Economic and Commercial Determinants of Health in South-East Asia: Regional consultation Report

17-19 October 2023, Bangkok, Thailand
# Table of Contents

**BACKGROUND** ................................................................................................................................................. 5

**AIMS AND OBJECTIVES OF THE CONSULTATIONS** ............................................................................................. 7

**SUMMARY OF THE PRESENTATIONS AND DISCUSSIONS** ................................................................................... 7

**SUMMARY OF PROCEEDINGS** ........................................................................................................................... 9

**PART I. INTRODUCTION OF THE CDH CONCEPT AND IMPACTS ON HEALTH** ....................................................... 9

**SESSION I: INAUGURATION SESSION** ..................................................................................................................... 9
1. **MEETING OBJECTIVES** ............................................................................................................................................... 9
2. **REGIONAL DIRECTOR’S MESSAGE** ............................................................................................................................... 9
3. **MEETING PROTOCOL** .............................................................................................................................................. 11

**SESSION II: INTRODUCTION OF WHO’S APPROACH TOWARD THE COMMERCIAL DETERMINANTS OF HEALTH (CDH)** .................11

**SESSION III: REGIONAL OVERVIEW OF BRIEF SCOPING OF CDH** .....................................................................................14
1. **OVERALL FINDING OF CDH IN SEAR BY DR. MONIKA ARORA** ........................................................................................ 14
2. **REGIONAL CONCERNS ON FREE TRADE AGREEMENT, PATENTS, REGULATION AFFECTING HEALTH SYSTEM, BY DR MANISHA SHRIDHAR, REGIONAL ADVISOR INTELLECTUAL PROPERTY AND TECHNOLOGY REGULATION (IPT), WHO SEARO**  .......................................................................................... 17
3. **REGIONAL PERSPECTIVES ON UNHEALTHY FOOD AND BEVERAGE, DR ANGELA DE SILVA, REGIONAL ADVISOR NUTRITION AND HEALTH RESEARCH, WHO SEARO** .................................................................................................................................. 19
4. **ILO APPROACH TO WORKERS’ HEALTH AND RESPONSIBLE BUSINESS, DR YUKA UJITA (OSH‐ILO)** ........................................ 22

**SESSION IV: COUNTRY EXPERIENCES ON MAIN COMMERCIAL DETERMINANTS OF HEALTH ON PEOPLE’S HEALTH (FOCUS ON NCD RISK FACTORS E.G. TOBACCO CONTROL, SUBSTANCE ABUSE AND ALCOHOL CONSUMPTION, UNHEALTHY FOOD AND BEVERAGES, OR AIR POLLUTION ETC.)** ............................................................................................................................23
1. **THAILAND EXPERIENCE CDH AFFECTING NCD RISK FACTORS BY DR PAIROJ SAONAUM, THAI HEALTH PROMOTION FOUNDATION** 23
2. **INDONESIA EXPERIENCE: DR PRIHANDRIYO SRI HIJIRANTI M. EPID., PROJECT MANAGER OFFICER (PMO) DIRECTORATE GERAL OF DISEASE PREVENTION AND CONTROL, MINISTRY OF HEALTH** ............................................................................................................................ 24
3. **NEPAL EXPERIENCE: MS. HIRA KUMARI NIRAJULA, DIRECTOR, NURSING AND SOCIAL SECURITY DIVISION, DEPARTMENT OF HEALTH SERVICES, MOHP** .................................................................................................................................................. 26
4. **PANEL DISCUSSION: BANGLADESH, BHUTAN, TIMOR LESTE** ........................................................................................... 28

**SESSION V: COUNTRY EXPERIENCES ON KEY CDH ON HEALTH CARE SERVICES AND HEALTH SERVICE DELIVERIES (E.G. INFANT FORMULAS, MEDICAL DEVICES, VACCINES, PHARMACEUTICAL PRODUCTS, TELECOMMUNICATION & DIGITAL HEALTH, TRANSPORTATION SYSTEM, ETC.)** ............................................................................................................................30
1. **THAILAND EXPERIENCE’S ON CDH IN HEALTH CARE SERVICES AND SERVICE DELIVERIES, MS. SULADDAA PONGUTTA, IHPP, THAILAND** ............................................................................................................................................. 30
2. **PANEL DISCUSSION: BANGLADESH, INDONESIA, SRI LANKA, MALDIVES** .......................................................................................... 33
SESSION VI: COUNTRY EXPERIENCES ON ECONOMIC GAINS / LOST FROM COMMERCIAL PRODUCTS AND ACTIVITIES .....................35
SESSION VII: SOUTH-EAST ASIA COUNTRIES PERSPECTIVE ON “ECONOMY OF WELL-BEING AND WELLNESS PRODUCTS” ..........39
1. MR. ODD HANSEN, TECHNICAL SPECIALIST ON HEALTH, TAXATION AND FINANCING, UNDP..............................................39
2. DR. SARAWUT BOONSUK, DEPUTY DIRECTOR GENERAL, DEPARTMENT OF HEALTH, THAILAND........................................41
3. DR. IFTIKHAR, TRADE AND DEPARTMENT, GOVERNMENT OF MALDIVES...........................................................................43

PART II ECONOMY OF WELLBEING AND EQUITY ..........................................................................................................................44

SESSION I: GLOBAL REPORT ON COMMERCIAL DETERMINANTS OF HEALTH – PRESENTATION BY MS. JULIETTE MCHARDY,
CONSULTANT, ECONOMIC AND COMMERCIAL DETERMINANTS, DEPARTMENT OF SOCIAL DETERMINANTS OF HEALTH (WHO HQ) ........................................................................................................................................................................................................................................44

SESSION II: EQUITY LENS ON COMMERCIAL DETERMINANTS OF HEALTH: 3 PRESENTATIONS ..................................................48
1. CONSUMER PROTECTION OF PEOPLE’S VOICES BY DR VINYA ARIYARATNE, SAVODAYA, SRI LANKA.......................................48
2. COMMUNITY’S VOICES BY PROFESSOR SHARAD ONTA, NEPAL PUBLIC HEALTH FOUNDATION .............................................50
3. COLLABORATIVE APPROACH FOR BETTER HEALTH BY DR THAN SIE, PEOPLE’S HEALTH ASSOCIATION OF MYANMAR..............51

SESSION III: BRAINSTORM SESSIONS: PEOPLE EXPERIENCE OF CDH THROUGHOUT THE LIFE-COURSE AND EQUITY LENS ON CDH ACROSS LIFE-COURSE ............................................................................................................................................52
Q1: .......................................................................................................................................................................................53
Q2: WHAT ARE THE CRITICAL CONCERNS? ...............................................................................................................................55
Q3: WHAT ACTIONS CAN INDIVIDUALS TAKE? ..........................................................................................................................57
Q4: WHO IS RESPONSIBLE FOR CURBING NEGATIVES AND ENHANCING POSITIVES? ............................................................59
Q5: WHAT DOES THE PUBLIC SECTOR NEED TO DO? ...............................................................................................................61
Q6: WHAT ARE THE ACTIONS TO ADDRESS EQUITY GAPS FOR VULNERABLE POPULATION? ..................................................63

PART III: REGIONAL POSITION ON COMMERCIAL DETERMINANTS OF HEALTH ...........................................................................65

SESSIONS I, II, III: COUNTRY PRESENTATIONS ON UNDERSTANDING OF BURDEN, SECTORS, ACTIVITIES, AND SYSTEMS FOR THE CDH AND ACTION POINTS: BANGLADESH, BHUTAN, NEPAL, INDONESIA, MALDIVES, TIMOR LESTE, SRI LANKA, THAILAND, MYANMAR ........................................................................................................................................................................65
1. TOP 3-5 CDH TO BE CRITICALLY CONCERNS IN THE NEXT 5 YEARS .........................................................................................65
2. COMMERCIAL DRIVERS/ACTORS THAT HAVE DIRECT IMPACTS ON PEOPLE HEALTH ........................................................66
3. EXISTING ECONOMIC MODELS/SYSTEMS THAT MAY REDUCE OR UNDERMINING HEALTH FOR ALL .....................................68
4. EXISTING PUBLIC PRIVATE PARTNERSHIPS AND GOVERNANCE THAT CAN MANAGE CDH ..................................................70
5. PUBLIC HEALTH APPROACH TO CDH ........................................................................................................................................72
6. COUNTRY ACTION POINTS IN 2024-2025 ......................................................................................................................................75
7. RECOMMENDATIONS FOR WHO ...............................................................................................................................................76

SESSION IV: REGIONAL MECHANISMS RESPONDING TO COMMERCIAL DETERMINANTS OF HEALTH........................................77
1. DR SHAMIM HAYDER TALUKDER, SEAR NCD ALLIANCE ........................................................................................................77
2. DR YUKA UJITA, ILO .................................................................................................................................................................78
3. THAKSAPHON(MEK) THAMARANGSI, WHO SEARO ................................................................................................................79

Page 3 of 97
**Background**

Increasingly, public health and medical professionals have witnessed commercial system and product influences over population health behaviours and conditions that change people’s ways of life. For example, NCDs were described as ‘lifestyle diseases’ due to their association with behaviours including tobacco use, alcohol use, unhealthy diet, and physical inactivity. Behaviours and consumption patterns are increasingly recognized as socially constructed actions, or commercially driven, heavily influenced by large-scale production, marketing, and distributing of services and products making them readily available and appealing to different groups of the population.

Products targeted towards children and adolescents with long lasting impacts on their health include tobacco, alcohol, and unhealthy diets leading to ill health conditions among children and adolescents. Advertisements of tobacco targeting adolescents cause harm to the young generation. Alcohol consumption among adolescents reported in GSHS over the years reveals, that early initiation of alcohol is at 12-13 years old in many countries. Childhood overweight and obesity is estimated to affect approximately 41 million in 2016 and almost half of all overweight children under 5 lived in Asia. Childhood obesity results in an increased risk of cardiovascular disease, diabetes, and lung diseases.

Recently, WHO attempted to define the commercial determinants of health (CDH) as *the conditions, actions and omissions by corporate actors that affect health, arising in the context of the provision of goods, or services, for payment, which include commercial activities, as well as the environment in which commerce takes place, with beneficial or detrimental impacts on health.*

The commercial system impacts much of societal living and actions such as social determinants of health (income disparities, education, housing conditions, stigma on population exploited in illicit trades) which are the non-medical factors that influence health outcomes and inequities. These determinants hold the key to turning the tide of rising global health challenges and health inequities. CDH exerts dramatic impacts on health from the local to global level, across sectors, settings and populations.

The burden of CDH impacts falls inequitably between regions and countries. In South-East Asia, commercial determinants of child and adolescent health, women’s health, and workers’ health, lies in not only the unhealthy products, but also the whole system of supply chains of products within a country, or through transnational establishments, causing labour exploitation of children, women, workers, including human trafficking for labour exploitation. Impacts of commercial products, services, and activities on health require public health intervention to change corporate practices and protect people’s health.

Business structures, regulatory regimes, and tax systems that allow profits to flow to other countries, away from the country or region where damaging health impacts and costs are incurred, compounds the problem, particularly where these profits are driven through the exploitation of population, the natural environment, inadequate labour laws and social protections systems. Consumer protections and rights of consumers are invariably effective in most countries in South-East Asia. While voices of research and academics to protect people’s health through health impact studies are diminishing, as influence of international trade and economic developments are intertwined. Building on experiences of FCTC implementation and cooperate interference on tobacco prevention, WTO plays critical roles in several trade agreements influencing LMICs, while Trade-related Aspects of intellectual property (TRIPS) is influencing disclosure of content of products as well as labelling disclosure policies.
The WHO Executive Board 152nd Session Agenda item 16, December 2022 on Social Determinants of Health reported by the Director-General, mentioned in paragraph 22 that **WHO Secretariat’s support for countries to strengthen understanding of the commercial determinants of health. Although much has been done to look at how specific private sector products and practices, notably the tobacco industry, have impacted on public health outcomes by WHO and other actors, there are increasing calls for WHO to take a more systematic approach to determining the contribution of harmful products and commercial practices to the global burden of disease and to develop approaches that allow for leveraging the co-benefits of working with the private sector, while safeguarding against conflicts of interest.**

This concept of commercial determinants of health needs to be comprehended and deliberate with multisectoral authorities and stakeholders. Critical areas of focus could be considered around tobacco, alcohol, ultra-process food, fossil fuels that impact large scale mortalities. It is important to have cross sectoral dialogues on positive and negative impacts of CDH, power relations, systematic pathways, public health interventions/solutions including upstream policies and opportunities to promote health in all public policies.

Commercial and economic determinants of health need to be discussed together between public health communities, professional associations and economic sector, finance, national and local governments responsible for governance and regulation of international and domestic trades. This meeting is timely to raise awareness and understanding of CDH in the region.

The meeting aimed at raising awareness of Member States on this important area of focus and discussing health care cost and health impacts of specific commercial determinants of health. WHO’s convening roles with multisectoral partners will support member states to identify further work on commercial determinants including its gaps and strategic directions to exert the importance of population’s health as national capital to be valued equally to economic gains.

This meeting was an important platform for Member States to review the Draft Outline of the first WHO Global Report on Commercial Determinants of Health, which will be published in 2024. Member States provided critical inputs via this consultation on how country level interventions and approaches can be accelerated (from regulatory interventions or integrated HiAP); or facilitated through policy coherence tools (HIA, Conflict of Interests, Transparency registers), or enabled through local governments addressing CDH and engagement with local economic operators and working with civil society.
Aims and Objectives of the Consultations

General objectives
To find common understanding and awareness of the economic and commercial determinants of health in South-East Asia

Specific objectives
1. To inform member states on the concept and potential impacts of economic and commercial determinants of health (CDH)
2. To share country experiences on economic and commercial determinants of health and common challenges faced by countries.
3. To solicit inputs for the Global Report on CDH from member states
4. To consult on priority actions and ways forward to strengthen understanding of the commercial determinants of health in South-East Asia

Target Participants
1. Member States: high level officials from MOH (DG level), National Programme managers (on child or adolescent nutrition Food safety, Tobacco Control, Chemical safety, etc.) and/or national health planning or commission; representative from Ministry of Finance/Commerce heading the work on commercial regulations, trade investments, or taxation of products, or market systems affecting the health of the population.
2. Representatives from academia or civil society organizations (CSOs) working on consumer protections, and civic and community’s rights to health.
3. NCD Alliance, ASEAN, SARRC, ADB, World Bank, World Trade Organization (WTO), FAO, UNTAD, UNESCAP, UN Human Rights, UNDP, ILO.
4. International Foundation for Health Promotion in Thailand, International Society for Health Promotion and Education Indonesia, and VHAI India.

A list of attending participants is attached as Annex 1.

Summary of the Presentations and Discussions

The regional consultation took place from 17 October to 19 October 2023, with a total of 62 participants attending. Participants included government representatives from ministries of health, finance/commerce from 9 countries. Other participants were representatives from academia or CSOs working on consumer protection, the NCD Alliance, UN agencies including ILO, 2 participants from WHO headquarters, 8 participants from WHO country offices, and 5 participants from WHO SEA regional office.

The themes guiding the 3 days of meetings were as follows:

- Day 1: Introduction of the CDH Concept and Impact on Health
- Day 2: Economy of Wellbeing and Equity
- Day 3: Regional Position on Commercial Determinants of Health
On Day 1, government representatives reflected on the country experiences with CDH on people’s health, healthcare services and health service deliveries, and economic gains/losses from commercial products and activities. Representatives also reflected on economic wellbeing and wellness products. On Day 2, participants were divided into five groups for brainstorming sessions on people's experiences on CDH throughout the life-course and equity lens on CDH across the life-course. On Day 3, government representatives presented an understanding of burden, sectors, activities, and systems for CDH and country action points. UN agency representatives reflected on the regional mechanisms responding to CDH. Day 3 concluded with recommendations for WHO including reflections on draft outline of the WHO’s Global Report on CDH.
Summary of Proceedings

Part I. Introduction of the CDH Concept and Impacts on Health

Session I: Inauguration session

1. Meeting Objectives

Regional consultation on economic and commercial determinants of health in South-East Asia started with a warm welcome to all distinguished participants from the South-East Asia Region (SEAR) countries. Dr. Suvajee Good, Regional Advisor for Social Determinants of Health and Health Promotion (RA-SDH), World Health Organization for South-East Asia Region (WHO-SEARO), introduced the commercial determinants of health (CDH) as the conditions, actions and omissions by corporate actors that affect health. Dr Good elaborated that CDH could be both positive or negative in the context of the provision of goods or services for payment, including commercial activities and the environment in which commerce takes place with beneficial or detrimental impacts on health. She highlighted that the WHO's attempt to define commercial determinants may not be the most comprehensive but is still developing based on the evidence.

Dr Good highlighted participants' geographies across SEAR countries, including Bangladesh, Bhutan, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, and Timor Leste. Participants from DPR Korea and India could not join.

The primary objective of the consultations is to find a common understanding and awareness of health's economic and commercial determinants in SEAR. The CDH and economic determinants are derivatives of the social determinants of health. The specific objectives of the meeting were laid out.

2. Regional Director’s Message

Dr Jos Vandelaer, WHO Representative to Thailand, delivered the message from Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia. He quoted Dr. Khetrapal’s speech (in Annex 3) and highlighted that globalization and commercial activities have increased the scope of economic opportunities, employment, access to essential and discretionary goods and services to national and local communities. Marketing strategies, promotion of choices, lobbying, donating, and funding research activities are increasingly influencing the decision making of individuals, families, communities, and public authorities to adopt the products and practices that could have beneficial or detrimental impacts on people’s health.
Dr. Khetrapal mentioned that WHO recognizes the importance of economic and commercial determinants of health that generate positive and negative impacts on public health while enabling political economic systems and norms for working conditions and other related activities. The term “commercial determinants of health” is used to understand how industrial driven commercial activities including all the products and services impacting public health (health care delivery systems and cost), influence lifestyle choices (healthy or unhealthy), and global health inequities (including occupational health of workers in different commercial systems). The production and consumption of ‘unhealthy’ products, for example, tobacco, alcohol, ultra-processed foods, and sugar beverages, impacts the earth (planetary health), degrades the environment, communities, families, people’s health and adds to pollution.

Furthermore, the burden of non-communicable diseases (NCDs) was highlighted in SEAR which accounts for 9 million deaths in 2019 accounting 22% of global NCD deaths. NCD mortality is attributed to lifestyle related risk factors, including increasing emission of pollutants, and burning of biomass for industrial development.

The nutrition transition (from home-grown organic food to mass industrial processed food products) has been evident in SEAR countries, which has led to an increase in consumption of high sugar, salt, and trans-fat and has contributed to obesity and metabolic disorders. The sales of sugar-sweetened beverage (SSBs) have increased everywhere in the region, with a particular increase in Indonesia and Thailand. Alcohol use is increasing in countries such as DPR Korea, India, and Thailand. Availability of cheap unhealthy items in the region e.g., tobacco, loose cigarettes, cheap liquor, uncertified contaminated food and vegetables, cheap unhealthy imitated food products, etc. is driving up noncommunicable diseases among the poor, rural, and less informative population.

Her quote stressed that the commercial system of pharmaceutical products, medical technologies, vaccination, and health supplements can divide healthcare services benefiting the rich and the poor differently. Commercial determinants of health pose a complex juxtaposition to health equities. It can increase health care costs including out-of-pocket expenditures and widening the gaps of health inequities.

Addressing determinants of health requires public policies (beyond the health sector) with attention to the role of power, equity, and governance. An increase in governance, sectoral accountability, regulation, licensing, and taxation are some examples of actions that can curb the proliferation of commercial activities that have negative impacts on health. An increase in health literacy among consumers and promotion of health as a human right would raise consumer demand for improved business operation and reform to create better products for health and wellbeing.

Call to action: Ministry of health and partner agencies should encourage other sectors to advance the economy for health and wellbeing, promotion of wellness and equitable access to health products, and increase the enabling environment for health for all populations. Dr Khetrapal stressed the need to follow-up on the commitments the world leaders have made during recent G20, as they are the drivers of some of these commercial determinants of health, to reach one earth, one health making the world a healthier place. Her quote highlighted that taking this as an opportunity to also understand the economy of well-being. Facilitating equitable access to safe, effective, quality-assured, and affordable vaccines, therapeutics, diagnostics, and other countermeasures, especially in low- and middle-income countries and small island development states is also a need of the hour.
3. Meeting protocol

Administrative instructions were provided by Dr Suvajee Good to the participants. Dr Good also insisted on following the WHO code of conduct to prevent all kinds of harassment.

Session II: Introduction of WHO’s approach toward the Commercial Determinants of Health (CDH)

Ms Monika Kosinska, global cross-cutting lead for economic and commercial determinants of health, WHO Headquarters, introduced the WHO’s approach to CDH. Ms Kosinska mentioned that the biggest public health challenges that the world is facing include NCDs and communicable diseases, climate change, related emergencies, occupational illnesses and injuries, mental health conditions and others.

She further stressed that many leading scholars are increasingly identifying commercial products and practices as the leading cause of the global burden of disease and threats to planetary health. Referring to a study published in the Lancet, in March 2023, she emphasized that one-third of the deaths globally are attributed to only four industries which include tobacco, alcohol, unhealthy food and fossil fuels. She highlighted the important role that the commercial sector and the private sector actors play in wealth, economic development, and partnership as part of the multi-sectoral approach and that WHO is sensitive to ensuring its work on economic and commercial determinants is reflective of both the positive and negative externalities to commercial practices.

