of the 10 countries with the highest rates of diabetes, are Pacific Island countries and areas (5). Islands in the Western Pacific Region and the Caribbean, which comprise most of the SIDS, have high levels of overweight and obesity (for example, over 60% of adults in the Caribbean, and up to 80% in some Pacific Island states) (133, 134). Childhood obesity is of particular concern in

SIDS, with rates above the global average, particularly in the Pacific SIDS (Figure 4). In 2020, the average prevalence of overweight in children under five years of age in SIDS was 6.6% (compared to the global average of 5.7%), having increased since 2012 (6.3% compared to the global average of 5.6% (135).

Many SIDS have higher diabetes prevalence rates than the global average, represented in figure five by the dashed line (Figure 5) (136) in (21).

Obesity in SIDS is primarily driven by a change in the diets of local populations from traditional, locally grown staples to imported, energy-dense, HFSS foods and beverages (21). This shift away from agricultural production has been shaped by economic and commercial factors driving this nutrition transition in SIDS, including the colonial legacy of land ownership and land division, land loss and pressures, as well as increasing migration and urbanisation (137-139). It is also impacted by climate change and increasing droughts within these countries, as

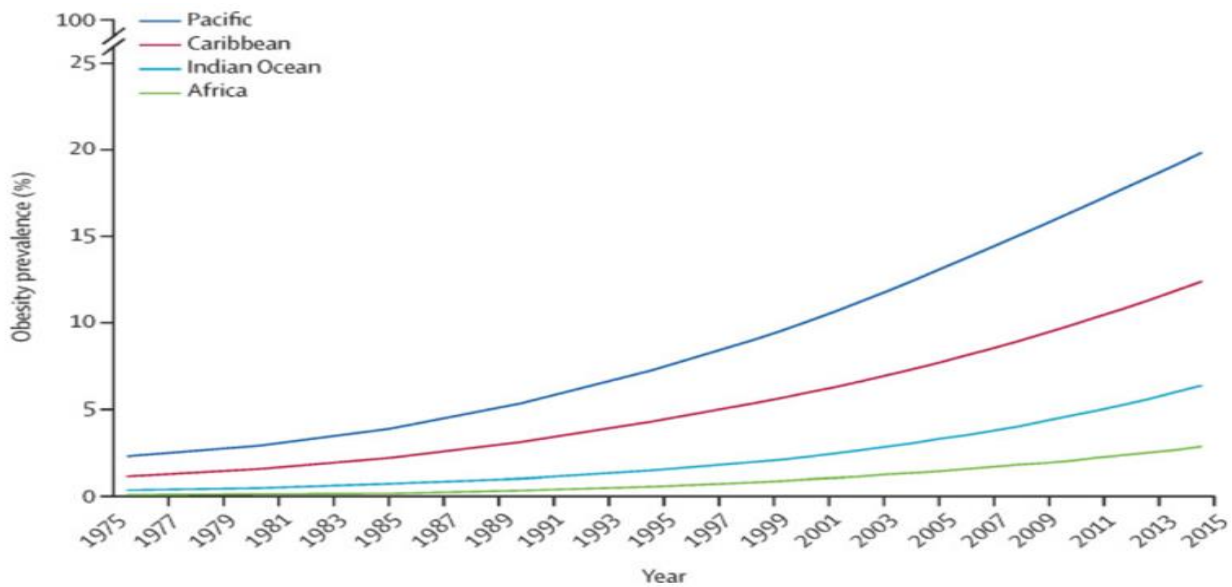


Fig. 4: Trends in childhood obesity prevalence in small island developing states (74)

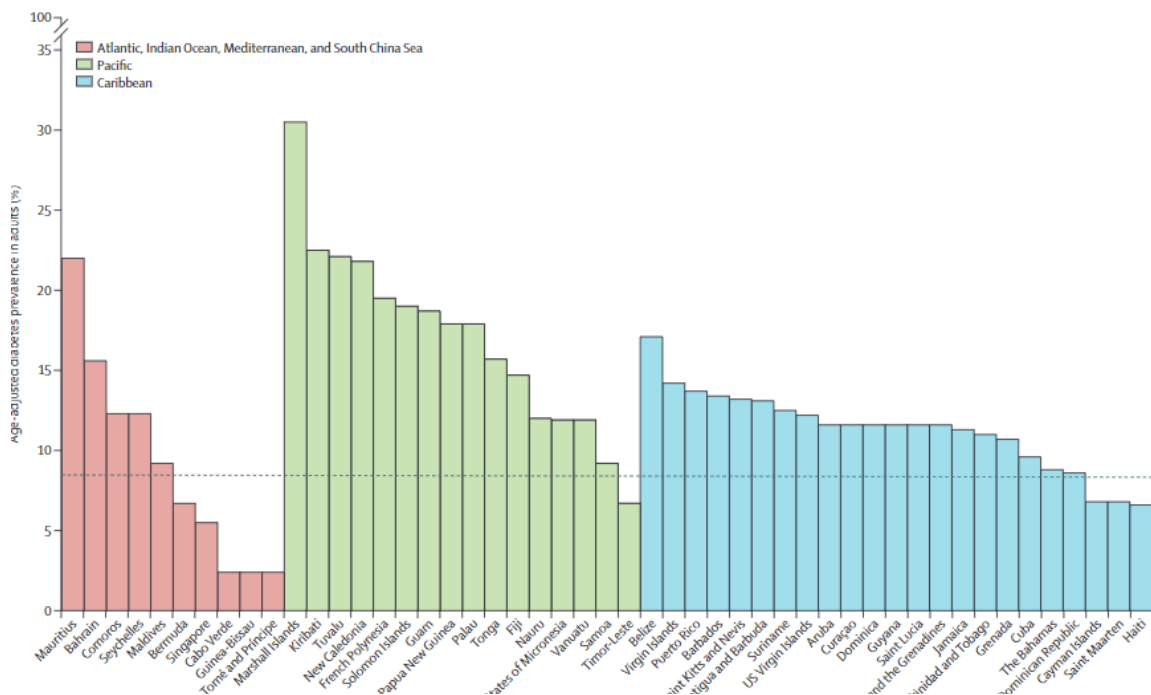
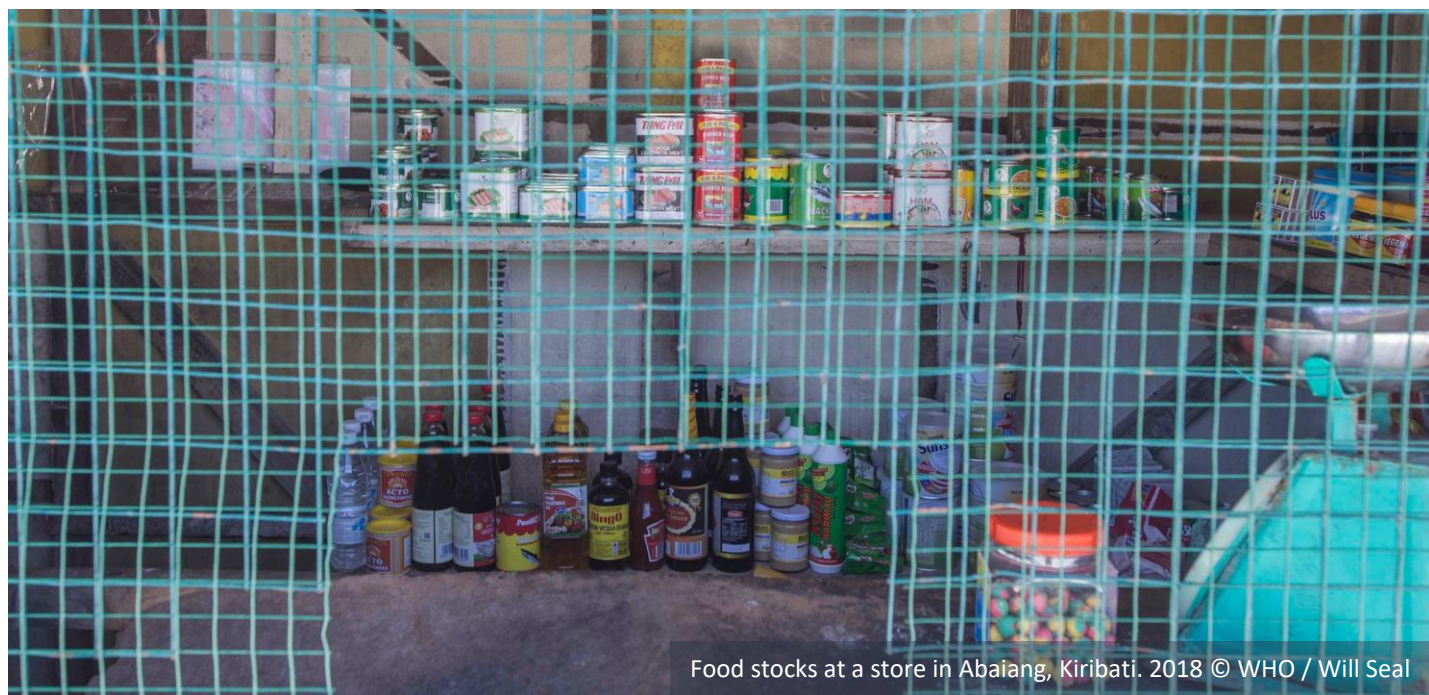


Fig. 5: Age-adjusted comparative prevalence of diabetes in adults (20-79 years) in small island developing states in 2019. (136) (21)



Food stocks at a store in Abaiang, Kiribati. 2018 © WHO / Will Seal

well as prohibitive inter-SIDS trade provisions and shipping costs and other barriers, when compared to importing food from non-SIDS.

Many traditional Indigenous diets are fibre-rich, including seasonal fruits, legumes, nuts and seeds and cultivating endemic species plants (21). As noted in a regional UN Conference on Trade and Development meeting, fishing remains a mainstay of economic activity despite being challenged by issues such as illegal fishing (140). Research has shown that Indigenous populations in rural areas of Pacific SIDS have a more varied diet which is more likely to meet WHO recommendations of consuming more than 400 g of non-starchy fruits and vegetables daily (132). In 2021, only 13 of the 38 Member State SIDS had food based dietary guidelines to inform and guide policy work along the food system, and none of these explicitly incorporated environmental sustainability elements (141).

