

# Economic and commercial determinants of health in Small Island Developing States (SIDS)

Noncommunicable diseases (NCDs), mental health conditions, injuries and violence



World Health  
Organization



# **Economic and commercial determinants of health in Small Island Developing States (SIDS)**

**Noncommunicable diseases (NCDs), mental health  
conditions, injuries and violence**

**DRAFT DOCUMENT VERSION 9 JUNE 2023**



**World Health  
Organization**

## Table of Contents

<i>List of terminology used in the Discussion Paper</i> .....	iv
<i>List of figures</i> .....	v
<i>Abbreviations used in the Discussion Paper</i> .....	vi
<b>Executive Summary</b> .....	vii
<b>1. Introduction: the case for an economic and commercial determinants lens</b> .....	1
1.1 SIDS face economic and health challenges characterized by unfair and avoidable health inequities .....	1
1.2 SIDS face specific challenges relating to conflicts of interest and negative health externalities from economic activity.....	4
1.3 SIDS face common challenges in mobilizing the resources needed to strengthen governance for health .....	7
<b>2. Impact of economic and commercial determinants on health and health equity in SIDS</b> .....	11
2.1 Economic and commercial drivers of tobacco use.....	12
2.2 Economic and commercial drivers of alcohol consumption .....	13
2.3 Economic and commercial drivers of physical inactivity .....	14
2.4 Economic and commercial drivers of unhealthy diets .....	17
2.5 Economic and commercial drivers of air pollution.....	22
2.6 Economic and commercial drivers of injuries and violence .....	22
2.7 Economic and commercial drivers of mental health conditions .....	25
<b>3. Action on economic and commercial determinants to improve health and health equity in SIDS</b> .....	28
3.1 Safeguarding against conflicts of interest and strengthening community participation .....	29
3.2 Empowering communities for participation and accountability .....	30
3.3 Strengthening policy coherence for health across trade, fiscal and other policies.....	31
3.4 Mobilizing development finance to build capacity for integrated health and economic development .....	33
3.5 Protecting and promoting health through economic and development approaches.....	34
<b>4. Summary of opportunities for action on economic and commercial determinants of health in SIDS</b> ...	36
4.1 Investment in creating policy environments that enable health. ....	36
4.2 Scaling up what works through safeguarded conflicts of interest.....	36

4.3 Investing in empowered community participation in governance of the commercial determinants of health. ....	37
4.4 Strengthening governance for health in development approaches.....	37
4.5 Investing in triangular cooperation for action on the commercial determinants of health .....	37
<b>References .....</b>	<b>39</b>
<b>Annexes .....</b>	<b>59</b>

CONFERENCE DRAFT: E

## List of terminology used in the Discussion Paper

Commercial Determinants of Health (CDoH)	Also known as the commercial dimension of the social determinants of health, these refer to the activities by commercial actors that affect people's health directly or indirectly, positively or negatively, and the pathways through and the environments in which commerce takes place.
Cultural determinants of health	Customs and traditions, and the beliefs of the family and community.
Economic determinants of health	Economic factors that determine people's opportunities for health as a wider set of forces and systems shaping the conditions of daily life. These include economic policies and systems, trade, and development agendas.
Environmental determinants of health	Environmental factors that influence human health, including physical, chemical, and biological factors external to a person, and all related behaviours.
Health Equity	Health equity is the absence of unfair, avoidable, or remediable health differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g., sex, gender, ethnicity, disability, or sexual orientation)
Health Inequities	Systematic unfair differences in the health status of different population groups
Political determinants of health	Increasingly used as a term to explain the various ways that politics – voting, government, and policy – create the social, economic, and commercial drivers of health and impact actual health outcomes, access to care, and other determinants of health.
Social Determinants of Health (SDH)	The non-medical factors that influence health outcomes. These are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life.
Structural determinants of health	Social determinants that generate stratification and social class divisions in the society and that define individual socioeconomic position within hierarchies of power, prestige, and access to resources, rooted in the key institutions and processes of the socioeconomic and political context.
Syndemic	The arising of epidemics from the complex interplay between the spread of diseases or global health threats with pre-existing disease burdens defined by social, environmental, economic, cultural, and political determinants.
Triangular cooperation	Triangular cooperation involves Southern-driven partnerships between two or more Low- or Middle-Income countries supported by a developed country(ies)/or multilateral organization(s) to implement development cooperation programmes and projects.

## List of figures

- |          |   |
|----------|---|
| Figure 1 | Levels of physical inactivity in SIDS UN countries and globally in WHO Member States                              |
| Figure 2 | Cost of predicted new cases of NCDs attributable to physical inactivity in SIDS between 2020-2030                 |
| Figure 3 | Trends in childhood obesity prevalence in small island developing states  |
| Figure 4 | Age-adjusted comparative prevalence of diabetes in adults (20-79 years) in small island developing states in 2019 |