Ms Kosinska mentioned that CDH is becoming an increasingly important area of inquiry for public health because of the role that commercial actors play throughout the social determinants that influence our health. A high-level strategic meeting on the social determinants of health held in Geneva in 2019 identified the rise of CDH and its direct impact on health particularly negatively and WHO was asked to scope this further. The purpose of the regional consultation is to contribute to this scoping, building on the existing work of WHO to cover the spectrum of corporate behaviour from supply chains through regulatory influence and embedding commercial dynamics within social determinants. The lens that needs to be applied on this emerging field of enquiry is of power, of equity in health, and of governance.

Ms Kosinska highlighted four key challenges:

- Commercial practices are embedded within broader economic and financial environments and these economic drivers act as the economic determinants and enablers that create the conditions in which commercial actors operate and impact public health
• There is a need to quantify and qualify in terms of the harm arising from commercial practices, and who bears the costs of these harms – too often those who can’t afford them.
• The health sector needs strengthening to understand and address the impact and the outcomes of negative externalities from the commercial determinants of health.
• Ensure that the focus is on both conflicts of interest and management of risks and maintains an equity lens on health outcomes arising from commercial practices.

Therefore, it is imperative to think about the pathways available to government to shift commercial practices from health-harming to becoming health-enabling and health-promoting. The first book published on CDH defines commercial determinants very broadly as any activity of the private sector. However, recently in the Lancet series, an international group of scholars defined CDH as systems, practices, and pathways in which commercial actors drive health and health equity. It is essential to start looking at these impact pathways and outcomes a little bit more closely. It is equally important to make a meaningful distinction between the commercial actors based on the nature of their health impacts. In CDH, the term commercial reflects the complexity and the heterogeneity that exists within the broader private sector. Commercial actors can be privately owned, but they can also be owned by the public sector, or indeed by not-for-profit entities – their classification as a commercial actor is not according to their ownership, but rather whether they engage in commercial practices.

WHO is using a working impact framework which consists of four domains: two impact domains and two activity domains. The two main groups of activities that drive commercial impacts on health include:
The first is core commercial business operations through the supply chain in the design and sale of products and service, and participation within the market. This also includes marketing activities and their impact on supply chains or on their employees.

The second is commercial citizenship or personhood. That is when commercial actors act as institutions, through CSR activities, public relations, political activities, lobbying, but also through their contributions to national tax budgets; national tax contributions, budgets and through third-party activity, such as funding business associations and ‘Astroturf’ or not-for-profit actors.

The impacts can also be grouped into two domains. First, the impacts on physical or social environments and ultimately behaviours, and second, the impacts on regulatory systems and processes. When looking at the way commercial activities impact on outcomes, we also need to consider power. An example of a power framework is that presented by Lima and Galea, which identifies five main vehicles of power through: firstly influences on political environments through for example lobbying and pressure; secondly through shaping the preferences of consumers; thirdly on shaping knowledge environments such as research funding, publications and studies influence; fourthly on the legal environment through court challenges, threats and pressures for self-regulation over regulation; and finally the extra-legal environment through illegal activity and tax evasion. The negative CDH emerges not only from health-harming products and services but also from a misalignment of power and resources which reinforce each other. This is then in turn shaped by institutional factors such as laws, finance, economics, development policies and state capabilities.

The Lancet series on CDH published in March 2023 presents the current state-of-the-art academic literature exploring the impact of CDH on the social determinants across the life course. The WHO global programme is a very young programme of about 2 years and the mandate is broad covering not only the political declaration on social determinants of health but also covers different areas where commercial actors play a huge role; the rise in CDH particularly negative externalities on non-communicable diseases and health threats, and the role of the private sector and the development sector. There are four main activities of the programme: coordination internally, advocacy for CDH, knowledge, practice and catalyzation of action.

Several dialogues with individual countries and groups of countries have been undertaken. It was revealed that there is a need for evidence, capacity building, and understanding the evidence of the impact of CDH to generate
awareness across public health and partners. NCDs remain an important entry point for countries due to their importance in global burden of disease.

A strategic approach is needed with a policy focus on taxation, trade, economic development and post-COVID recovery. In the area of governance, tools that support countries in managing and preventing conflicts of interest and guidelines on the prevention of private sector interference remain a gap. Policy coherence across sectors, particularly economy, commerce, and finance, is very important, and still more work is to be done. The private sector's involvement in policy processes has been institutionalized in some cases, and to protect public health in that process, the role of local government is critical. There is a greater need for private sector accountability for its impact on health outcomes. Engagement with countries also revealed that accountability outside of the public sector is also essential. Therefore, responsible investment, third-party mechanisms, and the important role that civil society plays not only in accountability and support, but also in understanding who in civil society is speaking for the voice of communities and who may also have commercial influences.

WHO is also synthesizing the first global report on CDH that will provide evidence to clarify the concepts and the terminology to present the case for action on commercial determinants and present countries with evidence-informed policy recommendations. This meeting will inform that process.

Session III: Regional Overview of Brief Scoping of CDH

1. Overall finding of CDH in SEAR by Dr. Monika Arora

Dr Arora briefed the participants about the scoping review report on CDH in SEAR. The report has a strong emphasis on NCDs and the existence of CDH around each individual risk factor of NCDs. NCDs contribute to accumulative deaths of 9 million every year. Governments need to focus on commercial entities and as a result on commercial determinants. Because of the premature mortality, individuals are losing their lives during productive years. It becomes a financial burden not only on the individuals but to society and to the government, with increasing spending on health care costs. It is important to shift the focus on commercial determinants and look at the regulations from enhancing the positive aspects of engaging the private sector and the commercial determinants and reducing the adverse impact on health.

The COVID-19 pandemic was devastating for the health systems as people living with NCDs were more vulnerable because their COVID-related outcomes were more severe. NCDs serve as an entry point for working on CDH. NCDs are preventable with the right choices and healthy lifestyle practices. NCDs are the major contributor to disability-adjusted life years (DALYs). All SEAR countries have national NCD action plans and extensive work
has been done in the area of Tobacco Control and national NCD programmes but actions on unhealthy diets and alcohol consumption remains to be accelerated. These areas are closely related to CDH.

The main industries focused in the review include tobacco, alcohol, ultra-processed food industry, palm oil, health care, breast milk substitute, cosmetics, and pharmaceuticals. Within these risk factors there are multiple issues like industry interference, marketing strategies, political activity, corporate social responsibility (CSR), that need to be addressed to attain health.

The major problem with CDH comes with SDG 17 which calls for multi-stakeholder partnerships. There is lack of direction and clarity on the potential conflict of interests that arise while partnering with commercial actors that might be directly or indirectly through their subsidiaries engage in health harming activities. Under the garb of partnerships, a lot of industries are engaging in health-harming activities. Industries with clear conflict of interest with health are seen to be partnering on health promotion or development issues, while their products and their use is leading to more poverty and health inequity. Therefore, it is critical to address this conflict of interest, and use frameworks like the Framework of Engagement with Non-State Actors (FENSA) to be able to have very clear regulations in place. Member States must adhere to FENSA which is a framework requested by member states themselves and ensure conflict of interest is absolutely avoided.

Industry uses commercial sector practices to operate and to be able to maximize their profits. Their main goal is profit, and their attention to population, health or the environment is usually weak. So, it is important to identify these commercial practices as they cause harm when left unregulated, therefore impacting health equity. The WHO SEAR Commercial Determinants of Health Report adopts the framework model identified in the Lancet Series on CDH. This framework shows the commercial sector and the determinants of health subsystem through which health is affected. These two are separated in the framework to acknowledge that commercial actors are an important but not the sole influence on that subsystem.

During the drafting of the Regional Report, we organized data from the desk review under political, scientific, marketing, supply chain and waste, labour and employment, financial and reputational management themes. These themes are being adopted to organize all the data being collected from SEAR. There is literature on the tobacco industry, alcohol industry, ultra-processed food industry, oil and gas energy and mining, transportation and logistics, breast milk substitutes, medical tourism, palm oil, pharmaceuticals, sugar sweetened beverages. Dr. Arora discussed commercial sector practices with examples from different industries in the SEAR:

- **Political practices** include lobbying with the governments and meeting various stakeholders to be able to have preferential policies for their profit-making objective. In Thailand, the CMF industry lobbyists met decision-makers to get the Milk Code revised and criminal penalties were removed. The industry was also able to lobby with not only the government but also decision makers involving media stakeholders for knowledge generation.

- The **labour and employment practices** of commercial actors increase the profits and reduce the quality that is provided to the labour. For example, the garment workers conditions in Bangladesh, and other countries, ¹ Giomor AB, Fabbri A, Baum F, Bertscher A, Bondy K, Chang HJ, et al. Defining and conceptualising the commercial determinants of health. The Lancet [Internet]. 2023 Apr 8 [cited 2023 Oct 17];401(10383):1194–213. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(23)00013-2/fulltext
and how, during the COVID-19 pandemic, they were pushed into further poverty because they were laid off from their jobs. The minimum wage rules were modified, and all of this happens in conjunction with being able to discuss policies with the stakeholders and get policies in their favour.

- **Corporate Social Responsibility (CSR):** the intent of this legislation is that the governments want the corporations to use a percentage of their profit for welfare of the society, but it is actually being used in various countries by the corporations to be able to enhance their reputation, even if their products are causing harms. Companies are building up a public image to show how positively they are contributing to the country's economy and to employment by providing livelihood to people and doing good for the country. Through these mechanisms, they get access to the highest political leaders to present companies' preferred policy options. There are CSR regulations in countries like Indonesia, Bangladesh, Bhutan, and India. Although, the tobacco industry cannot advertise directly under the legislation, but through CSR they gain traction and visibility.

- **Various marketing practices** such as of the tobacco and ultra-processed food industry are propagating misleading advertisements. The breast milk substitute industry is very strongly marketing its products. E-Cigarette is another unregulated product in the region that is health harming and being sold by circumventing national laws in SEAR countries. In countries like India, where the product is banned, there is online sale and promotions through influencers. So, there are new marketing practices that are coming into play in the region.

- **Supply chain, waste practices and environmental degradation** include the environmental impact of sugar, sweetened beverage (SSB) industry, depleting the groundwater and contaminating and releasing toxic waste in water bodies. In Maldives, plastic waste has had a severe environmental effect, with 8.55 metric tons discarded daily. The primary source of ambient particulate matter pollution in India, includes commercial biomass burning also for energy generation, the coal burning, industrial emission, construction activities, transport vehicles and diesel generators. All of these are contributing to environmental degradation.

- **Scientific practices** are again, a very important area where industry threatens the real science through producing their own funded research and science evidence to counter facts and health impact. This is another area where the report has been able to capture practices from the tobacco industry. The nicotine industry and commercial milk formula sector have questioned health-harming scientific evidence. Also, the commercial sector has engaged heavily in capturing the science and knowledge environment. They also build brand credibility and influence among health and other professionals through their own funded research.

Tobacco industry interference has reduced over the years in some countries of the region because of the Tobacco Industry Interference Index (TII) released every year by researchers and civil society. Thus, underscoring the need to monitor commercial sector and its activities to minimize their adverse impact on health. Tobacco industry tactics undermine science and lobby through questioning that there is no substantial evidence on health harms related to their products. Industry practices similar to tobacco have been seen in food and alcohol as well where there are subsidies which are provided to these industries.
It is essential to raise awareness about the commercial determinants of health through sensitization and advocacy, but also start capturing and monitoring the practices to have real evidence available. Multi-stakeholder action engaging the non-health sector to promote multi-sectoral response also prohibits contributing to CSR activities. It is essential to identify, prevent, and manage conflicts of interest and partnerships carefully.

2. Regional concerns on free trade agreement, patents, regulation affecting health system, by Dr Manisha Shridhar, Regional Advisor Intellectual Property and Technology Regulation (IPT), WHO SEARO

While SDG3 encompasses aspirations of health goals it is under the SDGs, Goal 9 that highlights the industry's involvement in SDGs. It is also significant that partnerships (SDG17) across the board are very important for public health and for the SDG agenda.

Free trade agreements (FTAs) as of October 14, 2023, sourced from the World Trade Organization (WTO) Secretariat highlight that there has been an exponential increase of free trade

International trade is progressing, and a free trade agreement is typically a bilateral agreement between two countries. These bilateral agreements are very critical because of multinational agreements, such as the WTO and regional engagements. Countries such as India, China, Australia, Indonesia, Peru, Columbia, Chile, the United States of America, Mexico, and Canada are engaged mostly in bilateral agreements.

Specifically, in Thailand the cumulative notifications of regional trade agreements (RTAs) in force are around 25. India has a similar number of RTAs in force. In Indonesia, the figure is slightly lower. Therefore, it may be seen that Thailand is engaging in a lot of FTAs which is influenced by its proximity to the ASEAN. The national treatment principle of engaging between two countries may apply to goods moving across the countries specific to bilateral agreement. The Ministry of Commerce deals with the most favoured trade treatment rules which have their genesis under the General Agreement on Tariffs and Trade (GATT). The agreement, which was negotiated post World War 2 metamorphosed into the WTO. It may be noted that in the regional agreement of the EU, Article 7 includes a precautionary principle that emphasizes decisions have to be taken to protect public health.

WTO agreements including the GATT 1947 impact NCDs. General Agreements on Trade and Services (GATS) includes digital health and the movement of national persons and nurses. The Sanitary and Phytosanitary (SPS) Agreement and Technical Barriers to Trade (TBT) Agreement are critical as they impact labelling and sanitary (animal) and phytosanitary (plant) products. In the Trade Related Intellectual Property Rights (TRIPS) agreement, enforcement of IP rights is another important aspect relevant in public health addressing substandard and falsified products. WTO has a binding dispute settlement mechanism which distinguishes it from other international conventions.

The Thai government has proposed to have a trade and health resolution at the World Health Assembly in 2024. The global strategy and plan of action on public health, innovation and intellectual property includes 108 action points across the 8 elements, and that has led to many other resolutions in public health, including traditional medicine, clinical trials resolution and local production.

In public health, patents, copyrights, and trademarks are important specially in context of vaccines and medicines, including labelling of vials. Access to medicines due to patents is a contentious issue within WTO law, especially the TRIPS agreement. In Article 8 of TRIPS, there is a clear mention that a country may make choices in the interest of public health and nutrition. The member countries have committed to amending their laws and regulations to adopt the necessary measures. In Article 27, for patents the public health provisions are very important. Often it is how an international provision is interpreted and advocated that matters, e.g. the original GATT agreement has only one mention of public health, yet an entire asbestos case hinged on that and public health succeeded.

SEARO publication Regulation & Legal frameworks for SDG3: Regulations and Laws promoting health and well-being goals (SDG3) in WHO South-East Asian countries outlines all laws in the 11 SEAR countries that contribute to public health. E.g., In Bangladesh, Bangladesh Labour Act and Penal Code have provisions which contribute to health and well-being goals. International agreements including conventions/WTO / customary international law have provided for state disputes; there are new dispute mechanisms such as investor-state and those under voluntary private standard schemes. Investor-state arbitration mechanism came under scanner in the tobacco Philip Morris case in the WTO.
While international laws influence public health, national laws and policies include industrial property rights that are territorial in nature and subject to the national laws of each individual country. For example, the patentability requirements across products are different in Indian law. They have slightly higher standards for therapeutic efficacy for medicines/drugs than they have for other products.

3. Regional perspectives on unhealthy food and beverage, Dr Angela de Silva, Regional Advisor Nutrition and Health Research, WHO SEARO

Unhealthy diets are one of the risk factors for NCDs. However, this doesn’t imply that all industry products are unhealthy. Drawing from regional experiences, there is a need to push back industry pressures to improve systematic responses towards commercial determinants.

Healthy foods or diets provide the appropriate number of calories tailored to individual needs, considering factors like age, occupation, and portion size. Conversely, commercial infant formula, high-fat, high-salt, high-sugar foods, additives, large portion sizes, and highly refined sugary beverages contribute to unhealthy or ultra-processed diets. Extruded products and items like potato chips, rich in salt, sugar, and fat with added emulsifiers for flavour enhancement, tend to be low in both micronutrients
and macronutrients but high in energy. These products are characterized by high salt content, flavour enhancers, and a strong appeal to the palate. They are highly refined and notably lacking in fibre.

In the Southeast Asia Region (SEAR), there is an increasing prevalence of both obesity and undernutrition. In 2019, the under-5 age group exhibited a 52.6% prevalence of stunting, 24.9% wasting, and 5.0% overweight. Alarming levels of undernutrition and overweight can be observed in children aged 5-9 and 10-19 in the region. Data from 2016 shows that women tend to have a higher rate of obesity compared to men.

Unhealthy foods and beverages contribute significantly to the global burden of disease, with various food components being linked to increased mortality and disability-adjusted life years (DALYs). In SEAR, high sodium intake and low vegetable consumption contribute to death and disability.

The sale of highly processed foods, including high in fat, salt, and sugar (HFSS) products, is widespread in many regions globally, such as Australia, Western Europe, and Central Europe. In contrast, sales in SEAR and Africa are currently low, but there is a rising trend. Due to the vast population in SEAR and limited knowledge about healthy diets, the industry is pushing to enter these markets, boosting the economy. The increased consumption of sugar-sweetened beverages (SSB) is often influenced by cultural and social norms, along with enhanced accessibility facilitated by the industry and supply chains. The availability and affordability of these products in smaller packages are structural drivers behind these food choices.

Commercial Determinants of Health (CDH) encompass business activities aimed at generating profits and increasing market shares, exerting influence on public health patterns and disease prevalence across populations. The consumption of processed packaged foods has risen due to their availability, accessibility, and desirability. Marketing and advertising campaigns often make bold claims through appealing packaging and corporate social responsibility (CSR) initiatives, including political activities and lobbying. Therefore, it's not just individual products being marketed; the industry is actively promoting its entire product portfolio.

In SEAR, the volume of advertisements for HFSS foods is exceptionally high, including marketing for unhealthy products, particularly confectionery and dairy items with sugared flavourings. Nearly 99% of the advertised products are high in sugar. An assessment conducted across Bangladesh, Nepal, India, and Thailand revealed that many products lack a nutrient panel, and only 6% of products with a nutrient panel meet the nutrient profile threshold. Most of the marketed products fall under categories like ready-to-eat savoury snacks, cakes, biscuits, confectionery, chocolates, and sweets. Children are exposed to an average of 31 advertisements per hour, with young children aged 5 to 18 being exposed to 50% of food-related advertisements. A staggering 95% of these advertisements promote HFSS foods, which are deemed unhealthy.

Evidence-based policy actions exist that promote the reformulation of foods, including breast milk substitutes (BMS). These actions involve restricting marketing and advertising targeted at children, implementing nutrition and labelling regulations, and enacting policies related to sugar-sweetened beverages (SSB). Such regulations increase consumer awareness and product labelling. Fiscal policies and other measures are designed to enhance the availability and accessibility of healthy products.
Currently, nine countries have implemented the marketing code for BMS, six countries have enacted SSB taxes, and four countries have established regulations for food labelling, including front-of-pack labelling and marketing restrictions. In one country, food procurement is in place, and two other countries are actively discussing food reformulation measures.

However, the industry is actively attempting to influence the policy landscape through lobbying and advocating for deregulation. They also oppose and disrupt public health efforts by conducting research and exerting influence over professionals. Furthermore, the industry strategically positions itself as a part of the solution to the public health problem by developing relationships with the government and proposing solutions that have no positive impact. For example, Coca Cola proposed branding the entire railway network in India, potentially exposing 1.4 billion people to their marketing. In Indonesia, there was a proposal to address child stunting by providing flavoured milk, but the Ministry of Health and other stakeholders pushed back to manage this billion-dollar industry in order to protect public health.

Evidence-based policy actions are crucial to protect public health, and it is essential for policymakers to understand this issue and ensure that the community's health and human capital are safeguarded.
Almost 3 million people die annually due to occupational accidents and diseases globally. Out of which 80% of the deaths are due to work-related diseases. Almost 402 million people die because of non-fatal occupational injuries globally. As a result, almost 5.4% of the global GDP is lost due to occupational accidents. According to a joint estimate of the work-related burden of disease, it was found that every year almost 2 million people die due to work related diseases. In the study, ILO picked up 19 occupational risk factors surrounded by hundreds of others which revealed that we lose almost 2 million people by death and 90 million people of disability. Out of all the risk factors, exposure to long working hours is the biggest challenge. This is followed by exposure to occupational particulate matter, gases and fumes, occupational injuries, and exposure to asbestos.

Asbestos is a commercial product that is exposed in the workplace. ILO has a fundamental principle right at work that was adopted in 1998 and amended in 2022 including freedom of association, elimination of all forms of forced labour, abolition of child labour and elimination of discrimination at work. As an implication, occupation safety and health (OSH) should be a fundamental right at work. This means that good health and safe working environment should be ensured for all genders irrespective of their gender, age, nationality, employment, or migrant status. Governments ensure legal and policy frameworks to promote a safe and healthy working environment for all workers. All workplaces should comply with national legal policy framework to ensure occupational safety and health. In addition, businesses should also ensure fundamental rights at work through CSR. Occupational safety and health should be included as some provisions of the trade agreement. There is huge opportunity for us to buy in from the business to ensure OSH. ILO has set up international labour standards as health regulation by WTO which is known as the International Treaty. So far, there are 190 international labour conventions. Under the treaty, member states should ratify these conventions. Out of 190 conventions, 40 conventions are directly or indirectly pertaining to OSH.