Traditionally most SIDS communities utilised climate-adaptive practices to create self-sufficient food production, mostly consisting of a plant-based and minimally processed diet (21). Although these practices continue, this self-sufficiency has increasingly been replaced by a reliance on imports. Approximately 50% of SIDS import more than 80% of their food (34). This not only impacts health, but also creates a lack of food sovereignty within SIDS, resulting in food insecurity as it renders SIDS more vulnerable to disruptions in supply chains, including those as a result of climate change or

global pandemics, as experienced during COVID-19. (142). The State of Food Security and Nutrition in the World 2022 report, jointly prepared by FAO, IFAD, UNICEF, WFP and WHO, notes moderate or severe food insecurity was experienced in 48.9% of the total population of SIDS (in 2019-2021, compared to the global average of 28.1%) (135). Calls for food sovereignty have been expressed by SIDS leaders during the UN Food Systems Summit. Fishing provides 50-90% of all animal-based protein in diets in SIDS and remains a key source of local food production, but it may be at risk due to unsustainable fishing or fishing insufficiently regulated to protect local fisheries and local consumption (143). These methods have, to a great extent, displaced traditional methods of marine stewardship. This shift also has direct impacts on health, as depleted stocks require island fishermen to work longer hours, farther from shore, and in less safe conditions (144).

Not only do pollution and climate-change-related extreme weather events hamper the ability of SIDS to reliably produce food, the current reliance of SIDS on imported food amplifies the risk of periodic food insecurity during natural disasters which may, perversely, further increase reliance on imported foods (21). For example, increased food insecurity due to climate change may force SIDS to import even more food products and fall into greater dependency on international trade. Similarly, severe climate-related health events may also create opportunities in which the food industry may step in and

distribute or market cheap HFSS foods at a time where consumption of high-quality foods is even more critical. Agricultural food production in SIDS is also likely to be affected by increased salinisation of aquifers associated with sea level rise and overall drought reducing water availability (145, 146).

FAO notes that HFSS foods and beverages constitute a large proportion of SIDS imports and are often less expensive and more widely available than locally produced foods (143). This is in part a consequence of economies of scale, as larger countries can produce large amounts of food at a cheaper price than produced food locally within SIDS. This dynamic is also partly attributable to the displacement of Indigenous Peoples from their land, which increased their dependency on food imports and increased food insecurity (139). It is also generally cheaper and there are fewer barriers to import foods from larger countries than conduct inter-SIDS shipping.

The challenge posed by this heavy reliance on imported foods is exacerbated by the fact that in many SIDS there are a limited number of retail outlets and

importers, therefore many deal in both unhealthy and healthy foods. The dual role of these commercial actors as suppliers of both beneficial and harmful foods challenges policymakers seeking to safeguard against conflicts of interest.

SIDS have used various measures to improve food environments, food security, and nutrition with the aim, in part, of reducing overweight and obesity. In 2017, to reduce the high obesity rates associated with imported unhealthy food, the province of Torba in Vanuatu explored restricting imported foods in favour of domestic produce. French Polynesia imposed production and consumption taxes on products identified as imposing health risks and Tonga, which has one of the highest obesity rates in the world, is implementing import duties on meat offcuts high in saturated fats (147). Countries that apply uniform SSB tax structures include Barbados, Bermuda, Cook Islands, Dominica, Kiribati, Mauritius, Nauru, Palau, Samoa, Seychelles and Vanuatu (148-150). An evaluation of the 10% tax imposed in Barbados found that this tax led to a 4% decrease in the average weekly sales of these drinks, and an 7.5% increase in bottled water sales (148). Barbados has since increased its tax on SSBs to 20%. Meanwhile, eight Pacific Island SIDS have SSB taxes of 20% or more, namely Cook Islands, Fiji, French Polynesia, Nauru, New Caledonia, Niue, Tonga, and Vanuatu (150). Seychelles introduced a sugar tax in 2019, raising SCR 44 million in 2020 (approximately US\$ 3.14 million) (151).

There has been mixed progress on the implementation of the WHO set of recommendations on marketing of foods and SSB beverages to children among SIDS (74). SIDS are prioritizing several food policies to create a health promoting and enabling food environment including regulating marketing of breast milk substitutes; banning the sale and marketing of unhealthy HFSS in school environments; restricting marketing of HFSS foods to which children are exposed; introducing front of pack labelling; and regulating industrially produced trans fatty acids (IP-TFAs). The regulation and implementation of marketing of HFSS food is a challenge in SIDS owing to majority of the content comes from broadcast media based in larger countries (74)

Some SIDS have implemented policies to reduce the availability of HFSS foods in schools. For example, Bermuda implemented a policy banning the sale of sugar-sweetened beverages (SSBs) in schools in 2007, with



Inspection of a grocery store in Nauru.
2017 © WHO / Yoshi Shimizu

Vanuatu implementing a similar policy in 2014, and Trinidad and Tobago in 2017, and Jamaica implementing a policy restricting the sale of SSBs in schools in 2019 (152, 153). More recently, Barbados has adopted a new policy that bans the sale and marketing of sugar-sweetened beverages in and around schools in 2022 (154). While St Lucia planned to implement a ban on sugar-sweetened beverages in schools in January 2023, this has been suspended until further notice to allow for broader stakeholder engagement and information dissemination (155).

IP-TFAs are banned in almost every high-income country, but in few LMICs. The implementation of such a ban in SIDS might be made more challenging by the lack of in-country testing, which limits enforcement. In the Caribbean some countries are working directly with their commercial actors to support their removal from the food supply (156).

Improving health through better food environments is a central component of the SAMOA Pathway and an integrated approach to sustainable development (157). A key follow-up to the SAMOA Pathway has been the

Global Action Programme on Food Security and Nutrition in Small Island Developing States, which aims to create healthy food environments, transform food systems, and empower local communities (143). Similarly, the outcome statement of the 2021 SIDS Health Summit emphasizes the need to maintain healthy, sustainable and resilient food systems which deliver healthy diets while preserving biodiversity (14).

Doing so will require addressing the role of some commercial actors in creating food environments that drive obesity within SIDS. As one example, a review of government consultation submissions in relation to the aforementioned ‘sugar tax’ in Bermuda showed how commercial actors universally opposed this measure, thereby potentially undermining the health goals that were envisioned through implementation of this tax (158). A second example from research in Fiji has shown that the food industry tried to shape public health-related policies and programmes in their favour, including by establishing relationships with the community, media and policymakers and by bringing in experts from overseas to consult with governments on public health policies (159). Similarly, an



A member of a women's association promoting health in the Federated States of Micronesia. 2015 © WHO / Yoshi Shimizu

unpublished paper identified that in Barbados, representatives of multinational soda companies attempted to persuade the government not to introduce its SSB tax by instead offering assistance with promoting physical activity as a substitute for a comprehensive set of evidence-based measures for preventing NCDs (133).

Power imbalances are at the heart of the challenge of action—this is particularly the case with multinational companies and other countries. For example, trade challenges by more powerful countries and commercial actors undermine the ability of lower- and middle- income countries to enact WHO recommendations, such as marketing legislation and other policy best-buys (160, 161). The consequences can be seen in study of certain SIDS which found that they were unable to enact WHO recommended restrictions to marketing of foods and beverages (133). Further WHO guidelines on “Policies to protect children from the harmful protect children from the harmful impact of food marketing” were published in July 2023.

This same dynamic can also be seen with respect to the breastmilk substitutes industry. Breastfeeding is one of the most effective ways to ensure child health and survival. However, while rates of exclusive breastfeeding have increased in recent years, fewer than half of infants and young children under 6 months old are exclusively breastfed as recommended by WHO (162). In addition to nutrients and antibodies, breastmilk actively influences health outcomes through other mechanisms such as the microbiome and the immune system. Breastfed children perform better on intelligence tests, are less likely to be overweight or obese and less prone to diabetes later in life. Women who breastfeed also have a reduced risk of breast and ovarian cancers (162).

In SIDS as globally, breastfeeding is considered highly beneficial in the context of sustainable food systems, hunger relief and climate resilience (163). In health emergency settings, the ability to prepare breastmilk substitutes safely is severely limited by factors including unreliable electricity, unsanitary water and food environments (164). Furthermore, displaced persons may not be able to transport supplies of breastmilk substitutes or to safely manage the practicalities of formula feeding in

emergencies (164). Children are also exposed to infections and malnutrition that may be mitigated against through exclusive breastfeeding, while physiological responses to stress in both infants and their mothers, helping them to cope with the stress of being caught up in a health emergency (164).

The marketing of breast-milk substitutes continues, however, to undermine efforts to improve breastfeeding rates and duration worldwide (162). A case study of a set of SIDS found they remain unable to implement regulations to promote, support and protect breastfeeding, in line with the International Code of Marketing of Breast-milk Substitutes (the Code) (165, 166). Between 2010 and 2022, global sales in the infant and toddler feeding sector overall grew from US\$ 33.2 billion to US\$ 67.9 billion (167). The underlying power asymmetries created by industry revenue, which dwarfs the GDP of most SIDS, are immense. In 2019, the industry spent a minimum of US\$ 3.5 billion globally in marketing their products and this amount did not include lobbying, social media or sponsorship of health professionals (168).

The resulting picture of implementation in SIDS shows the need for further progress to increase the proportion of SIDS with measures in place that are substantially aligned with the Code. As of 2022 26 SIDS countries have no legal measures of the Code (169).¹⁸

As part of the Healthy Islands Monitoring Framework, developed to monitor progress towards the Healthy Islands vision, infants aged 0–5 months who are fed exclusively with breast milk is one of 48 mandatory indicators. A 2020 WHO analysis of Pacific Island Countries and Territories (PICs) where data is available found this indicator shows “substantial variation between PICs, with a number of PICs having a worrisome less than 50% rate of exclusive breastfeeding” (170). In 2017, the WHO Regional Committee for the Western Pacific also endorsed resolution WPR/RC68.R3 calling for the development of a regional action plan to protect children from the harmful impact of food marketing, resulting in the Regional Action Framework on Protecting Children from the Harmful Impact of Food Marketing (171).

¹⁸ Antigua and Barbuda, Bahamas, Barbados, Belize, Cuba, Dominica, Grenada, Guyana, Haiti, Jamaica, Marshall Islands, Micronesia (Federated States of), Mauritius, Nauru, Niue, Saint

Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Singapore, Suriname, Timor Leste Tonga, Tuvalu and Vanuatu.

Research has found formula milk producers paying social media platforms and influencers to gain direct access to pregnant women and mothers (172). In the Caribbean, breast milk substitute manufacturers can adopt a transnational messaging strategy if any single market is not lucrative enough, with evidence of a manufacturer deploying a cross-Caribbean communication strategy to promote baby food (173).

Effective action to improve food environments for SIDS populations, including babies and children, means these economic and commercial determinants of health need to be addressed across the relevant sectors.

2.5 Economic and commercial determinants of air pollution

SIDS contribute among the least CO₂ emissions and other pollutants, even though they are heavily impacted by the consequences of this pollution. Despite a lack of baseline data on key pollutants in SIDS (174), more work can be done to provide technical guidance for SIDS in how to address this risk factor. Air pollution remains a major challenge for SIDS, although the median annual mean concentration of fine particulate matter is estimated to be, at 9 µg/m³, much lower than in other countries (20 µg/m³), yet still above the WHO guidelines of 5 µg/m³ or less (175).