International Labour Standards in OSH have core conventions including 155 on OSH, 187 on promotional framework on OSH, and a specific convention 161 on occupational health services.

The sector specific convention includes OSH in agriculture, ocean mining and ocean construction along with the conventions addressing specific hazards. For example – occupational cancer convention, and asbestos convention provide OSH requirements for employers and workers.

There is a Global Strategy on OSH (2003 ILC Conclusions) which is being updated by the end of this year. ILO has technical cooperation projects in 23 countries with focus areas on the palm oil sector, banana plantation, coffee, fishing, and other industries.
Responsible business is the core of decent work which is also covered under SDG 8 and engages people at work. The UN, ILO and OECD guidelines, trade agreements and the global framework agreements have specific strategies including National Action Plans (NAP), labour inspection & audit standards and supply chain laws. For example, public procurement laws are very important key and a corporate code of conduct.

We have specific guidelines for multinational enterprises focused on global supply chains in Multinational Enterprises and Social Policy (MNE Declaration). The approach is through WTO, ILO, and the UN where SDG goals, national level policy and the legal framework are integrated and supplement each other. It is essential to walk hand in hand towards the OSH at the workplace and in public spaces ensuring decent work.

Health and safety are the workplace mandates of the International Labour Organisation (ILO). Health cannot be considered in isolation; it should be approached in an integrated and comprehensive manner. Commercial Determinants of Health (CDH) are highly relevant to the ILO, including in context of employers, workers, and governments. The ILO collaborates with industries through employers and workers to encompass occupational safety within the broader scope of health. Commercial products often lack labour considerations between the producer and the consumer, leading to workers being exposed to hazardous conditions in their workplaces.

**Session IV: Country Experiences on main commercial determinants of health on people’s health (focus on NCD risk factors e.g., tobacco control, substance abuse and alcohol consumption, unhealthy food and beverages, or air pollution etc.)**

1. **Thailand experience CDH affecting NCD risk factors by Dr Pairoj Saonaum, Thai Health Promotion Foundation**

Non-communicable diseases (NCDs) impose a significant health and economic burden on Thailand, accounting for nearly 74% of all deaths. The primary contributors to NCDs are alcohol, tobacco, physical inactivity, and, particularly, unhealthy food. Drawing from international experiences and lessons learned from the "Crooked Nine," we gain insight into how the tobacco industry engages with public health practitioners. Tobacco smoking prevalence among individuals aged 15 and above in Thailand has decreased from 32% in 1991 to 17.40% in 2022.

The knowledge base of tobacco control provides robust evidence and facilitates timely updates to tobacco control legislation. Involving civil society in raising awareness about the harmful effects of tobacco is essential. For
instance, advocacy efforts led to the banning of point-of-sale displays in 2005. However, there is substantial opposition and industry interference in this process.

Total per capita alcohol consumption in Thailand declined by 20% between 2004 and 2014, thanks to shifting social norms favouring a non-alcoholic culture and the effective enforcement of state regulations and laws that have denormalized alcohol consumption.

Public campaigns like "Less Sugar, Less Disease" in Thailand focus on reducing sugar consumption, while events like the Thai Health Day Run promote increased physical activity through mass sports activities. Implementing laws that restrict advertising to curb sales is crucial.

Thailand places significant emphasis on alcohol control, and the enforcement of stringent laws has led to a decline in heavy drinking. The policy is reinforced by grassroots social movements, along with measures to control advertising.

During the COVID-19 pandemic, Thailand prohibited the online sale of alcoholic beverages. The commercial sector should comply with well-enforced, evidence-based government regulations. Collaborative efforts with other ministries, including health, commerce, energy, and the importance of data and monitoring, are critical. Therefore, it is of utmost importance to counter the industry's negative commercial determinants.

2. Indonesia experience: Dr Prihandriyo Sri Hijranti M. Epid., Project Manager Officer (PMO) Directorate General of Disease Prevention and Control, Ministry of Health

In Indonesia, significant products that impact human health include tobacco, e-cigarettes, sugar-sweetened beverages (SSBs), and high-fat, salt, and sugar (HFSS) foods. Post-COVID-19, childhood obesity has surged due to the influence of commercial products. Indonesia grapples with a significant challenge in the form of increased consumption of SSBs and HFSS foods. The aggressive marketing of these products and the use of corporate social responsibility (CSR) for sponsorship are among the challenges faced. In Indonesia, the issue isn't limited to industrial commercial determinants but extends to the external and personal environment.

The substantial influence of the tobacco industry presents a political challenge in Indonesia. Moreover, marketing of sugar-sweetened beverages and ultra-processed foods high in fat, sugar, and salt is aggressively carried out through digital media platforms, including social media. Social media remains a significant barrier to regulating commercial activities, with a considerable impact on the well-being of the Indonesian population.

At present, the government's primary focus is on economic growth and investment. Commercial products predominantly target children, teenagers, and working-age adults. Social health insurance data indicate a rising number of health expenditures for catastrophic diseases in Indonesia, mainly non-communicable diseases (NCDs),
from 2014 to 2018. Major risk factors include tobacco use, unhealthy dietary patterns, and increased consumption of sugar and fat. The Indonesian population consumes 52.7% of the recommended daily salt intake, 26.7% of fat, and 4.8% of sugar.

The tobacco epidemic poses a major challenge in Indonesia, with tobacco use among children showing an increasing prevalence of 34.5%. Adolescents as young as 15 are initiating tobacco use, often along with e-cigarettes. According to GATS 2021, the use of electronic cigarettes has surged nearly tenfold, from 0.3% in 2011 to 3% in 2021.

Introducing a new health law is imperative as an intervention for the country, considering that a significant portion of the debt in Indonesia is attributed to tobacco. Tobacco claims the lives of 290,000 Indonesians annually and is responsible for six out of every ten NCD-related deaths, making it the leading cause of death.

Indonesia is actively taking measures to address the Commercial Determinants of Health (CDH) for NCDs. Efforts include regulating tobacco and e-cigarettes through interventions such as tobacco excise and retail price adjustments to reduce affordability, establishing Ministry of Health regulations to prevent and manage conflicts of interest with the tobacco industry, limiting corporate social responsibility activities, implementing pictorial health warnings (PHWs), and introducing national regulations through the new health law.

A government regulation pertaining to SSBs is in the process of being drafted, including multi-sectoral discussions on SSB excise tax.

For HFSS foods, mandatory nutrient declarations are required on voluntary front-of-pack labelling (FOPL). Multi-sectoral policy dialogues have also been initiated to address issues related to unhealthy diets. The process of drafting and implementing regulations within the framework of the new health law is being strengthened under national regulations. Children, teenagers, and working-age adults are the target audience for a massive campaign promoting people to read nutrition labels and choose healthier foods.
Breast milk substitutes (BMS) marketing was aggressively carried out via digital media platforms such as social media, and the health centre targeted mothers and families. There is no evidence that more expensive formula milks or baby foods are better for a baby's health, but misleading mothers with milk nutrition can make children healthier and overshadow the benefits of exclusive breastfeeding in the first six months of life for mothers and infants. Indonesia has taken the first step toward developing a regulation and declaration to control aggressive marketing of BMS in accordance with international standards.

Dealing with the Commercial Determinants of Health (CDH) is indeed a struggle, but with efforts such as cross-sectoral support, community commitment, and government collaboration, we can lead towards healthier and more productive nations.

3. Nepal experience: Ms. Hira Kumari Niraula, Director, Nursing and Social Security Division, Department of Health Services, MOHP

The second national multisectoral action plan, spanning 2021 to 2024, is a response to the prevention and control of Non-Communicable Diseases (NCDs) in Nepal. NCDs are responsible for 71% of all deaths in Nepal. Almost 56.7% of total household expenditures on NCDs were out-of-pocket expenses. The government allocated approximately NPR 14.9 billion, contributing to 34% of the total expenditures on NCDs.

The national multisectoral action plan for 2021 to 2025 has received cabinet endorsement in Nepal. The plan focuses on four strategic priority areas: leadership, advocacy, and partnership; health promotion and risk reduction; health systems strengthening; and surveillance, monitoring, evaluation, and research. These areas embody a whole-of-society and whole-of-government approach.

Pillar 2 emphasizes addressing Commercial Determinants of Health (CDH) through health promotion and risk reduction. Nevertheless, leadership and partnership are essential to confront the challenges posed by NCDs. Nepal operates under a federal system with a multi-sectoral government mechanism. This comprehensive plan includes advocating and engaging parliamentarians, policymakers, and Civil Society Organizations (CSOs) to form alliances and participate in the implementation process.

The health promotion component of the plan accelerates the implementation of the World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC). Alcohol consumption presents a major concern in Nepal, and efforts such as tax reform, restrictions on the physical availability of retail alcohol, and bans on advertisement promotion and sponsorship have been initiated. High salt consumption in Nepal will be addressed through the recommended salt approach for the national salt reduction strategy. To promote physical activity, programs like the "Nirogi Nepal Programme" and the "school yoga initiative" are being sustained and expanded. A "drink driving" initiative is being launched and expanded nationwide. The "healthy setting" initiatives are an...
innovative approach aimed at creating healthy municipalities and health-promoting schools. Additionally, there are 1,011 school nurses focusing on promoting healthy diets. Regulation of food marketing, non-alcoholic reformulation of food products, the development of nutritional labeling systems for processed foods and beverages to eliminate trans-fats, and the implementation of clean technology to combat indoor and outdoor air pollution are on the agenda. A national public health campaign has also been initiated to prevent NCDs and reduce cost-effective risk factors.

It is crucial to diagnose and treat NCDs. The World Health Organization (WHO) recommends 30 minutes of daily physical exercise, a healthy diet incorporating fruits and vegetables, avoidance of alcohol and smoking, and early detection and management of diseases. The plan emphasizes monitoring and evaluation and provides training and capacity building for health personnel in all districts.

Nepal became a party to the WHO Framework Convention on Tobacco Control (FCTC) in 2007 and has banned tobacco products under the Tobacco Control and Regulatory Act of 2010. Sales to minors and pregnant women are prohibited. A ban on advertisement, promotion, and sponsorship of Electronic Nicotine Delivery Systems (ENDS), vending machines, incremental taxation policies, and cessation services have also been adopted.

According to MPOWER, Nepal had a 12% prevalence of daily smoking in 2021. Nepal has implemented a comprehensive system of Pictorial Health Warnings (PHWs) for tobacco control. Taxation in Nepal currently stands at 31.4%, with a target to reach 75%. Since 2021, advertising boards in Nepal have banned the promotion of alcohol, tobacco, and voting.

**SAFER Nepal Initiative Key Achievements**

- Elements of SAFER activities included in the Annual Work Plan and Budget in all 3 tiers of the Government
- SAFER interventions in 5 Municipalities
- Advertisement Board issued press release in 2021 to stop advertisements of alcoholic products and remove hoarding boards
- In 2022, MoFAGA instructed all local levels to implement Article 45 of Public Health Service Act
- February 9, 2023--Press Council appealed through the press release to kinds of communication media to stop advertisements of tobacco and alcohol products

Major stakeholders and collaborators in the Safer Initiative (SAFER) include civil society organizations, the ministry, media agencies, the United Nations, and various development partners. The multi-sectoral action plan brings together CSOs, ministries, and development partners through a multi-sectoral approach. Eight policy regulations incorporate NCDs into their agendas, including a commitment from high-level political leaders. Multi-sectoral interventions for tobacco detection have also been undertaken. The Ministry of Communication is focusing on advertising, promotion, and sponsorship of tobacco, the Ministry of Finance is working on taxation, the Ministry
of Home Affairs is working on creating smoke-free environments, and the Ministry of Health and Population is providing tobacco cessation services with a target of reducing current tobacco usage by 30%.

4. Panel discussion: Bangladesh, Bhutan, Timor Leste

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<th>What are the examples of commercial determinants and current situation in your country?</th>
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<td><strong>Bangladesh</strong></td>
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<tr>
<td>Dr. Mohammed Masood Islam, Deputy Secretary, Health Service Division, Ministry of Health and Family Welfare</td>
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<tr>
<td>• Unhealthy products, tobacco industry</td>
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<tr>
<td>• Last 15 years, have resulted in remarkable economic growth</td>
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<td>• People have the capacity to purchase these commodities that are harmful to health</td>
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<td>• Aggressive marketing, pricing, affordability, and influential</td>
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<td><strong>Bhutan</strong></td>
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<tr>
<td>Mr. Lekden David Dizard, Director NCDs, Ministry of Health</td>
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<td>• There is a direct marketing of unhealthy products by small food industries in Bhutan</td>
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<td>• A lot of food products are imported from India, Thailand, and Korea</td>
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<td>• There is no direct marketing of these products in mainstream media however it is</td>
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<td><strong>Timor Leste</strong></td>
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<tr>
<td>Mr. Helder Da Silva, Director of NCD Division</td>
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<tr>
<td>• Timor Leste has a population base of 1.3 million people</td>
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<td>• Every year government spends for more than 78 million on NCDs.</td>
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<td>• Prevalence of tobacco among youth is very high due to a free market for products like alcohol, tobacco,</td>
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<tr>
<td>Dr. Mohammed Masood Islam, Deputy Secretary, Health Service Division, Ministry of Health and Family Welfare <strong>Bangladesh</strong></td>
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| sponsorship through strong lobbying by the industry | popularized through influencers  
* Bhutan does not have a big tobacco industry but during the COVID-19 pandemic, despite a ban, a lot of people were smoking and imported these products illegally.  
* Although Bhutan has legalized tobacco sale recently, it has increased the tax to 100%  
* Alcohol is a cultural problem, however, there is no direct marketing for alcohol  
* In the previous alcohol policy there has been a restriction on the number of bars and alcohol industries however, following COVID this has taken a step back to improve the economy.  
* Ultra-processed foods which are imported.  
* Illicit trade is another major problem in the country.  
* Promotion and advertisement of alcohol is very common.  
* Homemade traditional alcohol is a major problem that contribute to NCDs | |
| How does a country push back and address these commercial determinants? | • Honourable PM of Bangladesh has envisioned a tobacco free Bangladesh by 2040.  
• Under Tobacco Control Act 2005, there is a complete ban on advertisement, sponsorship, and promotion of tobacco in public places. Minors cannot | • A long-term 13th five-year plan is underdeveloped to address NCD  
• Generating data and evidence is another important strategy to fight back against these risk factors  
• Health promotion campaigns, advertisement bans and increased taxation on | • It is essential to have a multi-sectoral intervention to address NCD in the country  
• There is a draft under progress on alcohol, tobacco, and SSB for implementing the intervention packages  
• Tobacco cessation services are also under action in eight municipalities |
Session V: Country experiences on key CDH on health care services and health service deliveries (e.g., infant formulas, medical devices, vaccines, pharmaceutical products, telecommunication & digital health, transportation system, etc.)

1. Thailand experience’s on CDH in health care services and service deliveries, Ms. Suladda Pongutta, IHPP, Thailand.

Thailand's healthcare system comprises four major schemes, including the Civil Servant Medical Benefit Scheme (CSMBS), which covers 7% of the Thai population. There is no predetermined expenditure ceiling for services provided by public hospitals. The second scheme is the Universal Coverage Scheme (UCS), which extends coverage to 75% of the Thai population not covered by CSMBS or employed by formal private businesses. This scheme operates on a closed-end budget with cost and benefit restrictions. Services are provided by contracted public hospitals. The third scheme is a Social Health Insurance scheme for individuals employed by formal private companies. The government partially sponsors the expenditure, while employers and employees contribute the remainder. This scheme covers around 18% of the Thai population and operates on a closed-end budget. Services are provided by contracted public and private hospitals. The Thai government shoulders most of the health expenditure, providing full financial support to approximately 82% of the population through public hospitals.

In comparison to middle-income and upper-middle-income countries, Thailand's health expenditure, when measured against GDP, is lower. In 2020, health expenditure accounted for 4.4% of GDP, while it was 6.2% for other countries. The Thai government assumes the largest share of health expenditure. According to the 2019 Health
Care Access and Quality Index from The Lancet, which includes mortality rates for 32 causes of death amendable to healthcare access and quality, Thailand slightly surpasses the global average but falls short of high-income countries.

Regarding Commercial Determinants of Health (CDH), hyperglycemia and tobacco were the first- and second-highest Disability-Adjusted Life Years (DALYs) in Thailand. Alcohol ranks as the third-largest contributor to DALYs in the country. Other significant risk factors include unhealthy dietary choices and inadequate physical activity. The health burden in Thailand is predominantly driven by unhealthy products and their associated industries. In Thailand, there exists a dominant food industry with substantial influence over the entire food supply chain, from farm to table. They engage in contract farming and own major retailers in Thailand. For the food industry, the top priority is maximizing profits, and ultra-processed foods offer high profits due to their low logistics costs, storage advantages, and longer shelf life. Thai people have increased their consumption of ultra-processed foods compared to the past decade, while vegetable and food consumption remains low. Moreover, unfair and monopoly food market lead to unsustainable agricultural practices, such as post-harvest burning and misuse of pesticides, that have adverse effects on the environment and public health. Every year, Thailand faces heavy air pollution during burning season (from late November to March), which causes both short and long-term effects on health.

According to the International Health and Universal Protection (IHUP) and the National Health Account, in 2016, Non-Communicable Diseases (NCDs) accounted for the largest share of healthcare expenditure in Thailand.

A SWOT analysis of the Thai healthcare system reveals strengths in having a robust health system mechanism and primary healthcare to combat CDH. The Ministry of Public Health and other autonomous health organizations collaborate synergistically in addressing commercial determinants from upstream to downstream. At the upstream level, there are the National Health Commission Office and Thai Health, the National Health Commission Office (NHCO), which engages and empowers the entire society, including civil society, mass media, NGOs, academia, and other networks, to set significant health policy agendas through the public policy-making process facilitated by the NHCO. Numerous policy agendas targeting CDH have been initiated through these mechanisms, such as fiscal policies to limit alcohol and sugary beverage consumption, controlling alcohol and infant formula marketing, and adopting the World Health Organization Framework Convention on Tobacco Control.

After the adoption of these policy agendas, Thai Health facilitates policy advocacy to put policy agendas into policy adoption and implementation. The Thai Food and Drug Administration (FDA) and the Health System Research Institute (HSRI) play vital roles both upstream and downstream. The Thai FDA promotes food and drug safety through market approval and post-marketing control. With their support, several interventions have been adopted and implemented in the past, including the implementation of a sugar-sweetened beverage (SSB) tax and a ban on added sugar in infant formula. The HSRI advances health system research and development, aiding in the promotion of health and healthcare services.

At the downstream level, the Healthcare Accreditation Institute (HAI) accredits all hospitals and healthcare facilities, promoting health service quality. The National Health Security Office (NHSO) manages the universal coverage fund. Also, NHSO and supports health technology assessment, economic evaluations, and treatment to provide evidence for informed decisions. This approach facilitates transparent and effective decision-making regarding what is included in the benefit packages of the universal coverage scheme. Thailand's primary healthcare
is strong and effective in preventing and controlling diseases, as seen in the example of COVID-19 prevention and control.

Thailand currently faces several challenges. The powerful unhealthy products industries, including tobacco, alcohol, and food, exert significant influence on the decision-making process, making it challenging to counter their impact. Political instability in Thailand over the years has undermined the country's development, affecting government budgets, efforts to combat CDH, and various aspects of the nation. Additional challenges include poverty and inequality, climate change, environmental degradation, pollution, and an aging society, all of which increase individual and national vulnerabilities to the effects of commercial determinants of health.

In terms of weaknesses, Thailand confronts issues related to an inadequate and uneven distribution of human resources, particularly the shortage of advanced health technologies. For instance, Thailand has approximately one doctor for every 1,900 people, and in remote provinces, this ratio can be as high as one doctor for every 5,000 people. This disparity impacts the quality of healthcare services and places a heavy workload on healthcare professionals. Thailand's lack of advanced health technologies leaves the country vulnerable to various health threats. For example, during the COVID-19 pandemic, Thailand had to rely on mRNA vaccines and treatments due to a lack of advanced healthcare technologies.

For opportunities, Thailand has valuable assets including well-being and wellness businesses (Thai local wisdom and traditional medicines), research and development that provides a solid foundation for a strong and effective healthcare system (health research organizations in Thailand), and digital health that represents one of the fastest ways to enhance the response to combat CDH and other health threats (Thailand has good internet infrastructure to support digital health). Adopting digital health. Investing more in these areas could strengthen the healthcare system.

![Opportunities](image-url)
2. Panel discussion: Bangladesh, Indonesia, Sri Lanka, Maldives

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<tr>
<th>Mr. Mazumdar</th>
<th>Dr. Niyamas</th>
<th>Ms. Maimoona Aboobakur</th>
<th>Dr. Asela</th>
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<tr>
<td>Bangladesh</td>
<td>Indonesia</td>
<td>DG of Public Health, Maldives</td>
<td>Sri Lanka</td>
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<td><strong>What are the commercial considerations that are affecting the health service delivery and how does one see them in the different areas of focus in the delivery of health services and the health systems?</strong></td>
<td><strong>Indonesia has a decreased stunting rate but still struggling with data of exclusive breastfeeding.</strong></td>
<td><strong>Maldives has increased NCD burden, and the health system has the burden of addressing healthcare delivery.</strong></td>
<td><strong>Sri Lanka offers free education and health services at the delivery point.</strong></td>
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<td></td>
<td><strong>Indonesia promotes exclusive breastfeeding to the mother and families and provides counselling in healthcare system.</strong></td>
<td><strong>Healthcare costs are too high; the focus is on expanding the healthcare delivery system and reorganizing the primary health care system.</strong></td>
<td><strong>CDH including tobacco, alcohol, unhealthy diets, NCDs, transportation, digitalization</strong></td>
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<td><strong>Indonesia is most affected by Breast Milk Substitutes (BMS) that are easily accessible in stores and free sampling is</strong></td>
<td><strong>Sri Lanka has unique regulations and countermeasures.</strong></td>
<td><strong>Sri Lanka has a curative arm of the health sector and a preventive arm that caters to vaccination, and maternal and child health.</strong></td>
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<td><strong>Example – For Diabetes, insulin is priced too high which cannot be afforded by the poor people. Chemotherapy for cancer and other</strong></td>
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- NCDs are a major problem in Bangladesh, wherein medical treatment is offered by government hospitals as well as private sector and the NGOs.
- Treatment cost for NCDs is very high which directly affect the CDH.
- Example – For Diabetes, insulin is priced too high which cannot be afforded by the poor people. Chemotherapy for cancer and other
<table>
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<tr>
<th>What action do we need in the countries to address commercial determinants of health that would be very useful in the long term?</th>
<th>Mr. Mazumdar Bangladesh</th>
<th>Dr. Niyamas Indonesia</th>
<th>Ms. Maimoona Aboobakur DG of Public Health, Maldives</th>
<th>Dr. Asela Sri Lanka</th>
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</table>
| Bangladesh learned a lot during the COVID-19 pandemic including vaccination accessibility and availability. Livelihood sources and earning were limited due to physical distancing. | treatment is also very high. | provided to mother and family in public spaces.  
- Indonesia has an opportunity to draft a new law for breastfeeding and has developed tele counseling to overcome the limited healthcare services to mother. | lifestyle of the people.  
- BMS code is also implemented, and milk substitutes are regulated in the country. | Training and capacity building is conducted on accidents, emergency care, and NCDs for all healthcare staff.  
- Telemedicine is also being promoted in the secondary and tertiary care institutions that would avoid a lot of unnecessary transfers. |

Other comments.  
- Preparedness for NCDs is essential to make the system resilient.  
- It is essential to improve healthcare technologies and invest in them.  
- It is essential to have the whole community together with a whole-of-society and whole-of-government approach.  
- Multi-sectoral approach is crucial.
### Session VI: Country experiences on economic gains / lost from commercial products and activities

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<tr>
<th>Mr. Syed Mahbubul Alam Tahin, Ministry of Health, Bangladesh</th>
<th>Mr. Laigden Dzed, Ministry of Health, Bhutan</th>
<th>Ms. Ursula Sinawang Trufvisa, Indonesia</th>
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<tr>
<td><strong>To what extent is health already considered in decision-making by non-health ministries and government entities?</strong></td>
<td>• In Bangladesh, the constitution emphasizes public health four times.</td>
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<td></td>
<td>• All kinds of advertisements of tobacco are banned as per the High Court verdict under the Tobacco Control Law</td>
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<td>• Government is also directed to regulate tobacco control, and tobacco cultivation</td>
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<td>• The Ministry of IT is also involved in regulating e-cigarettes and Ministry of</td>
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<td>• There are robust consultations across ministers for drafting any policy, regulation, or law</td>
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<td>• Ministry of Health has been advocating for health-promoting the policies including Gross National Happiness Index where health is a critical component</td>
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<td>• The 13th five-year plan will take into consideration three aspects of developmental agenda including people,</td>
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<td>• Ministry of Trade considers health as an important criteria in policymaking</td>
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<td>• For the businesses, there are standardization requirements to be fulfilled – these are the Indonesia National Standards</td>
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<td>• Standards include health concerns; so, licenses are only issued when all requirements are met</td>
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<td>• Stakeholders such as Health Ministry and National Agency of Food and Drug control</td>
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| Agriculture is discouraging tobacco cultivation  
- Bangladesh Bank have a direction not to support any loan for tobacco cultivation  
- The Ministry has adopted policies on tobacco for local governments including regulating the sales within 100 meters of schools and hospitals.  
- The rate of taxation is not increased by the revenue department. | progress, and prosperity  
- Health and NCD should be the priority for next 5-10 years and a part of interventions to offset the current trajectory addressing CDH.  
- It is essential to have agency at the grassroots and to shift decision making from higher ups. | make sure that trade agreements do not have a negative impact  
- The ministry of trade or economics need to strengthen health considerations while ratifying trade agreements in future. |

| Do you have any examples from your experience where there have been economic co-benefits to including health considerations? | In Bangladesh, tobacco has been imposed a 1% development surcharge where the money can be used for NCD and other programmes  
- Sustainable funding for tobacco control as well as taxation  
- According to 2009 CARES survey, there are 43% tobacco users in Bangladesh and in 2017 the prevalence is 35%.  
- There is a huge decline, but the revenue gain has increased 320 billion.  
- Government has banned three stroke engine and promote CNG and natural gas | Economic benefit in Indonesia is reduced health care cost and burden  
- In Bhutan, prevention to curative to referral outside the country is provided  
- Patients are now coming with comorbidities therefore the free health care is becoming a challenge  
- Increasing economic productivity for a healthier population to seek better opportunities  
- Out Of Pocket expenditure (OOPE) is there due to existing cultural norms having a rate between 14-20% | In Indonesia, cardiovascular diseases (CVDs) are covered under national insurance and cost largest portion of the budget  
- Creating awareness about NCDs and risk factors to maintain consumption and control healthy foods  
- National insurance could have effective costs in management and that could be one of the benefits gained by the government while regulating health issues |

| |
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Page 36 of 97
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| • Consumption of fruits and vegetables is very low due to transportation and affordability  
• A rail mango was introduced by the Ministry of Railways that reached different parts of the country and provided mangoes to all at a very low cost. Therefore, subsidy is a way that could benefit business and public health. | • The pollution levels are low in Bhutan and environment is clean to build a wellness center that can attract some economic opportunities | |

What lessons or what key messages would you take away from the COVID-19 pandemic with regards to commercial determinants of health?

| • During COVID-19 all ministries came forward; for example, religious ministry promoted COVID protocols at religious places; Ministry of Transportation offered free and a low-cost public transportation; ministry of postal supported businesses.  
• The tobacco industry was still given permission to continue their businesses during COVID-19 under the Essential Commodity Act. | • Bhutan was a champion in COVID-19 response with only 21 deaths across the whole country.  
• Bhutan managed to vaccinate 95% of its population.  
• Limited advertisements and marketing promotion of unhealthy products happened in mainstream media; according to reports there were only 40 advertisements related to food.  
• Resilience is important to counter marketing tactics and social media influences including CDH  
• Risk communication and media campaign | • Ministry of Trade issued a regulation to ban the export of surgical marks; it is important to diversify the supply chain.  
• It is important to engage in consumer awareness related to NCDs and critical for people to understand choices like daily nutrition intake to minimize unhealthy consumption. |
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<td>should be robust as a lesson to CDH</td>
<td>• Legislations are a rational way to address issues including economic burden • Capacity building of people to promote traditional food rich in nutrition</td>
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Session VII: South-East Asia Countries perspective on “Economy of Well-being and wellness products”

1. Mr. Odd Hanssen, Technical Specialist on Health, Taxation and Financing, UNDP

Traditional economies prioritize (Gross Domestic Product) GDP and market-paid economic activities. The notion of a well-being economy transcends GDP and encompasses factors such as health, equity, justice, livelihoods, sustainability, and more. The intrinsic value of health becomes evident when individuals enjoy good health. Equity emphasizes fair distribution in society. Environmental sustainability and the preservation of natural resources hold significance in a well-being economy, although they are not reflected in GDP. Interaction with society, including democratic governance and human rights, is also integrated into the well-being economy, demanding progress in gender equality and human rights.

The World Health Organization (WHO) has an Economy on Health and Well-Being Council, and UNDP collaborates with the WHO Europe Office through a sub-regional entity known as the Office of Investment for Health and Development. Under the Well-Being Economy Initiative, governments are encouraged to explore unconventional avenues for promoting well-being and health.

UNDP administers two programs that link taxation and health and well-being. The first is "Tax Inspectors Without Borders," which involves the exchange of personnel from tax authorities between countries to assist with tax-related functions and explore new tax markets, such as digital economy taxes and tax strategies of multinational corporations aimed at minimizing tax payments. The second program is "Tax for SDGs," which aims to leverage tax policies to achieve specific Sustainable Development Goals (SDGs), as well as raise revenues in general, as public finance is the best way to drive achievement of the SDGs.

A well-structured tax system can facilitate the delivery of services by raising revenue for health services, which is a key responsibility of countries in a well-being economy. Promoting health-related taxes is a strategic means to enhance well-being and contribute to the broader economy. The Abuja Declaration underscores the potential of health-related taxes as a source of financing for development.
Health taxes offer multiple benefits, such as by making cigarettes and alcohol more expensive, this reduces their affordability and generates additional revenue. Improved health leads to increased workforce productivity, stimulating economic growth and generating further revenue for sustainable development. A fourth benefit relates to equity, as higher taxes can modify behaviors and reduce health-related consequences, which are more likely in more price-sensitive, lower socio-economic groups resulting in a quadruple win.

The World Health Organization (WHO) Interagency Task Force on Non-Communicable Diseases (NCDs) collaborates with sectors such as finance, planning, and industry to identify common benefits of investments that are mutually advantageous for health, the labor force, and the economy. WHO's investment cases for health propose models that include raising taxes on tobacco and alcohol, which would lead to better control, reduced future spending, preventing individuals from leaving the workforce, higher GDP, overall improved health outcomes, and enhanced equity. The perspective should shift from the traditional GDP-centric approach to a well-being and health-oriented approach, engaging other industries and their perspectives to promote this paradigm.

The Ministry of Finance and tax authorities should implement tax reforms with *intrinsic value*, aimed at not only at generating additional tax resources, but also the betterment of health and the population. Nevertheless, certain measures that can positively impact both health and overall well-being may entail a reduction in tax revenues. As with spending decisions, such policies should go through a priority-setting process, comparing the expected impact on the SDGs and other key outcomes with the revenues it foregoes collecting.
There is a growing emphasis on maintaining good health and longevity. Consequently, healthcare has shifted its focus towards prevention, prediction, and precision medicine, prioritizing these over primary care treatments. Additionally, there is an increasing interest in integrative medicine, such as traditional Thai medicine, as an alternative to conventional medications.

In 2024, the Ministry of Public Health will introduce a policy aligned with the Department of Health's objective to emphasize the promotion of a wellness-oriented lifestyle and the development of the wellness economy. Thailand has implemented numerous strategies to enhance health literacy among the general public.

The primary issue at hand is the rising incidence of non-communicable diseases (NCDs) and unhealthy lifestyle choices. In Thailand, approximately 13% of school children are affected by obesity. The evolving healthcare landscape is witnessing a shift in addressing the diverse health needs of different generations. The first generation is grappling with chronic diseases and requires comprehensive care and management solutions. The second generation often prefers traditional healthcare settings and prioritizes maintaining a good quality of life during their retirement years. The third generation is highly competitive on a global scale. Thailand stands out as a significant player in the field of economic well-being and wellness products.

The culture in the northeast of Thailand, as observed in Chiang Mai, Phuket, Rangyong, and Chonburi, promotes staying healthy and staying close to nature and culture. Additionally, Thailand boasts Thai traditional medicine, known as "Nuat Thai," which is famous in Bangkok and remote areas.

Life expectancy in Thailand tends to be higher in the northwestern regions, with an average of about 73.5 years, and women achieve an impressive average of about 80.9 years. The wellness economy in Thailand reached a value of nearly 29 billion USD in the previous year. Thailand's robust wellness economy significantly contributes to its overall economic growth. The policy of the Thailand Ministry of Public Health focuses on enhancing Universal Health Coverage (UHC) and comprises about 13 key measures to bridge the gap in public health services. These measures are designed to address key issues, establish a solid foundation, and support the economy by generating income to fund various health programs.

The Department of Health is implementing a policy for 2024 in four key areas to promote health and environmental well-being. In alignment with the Ministry of Public Health's policy to ensure the health of the Thai population, this initiative involves strengthening partnerships, promoting extensive networking, and collaborating with regional
health zones to achieve their goals. In addition to the regional health zones, the Director of the Department of Health is collaborating with local NGOs and international organizations to broaden their reach.

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

The Safety Tourism measures consist of three components. First, accommodations must meet the Clean Health Hotel standards. Second, tourism activities must adhere to the Clean Health Protection standards. The last part focuses on food, including food sanitation standards and the provision of healthy menus. The Department of Health has taken a significant step forward by developing a national strategic plan for lifestyle and wellness. Key collaborators include the Thai Association of Lifestyle Medicine, the Thai Medical Council of Thailand, and the Thai Health Foundation, aiming to establish lifestyle medicine in Thailand. Collaboration and partnerships between the private and public sectors are vital for building wellness communities and healthcare services. Investments in tri-regional practices for evidence-based healthcare and well-being are essential for expanding research and development efforts. Promoting health literacy, education, and raising awareness are critical for informed choices by tourists. Lastly, sustainability efforts, integrating eco-friendly practices for long-term well-being and growth, play a significant role. A technology-based strategy to promote wellness economic growth in Thailand is also deemed essential.
3. Dr. Iftikhar, Trade and Department, Government of Maldives

Maldives relies on tourism and fisheries as its two primary industries. Tourism taxes play a crucial role in the country's economic development and service delivery. Since becoming a democracy in 2008, there has been a notable increase in the demand for services. Currently, import duties serve as the sole source of government revenue. In recent times, the introduction of GST, income tax, and corporate profit tax has had a significant impact on both the economy and the delivery of services.

As an island nation, the population is dispersed across 189 islands. The growth of tourism has elevated Maldives to the status of an upper-middle-income developing country, with a purchasing power parity nearing $20,000. While the capital is relatively well-developed with a range of services, the same cannot be said for the islands. In these outlying areas, the cost of providing healthcare, social services, and education is considerably high. Meeting the infrastructure needs to deliver these services poses a significant challenge for small islands.

To address these challenges, there is a need to increase the tax-to-GDP ratio, especially given the success of high-end tourism in Maldives. The current tax-to-GDP ratio remains low compared to the region. Therefore, it is essential to raise taxes and improve coordination among relevant authorities. Some positive steps have already been taken, such as the implementation of a green tax, which is being used for social purposes.
Part II Economy of Wellbeing and Equity

Session I: Global report on commercial determinants of health – presentation by Ms. Juliette McHardy, Consultant, Economic and Commercial Determinants, Department of Social Determinants of Health (WHO HQ)

The basis for WHO’s work on the commercial determinants and the Global Report is the mandate provided by our Member States. WHO draws principally on two Resolutions and a Declaration by the World Health Assembly on the social determinants of health. These are focused on the need to tackle inequitable distribution of power, engage all segments of society, and foster collaboration, while safeguarding against conflicts of interest. These are supported by numerous other resolutions vertically focused on commercially related risk factors, such as tobacco, alcohol, unhealthy foods, road safety, physical activity, medicines and many more that recognize the role of commercial actors as partners or participants in health sector processes.

The rationale now for the global report development is twofold. While WHO and its Member States are already doing a lot of work and have done a lot of work with respect to various commercial products and practices, there have calls to build on these specific approaches with a more systematic approach that joins them together. First, this will determine the overall contribution of harmful products and practices to the global burden of disease. Second, it will allow for leveraging the co-benefits of working with the commercial sector, while safeguarding against conflicts of interest.

An expert group was convened to advise the newly established economic and commercial determinants unit. The recommendation for a global report was provided in July 2021, and subsequently initiated. This included the production of a number of regional reviews, including one in SEAR, which is now in the process of being updated, alongside several specific technical papers.

In June 2022 WHO built on this work and began the process of scoping the global report, starting with a concept note, and then preparing a preliminary scoping paper, outlining the key considerations for the global report. WHO has worked through the goal report’s development with an editorial board, which comprised number of leading experts on the commercial determinants brought together to provide scientific guidance and inputs on during the development process and review drafts. This resulted in the creation of a scoping paper. This was consulted upon with experts and internally across WHO. WHO released a consultation across HQ, the regions, and with affiliated programmatic experts as well as with guidance from the editorial board, and expert input through two global expert meetings, and a number of topic specific consultations.
The report proposes to start out with setting out the basic problem posed by the commercial determinants. It then progresses on to an analysis of impacts in parts two and three. Next in parts four and five, it interrogates the enablers and barriers to action on the commercial determinants. Then in part six, it provides an analysis of the state of action. And then finally, in part seven, it looks at the key elements of the public health response to the commercial determinants, and what is needed for this to occur.

In this initial part, the problem analysis aims to present the context, the underpinning definitions, and the overall problem analysis for the commercial determinants of health. First among these is the economic drivers of negative impacts from the commercial determinants of health. This is the idea that commercial actors and prevailing business models are designed to put profit ahead of health and other concerns in many cases. This challenge goes to the basic market incentives and how they've been shaped by commercial actors and the public sector. Furthermore, it creates the conditions for the commercial determinants we have today. Externalities of commercial practices are the uncosted aspects of a transaction that are instead imposed on third parties and society. For example, the tobacco industry, sell a hugely dangerous product, and it causes a huge burden of health, ill health and a number of environmental impacts but they pay only a very small portion of this cost. These are externalities that varies with different sectors. The third challenge is that of identifying, managing and preventing conflicts of interest and undue influence. The idea being that the action to address harms to health by the public sector and others is prevented by the use by commercial actors of practices of power using methods of influencing public policy, knowledge environment and public preferences. Finally, a core challenge is ensuring an equity lens on outcomes. This is about the distributional consequences of commercial practices and products.

The theory of change underpinning the global report is that change will occur by leveraging the power and the potential of the commercial sector for better health and health equity while, and this is very crucial, protecting from conflicts of interest and preventing public health harms. At the same time, a critical underpinning assumption is that the obligation of commercial actors, and this is businesses, is in general, to continue practices that priorities profit over health unless required to do so otherwise. The Global Report will as a synthesis of evidence, test these assumptions and provide recommendations on related actions.
The scoping process and the broader development of the Global Report has also resulted in a working typology that places industries along an axis of alignment from health-harming industries, which are inherently misaligned with the public interest. These include fossil fuels, arms, tobacco, gambling, and segments of the food industry, whose portfolio largely comprises unhealthy options. Their business model and their need to make profit requires they continue to sell products and services which are harmful to health. These businesses grow their markets by reaching new customers and shaping preferences and knowledge in favor of harmful products or behaviors. They also may employ practices of influence over our politics and knowledge to prevent and shape regulation and obstruct the effective means for formulating and implementing it. Examples of businesses exclusively operating in these areas include commercial actors that provide marketing, retail, legal, consultancy, financial, and social media services and platforms for health-harming commercial actors.

Next, the global report will describe the burden on health and health equity associated with the commercial determinants of health. Its main purpose is to describe the burden on health and health equity associated with the commercial determinants of health. Under each of these headings, the global report will look at the risk factors and the industries involved, taking a life course approach, and looking at the equity impacts.

The report will take through the intermediate determinants and conditions, which provide the causative pathways through which commercial practices result in exposure to health-harming products and practices and environments. It will also include access or non-access to health-promoting goods, to equity or in-equity of health considerations. The major practices published in the Lancet series include political practices such as lobbying, scientific practices such as funding evidence generation or distortion, marketing practice such as advertising, supply chain practices such as pollution, labor practices such as those related to occupational health, worker safety, and financial practices such as the avoidance or the payment of tax, and then reputational practices which cut across all these other practices.

These practices shape policies, environments we live, work and play in. They shape our exposure to products and behaviors, marketing and other aspects that shape how we live and how we want to live, and our aspirations and ideals. Core health and health equity outcomes including CDH are shaped by commercial practices.

It goes through to how leadership and governance, availability of health information, health products and technologies, health financing, service delivery, health workforce, public health programs, are all, also, shaped in various ways, both positive and negative, by commercial practices.

Following this, it sets out how commercial actors and practices do not occur in a vacuum. Rather, they are occurring already in a preexisting distribution of power and resources and economic structures around the world. This affects both the capacities of the public sector and the capacities of commercial actors. This is tied in with complex interactions between the public sector, business, and others in society, as well as importantly, processes such as colonialism, the development of public international and economic law, and the spread of private international law and other arrangements that constitute the context to how and why commercial practices shape our politics, preferences, knowledge, and laws, as well as evade the latter.

The premise of action is based on making change through the correction of power imbalances, realigning incentives in favor of public health interests, and targeting industries that pose risks to health. A fundamental aspect of regulating these health-harming industries involves delving into the core business models of relevant commercial entities and reducing their capacity to shift external costs by influencing public preferences and knowledge. Such
regulatory actions serve to partially rectify the power disparities between communities and commercial entities. For instance, effective regulations pertaining to marketing, labeling, and the availability of specific products can form part of a broader strategy to shift the incentives of commercial actors away from engaging in the production of these harmful products in the first place. This approach can lead to the shrinking or gradual elimination of particularly detrimental markets or market segments.