Particulate matter, waste management and household air pollution are all contributing factors to this air pollution. As well as fossil fuel-driven transportation and power generation, other sources include the use of agricultural fumigants, unchecked industrial stack emissions, gas flaring, cruise ships and airplanes, rotting sargassum seaweed, inefficient waste management systems for hazardous and toxic wastes, and open pit burning, among others (174, 176). Due to a lack of alternative options, SIDS also experience heavy usage of dirty fuels for cooking in some places, poor controls of vehicle emissions and the burning of household refuse.

2.6 Economic and commercial determinants of injuries and violence

The way injuries manifest in SIDS varies by type of injury. A significant proportion of the disease burden attributable to alcohol consumption arises from unintentional and

intentional injuries, including those due to road traffic crashes, drowning, violence, and suicide (177).

Globally, with 1.19 million deaths in 2021, road safety, remains the main cause of injury and the burden of road traffic injuries is important in many SIDS, despite variability (178, 179). In SIDS, inadequate transport infrastructure also places strains on supply chains for healthier foods, water, medicines and health technologies (180). A 2012 population-based study into road traffic injuries in Viti Levu, Fiji found that 17% of all injury-related deaths and hospital admissions were related to road traffic injuries, making it the third most common cause of injury (181). In 31 SIDS countries with data, the death rate for road traffic deaths in 2021 was 17.4, which is higher than the global average (15.2 per 100 000 population) (178).

SIDS that have experienced rapid economic and infrastructure development, and accompanying motorisation, face higher rates of road injuries and death where the pace of development has not been matched by proportionate investments in capacity-building and road safety interventions (179). Road safety can be improved through measures including strengthening public transport systems, climate-resilient transport infrastructure, import of safe vehicles, safe speeds and post-crash care.

As SIDS primarily import their vehicles, there is an important role for ensuring import standards meet international vehicle safety standards, and particularly in preventing the import of those vehicles that are unsafe or substandard as this may lead to increased road traffic injuries and air pollution (182). The Global Plan for Road Safety recommends regulations for the export and import of used vehicles that are accompanied by inspections at entry and exit points, and mandatory periodic technical inspection of vehicles (179).

Increases in road transportation in SIDS places a burden on people's health not only through road traffic injuries but also through respiratory illnesses, noise, and reduced physical exercise (183). Similarly, climate change may itself be expected to have an impact on road safety, for instance when coastal erosion or floods threaten existing road networks. These impacts can be mitigated, as was shown in Anse a la Mouche, Seychelles, where the government instituted coastal protection through land reclamation in 2013, thereby protecting a main road as well as creating a local green space (184).

Drowning rates vary across SIDS, but are generally substantially higher than non-SIDS countries. This is due, in part, to the important role that water transportation plays in SIDS but drownings are also linked to commercial tourism and fishing. WHO 2019 Global Health Estimates show that, in the 31 SIDS with available data, the average drowning rate was 4.5 deaths per 100 000 population whereas the average drowning rate for the 152 non-SIDS countries was 3.1 deaths per 100 000 population (185). All six countries with drowning rates of over 10 per 100 000 population are SIDS (185). In the Caribbean, the countries with the highest level of unintentional drowning mortality are Guyana (18.5 deaths per 100 000 population), Haiti (10.8) and Saint Vincent and the Grenadines (6.8), while Jamaica has the lowest level of unintentional drowning mortality with 0.3 deaths per 100 000 population (185). Timor-Leste reported the highest standardized drowning death rate in the South-East Asia Region in 2019 (186).

Tourism is a major commercial sector for many SIDS with implications for drowning. Tourists may be at increased risk of drowning as not all travellers have adequate water safety skills and not all tour providers are trained to ensure their clients' safety while swimming, kayaking, snorkelling or diving (187). Participating in water-based activities in unfamiliar environments can

expose people to unknown dangers, particularly if signage or other forms of public information are not displayed to warn of potential risk or recommend minimum required water safety skills (188). There are opportunities to engage travel and tourism government agencies and industry stakeholders in drowning prevention initiatives, including to develop water safety messaging and training, CPR training for local businesses and accommodation providers, media awareness campaigns, water safety flyers and school education programmes (188). However, there is a lack of legislative and monitoring and evaluation roles across these sectors.

Fishing and fisheries are commercial sectors which provide livelihoods and nutrition for many communities in SIDS with implications for drowning. Risk of drowning while fishing increases during hazardous weather, at night-time when there is low visibility, and when safety equipment is not available. Safety at sea for small-scale fishers can be improved by performing routine safety inspections of vessels used for fishing, providing appropriate training for crew and regularly checking weather forecasts (189).

Drowning intersects closely with factors including the consumption of alcoholic beverages and drugs in and around the water, and a lack of swimming education,



including for Indigenous communities, women, ethnic minorities, migrants and rural residents (102, 187, 188). Across many SIDS, there is a lack of action to teach school-age children water safety skills, as well as a lack of interventions to create public awareness about drowning and alcohol use and swimming/boating (186).

Drowning is the leading cause of death in flood disasters, with climate change projected to increase the frequency and severity of flood disasters over time (190, 191). Flood disasters are a particular concern for SIDS, including those stemming from king tides, tropical cyclones and typhoons.

SIDS are taking action to prevent drowning. For example, the Ministry of Health in Guyana has recognized drowning as a key area of focus, focusing on actions such as installing barriers to control access to water, teaching swimming, water safety and rescue skills and setting, enforcing safe boating, shipping and ferry regulations and improving flood risk management (192). Similar approaches in other SIDS could go a long way to addressing drowning risk factors including those with ties to commercial activities and making transport over water—a daily reality in many SIDS—a safer prospect. In the

Maldives and Timor-Leste, multisectoral approaches to drowning prevention and water safety have been drafted and adopted, respectively, that address stakeholders in fisheries, tourism and transport (186).

Firearms, drugs and knives are risk factors and determinants common to all types of injuries, including homicide (193). In several SIDS (e.g. Haiti, Jamaica, Papua New Guinea, and Suriname) homicide was a leading cause of death in adolescent and young adult males in 2019, and a leading cause of physical injuries requiring costly emergency medical care (194, 195). The Caribbean is a significant route for trafficking of guns and drugs (196), and together with the increased use of firearms this has led to higher levels of crime and violence (197). As evidenced in Trinidad and Tobago, gang violence may also intersect with migration, radicalisation and violent extremism (198).

Trafficking of narcotics is one of the leading factors supporting the rise of guns and gun-related violence in the Caribbean as it has facilitated the accessibility of guns which are acquired and used as protection during the transportation of these narcotics (199). Increases in drug and organised crime throughout the Caribbean has given



A child on a boat, Fiji, 2017 © WHO / Yoshi Shimizu

impetus to illegal gun acquisition and violent crime, with exposure to and acts of violence mutually increasing gun culture that drives desire for access (200). Conversely, Pacific nations have been described as having some of the most stringent gun controls, and have low rates of gun trafficking and armed violence (201).

In domestic violence the contribution of firearms to homicides is notable. Data for several SIDS show firearms are a vector for gender-based violence, with evidence of women aged 15-49 being threatened or wounded with a knife, gun, or other weapon (202). Research in a Pacific SIDS has also identified the need for more research into the relationship between changing notions of masculinity and demand for firearms, and the role of gender within private security and the military (203). It has also been proposed that the use of guns in foreign films have become models for heroic masculinity and gun violence among Caribbean youths (204). A multi-country study on men and violence in Asia and the Pacific found that men's experience of abuse during childhood has been associated with, among others, gang membership, being involved in fights with weapons and violence perpetration (205).

Studies covering SIDS in the South East Asia and the Pacific regions have demonstrated that child maltreatment is a leading risk factor for adult involvement in physical, sexual and emotional violence against women (206, 207). Gender-based violence is experienced by more than 60% of women in some SIDS when the global average is one-third of women (5, 208). This is most often perpetrated by an intimate partner. Data from Kiribati in 2013 show that 68% of women have experienced physical and/or sexual violence by an intimate partner (209). Importantly, these numbers may not be an accurate representation of the burden of gender-based violence, as it has been noted that there is stigma associated with reporting this type of violence. Moreover, even when survivors are willing to report instances of violence, the appropriate systems and services may not be in place. Formal sexual and gender based violence services are largely absent in the Pacific region for example, and where they do exist, resources are scarce and inadequate to respond to the problem, particularly during disasters (209).

Climate-related and other disasters are likely to increase the prevalence of sexual and gender-based violence, through multiple pathways many of which are

linked to economic and commercial determinants—including economic instability, food insecurity, mental stress, and disrupted infrastructure—both during and after disasters (210). For instance, the population of Vanuatu experienced a 300% increase in new domestic violence cases at the Tanna Women Counselling centre after two tropical cyclones hit the Tafea region in 2011, and increased rates of sexual and gender based violence were reported following the Gizo tsunami that hit the Solomon Islands in 2007 (209, 211). Concerns of women being disproportionately affected have also been raised during the COVID-19 pandemic.

Gender equality varies substantially among SIDS in terms of rights, education level, and poverty, with women often working in more precarious, lower-paid employment. Particularly for single parent households, and in SIDS where the 'feminisation' of poverty has been observed, there is a risk that economic and social disruption associated with the pandemic may worsen gender inequalities, with long-tail consequences for women and children. These include pandemic-related job losses, unpaid work and risks of gender-based violence experienced disproportionately by women, and compounded effects of lack of access to education between mother and child (212).

The Women's Major Group has called for SIDS initiatives to "recognize and redistribute the unequal and unfair burden of women and girls in sustaining societal well-being and economies" (213), as well as a strengthening of action and legislative compliance to comprehensively address sexual and gender based violence (213). SIDS countries have increasingly integrated gender equality initiatives into climate action. For instance, Fiji, Grenada, Jamaica, Maldives, Papua New Guinea, St. Lucia, Tonga and Vanuatu have all integrated gender perspectives in their Nationally Determined Contributions (214).

2.4 Economic and commercial determinants of mental health conditions

Lack of adequate mental health statistics for SIDS makes it difficult to monitor and evaluate. Currently most countries only report on suicide rates, overlooking data such as disease burden and service activity (215). This lack of data

on youth mental health in some SIDS is a significant barrier to policy action (216).

The Global Burden of Disease Study 2019 estimates indicate mental health conditions are highly prevalent in SIDS, with an estimated 15.2% of the population in the Caribbean and 11.2% in the Pacific having a mental disorder and standardized suicide rates disproportionately high relative to global averages (12). While some SIDS in the WHO Region of the Americas are estimated to have suicide rates below one per 100 000, Guyana has one of the highest suicide rates in the world, with 17.4 per 100 000 for women and 63.0 per 100 000 for men in 2019 (183). Mental health conditions affect, and in turn are affected by, commercial determinants of other NCDs, and can be both a precursor and consequence of these factors. Research indicates that having a mental health condition makes a person approximately twice as likely to use tobacco products, after adjusting for other factors affecting tobacco use behaviour (217). Tobacco use increases levels of depression, anxiety and stress, attention deficit hyperactivity disorder and psychiatric symptoms and reduces the effectiveness of medications for mental health (217).