This response must also be a direct effort to confront the imbalances in power between the public sector and commercial entities through specific policies and practices aimed at identifying, preventing, and managing all forms of conflicts of interest, including policy capture. However, these measures, on their own, are insufficient. Robust rules and policies must be complemented by actions that enhance overall coherence within the public sector. This can include the implementation of health impact assessments, ensuring adequate financial and technical resources for the public health sector or other regulatory bodies with health interests, and addressing entrenched restrictions stemming from trade and investment agreements that undermine public health. It is also crucial to make effective use of existing exceptions to these agreements.

Enhancing the capacity of the public sector in this manner mitigates the power imbalances that erode political will and ability to effectively formulate, adopt, and enforce regulations—including those with potential lead to broader shifts in the market that benefit public health.

Taking action also requires supportive action to strengthen and protect the knowledge environment, the civic space and mechanism for change within the private sector. All these mechanisms have the potential to play supportive roles but are also subject to targeting by commercial actors that wish to distort the knowledge environment, misdirect civil society, and enfeebles or constrain investor action and other mechanisms for change from within the business community.

In the Global Report, WHO places its focus on collaboration across the public sector, working with health-aligned businesses and investors, as well as engaging with the UN, academia, researchers, media, and most importantly, with communities and social movements advocating for change, including civil society. The report is shaped by five related drivers of change: public sector intervention, corporate governance and investor initiatives, the prioritization of health at the international level, bolstering the public interest knowledge environment, and creating social demand for improved corporate and commercial practices.

The report places, however, a central emphasis on the public sector as the main driver of change. It concentrates on addressing conflicts of interest throughout the public sector while simultaneously reducing power imbalances and enhancing the public sector's capacity. The requires also that WHO other intergovernmental actors, and member states lead in the creation of better frameworks that can engage health-aligned commercial members of the business community, ultimately leading to stronger and more effective corporate governance.

Multilateral action on trade, investment, business and human rights, economics, environmental issues including climate and climate justice, financial mechanisms, and development assistance is also essential. This will boost overall public sector capacity and coherence and ensure that the playing field is not tilted in favor of commercial actors, especially large multinational corporations. Ultimately, the global report aims to establish a unified approach for addressing commercial determinants, leveraging the successes and experiences gained in the contexts of tobacco and non-communicable diseases (NCDs).
Research, media, and academia can play a vital role in holding commercial actors accountable, uncovering their practices, and building a case for change. Communities and civil society organizations (CSOs) are on the front lines of responding to commercial actors and are instrumental in empowering civil society, ensuring transparency, and building resilience against the influence of commercial entities.

The public health response, detailed in part seven, outlines the strategy for the health sector, communities, and other sectors, in conjunction with building up legal, surveillance and other capacities needed to meet the commercial determinants of health challenge.

WHO is currently in the process of finalizing the first draft outline, with the drafting process set to commence soon, and the goal of completing the global report over the coming year.

Session II: Equity lens on commercial determinants of health: 3 Presentations

1. Consumer protection of people’s voices by Dr Vinya Ariyaratne, Savodaya, Sri Lanka

Consumer protection is the practice of shielding buyers of goods and services, as well as the general public, from unjust practices in the marketplace. Consumer protection measures are often established by law. However, despite the existence of consumer protection laws in many countries, formal mechanisms for consumer protection are generally weak. Consumer protection, especially concerning the commercial determinants of health, plays a crucial role in public health policy and regulation.

Broadly, consumer protection aims to provide security to consumers against unfair trade practices carried out by traders, manufacturers, and service providers. It also seeks to educate consumers about their rights and responsibilities, offering them a speedy and cost-effective means of addressing their grievances.

Consumers are frequently uninformed due to their lack of awareness about critical factors, rendering them unorganized and, consequently, exploited. On the other hand, commercial actors are well-resourced and powerful. This complexity influences consumer behavior and further shapes it through media and various social channels.

The industry has grown increasingly sophisticated, particularly in its targeting of specific groups for commercial interests. Consequently, consumer protection, from a rights perspective, covers a wide range of areas. This includes the right to safety, encompassing protection from injuries and trauma, such as road safety and other forms of injury prevention. Additionally, it encompasses the right to information and the right to choose, even when producers and commercial interests are involved. Consumers have the right to be heard and represented, the right to redress, the right to consumer education, the right to basic needs, and the right to a healthy environment.
Consumer protection during crises and emergencies is of paramount importance. For instance, during an economic crisis in Sri Lanka, significant food insecurity emerged due to weakened regulatory mechanisms related to food and medicines. Parties with vested interests exploited this situation to introduce unsafe products, capitalizing on the absence of robust defense mechanisms.

Consequently, the role of civil society organizations (CSOs) and regulatory authorities becomes profoundly significant. The role of corporations can be either positive or negative. It requires strong determination and management to maximize positive outcomes and minimize negative ones. Non-state actors become critical, serving as key channels for delivering emergency and humanitarian assistance. This can even occur through official UN channels, addressing issues related to nutrition and food insecurity.

Addressing this multifaceted issue necessitates a combination of regulatory measures, consumer education, and industry accountability. Empowering individuals and communities through knowledge, skills, and recognition of their rights and responsibilities is crucial.

In Sri Lanka, the development of a patient charter outlining rights and responsibilities is underway. This emphasizes the role of patients who are consumers of a state healthcare system. It is also essential to take action to reduce wastage in our systems.

In conclusion, in tackling these issues, consumer protection is just one component, but it holds a significant role. It must be accompanied by empowering people by giving them a voice and organizing them, both as individuals and in groups and communities.
Nepal, as a small country facing significant challenges, has made remarkable progress in health indicators. It has successfully controlled and even eliminated various communicable diseases, reducing mortality rates and improving various health metrics.

Nevertheless, the overall progress of the country has cast a shadow on the existing health disparities. When addressing the population, it is essential to recognize that people are not a homogeneous mass. In the rural areas of Nepal, healthcare services are unavailable and inaccessible for majority of people although Nepal boasts a substantial number of health service facilities, with many private hospitals claiming to meet international standards.

Disparities exist in the access to healthcare services in Nepal. For instance, the infant mortality rate decreased from 93 per thousand live births in 1996 to 28 per thousand live births in 2022. This represents a significant reduction over the past three decades. However, this improvement is merely a national average. When we look at the differences today, the gap is more pronounced than it was 30 years ago. In 1996, the mortality rate ranged from 79 to 124, with a 45% difference in the national average. In 2022, despite the lower national average of 28 per thousand live births, the difference between the highest and lowest mortality rates is 21 per thousand live births - a substantial 75% of national average. This widening gap highlights how the overall improvement in the country has overshadowed these disparities.

It is vital to recognize that in a country like Nepal, 11% of service users face catastrophic healthcare expenditure. This occurrence of catastrophic healthcare expenditure for every service seeker is of great concern. Additionally, it's worth noting that every year, over 1% of the population, roughly 400,000 Nepali people, are pushed below the poverty line due to healthcare expenses.

These issues are closely related to Commercial Determinants of Health (CDH), with multiple dimensions to consider:

- Firstly, it's crucial to acknowledge the diversity of voices among the population. We must understand whose voices we are addressing and whose perspectives we are considering. Identifying and recognizing the underprivileged individuals in the worst situations is essential.
- Secondly, there's a double burden of both unavailability and inaccessibility and irrational use of healthcare services. For many people health services are not available and not accessible. On the other hand, when services are available, they are often irrationally used, leading to additional financial burdens on the population. Despite the development of health science and technology, such situation is emerging due to CDH.
- Thirdly, it is vital for people to comprehend CDH and the marketization of health.
The point of departure lies in addressing CDH, where market economy theories are being applied to healthcare. These theories, such as supply and demand, open competition, open markets, and consumer sovereignty, are typically suited for other commodities but not for health. Unfortunately, they have been enforced in healthcare, resulting in significant burdens on the population, causing suffering, pain, and further exacerbating disparities.

3. **Collaborative approach for better health by Dr Than Sien, People’s Health Association of Myanmar**

Health systems not only influence health outcomes but also play a role in determining equity. This encompasses both social determinants and health determinants. As the WHO has stated, the health system includes all organizations, institutions, and resources dedicated to providing healthcare. This involves personal healthcare, public health services, and inter-sectoral initiatives aimed at promoting, restoring, maintaining, or enhancing the health of the population.

Commercial products also contribute to health actions, either for health restoration or health promotion. For instance, consider Breast Milk Substitute (BMS) used when a child is born, and the mother cannot provide breast milk. However, BMS often does not meet the same standards as mother's milk. Artificially produced milk cannot equate to natural human milk.

While health actions are essential for improving health, the primary goal of the health system is not just to enhance health but to reduce disparities among individuals and population groups. Equity plays a crucial role in ensuring that health actions reach those who cannot afford or access healthcare services.

The health system comprises various components such as service delivery, health workforce, health information, medical products, vaccines, and technology, financing, as well as leadership and governance. In tobacco control, digital technology is used in vaping and e-cigarettes, replicating harmful effects.

In the Southeast Asia Region (SEAR), addressing Commercial Determinants of Health (CDH) necessitates the establishment of legislation, policies, and programs. Multisectoral actions for improving health, incorporating a life-course approach, are crucial. Diseases are not just linked to germs and risk factors but also to technology, commerce, trade, and bilateral/multilateral agreements. For instance, SEAR adheres to international health regulations, which have implications for disease control. India suffered significant economic losses due to the plague outbreak. International health regulations were subsequently updated based on India's experience.

A more recent example is the COVID pandemic. Before China officially announced the disease outbreak, it had already spread widely, resulting in a significant loss of lives. Trade and health are intertwined, and the extent of economic losses incurred by countries during the pandemic remains uncertain.
The WHO Framework Convention on Tobacco Control (FCTC) strives to combat the global tobacco epidemic and is one of the most significant international conventions. International agreements such as the Trade-Related Intellectual Property Rights (WTO - TRIPS) and SPSS, play a role in this context, along with local trade agreements like the ASEAN trade agreement and bilateral trade agreements.

The majority of the tobacco industry is based in developed countries, with four major companies controlling over 80% of the market. These companies include the Japan Tobacco Company, British American Tobacco Company, and Imperial.

Various challenges are associated with health systems. These challenges encompass areas like access to medicines, vaccines, and technology, with developed countries often dominating the market. Additionally, addressing the prevention and control of non-communicable diseases (NCDs) and risk factors requires dialogue and information sharing. Digital technology, health literacy, and financial literacy play a critical role in providing basic knowledge to people about Commercial Determinants of Health (CDH).

**Session III: Brainstorm Sessions: People Experience of CDH throughout the life-course and Equity Lens on CDH across life-course**
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<thead>
<tr>
<th>Experiences of commercial activities during parenting for early childhood development</th>
<th>Positive</th>
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<tr>
<td></td>
<td>• Increase awareness/information due to ICT</td>
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<td>• Access to health care services</td>
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<td>• New technology</td>
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<td>• Low cost due to competition</td>
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<td>• IVF, telemedicine</td>
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<td>• Stem cell therapy</td>
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<td>• Use of family planning</td>
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<td>• Transportation has improved</td>
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<td>Negative</td>
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<td>• Increase formula feeding</td>
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<td>• Misleading information</td>
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<td>• Increase intake of junk food</td>
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<td>• Increase sedentary life due to use of technology</td>
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<td></td>
<td>• Increase expenditure to buy commercial foods for baby and mother</td>
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<td>• Increase mental health disorder due to inappropriate workplace, stress, use of social media, COVID-19, etc.</td>
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<td>• Increase in Health expenditure due to lifestyle related diseases</td>
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<td>• Climate change</td>
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<tr>
<th>Experiences of commercial activities in children and adolescent age</th>
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<tr>
<td></td>
<td>• Increased access to technology</td>
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<td>• Exposure to online marketing targeting children such as junk foods, tobacco products</td>
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<td></td>
<td>• Decreased physical activity due to digital media</td>
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<td>• Easy accessibility of unhealthy products</td>
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<td>• Advanced targeting marketing</td>
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<td>• Increased substance abuse</td>
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<td>• More variety and choices of unhealthy foods</td>
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<th>Experiences of commercial activities in adults/working age groups</th>
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<tr>
<td></td>
<td>• Social changes and behaviours of commercial actors</td>
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<td></td>
<td>o Fast fashion – linked to determinants (pollution, waste, poor wages/unsafe labour)</td>
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<td>o More health-conscious consumers – linked to commercial ‘health washing’ and branding</td>
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<td></td>
<td>o Rise of social media incl. power of a few (western) companies controlling narratives</td>
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<td></td>
<td>o Corporate sponsorship &amp; marketing ever prevalent</td>
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<td></td>
<td>o Rise in ‘growth markets’ for health-harming products in SE Asian region</td>
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<tr>
<td></td>
<td>• Changes in public perceptions and behaviours</td>
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<td></td>
<td>o Better understanding of harms from tobacco</td>
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<td></td>
<td>o More sedentary work/online activity</td>
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<td></td>
<td>o Increasing consumption of processed foods</td>
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<td></td>
<td>• Changes in governance for health</td>
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| Experiences on commercial activities in **ageing population** | • Private sector fee levying services for the elderly (Sri Lanka)  
• Insurance scheme for elderly  
• Fixed deposit with high interest  
• Pension fund for elderly  
• Promotion of healthy products for elderly (nutrition supplement, healthy equipment, etc.)  
• Aggressive advertising and sale of unproven medical products  
• Increase cost of healthcare services  
• Temporary care home (during festivals)  
• Annual check-up packages |
| Experiences of the **intergenerational Influences/impacts** of commercial and economic determinants of health | • Products affect different generations differently (SSBs, vapes, etc.) due to differences shifts in market presence and strategies over time (due to trade policy and rules) and commercial targeting (by age) with an emphasis on exposure to digital environments as stratified by age  
• Importance of generational change in the region due to urbanization and the emergence of two earner households with both parents in work, reduced time for home cooked healthy traditional meals, and greater reliance on buying prepared “fast” highly-processed foods considering globalization and international trade  
• The commercialization of health service delivery and insurance markets in mediating access  
• The role of informalization in the labor market as a commercial driver of decreased access |
### Session 1: People Experience of CDH throughout the life-course

**Q2: What are the critical concerns?**

| Experiences of commercial activities during parenting for **early childhood development** | - New Technology in health sectors: Private sectors use for increasing profits or exploitation  
- Commercial Activity: Increasing greenhouse gases, commercial crops deforestation, chemical → climate change  
- Digital Technology: a. Negative effects → increase availability of tobacco and unhealthy diet, obesity, increase screen time, psychosocial development disorder  
  b. Positive effects: reduce medication errors, adverse effects, real time data, Telemedicine  
- Childcare practices changed due to working parents  
- Change in parenting system due to commercial impact  
- Corporate social responsibility  
- Increasing teenage pregnancy |
|---|
| Experiences of commercial activities in **children and adolescent age** | - Rise in obesity, overweight and NCDs  
- Sedentary lifestyle  
- Mental health issues  
- Negative behaviours influenced by social media influencers  
- Easy access to harmful/unhealthy products  
- Less social interaction  
- Malnutrition  
- Exposure to toxic environment (pollution and heavy metals)  
- Misleading information |
| Experiences of commercial activities in **adults/working age groups** | - Health outcomes and behaviours  
  o Rising NCDs, communicable diseases, COVID-19 and associated mortality & morbidity  
  o Rising mental health concerns  
  o Increases in unhealthy behaviours and social changes |
<table>
<thead>
<tr>
<th>Experience Area</th>
<th>Potential Consequences</th>
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<tr>
<td>Greater sedentary lifestyles</td>
<td>• Less access to affordable, healthy food</td>
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<td>Living and working conditions</td>
<td>• Air/waste disposal/water pollution</td>
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<td>• Affordable, accessible and quality health care - including cost of imports</td>
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<td>• Loss of jobs, income / rising costs of living</td>
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<td>• Rising injuries / workplace diseases / burnout</td>
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<td>Information and marketing</td>
<td>• Misinformation/disinformation/increasing volume of information</td>
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<td></td>
<td>• Gaps in health and media literacy</td>
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<td>• Youth targeted marketing</td>
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<td>Society and government</td>
<td>• Rising inequalities and health inequity</td>
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<td>• Public trust in govt is reducing</td>
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<td>• Corruption, lobbying, political practices</td>
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<td>• AI and digital transformation / exclusion</td>
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<td></td>
<td>• Armed conflict (within and between countries)</td>
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<td>• Effects of climate change and emergencies</td>
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<td></td>
<td>• Biodiversity loss</td>
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<tr>
<td>Experiences on commercial activities in ageing population</td>
<td>• Pension scheme – lack of funds</td>
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<td>• Taxation policy not targeting to old age population</td>
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<td>• Out migration of children leading to isolation of elderly</td>
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<td>• Productivity of working age population decrease due to increase elderly population</td>
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<td>• Health dynamics of the population shift to more costly intervention at the old age</td>
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<td>• Increase household debt</td>
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<td></td>
<td>• Increase of psychological issues such as dementia</td>
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<tr>
<td>Experiences of the intergenerational Influences/impacts of commercial and economic determinants of health</td>
<td>• The need for health in all policies to cover all aspects of policy across and between generations</td>
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<td>• Harmful digital environments with social media addiction, gaming addiction reduce physical activity, exposure to the marketing of unhealthy products with a particular risk and severity for young people</td>
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<td>• Aggressive marketing by commercial actors targeted at young people and particular sub-populations (e.g., woman with alcohol) coupled with weak regulation</td>
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<td>• New technologies and culture</td>
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<td>• Erosion of food environment and cultures</td>
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<td>• Introduction of novel commercial products (e.g. vapes)</td>
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<td>• Increased cost of healthcare</td>
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<td>• Climate change</td>
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### Session 1: People Experience of CDH throughout the life-course

**Q3: What actions can individuals take?**

| Experiences of commercial activities during parenting for early childhood development | • Individual parents should reduce screen time  
• Formulating peer group to empower each other  
• Promote establishment of child-care centre in workplace  
• Follow the Ethics by Professional  
• Increase cash max skills  
• Increase life skills & Moral education  
• Promote traditional food/healthy choice food  
• Raise child to care about environment climate and natural food |
|---|---|
| Experiences of commercial activities in children and adolescent age | • Increase in health education  
• Improve legal and fiscal measures  
• Improve parenting  
• Providing more opportunities to support youth  
• Youth groups and school health clubs should promote healthy food environment  
• Teachers should be role models of change  
• Healthy school meal programmes  
• Children and youth should become health ambassadors |
| Experiences of commercial activities in | • Take ownership over own health  
  o Consume less, especially harmful products |
| adults/working age groups | o Make healthier food and lifestyle choices, where they are available  
o Increase physical activity  
o Breastfeed  
o Regular health checks  
o Increase participation in social activities  
o Promote indigenous/traditional cultural behaviours that contribute to health & wellbeing (food, yoga etc.)  
o Do not engage in smuggling of health harming products  
o SMART working/work life balance/stress management techniques, and workplace health initiatives |
| --- | --- |
|  | **Build health literacy**  
o Invest in own health and digital literacy  
o Educate oneself on health, food, supply chain issues  
o Use new technology to raise awareness of different health issues |
|  | **Build agency and empowerment**  
o Participate in politics  
o Act as change agents in their communities  
o Organize at community level to lobby policymakers and companies |
|  | **INDIVIDUALS CANNOT:**  
o Tackle advertising and marketing  
o Tackle trade in alcohol and tobacco (legal and illegal)  
o Affect the price and availability of products  
o Ensure that online information is reliable  
o • Control tax schemes |
| Experiences on commercial activities in **ageing population** | **Healthy lifestyle**  
**Increase health literacy**  
**Eager to learn new things**  
**Engage in regular health checkups** |
| Experiences of the **intergenerational Influences/impacts** of commercial and economic determinants of health | **Individuals cannot do much**  
**Individuals can influence their own decisions to some extent**  
**Individuals can influence household consumption decisions**  
**Individuals can form a common platform and organize together as a community group**  
**Individuals can vote and attempt to influence the rules and regulations of their country** |
### Session 1: People Experience of CDH throughout the life-course

#### Q4: Who is responsible for curbing negatives and enhancing positives?

| Experiences of commercial activities during parenting for early childhood development | • Legislator's  
| • Government Institutions (MoH, MoF, MoEducation, MoCommerce and Industry) act.  
| • Unions  
| • CSOs  
| • Academia and professional  
| • NGOs  
| • Development partners  
| • Philanthropists |
| Experiences of commercial activities in children and adolescent age | • Government and ministries including health, energy, trade, etc  
| • CSOs  
| • Religious leaders  
| • Youth groups  
| • UN Agencies  
| • Academia  
| • Research  
| • Private sector  
| • Parents/care givers  
| • Individuals  
| • Public figures |
| Experiences of commercial activities in adults/working age groups | • Government (policy, national and subnational levels)  
| o Putting health as one of the highest priorities across govt  
| o Through laws, policies and taxation  
| o Enforcement, monitoring, evaluation and punishing no-compliance  
| o Investments, including healthy investments by public investors (pension funds, government bonds) |
Adopting a holistic healthy cities approach to municipal development
- Good governance, anti-corruption, addressing conflicts of interests and including whistleblower protection
- Building participatory fora and investment in promotion of the engagement of civil society and communities
- Legally empowering civil society to monitor government and business