Mental health challenges can be caused or exacerbated by several practices of commercial actors, particularly through their sale of health-harming products or services, such as alcohol or gambling, linked to adverse mental health risk. Through seeking to maximize sales, commercial actors play a key role in shaping the social and physical environments that lead to these health-harming outcomes. Alcohol use is associated with direct NCD risks and high alcohol is particularly associated with gender-based violence as well as mental health conditions. High alcohol use occurs more frequently in settings where there is high unemployment, limited leisure activities or local economy orientated around attracting tourism (206). Besides those using their products, commercial actors may also negatively impact the mental health of their workforce through poor labour conditions. In some countries the mental health burden is exacerbated by the social disruption and poverty caused by bonded labour and child labour in tobacco farming.

Research identifies an adverse relationship between over-tourism, community well-being, and economic development, with SIDS at risk of tourism models disconnected from society and the community



Aerial view of a coastline in Vanuatu. © Adobe Stock / Triocean

while exacerbating ecological degradation, policy ambiguity, economic disconnectedness, institutional distrust, community discontent and social inequality (218). While a contributor to economic development, the growth of tourism in SIDS is not synonymous with the mental health benefits of poverty reduction, and may risk entrenching existing inequalities if social sustainability is not valued alongside environmental sustainability and economic growth (219). One example is that the excluding local populations from natural environments for the purposes of tourism can undermine local well-being, by depriving local population of access to resources important for maintaining their livelihoods (219).

The COVID-19 pandemic impacted on mental health in SIDS in numerous ways, including through its impact on the workforce. SIDS health systems, including for mental health, faced additional disruptions to their existing workforce challenges, with exhaustion, anguish and stigma impacting on the mental health of health workers (220). Service industries largely in the tourism sector were heavily affected, including cruise ships, retail and hospitality. The fear of loss of employment negatively affected mental health (221) and the absence of stable employment can also negatively affect mental health and well-being, perpetuate vulnerability and increase household conflict (222). People working in sectors where mitigation measures are not easy to implement were also negatively affected by anxiety and stress (223).

There is evidence to suggest that the mental health of service workers benefited from community resilience including employment versatility and family emotional support (221). Similarly, in sectors such as tourism where employment practices included long hours away from families and communities, some improvements to mental well-being was reported, as a result of people's greater connection to families and communities, appreciation for and connection to the social and cultural gains that stem from a return to ancestral land, spirituality, relearning traditional knowledge, reconnecting with nature, and engaging in alternative livelihoods activities (222).

There is also a strong association between impacts on mental health and extreme weather events, which are increasing due to commercially driven climate change. SIDS in the Western Pacific are in one of the regions most affected by extreme weather events. Evidence is emerging that they face disruption to "life-support systems and

population livelihoods and well-being by affecting determinant factors such as food security, malnutrition, water security, vector- and water-borne diseases and displacement affect the population's mental health/psychosocial condition" (52). These impact on communities through fear, stress, anxiety, anger, powerlessness and exhaustion due to acute and slow-onset weather events, which are becoming more frequent, prolonged, and intense. These disasters also solicit grief and sadness from a reckoning of losing places of identity and culture (53). The damage to health buildings, essential supplies and transportation infrastructure during adverse weather or climate events affects their capacity to provide critical health services in emergency situations, compounding stress for those in need of acute or chronic care due to NCDs (3).

At the same time, a lack of mental health professionals also means that conditions are often untreated (224). Owing to the relatively small population sizes, remoteness and limited resources of the SIDS, their mental health care systems face many common difficulties. These include having few mental health specialists per country, limited access to mental health services, including in schools, and stigmatization leading to underreporting. Data from 2017-2020 across 33 SIDS shows that the median number of mental health workers was 17 per 100 000, although in some SIDS, including Guinea-Bissau, Haiti, Papua New Guinea, the Solomon Islands and Vanuatu, this number was below five per 100 000 (3).



Chapter Three

Action on economic and commercial determinants to improve health and health equity in SIDS

Key Messages

Current economic and development approaches may permit and produce economic conditions and policy environments, particularly in trade, which expose SIDS to commercial practices with negative externalities.

This is in part because of the commercial practices of power that exert influence over health outcomes in SIDS through both direct means, such as lobbying and marketing, and indirect means, such as shaping knowledge and societal norms.

A comprehensive response requires action to explore alternative economic approaches that prioritize well-being, embrace Indigenous knowledge and participation, and support local businesses, people, products and services.

It also requires action and policy coherence across sectors, such as increasing revenue through taxes on harmful products and aligning trade and broader fiscal policies with health goals.

These efforts can be supported with the development of conflict-of-interest tools to safeguard public health policies from commercial interests and increase community participation in decision-making and accountability mechanisms.

At the same time, SIDS need international support in the form of more accessible development finance, assistance and debt relief as well as specific initiatives related to climate change mitigation and risk insurance and protection against biodiversity loss.

To achieve the SDGs in SIDS, the economic and commercial determinants of health will need to be addressed as part of national strategies for NCDs, mental health conditions, injuries and violence. It is necessary, however, for SIDS and those supporting them to go further than this and advance systemic and transformational change for health and well-being that addresses the negative externalities from the commercial determinants of health. This requires embracing progressive economic approaches, international frameworks, and regulations (225). It should also include strategic civil society mobilization, compliance mechanisms for commercial actors, and the embedding of health, social, and environmental goals in new regenerative types of businesses and business models (225).

Given the small size and interconnectedness of SIDS, commercial actors play critical roles in the health of their communities. Therefore, action that reduces the negative externalities from commercial products and practices and shifts commercial actors from health-harming to health-promoting practices, is essential to fulfilling their potential as partners for health for all. This will require a greater understanding of how economic and commercial determinants impact on population health in SIDS, tailored approaches to safeguarding against conflicts of interests, and the critical role of contextualised development approaches in shaping health outcomes in SIDS.

Their small sizes and close-knit social fabrics also means that SIDS have unique opportunities for using “whole of Island” approaches that act across sectors and levels to address population health and ecosystem impacts with integrated policies and interventions based on adaptive governance structures and community leadership. Such approaches are particularly needed for addressing the inherently cross-sectoral and structural challenges of addressing the economic and commercial determinants of health. Moreover, as regionally and globally united networks of countries facing common challenges, SIDS also hold immense potential for collaborating in creating and implementing these solutions.

3.1 Safeguarding against conflicts of interest

As the Rio Declaration emphasizes, safeguarding against conflicts of interest is key to effective governance in health and development (18). But the evidence indicates that

SIDS face unique challenges in safeguarding against conflicts of interests due to their geographical and economic characteristics. That is to say, their small populations and economies, reliance on external supplies and undiversified economies. This situation leaves SIDS particularly vulnerable to the influence of large foreign and multinational commercial actors, who can wield disproportionate power and unduly sway public sector decision-making. Meanwhile, local commercial actors are often deeply integrated within SIDS' tightly-knit communities which gives them access to decision-makers and makes it challenging to maintain impartiality in the public sector.

Some commercial actors attempt to influence public health through lobbying, corporate social responsibility and party donations. An example of this is the donations to several political parties made by a tobacco company in one of the two SIDS to not have ratified the WHO FCTC (226-228). These practices have been known to incentivise politicians and political parties to align their decisions with commercial interests misaligned with the public health interest. In an example of this type of influence in SIDS, qualitative analysis reveals how tobacco industry exploited governance vulnerabilities in two SIDS to maintain and extend their influence. This resulted in, among other things, the approval of a new factory (99). Furthermore, some commercial actors influence branches of government as a way of preventing or weakening regulation of their products and services. This leaves policy planning pre-empted, commercial practices unregulated and underregulated, and commercial actors with limitations in their liability and minimized exposure to litigation risks (229).

This influence extends to impacts on health policy in the domestic legal environment—with both known and undisclosed threats of legal action contesting or undermining health promotion efforts within SIDS (159, 230, 231). The influence of commercial actors may also entrench norms favourable to them leading to cross-border negative health externalities in the form of inter-state legal challenges that advance health harming commercial interests. For example, a tobacco company supported a request made by a SIDS country before the World Trade Organization (WTO) Dispute Settlement Body, alleging that Australia's plain packaging laws breach the WTO's General Agreement on Tariffs and Trade (GATT), Agreement on Technical Barriers to Trade (TBT) and

agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) (232).

More subtly, commercial actors have been known to influence the knowledge environment, shaping how information and data are created, obtained and presented to populations and policymakers, resulting in power over research agendas, policy decisions and public preferences (229, 233-237). Part of the challenge for policy makers remains gaps in information about and monitoring of commercial practices (236). Timely, readily understandable, and accurate data about commercial actors and their practices is needed as part of public health monitoring and surveillance, programming and policy development including for tools such as health impact assessments.

Preference shaping occurs through advertising, sponsorship, marketing practices and sales promotions. This includes presenting products harmful to health as beneficial to society, or as aligned with socially desirable traits, or efforts to counter the ‘signalling effects’ following the adoption of a public health law or policy. For example, following the introduction of the SSB tax in Barbados, some commercial actors misled consumers by advertising “juice drinks” as healthy, despite their high levels of free sugars (236).

To further influence knowledge and preferences, some commercial actors found or fund other non-state actor entities such as front groups, consumer groups and think tanks, or exploit the broader perpetuation of corporate social responsibility for marketing or promotional purposes, allowing them to manufacture doubt and promote industry-favourable framings (225, 238, 239). For example, after Mauritius banned most forms of tobacco advertising, one multinational tobacco company began funding university scholarships, libraries, other cultural institutions, medical facilities, and graduate internships while publicizing this funding widely as a form of proxy advertising and attempt at influencing government policy (240).

3.2 Empowering communities for participation and accountability

A key action area identified by the Rio Declaration and many other international commitments is empowerment of communities. This involves enhancing and increasing

rights-based participation for strengthening accountability and governance for health. The Rio Declaration acknowledges multiple needed actions including inclusive and transparent decision-making, strengthened accountability, empowering communities, and governance approaches which span sectors and involve civil society and commercial actors (18). This process of community engagement and participation, coupled with mechanisms to manage and prevent conflicts of interest in political decision-making, is relevant for all efforts to address health-related issues, promote well-being, and develop more effective health interventions, programmes, services, and policies.

Empowering communities as key actors for advancing the right to health, while increasing transparency and inclusion in decision-making, can serve as a catalyst for shifting governance for health toward accountability and participation from the ground up. This community engagement is relevant for all efforts to address health-related issues, promote well-being, and develop more effective health interventions, programmes, services, and policies. Such active and meaningful participation serves to advance both multisector (whole-of-government) and multistakeholder (whole-of-society) actions to align economic approaches and commercial practices with health and health equity.

Institutionalising meaningful participation in policy decision-making and accountability processes within SIDS is an enabling action to enhance governance and coordination to efficiently and equitably improve health and well-being, including the prevention and control NCDs, mental health conditions, injuries and violence, and their respective modifiable risk factors and determinants (33). Such objectives are already being actioned through the WHO Western Pacific Community Toolkit, in support from partners, to conduct vulnerability assessments, build mental health capacity and community-based microplanning of health decisions (241-243). In 2021, WHO published a Handbook on strengthening the participation of people, communities and civil society in health decision-making processes (244). The handbook follows through different tasks which policymakers must reflect on when strengthening participatory mechanisms, such as mitigating power imbalances, representativeness, capacity-building and policy uptake of participatory process results. More recently, WHO published a framework for meaningful engagement of people living

with noncommunicable diseases, and mental health and neurological conditions (245). This framework acknowledges a core part of community participation is redressing existing institutional and power imbalances that marginalise or discriminate against lived experience perspectives in policy and programme design.

Civil society plays an important role in policy and programme development processes, as an intermediary between government and communities to voice concerns, hold commercial actors and government accountable and support the development and implementation of policies. Safeguarding against conflicts of interest and ensuring transparency and other principles of good governance is a critical component in civil society participation in public policy processes. To institutionalise meaningful participation mechanisms, SIDS countries will need to be able to invest and sustain sufficient and stable resources, as this requires a commitment to strengthen the capacities of government and communities, ensure routine and sustained participation, and monitor and evaluate the quality of participation and the extent to which community voices inform decisions made.

3.3 Strengthening policy coherence for health across trade, fiscal and other policies

Since the economic and commercial determinants of ill-health and health inequities in SIDS arise from market failure, the resulting burden of ill-health and health inequities should be considered negative externalities that need to be corrected. Policy and regulatory environments play an important role in influencing commercial actors because these environments incentivise some practices and disincentivise others (15). Therefore, action requires an integrated policy focus that removes incentives with health-harming consequences and adopts incentives with health promoting consequences.

This encompasses regulatory incentives, fiscal incentives and trade policy incentives, among others. It also includes regulating health-harming commercial practices by reducing their ability to shape preferences at the demand and supply stages. It requires learning from existing efforts to protect and empower nations of all sizes from predatory marketing of breastmilk substitutes (164), from the influence of tobacco companies, from heavy marketing of alcohol, and efforts to improve healthy diets

through sustainable food systems. For example, to reduce the consumption of tobacco, alcohol and SSBs, SIDS that have excise taxes for these products may consider increasing them and those who do not may consider introducing them.

Trade agreements and policies, through their influences on price, availability, and promotion of HFSS food products, cigarettes, and alcohol, have accelerated the transition away from traditional diets and nutrition in SIDS. Combining health, trade, and other relevant policy domains is important to identify action points, including through health impact assessments (246, 247). Evidence suggests that this is needed in the context of bilateral trade arrangements, which tend to have weaker provisions supportive of public health objectives (248), which is particularly important for SIDS given they are often dependent on a few much larger trading partners.

Strengthening coherence between trade, health and fiscal policies more broadly presents opportunities for co-benefits, for example in strengthening inter-regional trade in the Pacific region for improved food security and increased access to healthier foods (249). Given the size of government procurement in small economies, consolidating procurement for SIDS who are geographically close, while building and improving transportation connections, is an important area for further consideration (250).

The unique development challenges of SIDS create greater volatility in revenue generation and domestic public finances than in other LMICs and include their greater exposure to external shocks from natural disasters and climate change, their small and undiversified economies, vulnerability to price fluctuations and their vulnerability to revenue volatility from non-tax sources, such as fishing license fees (54, 251). Finding fiscal space for critical economic and social investments is necessary for achieving the SDGs, for sustained health and human development of children and women, and for realizing human rights, particularly during health crises (252). Accordingly, health taxes can be a revenue booster as part of domestic resource mobilization in SIDS to deliver co-benefits with improving NCD, mental health, injuries, and violence outcomes.

Strengthening coherence of trade and fiscal policies with health goals relating to commercial determinants of NCDs, mental health conditions, injuries

and violence is crucial to boosting fiscal space in a matter that will deliver sustainable economic development. As emphasized in the Outcome Statement of the 2021 SIDS Health Summit, strengthening whole-of-government approaches is a governance opportunity for such policy coherence (14). Modelling with one SIDS indicated that the only way for it to achieve the SDGs within planetary boundaries required scaled increases in public investment, alongside increased taxes on consumption, trade, income, profits, and increased access and utilisation of international grants in support of SDG finance (253).

The public health potential of fiscal measures would allow redress in relation to the negative externalities relating to NCDs, mental health conditions, injuries and violence (e.g., taxes on alcohol, tobacco or SSB taxes, or the repurposing subsidies across sectors, among others). The adoption or increase of taxes on tobacco and SSBs is increasingly common across SIDS, with many early global adopters of such fiscal measures (81, 110, 149). There are opportunities for further using best practice to strengthen the design of fiscal measures, for example in the threshold of sugar or ensuring they are at a level of tax that will produce measurable health effects at the population level in the short to medium term. Rebalancing fiscal revenues to reduce risks to health also relates to the levels import taxes on healthy imported products such as fresh food (133).

Since the share of tax revenues in the external financing mix for those SIDS with a Gross National Income per capita of over US\$ 3 800 in 2023 is on average lower than for other LMICs at a similar level of development, appropriate policy to optimize taxation structures and domestic resource mechanisms remains a priority (60). The IMF has explored specific fiscal rules for SIDS due to their economic vulnerabilities, including fiscal rules that encompass the expected impact of external shocks on fiscal balances, and the adoption of a recurrent expenditure rule as a countercyclical policy tool to handle natural disasters, volatile resource revenues, and uncertain foreign grants (251). Other suggested opportunities for SIDS include exploring untapped tax revenue sources, strengthening uptake of tax and transparency standards, improving tax tracking and collection including with technology, formalising the informal economy and incentivising micro, small and medium enterprises (254).

To enhance the resilient and sustainable development of SIDS, the OECD recommends

governments and providers of development co-operation partner to (54):

- i) Introduce further tax policy and tax administration reforms, learning from and building on previous experience of many SIDS, to enhance the volume and stability of tax revenues.
- ii) Enhance the management of existing key ocean economy sectors, such as fisheries and tourism, and harness new opportunities from an expanding global ocean economy that are environmentally and socially sustainable.
- iii) Support international and domestic efforts to curb illicit, unreported and unregulated fishing, which represents a significant source of foregone revenues.

In addition, the OECD advises that the further use of environmentally-related taxes—including on pollution and on environmental resources—would have the advantage of both increasing domestic revenues and incentivising the more sustainable use and conservation of natural assets (54). It is important that the above discussions relating to revenue mobilization and the respective recommendations are implemented in a manner sensitive to health and health equity.

More broadly, current revenue rules for SIDS may limit their ability to generate and spend tax revenue on the determinants of health and the necessary capabilities to safeguard against conflicts of interest and govern for health and development (251, 255-257). This could impede the ability of countries to build public capacity and instead requires an undue reliance on external aid for several public capital investments critical for improved NCD, mental health, injury and violence outcomes, such as health, education, social spending, water and sanitation and roads (46, 258, 259). Therefore, approaches to strengthen policy coherence between health and fiscal policy needs to consider the design of fiscal rules to allow for investments that are essential to improve health and health equity outcomes.

Alongside action on IMF Special Drawing Rights (SDRs) for a transition to climate mitigation and climate adaptation policies, recent calls for a proposed new UN convention on tax that aims to give low-and middle-income countries decision-making power over global tax affairs (260). In addition to this, further work to strengthen the implementation of existing commitments under the so-

called Two Pillar Solution can address the economic and commercial determinants of health, specifically through the minimum tax rate of 15% as part of their approaches to plug base erosion profit shifting practices of multinationals (261, 262).

As emphasised in the Outcome Statement of the 2021 SIDS Health Summit, strengthening whole-of-government approaches is a governance opportunity (14) and the use of “intersectoral mechanisms such as Health-in-all-Policies, promot[ing].monitoring systems that take into consideration civil society and commercial actors with appropriate safeguard against conflict of interest”, and “assessing the impacts of policies on health and societal goals”, are already existing commitments by SIDS in their endorsement of Rio Declaration (18). Further investment by SIDS in operationalising these commitments, with a focus on facilitating policy coherence amongst relevant policy sectors would be an important action for improving the economic and commercial determinants of health.

3.4 Mobilizing development finance to build capacity for integrated health and economic development

There is an urgent need to increase capacity of SIDS governments, enabling the health sector to improve the economic and commercial determinants as part of a coherent approach to sustainable development. This can occur by taxation as above, but also by addressing broader structural barriers to public health capacity in SIDS—particularly development financing, overseas development assistance (ODA) and debt relief.

There are opportunities to alter the ways in which ODA is defined and distributed to benefit SIDS. Currently, some SIDS do not qualify for ODA despite the small size and precarity of their economies, while much larger emerging economies do (263). The same is true of climate finance arrangements, which not only under-delivered compared to commitments but are also often heavily skewed towards reducing emissions, which SIDS have little of, rather than financing climate change adaptation and resilience, which SIDS need (68). A significant proportion of climate finance is also currently in the form of loans and similar non-grant instruments, which is especially unappealing to SIDS who already face disproportionate debt payments. Across environmental risks more broadly, several other underutilised finance

options are available to SIDS including debt-for-climate, debt-for-nature, debt-for-development and debt-for-export swaps, national climate change funds, country financing roadmap, green bonds, key performance indicator (KPI) bonds such as sustainability linked bonds, ecological fiscal transfers, payment for ecosystem services, and airline and hotel taxes (264-266).

Rectifying development finance gaps will meaningfully improve resilience, economic development and health. This includes agreeing mitigation goals among SIDS and tailoring financing packages to better reflect the realities of SIDS. There is an increasing call for the international community to explore the role of debt relief at this critical time for SIDS. Beyond multilateral debt, this appraisal should also include evaluation of innovative mechanisms for debt forgiveness that encompasses private and bilateral debt, as these payments prevent SIDS from investing in the very drivers of health and development that donors hope to strengthen.

More immediately, in light of the COVID-19 pandemic the IMF Special Drawing Rights (SDRs) are receiving attention as an instrument that promises immediate benefits, however falling short of LMICs’ financial needs (267). In addition, in October 2021, the G20 and guest countries pledged close to US\$ 45 billion of their SDRs towards vulnerable countries (268). This would involve high-income countries and the People’s Republic of China transferring their recently allocated SDRs to low- and middle-income countries, including SIDS, to be used immediately (269). It also mirrors a similar but more ambitious proposal by the Prime Minister of Barbados to use SDRs in the context of COP26, specifically an annual US\$ 500 billion allocation of SDRs to finance climate mitigation and adaptation policies (270).