- Business (including chambers of commerce)
  - Codes of conduct and adoption of business ethics
  - Compliance to national and international laws and standards
  - More health alignment in products and practices
  - Greater demand for health aligned products and practices from private institutional investors
  - Whistle blower protections

- Public (customers, service users, civil society)
  - Public monitoring
  - Public organization and movement for change
  - Increasing media literacy on CDOH
  - Acting as whistleblowers

- International organizations
  - Sharing international good practices

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**Experiences on commercial activities in ageing population**
- Individuals / Families
- Government
- Society
- Private sector/ Industries
- International institutions and organizations

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**Experiences of the intergenerational Influences/ impacts of commercial and economic determinants of health**
- The primary responsibility is with the government including ministries of health, education, commerce, labour, information
- UN, WTO and other intergovernmental actors have a role in advocacy, guideline production and determining joint regulations
- Governments can also influence across borders bilaterally and multilaterally to address harmful commercial practices of multinational and transnational businesses
- Community leaders, religious leader, influencers, celebrities, and academics and researchers have a role
- Industry and industry leaders, multinational corporations, media and streaming platforms
- Civil society organizations and community groups
### Session 1: People Experience of CDH throughout the life-course

#### Q5: What does the public sector need to do?

| Experiences of commercial activities during parenting for **early childhood development** | • Legislation → improve /revise regulation, improve monitoring and implementation, develop code of conduct  
• Evidence based decision making  
• Government:  
  o Implement policy and enforcement  
  o Strengthen the system and improve advocacy  
  o Resource: finance, human capital, stewardship management  
  
• Potential Institution: Academic and research, advocacy,  
• Multisectoral collaboration |
|---|---|
| Experiences of commercial activities in **children and adolescent age** | • Ministry of health should accelerate multi-sectoral action plans to address CDoH  
• Government needs to develop legislations  
• Increase/introduce excise tax on harmful products  
• Impose subsidies on healthy food (fruits and vegetables)  
• Convene a forum with industry  
• Establish code of conduct to manage/prevent conflict of interest  
• Government needs to negotiate with WTO on subsidies  
• Government needs to issue regulations to restrict/ban advertising, promotion, sponsorship of unhealthy foods  
• Provide more facilities for physical activity  
• Resource allocation for CSOs |
| Experiences of commercial activities in | • Strengthened use of governance instruments for CDOH  
  o Putting health as one of the highest priorities of government |
| **adults/working age groups** | • Increase investments in the health sector  
  • Tax incentives for health alignment/promotion  
  • Tax and fiscal measures to address CDOH (consumer & corporate schemes)  
  • Creating effective conditions for implementation:  
    - Leadership, resources, accountability/monitoring and evaluation mechanism  
    - Research and data  
  • Building capacity  
    - Invest into building capacity of communities/CSOs in health space  
    - Invest in health literacy of institutions and populations  
  • Strengthening governance of the commercial determinants of health  
    - Establish multisectoral platforms in government  
    - Invest in regulatory approaches to tackle CDOH  
    - Ensure PPPs are robust (including accountability and COI)  
    - Addressing/mitigating conflicts of interest  
    - Good governance, transparency and anti-corruption, including to protect whistle-blowing  
    - Legally empowering civil society to monitor government and business actions  
    - Creating a participatory forum and promoting the engagement of civil society and the public |
| **Experiences on commercial activities in ageing population** | • Government provides for wellness centers, physical activity and rehabilitation, park or places  
  • Government should develop policies to support elderly population  
  • Promote indigenous-traditional actions on elderly people  
  • Support elderly in providing job, home care, facilities, research centers on ageing population  
  • Individual responsibility to take care of their parents  
  • Protect elderly from abusive behaviours  
  • Social security  
  • Age-friendly healthy city initiatives |
| **Experiences of the intergenerational Influences/impacts of commercial and economic determinants of health** | • The basis of progress is high-level leadership  
  • The first step is identifying the problems of CDoH  
  • The second step is developing a multi-sectoral action plan  
  • The third step is incorporating it at the national level and subnational levels through legislation and regulation  
  • Multi-sectoral action should be coupled with conflict of interest regulations and laws as well as a right to participation  
  • This needs to be reinforced with monitoring and evaluation criteria, surveillance, evaluation and research  
  • There also needs to be capacity with taxes on risk factors and other financing – including along the polluters pays principle for other health-harming commercial practices |
### Session 2: Equity Lens on CDH across life-course

#### Q6: What are the actions to address equity gaps for vulnerable population?

| Experiences of commercial activities during parenting for **early childhood development** | • New Technologies that exploited people  
  o Health Care: Improve access, Quality, Coverage of information healthcare, increased technical capacity, free health care  
  o Digital Technology Commercial activities: health insurances on equity  
  o Education: free education and promoting education  
  o Improve signals to enable access or work  
  o Healthy Food expending: Subsidies/ increasing assess, reduce taxes for healthy food and increase taxes for unhealthy produce commercial  
  o Cash transfers in accessing food and health care  
  o Commercialization: Climate change, environmental pollution  
  
  • Overall  
    o Gender equity and social inclusion policy and strict implementation  
    o Multisectoral coordination  
    o Evidence-based decision making  
    o Using data to identify vulnerable group  
    o Preference system/Positive discrimination  
    o • Policy to reduce disparity between indifference group |
|---|---|
| Experiences of commercial activities in **children and adolescent age** | • Equity lens  
  o Ban advertisement, promotion and sponsorship  
  o Increased advocacy, capacity building, policies on urban health  
  o Health promotion  
  o Improved regulation and monitoring  
  o Create enabling environment  
  o Cross border regulation on advertisement and marketing  
  
  • Gaps  
    o Industry Interference  
    o Limited resources  
    o Enforcement/Implementation gaps  
    o Policy gaps  
    o Knowledge gaps |
| Experiences of commercial activities in **adults/working age groups** | • Promoting health literacy in the elderly, living in healthy environment with strong policies with health including telemedicine and medical record  
  • Need for policy to implement all the literacies (health, financial, and digital literacy)  
  • Social protection (the pension, social insurance)  
  • Gap: Resources allocation and awareness, legal protection |
### Experiences on commercial activities in ageing population

- **Vulnerable population**
  - Single mother
  - People under poverty
  - People in remote area
  - Ethnic minorities Worker
  - Immigrant Worker
  - People displaced within country

- **Separated budget**
  - Social marketing/ awareness raising/ health literacy targeting population to involve them in decision making
  - Social safety net (housing, health, education, WASH, essential food)

- **Collaboration to other sector**
  - Community support center to be established in remote area
  - Increasing accessibility and affordability to health product
  - Ensure fair trade for marginalized entrepreneurs/individuals/MSMEs

### Experiences of the intergenerational Influences/ impacts of commercial and economic determinants of health

- There is a close relationship between commercial determinants and economic factors which means greater exposure to unhealthy commercial practices and product and other distinctions based on group: the focus needs to be on the distribution of health harms, not just overall impact on health

- Socio-economic position (e.g., wealth quintile) is the key structural determinant of access to intermediary determinants of health (such as healthy food, transport, healthcare, education, information)

- Urban areas can have overall better health outcomes but deep inequities with some subgroups having worse outcomes than in rural areas

- Young people in urban settings can be particularly exposed to harmful commercial practices and products

- Older people will be vulnerable (65+) due to loneliness and exposure to multi-morbidities (NCDs)

- Rural people may have less exposure to commercial practices and products but will have less access to health services and may suffer in other ways

- Minority population focus is needed but inequities within these groups need to be considered too based on socio-economic position

- Keep in mind the tipping point phenomenon – we cannot ignore different population groups and how the position of groups affect one another and interventions aimed at any one affect across them
### Part III: Regional position on commercial determinants of health

**Sessions I, II, III: Country presentations on understanding of burden, sectors, activities, and systems for the CDH and action points: Bangladesh, Bhutan, Nepal, Indonesia, Maldives, Timor Leste, Sri Lanka, Thailand, Myanmar**

<table>
<thead>
<tr>
<th>Country</th>
<th>Top 3-5 CDH to be critically concerns in the next 5 years.</th>
</tr>
</thead>
</table>
| **Nepal**    | • Tobacco products (smoke and smokeless)  
                • Alcohol  
                • Unhealthy food (Transfat elimination, sugar sweetened beverages)  
                • Unnecessary promotion of health services by private health sector for profit |
| **Bangladesh** | • Tobacco  
               • Unhealthy food  
               • Unhealthy beverage including SSB  
               • Air & Sound pollution  
               • Excessive Marketing of Pharmaceuticals |
| **Bhutan**   | • Tobacco  
                o Bhutan had a history of strong tobacco control measures, including a ban on the sale of tobacco  
                o Following the pandemic, this has been reversed  
                o Strengthen tobacco control policies to prevent tobacco-related health issues  
                • Alcohol Industry  
                o Sale and marketing of alcohol, significantly impacts public health – ALD on the rise  
                • Processed and Unhealthy Food: Ultra processed foods, Sugar sweetened beverages  
                o Consumption of processed and unhealthy foods may increase  
                o Rising rates of diet-related diseases, including obesity and diabetes  
                • Marketing and Advertising:  
                o Both online and offline, influence choices and behaviors |
| **Timor Leste** | • Increases in unhealthy behaviors, Obesities, and social changes  
                 • Rising NCDs issue associated mortality & morbidity  
                 • Mental health issue  
                 • Increased cost of healthcare  
                 • Less of physical activities due to increasing the number of transportation |
| **Maldives** | • Young generation adopting sedentary lifestyle, increase in tobacco use/ drug abuse  
                 • Wide and easy availability of fast food and ultra-processed foods  
                 • Weak regulatory system to monitor food products including processed food  
                 • Climate and its detrimental effects |
| **Indonesia** | • Tobacco use (including nicotine products)  
                  • Unhealthy food and beverages |
• Aggressive marketing of unhealthy products that contribute to NCD’s (tobacco, SSB, ultra-processed food)
• Air pollution

**Thailand**
- Unhealthy food industries
- Addictive substances (e.g., alcohol, novel tobacco products, cannabis)
- Agricultural chemicals
- Antibiotics in agriculture, livestock, fisheries
- Air pollution generators (e.g., factories, agricultural burning, transportation)

**Myanmar**
- Expanding international trade investment in Tobacco, alcohol and SSB
- Reliance on private health market and medical tourism promotion from neighbouring countries
- Unregulated advertisement and sales promotion on baby food, breast milk substitutes and supplementary food for the young children and elders
- Cross-border online sales of harmful products

**Sri Lanka**
- Injuries and trauma E.g., Increased Road Traffic Accidents
- Tobacco
- Alcohol including illicit liquor
- Unhealthy diet
- Pharmaceuticals
- Narcotics
- Mental wellbeing issues

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2. **Commercial drivers/actors that have direct impacts on people health**

**Nepal**
- Tobacco industry
- Alcohol industry
- Multinational companies
- Food and beverage industry
- Private health service providing institute
- Pharmaceutical industries
- Media: Advertisement, promotion

**Bangladesh**
- Aggressive advertisement (TV, social media and other digital platform including OTT)
- Tobacco, unhealthy food & SSB Multinationals
- Pharmaceutical Companies
- High influential sponsorship
- Lobbying (Tobacco, unhealthy food and beverage)
- Influence of transport association

**Bhutan**
- Tobacco
  - Retailers and Vendors -who sell tobacco products play a significant role in making these products accessible to the public
  - Cross border issue
<table>
<thead>
<tr>
<th>Country</th>
<th>Industries and Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Industry</td>
<td>- Breweries and Distilleries - produce alcoholic beverages</td>
</tr>
<tr>
<td></td>
<td>- Bars and Liquor Stores – increases availability of alcohol</td>
</tr>
<tr>
<td></td>
<td>- Processed and Unhealthy Food: Ultra processed foods, Sugar sweetened beverages</td>
</tr>
<tr>
<td></td>
<td>- Fast Food Restaurants offer “attractive” unhealthy foods</td>
</tr>
<tr>
<td></td>
<td>- Food Manufacturers – both from within and from outside the produce and market processed foods</td>
</tr>
<tr>
<td></td>
<td>- Marketing and Advertising</td>
</tr>
<tr>
<td></td>
<td>- Traditional and digital adverts influence consumer behavior</td>
</tr>
<tr>
<td></td>
<td>- Online platforms and social media companies that allow targeted advertisements</td>
</tr>
</tbody>
</table>

| Timor Leste      | Corporates, retailers, transnational companies, marketing etc.                       |
|                  | Alcohol manufacture industry available in country                                    |
|                  | Tobacco import interference such promotion, advertising                              |
|                  | Medicine (private clinic)                                                            |
|                  | Uncontrolled SSB                                                                    |
|                  | Media                                                                                |

| Maldives         | Expansion of food serving industries (Fast foods, processed foods)                   |
|                  | Tobacco industry (Sale, demand/creation), introduction of new products, e-cigarettes. |
|                  | Prevalence of drug dealing.                                                          |
|                  | Heavy import dependency.                                                            |
|                  | Adverse impact of social media that may influence the young and vulnerable groups in the community. |

| Indonesia        | Tobacco and nicotine industry                                                       |
|                  | Food and beverage industry                                                           |
|                  | Energy sources and palm oil industry                                                 |
|                  | Digital technology                                                                   |
|                  | Pharmaceutical and healthcare industry                                               |
|                  | Professionals endorsed by industries                                                |
|                  | Influencers endorsed by industries                                                   |
|                  | Retailers (convenience store, vape store)                                           |

| Thailand         | Monopoly capital (e.g., contract farming and major retailers)                       |
|                  | Social media platform (e.g., online marketing, misinformation, and toxic content)   |
|                  | Irresponsible industries, commercial, and agricultural practices                   |
|                  | Legal loophole and ineffective enforcement                                           |
|                  | Conflict of Interest/ Lack of good governance                                        |

| Myanmar          | Multi-national corporates                                                           |
|                  | Foreign and local joint investments on the harmful products                          |
|                  | Marketing agencies who are very creative to avoid the regulatory measures            |

| Sri Lanka        | Legislature (Parliament)                                                            |
|                  | Multi-national Companies                                                            |
| Government Entities  
(MoH/MoE, Mo Public Security/MoF, Mo T/ Mo Mass media/ Ministry of Transport & Highways, Mo J/Dept of Excise etc.)  
| Tobacco and Alcohol Industry  
| Food Industry  
| Media  
| All relevant Professionals  
| CSOs  
| Bilateral/ Multilateral Agencies |

3. Existing economic models/systems that may reduce or undermine health for all

| Nepal | Ratification with GATT (general agreement on tariff and trade)  
| Liberalization  
| Unregulated policy to establish industries |

| Bangladesh | FTA or Economic Zone as well as export processing zone does not really impact health in our country. This option creates the import of products especially raw materials and capital machineries with less duty or duty free terms. So, there is no direct relation between trade liberalization and FTA or economic zone.  
| Circular economy  
| As a multilateral trade forum WTO already promote circular economy for sustainable development. It includes recycling of products and discourage “fast fashion”.  
| The Bangladeshi garment industry has already announced to the world that it is ready to embrace the idea of the circular economy in textile manufacturing. A partnership between the Global Fashion Agenda (GFA), Reverse Resources, P4G and the Bangladesh Garment Manufacturers and Exporters Association (BGMEA)—known as the Circular Fashion Partnership—has been initiated to reduce waste and depletion of natural resources caused by textile manufacturing through supporting the development of the recycling industry in Bangladesh.  
| The Circular Fashion Partnership, which has currently united more than 30 international brands such as H&M, Marks & Spencer, OVS, Bershka, C&A, Kmart Australia, garment manufacturing companies and recycling firms in Bangladesh, can prove to be the epitome of sustainability in fashion. |

| Bhutan | Free Trade agreements – Bilateral/Multilateral  
| Facilitate the spread of unhealthy products and practices across borders  
| Market liberalization can undermine the ability to regulate and control harmful commercial determinants of health |

<p>| Over reliance on GDP - Economic Growth |</p>
<table>
<thead>
<tr>
<th>Country</th>
<th>Section</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Growth motive</td>
<td>Growth motive may drive the nation to prioritize revenue over public health</td>
</tr>
<tr>
<td></td>
<td>Circular economy</td>
<td>- Circular practices can reduce food waste, promote locally sourced and healthier food options, and address environmental concerns related to the food industry</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>Impact to Health</td>
<td>- Number alcohol production increased with uncontrolled of marketing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Uncontrolled marketing of Junk foods, sugar beverages and tobacco</td>
</tr>
<tr>
<td></td>
<td>Increase domestic livelihood</td>
<td>- Produce cassava by farmer and recycle of alcohol cans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Increased daily income of selling junk foods, sugar beverage and tobacco by small shop</td>
</tr>
<tr>
<td>Maldives</td>
<td>Free Trade agreements – Bilateral/Multilateral</td>
<td>- Multilateralization of the trading environment could be a factor for the entry of low cost, questionable quality, ultra-processed and unhealthy products into the market, when there are limitations on domestic regulations and standards to monitor and enforce the quality and efficacy of such products may have a detrimental health impact on its consumption.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- When industrial activities expand in a pristine environment, such as on small island nations as ours, and when enforcement of regulations are weak, it may have a detrimental impact on the health of the population. E.g.: proper disposal of industrial waste, inhaling chemical components of fiberglass, affecting the lungs of the workers as well as to the community; improper handling of chemicals; improper disposal of used engine oils etc.</td>
</tr>
<tr>
<td></td>
<td>Circular economy</td>
<td>- As the Maldivian economy is highly dependent on a service sector such as tourism and one of the critical selling point and one of the success factors is a pristine environment, it is important to have a mechanisms /arrangements in place to encourage establishment of a circular economy model in order to further enhance the tourism product, so that the benefit of tourism revenue will have positive impact on the economy, through job creation and increase in government revenue that could be used to deliver services to the population.</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Free Trade agreements – Bilateral/Multilateral</td>
<td>- Indonesia focuses on expanding the market access by various trade agreements with other countries.</td>
</tr>
<tr>
<td></td>
<td>Pro-economic growth</td>
<td>- Indonesia prioritizes more economic growth and investment than health (such as investment in e-cigarettes, asbestos, etc.)</td>
</tr>
</tbody>
</table>
**Thailand**

- Monopoly capital: Food monopoly throughout food supply chain shapes food consumption of the population, and contract farming degrades environment
- Free trade agreement: Tradeoff between economy and health, removal of public participation to protect health and environment, and ineffective surveillance system for imported products
- Bio-circular green economy: green procurement (supply safety/organic food to hospitals, schools, hotels, restaurants, prisons, communities)

**Myanmar**

- 3 SEZ – 2 have been functional off and on – job insecurity and stress
- Controlled economy and currency fluctuation – high prices of essential drugs
- Unstable border trades – impact on availability of household and health products
- Illicit trade – cheaper harmful products
- Insufficient capacity to inspect the imported products by regulatory authorities

**Sri Lanka**

- SAPTA, APTA, SAFTA and other FTAs for trade in goods and services
- Bilateral partnerships – neighboring countries
- Circular economy needs to be strengthened
  - Waste management 5R – Refuse, reduce, reuse, repurpose, recycle
  - Leasing high-end equipment – CT, MRI, PET scans
  - Outsourcing medical investigations – rare and specific

---

4. **Existing public private partnerships and governance that can manage CDH**

**Nepal**

- Promoting breast feeding (establishment of breastfeeding corner in some public and private institutions)

**Bangladesh**

- Task force on Tobacco control run by PPP (to implement Tobacco Control Act, Resource sharing etc.) Government includes Civil Society Organizations,
Academia, and other relevant stakeholders excluding industries to avoid the conflict of interest for the drafting of tobacco control act

- BHNPH (Bangladesh Health and Nutrition Project): works on health, nutrition, breast feeding, hand washing, air pollution etc.
- Government and representative of WHO, CSO and representatives of Oil Industries and Academia personnel jointly worked as a Committee to introduce the Trans-fat Control Regulation 2021.