A further option to consider is the adoption of the Multidimensional Vulnerability Index (MVI) as a substitute for Gross National Income in guiding external aid (271). Unlike GDP, MVI, is tailored to the specific needs of these countries, takes into account their high vulnerability to climate change and external economic shocks (272). This shift in development financing would embed a more nuanced understanding of the challenges SIDS face and, thereby, ensure that external assistance is effectively targeted where it is most needed for supporting sustainable development, climate resilience, and economic stability (273).

Research from various sources, including across several multilateral institutions, highlights how SIDS have unique governance resiliencies, capacities and needs at local, regional and international levels. These must be recognized and acted upon to improve and the mitigate adverse effects of the commercial determinants while improving overall health outcomes. The vulnerability of SIDS as outlined in previous sections of this Technical Paper needs to be understood as the failure of development approaches to respond to the development needs of SIDS and a result of homogenising economic approaches and trends that exacerbate health inequities between nations (274). Therefore, the mobilization of additional resources both nationally and internationally is essential to building the necessary capacity to act on the negative externalities and capitalize and increase the positive externalities arising from the economic and commercial determinants of health.

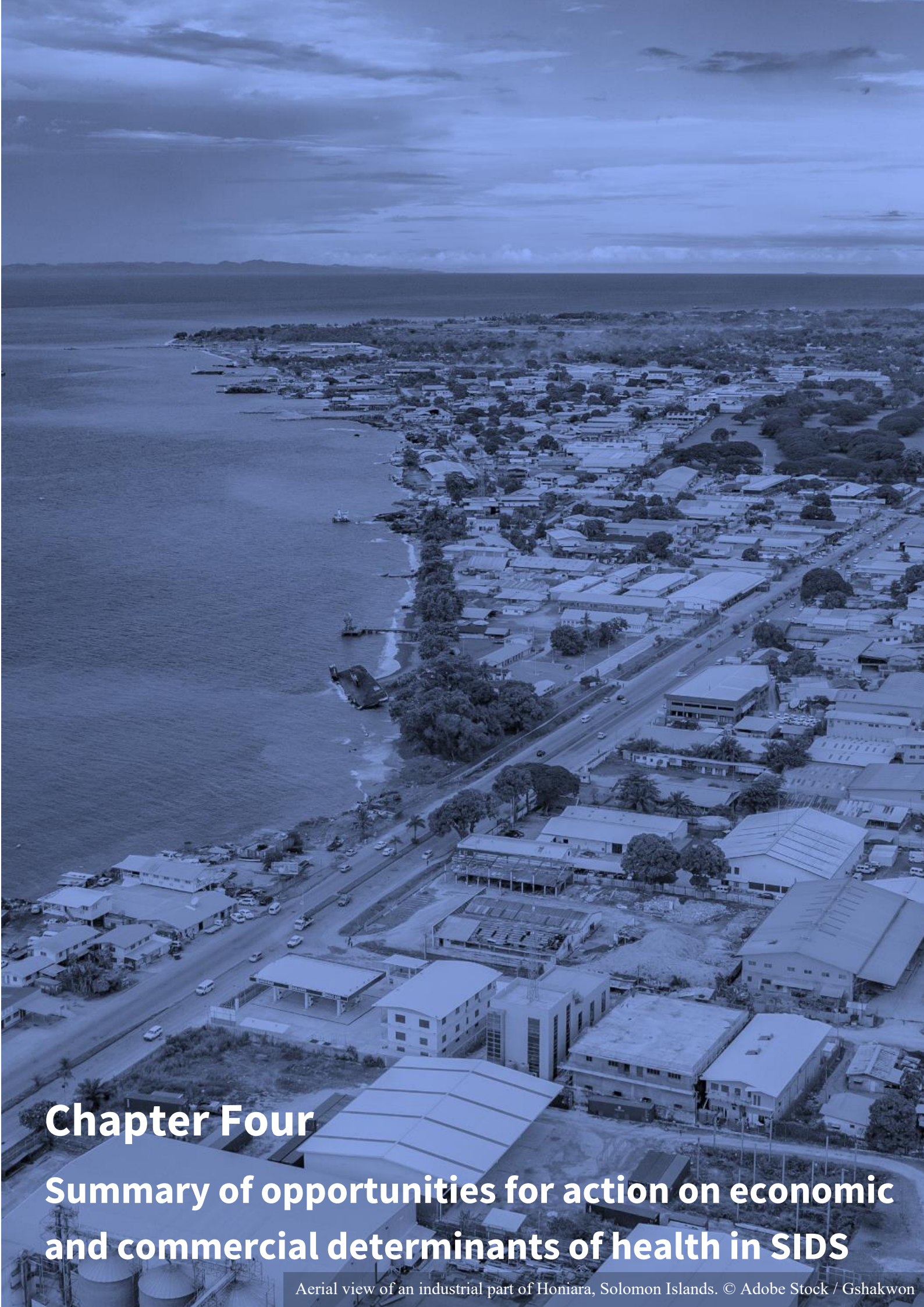
3.5 Protecting and promoting health through economic and development approaches

Fundamentally, the examples of economic and commercial determinants of health in SIDS demonstrates the failures of existing economic development approaches, particularly with the use of GDP as a proxy measure for development, to deliver for equitable health outcomes for populations in SIDS (275). This highlights the need for alternative economic approaches, that move beyond simple measures of GDP but rather include considerations of well-being, equity and justice, and therefore measuring what matters, to people, to the planet, and the future, as called for by the WHO Council on the Economics of Health for All in its final report (275, 276). This creates a leadership opportunity for SIDS, who have a long tradition of unconventional economic development strategies, often with great success (68). Barbados has introduced a comprehensive set of laws aiming to improve women's labour rights, as well as introducing non-discrimination,

equal pay, and improved rape laws since 2019 (277). The Maldives introduced a nationwide minimum wage (277). Hawaii's feminist economic recovery plan for COVID-19, 'Building Bridges, Not Walking on Backs', is one example of a model to mitigate persisting economic marginalisation, particularly for women (278, 279).

The WHO FCTC provides an example of how the vulnerability of certain groups to harms to their health and development can be accounted. In the case of the WHO FCTC, this threat was tobacco and the response was promoting the participation of Indigenous individuals and communities in the development, implementation and evaluation of tobacco control programmes that are socially and culturally acceptable (280). It is also a legal tool that further equips Parties to the Convention to contribute to the protection of the environment. Article 18 of the Convention further calls for the protection of the environment in addition to human health. Adopting economic approaches that prioritize shifting to economic alternatives to tobacco growing, in accordance with Article 17 of the Convention, can help restore biodiversity and protect land resources whilst protecting farmers from loss of livelihoods. Given the threat posed to SIDS by negative externalities from the economic and commercial determinants of health, a similar approach in other commercial areas could be explored.

Exploring economic approaches that address reducing immediate NCD risks, addressing inequities such as in Hawaii or Barbados, as well as investment in social policy such as in the Maldives, offer pathways to improve the conditions for social determinants of health equity in SIDS. Including integration with a shift in policies to favour and support local businesses and local people in tourism activities, promoting local products and services (35). In acknowledgement of the disproportionate burden faced by SIDS, several UN programmes of action in relation to climate change mitigation, insurance against risk, protection against biodiversity loss, and human and social development have been initiated (281-286).



Chapter Four

Summary of opportunities for action on economic and commercial determinants of health in SIDS

A healthy population is fundamentally and inextricably linked to socioeconomic development and the right of every person to achieve their highest attainable level of health and well-being. In SIDS, these links risk being undermined by widening disparities in health, exploited by some commercial actors for private profit, and supported by economic determinants that do not always prioritize health-promoting over health-harming outcomes.

While potential for improvements to health exist in important fields including supply chains, workplaces, products, services, road safety, access to innovations and technologies as well as many other areas of leadership and excellence by the private sector, more work is needed to prevent the negative health impacts of commercial products and practices. In their continued commitment and leadership to improving health despite a combination of vulnerabilities and difficulties, SIDS continue to demonstrate remarkable resilience in the face of challenging circumstances. SIDS also have unique opportunities for action because of the same characteristics that give rise to their shared challenges, this includes the potential for "whole of Island" approaches that capitalize on their small size and cohesive communities to implement integrated, multisectoral strategies for addressing harmful commercial practices and safeguarding against conflicts of interest through adaptive governance and community leadership.

The following is a summary of examples of actions available to SIDS countries, supporting partners and international organisations to improve health and well-being for all.

4.1 Creating policy environments that enable health

Addressing commercial practices at the demand and supply side of risk factors by supporting health promoting products and practices and regulating health-harming products and commercial practices. Actions could include:

- i) Comprehensive best practice health taxation to raise the prices of health-harming products as well as trade rules and excise duties that support health-promoting products including safer vehicles;
- ii) Regulation of the availability and use of health-harming products (e.g., regulate alcohol outlets; smoke-free laws);

- iii) Bans or restrictions on health-harming advertising and marketing, including the advertising and marketing of health-harming products;
- iv) Bans on the promotion of health-harming products in schools, including bans on nominally educational programmes which promote health-harming product use;
- v) Policies for sustainable local food production and processing to support improvements in the food environment and strengthen climate-resiliency;
- vi) Urban and rural planning and development policies that provide safe and inclusive urban and rural environments, including safe green and blue space for physical activity, and prevention of pollution and health-harming waste;
- vii) Integration of commercial determinants considerations into procurement policies;
- viii) Using health impact assessments as part of strengthening policy coherence between health and other policies with economic and commercial relevance to NCDs, injuries and violence, and mental health, such as trade, education, labour policy, social protection, urban planning, energy, fisheries and agriculture;
- ix) Improving data and surveillance on the commercial determinants of health including commercial influence over public policy and national, regional and international regulatory authorities;
- x) Whole-of-government accountability for sentinel child and adolescent health outcomes and behaviours as part of future proofing policy.

4.2 Safeguarding against conflicts of interest

Safeguarding against conflicts of interest is critical in the development, adoption, implementation, and monitoring of public health interventions, policies, strategies and approaches as recommended by WHO. This also includes ensuring conflicts of interest are fully addressed in the implementation of WHO technical packages (Annex 2). Actions could include:

- i) Whole-of-government policies to prevent and manage conflicts of interests for commercial actors, especially those whose products and services are health-harming;

- ii) Access-to-information legislation to facilitate transparency, monitoring and accountability including implementation of health impact assessments.

4.3 Empowering community participation in governance for health and the commercial determinants of health

Investing in institutionalised and empowered community participation in governance for the commercial determinants of health, as part of whole-of-society approaches, is need to deliver effective, equitable, long-term and health-enabling environments across the life course and over the long-term. This involves working with community-led and community-based organisations, Indigenous people and communities, civil society, the media and health-aligned local commercial actors, youth, people living with NCDs, and academics. Actions could include:

- i) Institutionalising community participation as part of action on the economic and commercial determinants of health;
- ii) Strengthening commercial determinants considerations in existing health-in-all-policies approaches including Healthy Islands, healthy cities, and other settings-based approaches.