<table>
<thead>
<tr>
<th>Country</th>
<th>Partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhutan</td>
<td>Regulatory Agencies</td>
</tr>
<tr>
<td></td>
<td>o BAFDA - enforcing health-related regulations - work with food manufacturers to improve labeling and reduce unhealthy ingredients</td>
</tr>
<tr>
<td></td>
<td>Public Health NGOs</td>
</tr>
<tr>
<td></td>
<td>o Engage in projects related to tobacco control, alcohol harm reduction, and promoting healthy diets</td>
</tr>
<tr>
<td></td>
<td>Multi-Stakeholder Partnerships</td>
</tr>
<tr>
<td></td>
<td>o Collaborative efforts involving governments, the private sector, civil society, and international organizations</td>
</tr>
<tr>
<td></td>
<td>Social Responsibility Initiatives</td>
</tr>
<tr>
<td></td>
<td>o Engage in CSR programs aimed at improving public health</td>
</tr>
<tr>
<td>Timor Leste</td>
<td>Chamber of Commerce</td>
</tr>
<tr>
<td></td>
<td>Owner of Alcohol Manufacture</td>
</tr>
<tr>
<td></td>
<td>Civil Societies</td>
</tr>
<tr>
<td></td>
<td>UN Agencies cooperation</td>
</tr>
<tr>
<td></td>
<td>Consumer Protection Organization</td>
</tr>
<tr>
<td>Maldives</td>
<td>There is a need to strengthen the governance and coordination within the public and private sector, through a proper mechanism which includes dialogues, engagements, buy-in and partnerships with a broader view to address the issues of CDoH</td>
</tr>
<tr>
<td></td>
<td>Identify and emphasize the role that each party must play in addressing the CDoH</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Indonesia currently does not have official public private partnership platform to address CDH. However, MOH has MOUs with private sectors to support health promotion.</td>
</tr>
<tr>
<td>Thailand</td>
<td>Nontax measures on sugar sweetened beverages (DoH vs Thai beverage industry association, large coffee chains)</td>
</tr>
<tr>
<td></td>
<td>Healthier choice logo (Thai FDA &amp; Institute of Nutrition vs food industries)</td>
</tr>
<tr>
<td></td>
<td>Thailand Consumer Council (autonomous organization to work with government organizations)</td>
</tr>
<tr>
<td></td>
<td>PRS social enterprise (platform that supplies healthy food to hospitals)</td>
</tr>
<tr>
<td>Myanmar</td>
<td>PPP – telecommunication, electricity, infra-structure and extraction projects</td>
</tr>
<tr>
<td></td>
<td>Coordinated by Directorate of Investment and Company Administration (DICA)</td>
</tr>
<tr>
<td></td>
<td>Managed by the line ministries</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Fortification –Salt, Wheat</td>
</tr>
<tr>
<td></td>
<td>Emergency Ambulance Service -1990</td>
</tr>
<tr>
<td><strong>NCD Steering Committee</strong></td>
<td><strong>Multi-sectoral Action Plan for Prevention &amp; Control of NCD 2022-2027</strong></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

### 5. Public health approach to CDH

#### Nepal

- **What would be key actions from government?**
  - Accelerate WHO FCTC
  - Develop and implement trans-fat regulation
  - Increase health literacy
  - Mitigate conflict of interest by industries to implement act, regulation
  - Implement MSAP 2021-2025 and related policies of line ministries

- **What coordination mechanism MOH must leverage with economic sector?**
  - Coordination with Federation of Nepalese Chambers of Commerce and Industry (FNCCI), Hotel association of Nepal (HAN), chamber of commerce, Media

- **What does the public health profession need to tackle CDH in your country?**
  - Awareness, inclusion in curriculum, advocacy, capacity enhancement, being role model, research

#### Bangladesh

- **What would be key actions from government?**
  - Strengthening the existing Multi-sectoral Action Plan 2018-25
  - Coordinate with various MSAP for example NCD and Nutrition
  - Increase the allocation of budget in the Health Sector
  - Address different Social Determinants
  - Include preventive actions under the purview of the Health Administration

- **What coordination mechanism MOH must leverage with economic sector?**
  - To strengthen the tie among different Ministries or divisions including MOC, MOA, MOF etc.

- **What does the public health profession need to tackle CDH in your country?**
  - To generate evidence through research and to support government in policy intervention

#### Bhutan

- Develop and enforce regulations to restrict marketing
- Implement public health campaigns to educate the public about the risks associated with CDH
- Collaborate with relevant government sectors (e.g., trade, finance, agriculture) to ensure health considerations are integrated into economic and trade policies
- Collect and analyze data related to CDH to monitor the impact of regulatory measures, market changes, and public health outcomes
- Collaborate with businesses and industry associations to implement voluntary agreements or initiatives that promote public health goals

#### Timor Leste

- Establishment of Multisectoral Approach
<table>
<thead>
<tr>
<th>Country</th>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maldives</td>
<td>Government</td>
</tr>
</tbody>
</table>
|         | • Identify the CDoH specific to the country.  
|         | • Develop multisectoral action plan at national and subnational level, through legislations and regulations to address conflict of interest of all stakeholders and provide a platform for all parties to address their concerns and grievances.  
|         | • Strengthen regulatory mechanisms to identify CDoH to reduce the impacts on public health.  
|         | • Closer coordination between MOH and Economic Ministry and the Economic sectors to address issues related to CDoH.  
|         | • Conduct health impact assessments, prior to licensing business or commercial activity.  
|         | • Develop fact and evidence-based policies.  
|         | • Strengthen polluters pay principle, to reduce health harming practices.  
|         | • Invest in health literacy of both public and private sector.  

<table>
<thead>
<tr>
<th>Public Health Professionals</th>
</tr>
</thead>
</table>
| • Create awareness among related sectors, and to have an in-depth understanding of the intricacies and complexity of CDoH.  
| • Obtain adequate funding and budget to address issues related to CDoH.  
| • Develop a platform for wider engagement of stakeholders, in order to address issues.  
| • Creating participatory forums and promoting the engagement of public and civil society. |

| Indonesia | • Develop, implement and enforce policies and regulations that address CDH:  
|           | ⇒ Marketing restrictions on tobacco, SSBs, and unhealthy food  
|           | ⇒ Impose excise tax on SSBs  
|           | ⇒ Introduce subsidies on healthy food  
|           | • Establish formal inter-Ministerial task force (MOH, and various economic Ministries, such as agriculture, trade, and industry) under the President to align economic policies with public health goals.  
|           | • Collect and analyze data on the impact of CDH on public health, including monitoring the consumption of harmful products, health outcomes, and health inequalities. |
- Implement effective public campaigns to raise awareness of the population on the risks associated with CDH
- Establish a monitoring and evaluation system to assess the effectiveness of policies and interventions addressing CDH

**Thailand**

**Government**

- **Existing Key Actions**
  - Fiscal policy
  - Marketing control (tobacco & alcohol & infant formula)
  - Zoning (smoking & alcohol)
  - Labelling and warnings
  - Campaigns

- **Recommendations**
  - Robust monitoring and evaluation
  - Health impact assessment of CDH
  - International and national online marketing control
  - Transparent and participatory governance (to address COI and monopoly capital)
  - Polluter pay implementation

- **What coordination mechanism MOH must leverage with economic sector?**
  - Standard, guideline, and quality certify to promote (e.g., health for wealth and safety tourism policy)

- **What does the public health profession need to tackle CDH in your country?**
  - Health Communication
  - Counselling
  - Watch dog skills
  - Advocate
  - Negotiation
  - Diplomatic communication

**Myanmar**

- Awareness raising to the public
- Advocacy to the professional bodies and government agencies
- Coordination with the private sector and chamber of commerce

**Sri Lanka**

- Advocate the relevant authorities to improve resources for lifestyle modifications. For example, Recreational and physical activity facilities (open space walking paths, yoga/mindfulness facilities etc.)
- Educational reforms – curricula, exams
- Health promotion including self-care and ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness
### 6. Country action points in 2024-2025

<table>
<thead>
<tr>
<th>Country</th>
<th>2024</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nepal</td>
<td>• Convene stakeholder meeting to discuss CDH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Develop trans-fat regulation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Enforcement of tobacco control and regulation act 2068, and alcohol act and regulation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Regulation of private health institution to provide scientific, evidence-based service</td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>• Strengthening the existing Multispectral Action Plan 2018-25 to address NCD related CDH</td>
<td>• Implement the health development surcharge policy for NCD control</td>
</tr>
<tr>
<td></td>
<td>• To strengthen package ingredient list and to introduce front of pack labeling</td>
<td>• Implement the Trans Fat Regulation 2021</td>
</tr>
<tr>
<td></td>
<td>• To impose excise tax on SSB</td>
<td>• Implement the Road Safety Act</td>
</tr>
<tr>
<td></td>
<td>• To generate evidence through research</td>
<td>• Implement the Air Pollution Regulation 2022</td>
</tr>
<tr>
<td></td>
<td>• Implement the health development surcharge policy for NCD control</td>
<td>• 360-degree awareness campaign on NCD and other risk factors</td>
</tr>
<tr>
<td>Bhutan</td>
<td>• Develop and implement high impact actions to reduce the effects of Alcohol, tobacco and unhealthy foods - 13 FYP and MSAP II</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Strengthen regulations on tobacco and alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Promote healthy eating habits through public education campaigns</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Engage with relevant sectors to address CDH</td>
<td></td>
</tr>
<tr>
<td>Timor Leste</td>
<td>• Review and develop multisectoral action plan for non-communicable diseases strategies and action plan</td>
<td>• Establishing Laboratory regulation</td>
</tr>
<tr>
<td></td>
<td>• Accelerate for finalizing alcohol control bill and policy implementation</td>
<td>• Review Mental Health Strategic and Action Plan including Standard treatment guideline</td>
</tr>
<tr>
<td></td>
<td>• Capacity Building for multisectoral focal points</td>
<td>• Strengthening school health</td>
</tr>
<tr>
<td></td>
<td>• Strengthening the health system for prevention and control NCDs, Mental Health and CDCs</td>
<td></td>
</tr>
<tr>
<td>Maldives</td>
<td>• Develop action plan on CDoH (based on research and evidence/ statistics).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A proper budget to implement the action plan.</td>
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<tr>
<td></td>
<td>• Seek assistance from donor community to implement the action plan.</td>
<td></td>
</tr>
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<td></td>
<td>• Implement a monitoring and evaluation mechanism.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Establish inter-ministerial coordination committee at a high level and include civil society and the public.</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>2024</td>
<td>2025:</td>
</tr>
<tr>
<td></td>
<td>• Convene inter-Ministerial consultative meeting on CDH</td>
<td>• Implement and enforce relevant regulations on marketing restrictions,</td>
</tr>
<tr>
<td></td>
<td>• Conduct capacity building on CDH to multi-sector</td>
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</tr>
<tr>
<td></td>
<td>• Conduct in-country scoping study on the impact of CDH to health</td>
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</tr>
<tr>
<td></td>
<td>• Enact relevant regulations on marketing restrictions, excise taxation, etc.</td>
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</tr>
<tr>
<td>Country</td>
<td>Actions</td>
<td></td>
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<tr>
<td>---------</td>
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<tr>
<td><strong>excise taxation, etc.</strong></td>
<td>• Implement effective public campaigns to raise awareness of the population on the risks associated with CDH</td>
<td></td>
</tr>
<tr>
<td><strong>Thailand</strong></td>
<td>• Marketing restriction of food and beverages affecting child health Act (DoH and stakeholders) • National Health Assembly resolution on public participatory policy to address CDH (NHCO and stakeholders)</td>
<td></td>
</tr>
<tr>
<td><strong>Myanmar</strong></td>
<td>• TBD</td>
<td></td>
</tr>
<tr>
<td><strong>Sri Lanka</strong></td>
<td>• Pricing formula – tobacco and alcohol • Gap analysis of existing laws /regulations • Implementation of law enforcement E.g., RTA related, Advertisements (all media platforms) • Preparation of policy, guidelines, and plan for Healthy Cities/villages • Establishment of recreational facilities at local level • Establish Policy for Green Economy - Reduction of emission by 14.5% - Usage of renewable energy by 70%</td>
<td></td>
</tr>
<tr>
<td><strong>Nepal</strong></td>
<td>• Convene stakeholder meeting to discuss CDH • Develop trans-fat regulation • Enforcement of tobacco control and regulation act 2068, and alcohol act and regulation • Regulation of private health institution to provide scientific, evidence-based service</td>
<td></td>
</tr>
<tr>
<td><strong>Bangladesh</strong></td>
<td>• To support in evidence generation in terms of identifying CDH and country action plan to address CDH • To develop monitoring and evaluation indicators and criteria • To provide technical support in strengthening Multisectoral Action Plan 2018-25 to address the CDH • To organize advocacy meeting inviting policy makers i.e., member of parliaments and/or senior government officials and from various ministry like MOHFW, MOF, MOC, MOE, MOA, MOI etc. from each country under WHO SEAR • To provide support in capacity building of officials from various ministries, CSO in addressing CDH • To provide support in implementation of health development surcharge policy for NCD control, the Trans Fat Regulation 2021, the Road Safety Act, the Air Pollution Regulation 2022 and other relevant acts and regulations to be introduced • To support in developing and implementing global best practices • To develop case study report incorporating best practices to address CDH across the world</td>
<td></td>
</tr>
<tr>
<td><strong>Bhutan</strong></td>
<td>• Develop global frameworks, guidelines, and conventions that address CDH, similar to the FCTC</td>
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</table>

**7. Recommendations for WHO**
Session IV: Regional mechanisms responding to commercial determinants of health

1. Dr Shamim Hayder Talukder, SEAR NCD Alliance

Civil society can significantly influence the development of countries, especially those vulnerable to Non-Communicable Diseases (NCDs). Reflecting on the progress of the Millennium Development Goals (MDGs) over the past decade and the Sustainable Development Goals (SDGs) in the South-East Asia Region (SEAR) reveals
important lessons, including the existing gaps. Commercial Determinants of Health (CDH) affect people's health, economic policy models, and their rights. An approach to tackling NCDs involves establishing public-private partnerships with governance and adopting a public health perspective. The NCD Alliance has issued a report on the impact of CDH on children's health.

Within the health system, key components encompass communicable diseases, NCDs, maternal and child health, adolescent health, geriatric health, and family planning. It extends to other areas such as media, commerce, politics, governance, and climate change. Human security, including arms, digital security, and various perspectives, is another crucial aspect. Organizations should raise awareness about the harm caused by CDH. The NCD Alliance is well-informed about the sector's practices and collaborates with organizations such as WHO, The Union, PMNCH, and many Civil Society Organizations (CSOs). Their focus is less on identifying gaps, legal issues, or competition within the system.

Analyzing foreign investments in SEAR requires a macroeconomic perspective. For example, the economic development in Bangladesh is influenced by microeconomic perspectives, leading to substantial commercial investments. It is also vital to consider pollution, environmental damage, and climate change. Civil society plays a significant role in monitoring public-private partnerships that lack ethical and human health perspectives. CSOs contribute to policy analysis, research, innovation, and model development. They also advocate for multi-stakeholder actions related to CDH. Establishing a regional and global knowledge hub on CDH is essential for sharing knowledge and taking actionable steps. Furthermore, it's crucial to raise voices and collaborate with governments to negotiate with the private sector and international business communities.

2. Dr Yuka Ujita, ILO

To act upon the solutions derived from this meeting regarding Commercial Determinants of Health (CDH), the allocation of resources is critical. It is imperative to have the necessary human resources, financial backing, and logistics in place. Dr. Yuka provided insights into harnessing existing resources.

Firstly, it entails strengthening the coordination and collaboration between health and labor sectors. It is essential to acknowledge not only health but also the roles of industry, labor, commerce, and business. The International Labor Organization (ILO) convention specifies international labor standards, including conventions on occupational safety and health (OSH). This convention mandates all member states to establish coordination mechanisms for health and safety at the workplace. The Ministry of Health and other stakeholders in the field of health and occupational health play pivotal roles. The ILO tripartite advisory body at the national level serves as one of the mechanisms to address labor issues in the workplace.
The next critical convention is the Promotional Framework Convention, aimed at developing a framework for health and safety in workplaces. All member states are obligated to establish national OSH awareness programs, which many countries have already implemented. For instance, Thailand is currently working on its second and third national OSH programs. While the framework is already in place, it is crucial to incorporate CoH components into it to create joint programs for health and safety. Another example is the joint order developed by the Philippines Department of Health, Department of Labor, and the Civil Service Commission, addressing the national policy framework for the promotion of healthy workplaces. This initiative encompasses various aspects, including food, beverages, exercise, environmental factors, air pollution, COVID-19, mental health, and tackling issues of violence and harassment.
Approximately 15 years ago, ILO collaborated with the Ministry of Public Health in Thailand to implement an integrated approach to public health and occupational health services. Public health practitioners were engaged and trained in occupational health services to collaborate at the village level. Additionally, the ASEAN OSHNET, a government network with a strong focus on occupational safety, fosters extensive connections, conducts various activities, offers policy support, and provides training.

3. Dr Thaksaphon (Mek) Thamarangsi, WHO SEARO

It is crucial to address the roles of the public sector, private sector, and the people. The government listens to the people, and the private sector adheres to government policies. Meanwhile, people's behaviors are influenced by market availability. Therefore, considering Commercial Determinants of Health (CDH) becomes essential, especially when the private sector gains influence over the government and the people.

CDH should be integrated as an approach to health and well-being. It is a concept that every committee, particularly multi-stakeholder committees and coordination platforms, should always bear in mind, much like the consideration of conflicts of interest in their practices.

CDH should be tailored to suit the needs of the people rather than the context alone. The businesses involved in alcohol, tobacco, and fossil fuels are particularly impactful on public health. In the South-East Asia Region (SEAR), where 70% of healthcare transactions occur in the private sector, CDH significantly affects the health of the population. The behavior and practices of the private sector cannot be disregarded as they directly impact our lives and well-being. Reassessing the power dynamics among the state, market, and community is also crucial. Communities often lack a strong voice naturally, so it is essential to have Civil Society Organizations (CSOs) in place to ensure the voices of the community are heard.
In the era of trade liberalization and digitalization, people cherish their freedom, can express themselves through various means, and essentially become media outlets themselves. They have three options: amplify a message, distort it, or remain silent. Promoting sustainable development is a strategy that benefits everyone and encourages policy coherence. For organizations like the World Health Organization (WHO) and other intergovernmental agencies, the government acts as the gatekeeper. Therefore, policies, advocacy, and raising awareness are crucial for addressing CDH. This also involves monitoring the situation, assessing behaviors, and ensuring accountability. An accountability framework helps guide individuals to do the right thing at the right time. Key core areas of WHO include advocacy, monitoring, and strengthening organizational capacity. It is essential to identify the essential and effective treatments and services needed, while also considering the technological aspects of treatment, rather than just focusing on prevention and promoting the health and well-being of the population.

**Session V: Regional perspectives on commercial determinants of health: Compilation and Synthesis of Country Presentations**

<table>
<thead>
<tr>
<th>Compilation and Synthesis of Country Presentations</th>
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<tbody>
<tr>
<td><strong>Top 3-5 CDH to be critically concerns in the next 5 years.</strong></td>
</tr>
<tr>
<td><strong>Commercially Determined Health Outcomes and Inequities</strong></td>
</tr>
<tr>
<td>• NCDs (including liver disease, diabetes)</td>
</tr>
<tr>
<td>• Mental health</td>
</tr>
<tr>
<td>• Injuries and trauma</td>
</tr>
<tr>
<td>• Private Healthcare Services/cost and access disparities (including for pharmaceuticals)</td>
</tr>
<tr>
<td><strong>Commercially Determined Risk Factors</strong></td>
</tr>
<tr>
<td>• Tobacco, SSBS, ultra-processed foods/obesity, alcohol, drug use,</td>
</tr>
</tbody>
</table>
cannabis
• Physical inactivity and other social changes
• Climate change and its effects- Air pollution (e.g., factories, agricultural burning, transportation)
• Sound pollution
• Agricultural chemicals
• OTT, social media, digital platforms
• Antibiotics in agriculture, livestock, fisheries
• Reliance on motorized transport (inactivity)
• Road traffic accidents

Subpopulations: Young people

Commercial practices
• Aggressive marketing (including advertising, online and offline advertising, influence over choice and behaviour, promotion)
• Market entry of unhealthy products
• Product design (transfat, sugar content, sweetening)
• Cross-border online sales and promotions
• Promotion of unnecessary products and services
• Illicit alcohol production and sale
• Lobbying

Regulatory context
• Insufficient regulation, gaps in regulation
• Weak monitoring

Economic context
• Expanding international trade and investment from commercial actors, products, services
• Reliance on private health markets and medical tourism (inbound and outbound)

<table>
<thead>
<tr>
<th>Commercial Drivers/Actors that have Direct Impacts on People’s Health</th>
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</thead>
<tbody>
<tr>
<td>Public sector actors: Legislatures and executive agencies</td>
</tr>
</tbody>
</table>

Civil society

Commercial actors
• Tobacco and nicotine industry: the core industry, its affiliates, retailers with a corner for its cross-border trade and marketing and promotion—particularly novel tobacco and nicotine products
• Alcohol industry: the core industry of manufacturers, distilleries, brewers as well as retailers (bars, liquor stores) with a concern for increasing availability
• Food and Beverage Industry: processed, unhealthy food and SSB manufacturers and promoters both local and international with a concern for expansion of fast-food restaurants and
• Pharmaceutical industry both local and multinational
• Healthcare businesses including providers and clinics
• Media and Marketing Firms: traditional and digital advertising, online
platforms, social media providers, with a concern for targeted and creative advertising and marketing that circumvents regulation
  • Technology and Social Media business with a concern for the adverse impact of social media use—particularly for vulnerable populations
  • Palm Oil Industry and Agriculture Industry and with a concern for irresponsible activities including exploitation of monopoly over contract farming
  • Fiber glass industry
  • Retailers particularly retailers of unhealthy products and large retailers exploiting market monopolies
  • Influencers and professionals used by or endorsed by industries

<table>
<thead>
<tr>
<th>Types of Actors</th>
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</thead>
<tbody>
<tr>
<td>Local businesses</td>
</tr>
<tr>
<td>Multinational and transnational businesses</td>
</tr>
</tbody>
</table>