4.4 Strengthening governance for the commercial determinants of health in development approaches.

Building public sector capabilities to integrate economic and commercial determinants of health considerations within development strategies is essential for advancing the UN Sustainable Development Goals (SDGs). This includes development finance, debt relief tax agreements,

trade mechanisms, and the governance of global public goods, such as essential medicines and key health sector inputs. Actions could include:

- i) Exploring the adoption of innovative economic and development approaches that create enabling markets for health and reduce harm from the negative externalities of commercial products and practices;
- ii) Integrating redress for NCDs, mental health, injuries and violence related to climate change within relevant finance discussions;
- iii) Integrating economic and commercial determinants of health considerations within discussions on development financing including debt;
- iv) As part of addressing the commercial determinants of health, implementing rules that prevent profit-shifting.

4.5 Investing in SIDS-SIDS and triangular cooperation for action on the commercial determinants of health

Collective political leadership and action among SIDS, with the support of international partners, is critical to the addressing the commercial determinants. It enables the development of regional and SIDS-level norms, protection against industry interference, and capacity building.

Actions could include:

- i) Integrating commercial determinants of health considerations within the implementation of SAMOA pathway commitments;¹⁹
- ii) Exploring a ONE UN approach to the commercial determinants of health;
- iii) Considering the establishment of a SIDS Technical Network on economic and commercial determinants of health, with support from WHO and partners.

¹⁹ The Small Island Developing States Accelerated Modalities of Action Pathway (2014) on the sustainable development of SIDS

as adopted at the third International Conference on Small Island Developing States and reaffirmed by the UN General Assembly

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Noncommunicable diseases, mental health conditions, injuries and violence**



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Annexes

Annex 1: Member States, SIDS, and others represented at the SIDS Ministerial and Technical Meeting

Breakout session on commercial determinants of health at the High-Level Ministerial on NCDs and Mental Health in SIDS, June 2023

Member States and other SIDS

- Barbados
- British Virgin Islands
- Dominica
- Jamaica
- Mauritius
- Suriname
- Timor-Leste
- United Kingdom of Great Britain and Northern Ireland
- Vanuatu

UN & AFP

- WHO

Intergovernmental Organizations

- Commonwealth Secretariat

Other Non-State Actors

- Healthy Caribbean Coalition
- NCD Alliance
- The University of the West Indies
- World Diabetes Foundation

Full session on multisector collaboration to address NCD risk factors and commercial determinants at the High-Level Ministerial on NCDs and Mental Health in SIDS, June 2023

Note: Session was open attendance and registration not required---accordingly, WHO and Member State speakers and moderator only are listed below

Member States and other SIDS

- Bahamas
- Belize
- Mauritius

- Suriname
- Vanuatu

UN & AFP

- WHO

Breakout session on commercial determinants of health at the SIDS High-level Technical Meeting on NCDs and Mental Health, January 2023

Note: Session was open attendance and registration not required---accordingly, only participants with representatives who intervened during the session and identified their organisational affiliation are recorded

Member States and other SIDS

- Jamaica
- Tuvalu
- Anguilla
- United Kingdom of Great Britain and Northern Ireland

- The Pacific Community

Other Non-State Actors

- Healthy Caribbean Coalition
- Faculty of Law, University of the West Indies
- Faculty of Medical Sciences, University of the West Indies
- School of Social and Political Science, The University of Edinburgh
- Trinidad and Tobago Association of Nutritionists and Dietitians

UN & AFP

- WHO
- PAHO

Intergovernmental Organizations

**Economic and commercial determinants of health considerations in Small Island Developing States:
Noncommunicable diseases, mental health conditions, injuries and violence**

Annex 2: Summary of select WHO implementation guides, technical and policy packages relevant to SIDS

Alcohol control

- The SAFER initiative (287)

Cancer

- The Global Breast Cancer Initiative (288, 289)
- The Global Initiative for Childhood Cancer (290)

Cardiovascular diseases

- HEARTS: Technical package for cardiovascular disease management in primary health care: Risk-based CVD management (291), including the complementary HEARTS in the Americas Initiative (292)

Climate change

- Special Initiative on Climate Change and Health in Small Island Developing States (293)

Drowning prevention

- Preventing drowning: an implementation guide (294)

Industrially produced trans fat

- REPLACE trans fat: an action package to eliminate industrially-produced trans-fat from the global food supply: trans fat free by 2023 (301)

Mental health

- The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health (295)

Noncommunicable diseases (updated NCD ‘best buys’)

- Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2030 (296)
- WHO package of essential noncommunicable (PEN) disease interventions for primary health (297)

Physical activity

- ACTIVE: a technical package for increasing physical activity (298)

Road safety

- Save lives: a road safety technical package (302)

Salt reduction

- The SHAKE technical package for salt reduction (303)

Tobacco control

- MPOWER measures, to assist in the country-level implementation of effective interventions to reduce the demand for tobacco, contained in the WHO FCTC (300)

Violence

- INSPIRE Handbook: action for implementing the seven strategies for ending violence against children (299)

**Economic and commercial determinants of health considerations in Small Island Developing States:
Noncommunicable diseases, mental health conditions, injuries and violence**

Annex 3: Relevant milestones and commitments

NCDs and SIDS

- **SIDS High-level Technical Meeting on NCDs and Mental Health, prior to a Ministerial Conference in June 2023 (304)** – WHO, PAHO, Government of Barbados (2023)
- **WHO Global NCD Compact and first annual gathering of a Heads of State and Government Group for the Prevention of NCDs (305)** – WHO, Government of Ghana, Government of Norway (2022)
- **Agriculture development, food security and nutrition (A/RES/77/186) (306)** – WHO (2022)
- **SIDS Summit for Health: Outcome Statement (14)** – WHO (2021)
- **Political declaration of the 3rd High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (307)** – WHO (2018)
- **Outcome document of the High-Level Meeting of the General Assembly on the e Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-communicable Diseases (308)** – WHO (2014)
- **Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases : draft resolution / submitted by the President of the General Assembly (309)** – WHO (2011)
- **Political Declarations of the UN High-level Meetings on the Prevention and Control of NCDs in 2011, 2014 and 2018 (307-309)** – WHO (2018)
- **Special Initiative on Climate Change and Health in Small Island Developing (293)** – WHO, UNFCCC (2017)
- **2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development (310)** – UN (2015)
- **Yanuca Island Declaration and the Healthy Islands approach (311, 312)** – WHO, Pacific Community (1985, reaffirmed in 2015)

- **SIDS Accelerated Modalities of Action Pathway (SAMOA Pathway) (313)** – UN-OHRLLS (2014)
- **Declaration of Port-of-Spain: Uniting to Stop the Epidemic of Chronic NCDs (314)** – CARICOM (2007)
- **WHO Framework Convention on Tobacco Control (WHO FCTC) (280)** – WHA (2003)

Business and human rights in SIDS

- **Small Island Developing States Global Business Network (315)** – UN-OHRLLS
- **United Nations Forum on Business and Human Rights**, Working Group on the issue of human rights and transnational corporations and other business enterprises (316-318) – OHCHR (various)
- **Regional Forums on Business and Human Rights** (Latin America and the Caribbean; Pacific; Africa; South Asia; and Eastern Europe and Central Asia) (205, 206) – OHCHR (various)

Economic and commercial dimensions of the social determinants of health

- **Seventh-Fourth World Health Assembly Resolution WHA74.16 on Social Determinants of Health (319)** – WHO (2021)
- **Geneva Charter for Well-being (320)** – WHO (2021)
- **Rio Political Declaration on Social Determinants of Health (18)** – WHO (2011)
- **Sixty-Second World Health Assembly Resolution WHA62.14 on Reducing health inequities through action on the social determinants of health (321)** – WHO (2009)

Sustainable development

- **UN 2030 Agenda for Sustainable Development (322)** – UN (2015)

**Economic and commercial determinants of health considerations in Small Island Developing States:
Noncommunicable diseases, mental health conditions, injuries and violence**

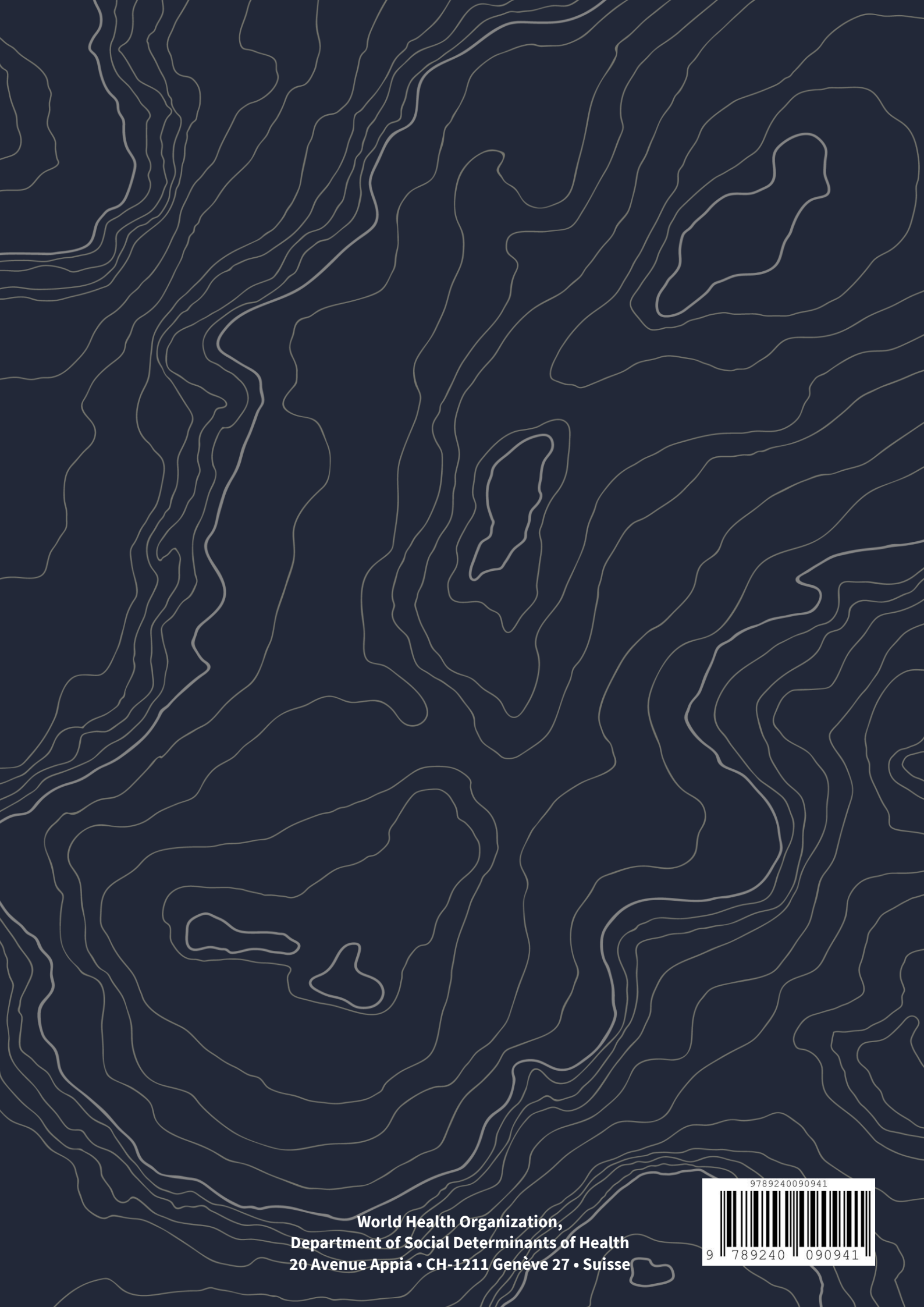
Annex 4: Summary of economic and commercial determinants of NCDs, injuries and road safety and Mental Health conditions