### Practices
- Joint investments in harmful products
- Exploiting market monopolies
- Irresponsible practices across industry, commerce, and agriculture
- Practices targeted at conflict of interest and governance
- Exploiting legal loopholes and evading enforcement
- Exploiting import dependency
- Irresponsible cross-border practices

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Existing Economic Models/Systems that may Reduce or Undermine Health for All

<table>
<thead>
<tr>
<th>Existing Economic Models/Systems that may Reduce or Undermine Health for All</th>
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<tbody>
<tr>
<td><strong>Existing</strong>: Prioritization of economy over health</td>
</tr>
<tr>
<td>• Emphasis of narrow economy growth and investment concerns over health concerns</td>
</tr>
<tr>
<td>• Overreliance on narrow measures, such as GDP and economic growth, drive prioritization over health</td>
</tr>
<tr>
<td><strong>Existing</strong>: Trade liberalization and free trade agreements</td>
</tr>
<tr>
<td>• Facilitate the cross-border spread of unhealthy products and practices</td>
</tr>
<tr>
<td>• Can undermine the ability to regulate and control in favour of improved commercial determinants of health</td>
</tr>
<tr>
<td>• The need to balance economic benefits and health costs</td>
</tr>
<tr>
<td>• Special economic zones can lead to job insecurity and stress</td>
</tr>
<tr>
<td>• Low trade barriers can mean low-quality, ultra-processed and unhealthy products particularly given limited regulatory scope and capacity</td>
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</table>

**Existing**: Regulatory and policy concerns
- Concern around illicit trade, the difficulty to control and inspect, and impact on pricing and availability of harmful products
- Concern around the impact of economic controls and currency fluctuations on essential drug pricing
- Regulatory gaps for harmful industries

**Existing**: Harmful commercial practices
- A rising tide of unhealthy production and importation of harmful products
• Harmful monopolistic practices in food systems with impacts both on consumption and environment (e.g., contract farming)

**Needed:** Greater recognition of the link between economic growth and health
• Economic growth can be reliant on health and sustainability as with tourism and the need for a pristine environment

**Needed:** Circular economies
• To reduce waste, promote healthier food and address environmental concerns
• Creating green economies and green procurement

<table>
<thead>
<tr>
<th>Public Health Approach to CDH</th>
<th>Governance</th>
</tr>
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<tbody>
<tr>
<td>• Multisectoral approaches under high-level leadership and through institutionalized multisectoral institutions to ensure coherence that aligns economic policy with public health goals</td>
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<tr>
<td>• Ensure incorporation of health considerations in economic and trade policies</td>
<td></td>
</tr>
<tr>
<td>• Address and mitigate conflict of interest in the design and implementation of legislation and regulations on harmful products and practices</td>
<td></td>
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<tr>
<td>• Transparent and participatory governance</td>
<td></td>
</tr>
<tr>
<td>• Build public sector and public health capacity including funding</td>
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</tbody>
</table>

**Addressing Harmful products and practices**
• Introduce and implement the Principle of Polluters pay
• Implement health impact assessments prior to licensing commercial activities
• Regulation of product composition
• Marketing restrictions on harmful products – including cross-border and online
• Excise taxes on harmful products
• Regulate the use and sale of harmful products
• Introducing labelling and warnings
• Increasing health literacy
• Raise awareness through public health campaigns

**Promote Healthy products and practices**
• Subsidies for healthy products and practices with access to public

**Need for measurement and monitoring CDH**
• Of market changes
• Of risk factor exposure
• Of health outcomes
• Of health inequities
• To determine the effectiveness of policies and interventions for addressing commercial determinants
<table>
<thead>
<tr>
<th>Civil society</th>
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</thead>
<tbody>
<tr>
<td>• Supporting and establishing local organizations for advocacy against harmful products and practices</td>
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</table>

**Collaboration and coordination with commercial actors**

<table>
<thead>
<tr>
<th>Collaboration and coordination with commercial actors</th>
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<tbody>
<tr>
<td>• Collaboration and coordination with businesses and industry associations on voluntary agreements</td>
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<tr>
<td>• Coordinate with media to control commercial determinants</td>
</tr>
</tbody>
</table>

**Country Action Points in 2024-2025**

<table>
<thead>
<tr>
<th>Governance</th>
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<tbody>
<tr>
<td>• Convene for multisectoral coordination on commercial determinants</td>
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<tr>
<td>• Create action plans for multisectoral approach on commercial determinants</td>
</tr>
<tr>
<td>• Develop commercial determinants action plan and properly fund it in budget and with assistance of donors</td>
</tr>
<tr>
<td>• Review existing vertical public health plans to incorporate commercial determinants focus</td>
</tr>
<tr>
<td>• Establish public participatory approaches to commercial determinants</td>
</tr>
<tr>
<td>• Build capacity for multisectoral action on commercial determinants</td>
</tr>
<tr>
<td>• Include a focus on the subnational and addressing the commercial determinants with the healthy cities agenda</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research and scoping</th>
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<tbody>
<tr>
<td>• Research and scoping on commercial determinants</td>
</tr>
<tr>
<td>• Implement a monitoring and evaluation mechanism</td>
</tr>
<tr>
<td>• Analyze gaps in existing laws and regulations</td>
</tr>
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<table>
<thead>
<tr>
<th>Enact measures</th>
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<tbody>
<tr>
<td>• For a Green Economy with reductions in emissions and increasing in renewable energy share</td>
</tr>
<tr>
<td>• For marketing restrictions and excise taxation on unhealthy commercial products, for regulation of product composition, for labelling and packaging</td>
</tr>
<tr>
<td>• Enforcement of existing regulations</td>
</tr>
<tr>
<td>• Focus on vulnerable populations such as youth</td>
</tr>
<tr>
<td>• Implement programmes in settings such as schools</td>
</tr>
<tr>
<td>• Public health campaigns on unhealthy products and practices</td>
</tr>
<tr>
<td>• Require private health institutions to provide evidence-based services</td>
</tr>
<tr>
<td>• Focus on NCDs, tobacco, foods, beverages, trans-fat, road safety, air pollution, climate</td>
</tr>
</tbody>
</table>

**Session VI: Recommendations for WHO**

1. **Focus on particular settings**
   - Across the region
   - Develop specific approaches and focus on fragile and conflict-affected settings
Ensure a special focus on island economies where the negative impact of commercial determinants may be more severe due to specific vulnerabilities based on geographic situation, economic conditions, import dependency and environmental factors.

2. Governance and normative support
   - Develop and disseminate Global Report and regular updates from CDH work to be shared with member states
   - Develop guidance on global best practices for addressing commercial determinants in the region
   - Develop monitoring and surveillance systems for tracking activities and interventions of CDH
   - Develop guidelines and indicators for monitoring the impact of commercial determinants on Health and Industry Interference

3. Capacity Support
   - Help convene policymakers across government to build support for multisectoral action on commercial determinants and its prioritization
   - Provide capacity building on commercial determinants across government and civil society
   - Financial support for country action on CDH

4. Research and Scoping
   - Support research on CDH nationally, regionally and globally
   - Support country action plan development and regular regional and country level report
   - Provide evidence generation on commercial determinants
   - Support country-specific scoping studies
   - Study the impact of CDH and its investments on stakeholder perspectives and consumer behaviours

5. Technical Support
   - On the introduction of legally binding mechanisms
   - Provide support in implementing multisectoral approaches on commercial determinants
   - Support implementation of regulations on unhealthy products and practices (e.g., Ultra Processed Food Industry, Alcohol Industry, Pollution causing Industry and Practices etc.)

6. International Cooperation
   - Collaborate with other UN agencies and intergovernmental actors on addressing the commercial determinants, including exploring a ONE UN approach
   - Specific collaboration on the trade agenda with WTO and other multilateral areas to ensure that trade agreements provide room for addressing commercial determinants and prioritizing health
   - Help develop frameworks for addressing commercial determinants similar to the WHO FCTC on addressing across border promotions of CDH (e.g. Online promotions and marketing, social media promotions, streaming platforms etc.)
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## Annex 2: Programme

**Day 1: Introduction of the CDH concept and impacts on health**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topics</th>
<th>Key facilitator</th>
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</thead>
<tbody>
<tr>
<td>8.30-8.45</td>
<td>Registration</td>
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<tr>
<td>8.45-9.30</td>
<td><strong>Inauguration session</strong></td>
<td>Suvajee Good</td>
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<tr>
<td></td>
<td>- Introduction of meeting objectives</td>
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<td>- WR read RD’s message</td>
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<td></td>
<td>- Introduction of participants</td>
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<td>- Meeting protocol</td>
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<tr>
<td>9.30-10.00</td>
<td><strong>Introduction of WHO’s approach toward the Commercial Determinants of Health (CDH)</strong></td>
<td>Dr Monika Kosinska, WHO-HQ</td>
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<tr>
<td>10.00-10.15</td>
<td><strong>Group photo &amp; healthy break</strong></td>
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<tr>
<td>10.15-11.15</td>
<td><strong>Regional overview of brief scoping of CDH</strong></td>
<td>Moderate by Dr Suvajee Good</td>
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<td></td>
<td>- Overall finding of CDH in SEAR by Dr Monika Arora</td>
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<td></td>
<td>- Regional concerns on free trade agreement, patents, regulation affecting health system, Dr Manisha Shridhar</td>
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<td></td>
<td>- Regional perspectives on unhealthy food and beverages, Dr Angela de Silva</td>
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<td></td>
<td>- ILO approach to workers’ health and responsible business, Dr Yuka Ujita (OSH-ILO)</td>
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<td></td>
<td>Reflection from Participants</td>
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<tr>
<td>11.15-12.30</td>
<td><strong>Country experiences on main commercial determinants of health on people’s health</strong> (focus on NCD risk factors e.g. tobacco control, substance abused and alcohol consumptions, unhealthy food and beverages, or air pollution etc.) Three country’s presentations</td>
<td>Facilitate by Dr Angela De Silva</td>
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<td></td>
<td>- <strong>Thailand experience CDH affecting NCD risk factors</strong></td>
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<td></td>
<td>by Dr Pairoj Saonaum, Thai Health Promotion Foundation (10 minutes)</td>
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<td>- <strong>Indonesia experience:</strong> Dr Prihandriyo Sri Hijranti M. Epid., Project Manager Officer (PMO) Directorate Geral of Disease Prevention and Control, Ministry of Health</td>
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<td></td>
<td>- <strong>Nepal experience:</strong> Ms. Hira Kumari Niraula, Director, Nursing and Social Security Division, Department of Health Services, MOHP.</td>
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<td><strong>Followed by 3 panel discussion</strong> from selected countries</td>
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<td></td>
<td>(Bangladesh-, Bhutan- Mr Laigden, Timor Leste)</td>
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<tr>
<td>Time</td>
<td>Topics</td>
<td>Key facilitator</td>
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<tr>
<td>12.30-13.30</td>
<td><strong>Lunch Break</strong></td>
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</tbody>
</table>
| 13.30-14.30  | **Country experiences on key CDH on health care services and health service deliveries** (e.g. infant formulas, medical devices, vaccines, pharmaceutical products, telecommunication & digital health, transportation system, etc.)  
- Thailand experience’s on CDH in health care services and service deliveries, Ms. Suladda Pongutta, IHPP, Thailand.  
- Maldives experiences on health system services: Ms. Maimoona Aboobakur, DG of Public Health, MOH.  
Followed by panel discussion from selected countries:  
(Bangladesh – Dr Islam, Indonesia – Dr Mulasih, Sri Lanka – Dr Asela) | Moderate by Dr Manisha Shridhar |
| 14.30-15.15  | **Country experiences on economic gains / lost from commercial products and activities**  
- Roles of **ministry of finance or commerce** in controlling price (negotiation on drug pricing), quality of products, and using taxation mechanisms (e.g. tobacco controls)  
- **Food and drug administration** and market system for healthier choices  
- **Consumers protection system**  
- Discussion | Moderate by Dr Monika Kosinska |
| 15.15-15.45  | **Healthy break**                                                      |                                                     |
| 15.45-16.30  | **South-East Asia Countries perspective on “Economic of Well-being and wellness products”**  
- Wellness initiatives across countries  
- Medical tourisms  
- Coherence of economic polices for health and well-being?  
- Who win-loose or win-win?  
- What could be a best-buy economic of well-being? | Moderate by Dr Suvajee Good |
| 16.30-17.00  | **Key take away messages**                                             | Participants                                         |

**Day 2: Economic of Wellbeing and Equity**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topics</th>
<th>Key facilitator</th>
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</thead>
<tbody>
<tr>
<td>8.30-9.00</td>
<td><strong>Recap</strong></td>
<td>Participants</td>
</tr>
<tr>
<td>9.00-9.45</td>
<td><strong>Global report on commercial determinants of health: key messages and inputs to be discussed by participants</strong></td>
<td>WHO-HQ</td>
</tr>
<tr>
<td>9.45-11.00</td>
<td><strong>Brainstorm Session1: People Experience of CDH throughout the life-course:</strong></td>
<td>Moderate by Dr Monika Arora</td>
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<tr>
<td>Time</td>
<td>Topics</td>
<td>Key facilitator</td>
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<tr>
<td>11.00-11.15</td>
<td><strong>Healthy break</strong></td>
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<tr>
<td>11.15-11.40</td>
<td><strong>Equity lens on commercial determinants of health:</strong> 3 Presentations (7 minutes each)</td>
<td>Moderate by Suvajee Good</td>
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<tr>
<td></td>
<td>• Consumer protection by Dr Vinya Ariyaratne, Savodaya, Sri Lanka</td>
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<td></td>
<td>• Community voices by Professor Sharad Onta, Nepal Public Health Foundation</td>
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<td></td>
<td>• Collaborative approach for better health by Dr Than Sien, People’s Health Association of Myanmar</td>
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<tr>
<td>11.40-12.30</td>
<td><strong>Brainstorm session 2: Equity Lens on CDH across life-course</strong></td>
<td>Facilitators for each café table.</td>
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<tr>
<td></td>
<td>• How and when can people take control over their health and wellbeing in each cohort?</td>
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<td></td>
<td>• Can digital technology be a solution? How and when does innovation deliver health equity?</td>
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<td>• How People’s literacy plays roles? (Health literacy, media literacy, digital literacy, financial literacy, etc.)</td>
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<tr>
<td>12.30-13.30</td>
<td><strong>Lunch</strong></td>
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<tr>
<td>13.30-14.15</td>
<td>Presentations of 5 café’s brainstorm sessions (7 minutes per group)</td>
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<tr>
<td>14.15-15.30</td>
<td><strong>Understanding commercial determinants of health from South-East Asia Perspectives</strong></td>
<td>Each country discusses in the table</td>
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<tr>
<td></td>
<td>• Commercial actors/drivers and their direct impacts on health</td>
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<td></td>
<td>• Economic policies/models/systems that reduce or undermining health for all and rights to health</td>
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<td></td>
<td>• Public-Private Partnership and governance</td>
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<td></td>
<td>• Public health approach to commercial determinants</td>
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<tr>
<td>15.30-16.00</td>
<td><strong>Healthy break</strong></td>
<td></td>
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<tr>
<td>16.00-16.30</td>
<td>Continue country discussion on country’s action points to raise awareness of commercial determinants of health for policy makers, public, and recommendations for WHO</td>
<td>Countries</td>
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<tr>
<td>Time</td>
<td>Topics</td>
<td>Key facilitator</td>
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<tr>
<td>16.30-17.00</td>
<td>Country presentations’ preparation, submit by 18.00 hr. to Dr Suvajee Good and copy Shalini Khattar</td>
<td>Countries</td>
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</tbody>
</table>

**Day 3: Regional position on commercial determinants of health**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topics</th>
<th>Key facilitator</th>
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</thead>
<tbody>
<tr>
<td>9.00-9.30</td>
<td>Recap</td>
<td>WHO focal points</td>
</tr>
<tr>
<td>9.30-10.30</td>
<td>Country presentations on understanding of burden, sectors, activities, and systems for the CDH and action points: <strong>Bangladesh, Bhutan, Nepal</strong></td>
<td>Country present 10-12 minutes per country</td>
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<td></td>
<td>Follow by inputs from experts</td>
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<tr>
<td>10.00-11.00</td>
<td>Country presentation on understanding of burden, sectors, activities, and systems for the CDH and action points: <strong>Indonesia, Maldives, Timor Leste</strong></td>
<td>Country present 10-12 minutes per country</td>
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<td></td>
<td>Follow by inputs from experts</td>
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<tr>
<td>11.00-11.15</td>
<td><strong>Healthy break</strong></td>
<td></td>
</tr>
<tr>
<td>11.15-12.15</td>
<td>Country presentation on understanding of burden, sectors, activities, and systems for the CDH and action points: <strong>Sri Lanka, Thailand, Myanmar</strong></td>
<td>Country present 10-12 minutes per country</td>
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<td></td>
<td>Follow by inputs from experts</td>
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<tr>
<td>12.00-13.00</td>
<td><strong>Lunch Break</strong></td>
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<tr>
<td>13.00-14.00</td>
<td><strong>Regional mechanisms responding to commercial determinants of health</strong></td>
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<td>- FAO</td>
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<td>- ILO</td>
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<td>- UNDP (online)</td>
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<td></td>
<td>- NCD alliances</td>
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<tr>
<td>14.00-15.00</td>
<td>Presentation on Regional perspectives on commercial determinants of health</td>
<td>Monika Arora</td>
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<tr>
<td></td>
<td>- South-East Asia region (Monika Arora)</td>
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<tr>
<td></td>
<td>- Examples of other WHO regions (Monika Kosinska)</td>
<td></td>
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<td></td>
<td>- Q&amp;A</td>
<td></td>
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<tr>
<td>15.00-15.30</td>
<td>Recommendations for WHO</td>
<td>Participants</td>
</tr>
<tr>
<td>15.30-16.00</td>
<td>Conclusion and vote of thanks</td>
<td>Suvajee</td>
</tr>
<tr>
<td>16.00-16.15</td>
<td>Closing remarks</td>
<td>WR Thailand</td>
</tr>
</tbody>
</table>
Annex 3: Regional Director’s Message

Good morning and welcome to this Regional consultation on economic and commercial determinants of health in South-East Asia.

Global economic and commercial activities have brought economic opportunities, employment, access to essential and discretionary goods and services to national and local communities. We recognize flourishing of consumerism and economic growth everywhere. Commercial operations, products, and services influence consumer behaviours in everyday lives. Our choices for health and wellbeing have been tremendously driven by many of these activities and they are increasingly impacting our health outcomes.

Marketing strategies, promotion of choices, lobbying, donating, and funding research activities are increasingly influencing decision making of individuals, families, communities, and public authorities to adopt the products and practices that could have beneficial or detrimental impacts to people’s health.

WHO recognizes importance of economic and commercial determinants of health that generate positive and negative impacts on public health while enabling political economic systems and norms for working conditions and other related activities. The term “commercial determinants of health” is used to understand how industrial driven commercial activities including all the products and services impacting public health (health care delivery systems and cost), influence lifestyle choices (healthy or unhealthy), and global health inequities (including occupational health of workers in different commercial systems).

The production and consumption of ‘unhealthy’ products, for example tobacco, alcohol, ultra-processed foods, and sugar beverage, impacts the earth (planetary health), degrades environment, communities, families, people’s health and adds to pollution.

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

The nutrition transition (from home-grown organic food to mass industrial processed food products) has been evident in SEAR countries, which has led to increase in consumption of high sugar, salt, and trans-fat and has contributed to obesity and metabolic disorders. The sales of sugar-sweetened beverage (SSBs) has increased everywhere in the region, with particular increase in Indonesia and Thailand. Alcohol use is increasing in countries such as DPR Korea, India, and Thailand.

Availability of cheap unhealthy items in the region e.g., tobacco, loose cigarettes, cheap liquor, uncertified contaminated food and vegetables, cheap unhealthy imitated food products, etc. is driving up noncommunicable diseases among the poor, rural, and less informative population.

Commercial system of pharmaceutical products, medical technologies, vaccination, health supplements can divide health care services benefiting the rich and the poor differently. Commercial determinants of health pose a complex juxtaposition to health equities. It can increase health care cost including out-of-pocket expenditure and widening the gaps of health inequities.
Addressing determinants of health requires public policies (beyond health sector) attention to the role of power, equity, and governance. Increase governance, sectoral accountability, regulation, licensing, and taxation are some examples of actions that can curb proliferation of commercial activities that have negative impacts on health. Increase health literacy among consumers and promotion of health as human rights would raise consumer demand for improved business operation and reform to create better products for health and wellbeing.

Ministry of health and partner agencies should encourage other sectors to advance economy for health and wellbeing, promotion of wellness and equitable access to healthy products, and increase enabling environment for health for all population. We need to follow-up the commitments the world leaders have made during recent G20, as they are the drivers of some of these commercial determinants of health, to reach one earth, one health making the world a healthier place. We should take this opportunity to also understand the economics of well-being.

We need to facilitate equitable access to safe, effective, quality-assured, and affordable vaccines, therapeutics, diagnostics, and other counter measures, especially in low- and middle-income countries, and small island development states.

Dear colleagues,

I know that this is a new subject to us and a complex one to be addressed. I believe this consultation is a steppingstone for us to get deeper understanding and empowering all sectors to take necessary action.

Deliberations in this consultation will be valuable for our region to scope the actions that we can feasibly take in short- and long-term plans.