NCD 5x5 framework risk factors	Impact on SIDS
Tobacco use	<ul style="list-style-type: none"> • Tobacco use is a common risk factor for the main noncommunicable diseases, which continue to be a major problem in SIDS. SIDS countries have some of the highest smoking rates in the world. Three of the top ten worst rates of adult smoking in the world are countries in the Western Pacific region. The Caribbean in contrast, has relatively low tobacco smoking rates; however, rates of tobacco use amongst Caribbean youth are the highest in the Americas and vaping is on the rise. SIDS are also highly vulnerable to tobacco industry tactics to interfere with, and undermine, the development and implementation of public health policies. • Smokeless tobacco is commonly used in some Pacific Island countries. • In pointing out the particularly challenging economic burden of NCDs on SIDS, the Addis Ababa Action Agenda recognized that as part of a comprehensive strategy of prevention and control, price and tax measures on tobacco can be an effective and important means to reduce tobacco consumption and healthcare costs and represent a revenue stream for financing for development in many countries. • 92% of SIDS are Parties to the WHO Framework Convention on Tobacco Control, an evidence-based treaty that reaffirms the right of all people to the highest standard of health. • The tobacco industry in the Caribbean continues to profit economically and socially from the manufacturing and distribution of cigarettes and the implementation of CSR programmes in some of the most vulnerable communities all while interfering in tobacco control policymaking.
Alcohol use	<ul style="list-style-type: none"> • Alcohol consumption is generally lower in SIDS (4.35 litres of pure alcohol per capita (15+)) than it is globally (5.45 litres of pure alcohol), although the rates for the Caribbean region (5.43 litres of pure alcohol) is comparable to global rates. As is the case globally, alcohol consumption in SIDS is more prevalent among men (6.96 litres of pure alcohol) than women (1.74 litres of pure alcohol). • Alcohol use among teenagers (13-17 years) in the Caribbean is almost the same as among adults. • The Caribbean exports alcohol, and is dependent on tourism, so reducing alcohol consumption has implications for the country's economy and employment. • Increased taxation on alcohol was one of the most reported policies to be partially or fully achieved in SIDS between 2000 and 2019.

<p>Unhealthy diets</p>	<ul style="list-style-type: none"> • SIDS have some of the highest overweight and obesity rates in the world, with up to 80% of adults in some Pacific Island states and over 60% in the Caribbean being obese/overweight. Childhood obesity rates in SIDS in the Caribbean are increasing at 1% / year, primarily driven by the high availability of imported, affordable and heavily marketed, energy-dense and highly processed foods, as approximately 50% of all small island economies import over 80% of their food. • More than 85% of adults do not consume recommended 400 grams of fruits and vegetables each day. • In 2021, only 13 of the 38 Member States SIDS had food based dietary guidelines to inform and guide policy work along the food system, and none of these explicitly incorporated environmental sustainability elements. • Improving health through nutritional environments is a central component of the SIDS Accelerated Modalities of Action (SAMOA) pathway and a key policy option for SIDS who have taken measures such as imposing taxes on sugar-sweetened beverages and other unhealthy products. • Industrially produced trans fats (IP-TFAs) are banned in almost every high-income country, but in few LMICs. It requires legislation which is a challenge for SIDS with limited human resources. • Domestic food security is undermined by a reliance on imported processed products including ultra-processed foods and beverages. • Regulation of marketing through television is very difficult as most broadcast content available in SIDS originates from larger countries.
<p>Physical inactivity</p>	<ul style="list-style-type: none"> • The average prevalence of insufficient physical activity in SIDS (27%) is similar to the global level (28%). • The unhealthy relationship between sport and the health-harming products' industries is a challenge globally and exacerbated in SIDS where funding sources are limited, and 'sport' from primary school through to secondary school and amongst elite athletes, is often funded/sponsored by the alcohol and ultra-processed foods and beverages industries normalizing their consumption from childhood and indirectly undermining benefits gained from physical activity. • Considering perceptions and barriers to physical activity for specific population groups requires an understanding of values, norms, ways of life, motivations, enjoyment, family commitments, social support, and integration with cultural components such as traditional dance and music, prayer, community orientation and family inclusiveness. • Considerations of gender and cultural contexts are also particularly important to engage women and girls in structured exercise, incidental exercise, and sports, providing them with environments in which they are safe and accepted in which to exercise and play.
<p>Air pollution</p>	<ul style="list-style-type: none"> • SIDS are some of the least contributing countries to CO2 and other polluting emissions, though they are some of the most impacted countries. • SIDS experience heavy usage of dirty fuels for cooking in some places, poor controls of vehicle emissions and the burning of household refuse due to lack of alternative options. As well as fossil fuel-driven transportation and power generation, other pollutant sources include the use of agricultural fumigants, unchecked industrial stack emissions, gas flaring, cruise ships and airplanes, rotting sargassum seaweed, inefficient waste management systems for hazardous and toxic wastes, and open pit burning, among others.

	<ul style="list-style-type: none"> • Air pollution remains a major challenge for SIDS, although the median annual mean concentration of fine particulate matter is estimated to be, at 9 µg/m³, much lower than in other countries (20 µg/m³), yet still above the WHO guidelines of 5 µg/m³ or less (3). Particulate matter, waste management and household air pollution are all contributing factors to this air pollution. • With a lack of baseline data on key pollutants in SIDS, more work can be done to provide technical guidance for SIDS in how to address this risk factor.
Compounding Challenges	
Climate change	<ul style="list-style-type: none"> • As temperatures increase, sea levels rise, drought and extreme weather events become more common, climate change presents an existential threat for SIDS communities. • Biodiversity and access to natural resources, which are threatened by climate change, are central to economic, cultural and spiritual life for SIDS. • Extreme events disrupt supply chains deepening vulnerability and creating insecurity as it relates to foods, medicines, etc. and create the conditions for commercial actors including those in the health-harming industries to expand and exploit vulnerable market opportunities.
Fishing	<ul style="list-style-type: none"> • One key challenge that SIDS face are illegal and unsustainable fishing and the resulting depleted fish stocks, which risk a key food source. • Fisheries face further risk of depletion due to the threat of climate change, posing a challenge to livelihoods and nutrition. • Plastics, sewage and agricultural and industrial pollutants are major threats to environmental sustainability, both on land and in the sea. • The Caribbean Sea has one of the highest levels of plastic pollution globally, and microplastic pollution is widespread.
Agriculture	<ul style="list-style-type: none"> • Local food production continues to be challenged by the distinct vulnerability SIDS face to the impacts of climate change. This is further compounded by ongoing gender-based barriers to land access, fisheries resources, tools and credit which impact the agricultural and fishery workforce, as well as the global overexploitation of oceanic resources which have threatened SIDS blue economy and rich aquatic resources. This is impacting availability and affordability of healthy foods.
Access to medicines	<ul style="list-style-type: none"> • The pharmaceutical industry intersects with CDoH in many ways, from the provision of essential medicines and technologies to COVID-19 related and other vaccine inequity arising from single source supply chains and paying disproportionately higher cost as a percentage of health expenditure for the cost of vaccinating populations. • Small size means a lack of economies of scale and high costs for imports which cannot come by land. • Purchasing of small amounts of pharmaceuticals means higher unit prices. • Many SIDS lack the capacity to monitor quality of pharmaceutical imports. • Recent acquisitions by transnational tobacco corporations of pharmaceutical companies may need to be considered in light of the potential that the tobacco industry could influence public health policy, including tobacco control implementation in SIDS.

<p>Road safety, drowning and injuries</p>	<ul style="list-style-type: none"> • Road safety and injuries intersect with commercial determinants of health in several ways, including pollution from combustion engines, alcohol-related road morbidity and mortality. • Drowning is associated with the tourism industry, but also in examples of actions commercial actors in hotels and tourism to address drowning prevention through risk management strategies and trainings. • This area has been relatively less developed within the literature of CDoH and is a topic WHO will address in an evidence review.
<p>Dependency on the tourism sector</p>	<ul style="list-style-type: none"> • Tourism accounts for around 30% of annual GDP on average across SIDS but exceeds 50% for some states. • The long-term impacts of even temporary unemployment should not be underestimated, as unemployment is a key social determinant to affect people across their life course, particularly for young people.
<p>Overseas Development Assistance</p>	<ul style="list-style-type: none"> • Some SIDS do not qualify for ODA in spite of their small size and precarity, while much larger emerging economies do. Redressing development assistance opportunities, both by agreeing goals among SIDS and by tailoring packages in ways that better reflect the reality that SIDS face, could meaningfully improve resilience, economic development and health.
<p>Macro-economic systems and international trade</p>	<ul style="list-style-type: none"> • The unhealthy environments contributing to health risks are shaped by market penetration and marketing of large-scale commercial actors. • The reliance of SIDS on imports from larger and more powerful stakeholders creates specific vulnerabilities that further compound the challenges presented above. • Trade agreements can create economic conditions requiring SIDS to import foods which harm health and adopt limited options to control imports or adjust local pricing.
<p>COVID-19 and equitable recovery</p>	<ul style="list-style-type: none"> • Global vaccine distribution and uptake has created challenges in providing COVID-19 vaccines to SIDS populations. • The Director of PAHO was required to issue a statement combatting vaccine hesitancy among Caribbean nations. • Due to reliance on tourism and remittances from relatives working abroad, the economic impact of COVID-19 was forecast to be largest in SIDS compared to other country categories, with the highest impact likely to fall on low-income, seasonal, women and young workers. • Gaps in public sector services and disrupted supply chains created by the pandemic were in many instances filled by commercial actors, especially the alcohol, tobacco and ultra-processed food industries who leveraged the opportunity to promote products and build brand visibility and loyalty.



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