CONFERENCE DRAFT: E

## Abbreviations used in the Discussion Paper

ADHD	Attention deficit hyperactivity disorder
CARICOM	The Caribbean Community
CDoH	Commercial determinants of health
CPR	Cardiopulmonary resuscitation
ENDS	Electronic nicotine delivery systems
ENND	Electronic non-nicotine delivery systems
FAO	Food and Agricultural Organization of the United Nations
FBDGs	Food-based dietary guidelines
GAP	Global Action Programme on Food Security and Nutrition in Small Island Developing States
GDP	Gross Domestic Product
HIC	High-income economy
HFSS	Food High in Fat, Salt, and Sugar i.e., that are high in saturated fats, trans fats, free sugars and/or sodium and are typically heavily processed.
HTPs	Heated tobacco products
IFAD	International Fund for Agricultural Development
IP-TFAs	Industrially produced trans fatty acids
LIC	Low-income economy
LMIE	Lower-middle income economy
NCDs	Non-communicable diseases
OECD	Organisation for Economic Co-operation and Development
ODA	Overseas Development Assistance
PAHO	Pan-American Health Organization
PICTS	Pacific Island Countries and Territories
PTSD	Post-traumatic stress disorder
SAMOA	SIDS Accelerated Modalities of Action Pathway
Pathway	
SDGs	The Sustainable Development Goals
SDH	Social Determinants of Health
SDRs	IMF Special Drawing Rights
SIDS	Small Island Developing States
SIDS-GBN	SIDS Global Business Network
SSBs	Sugar-sweetened beverages
UMIC	Upper-middle income economy
UN-OHRLLS	United Nations Office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States
UNCTAD	United Nations Conference on Trade and Development
UNICEF	United Nations Children's Fund
UNFAO	United Nations Food and Agricultural Organization
UPFBs	Ultra-processed foods and beverages
WFP	United Nations World Food Programme
WHO	World Health Organization
WHO FCTC	WHO Framework Convention on Tobacco Control
WTO	World Trade Organization

## Executive Summary

This Discussion Paper is the first in a series of Discussion Papers on economic and commercial determinants of health in Small Island Developing States (SIDS). This paper focuses on the economic and commercial drivers of noncommunicable diseases (NCDs), mental health conditions, injuries and violence.

SIDS are a distinct group of countries facing common economic challenges. Due to their geography and remoteness, SIDS often rely on other countries for the production of essential goods and are characterised by a disproportionate burden of vulnerabilities. As countries dependent on single industries and imports of food, medicines, vehicles and other consumer products and commodities, SIDS are especially vulnerable to economic and commercial drivers of health harm. They can be exposed to greater pressure from industry due to, for example, their size in relation to multi-national commercial actors, or through bi-lateral or multinational trading agreements. These determinants can shape what health care is available to whom and at what cost, whether housing and broader environments are safe and health-promoting, workplace health protections, and the legal right of States to regulate in the interests of health. They also create existential challenges such as biodiversity loss as a consequence of unsustainable commercial practices and resultant climate change detrimental to the livelihoods of many SIDS.

Given the small size and interconnectedness of SIDS, local commercial actors play critical roles in the health of these communities making it a priority to ensure a shifting of existing health-harming practices to health-promoting. This is essential to fulfilling the potential of commercial actors where there is an alignment in their products and services to health to be partners for health and well-being of SIDS populations, and improving NCD, mental health, and injuries and violence outcomes. Understanding these commercial determinants of health, whether health-harming or with opportunities to be health-promoting, the power imbalances between regulators and commercial actors, and the critical role of global governance in shaping commercial determinants of health in SIDS, is an important step in supporting SIDS to improve equitable health outcomes.

Current economic arrangements and development approaches are insufficient to address the burden of NCDs, mental health conditions and injuries in SIDS. These arrangements and approaches have permitted and produced economic conditions and policy environments, particularly in trade, that have exposed SIDS to negative externalities related to the commercial determinants of health. This includes the actions of some commercial actors to exert influence over health outcomes in SIDS through both direct means, such as lobbying and marketing, and indirect means, such as shaping knowledge and societal norms. Action on the commercial determinants to prevent negative externalities is essential for SIDS to reduce demand for or exposure to health-harming products, improve diets, develop safer infrastructure and lived environments, and curb air pollution. Action is also required to incentivize commercial actors to support the promotion of physical activity, access to improved food environments, and to support communities affected by climate-related weather events and disasters.

A comprehensive response requires action to explore alternative economic arrangements that prioritise well-being, embrace indigenous knowledge and participation and support local businesses, people, products and services. It also requires action and policy coherence across sectors, such as increase revenue through taxes on harmful products and the alignment of trade and broader fiscal policies with health goals. These efforts can be supported with the development of conflict-of-interest

tools to safeguard public health policies from commercial interests, and through increased community participation in decision-making and accountability mechanisms.

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

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

1. **Investment in creating policy environments that enable health.** Addressing the demand and supply side of risk factors linked to commercial practices by fostering policies that support health promoting products and regulating health-harming products and commercial practices. Actions could include:
  - i) Comprehensive best practice health taxation and enforcement to raise prices of health-harming products;
  - ii) Regulation and enforcement of availability and use of health-harming products (e.g., regulate alcohol outlets; smoke-free laws);
  - iii) Bans or restrictions on advertising and marketing of health-harming products;
  - iv) Adoption of policies for sustainable local food production and processing to support improvements in the food environment and strengthen climate-resiliency;
  - v) Adoption of trade rules and excise duties that support health-promoting products including safe vehicles;
  - vi) Integration of commercial determinants considerations into procurement policies;
  - vii) Using health impact assessments as part of strengthening policy coherence between health and other policies with economic and commercial relevant to NCDs, injuries and violence, and mental health, such as trade, fisheries and agriculture;
  - viii) Improving data and surveillance on the commercial determinants of health.
2. **Scaling up what works through safeguarded conflicts of interest.** Safeguarding against conflicts of interest as part of adopting, implementing, and monitoring good practices, public health policies, NCD strategies and risk factor approaches as recommended by WHO. This includes ensuring conflicts of interest are fully addressed in the as part of implementation of WHO technical packages (Annex 4). Actions could include:
  - i) Whole-of-government policies to prevent and manage conflicts of interests for commercial actors aligned with health, and those whose products and services are health-harming;
  - ii) Access-to-information legislation to facilitate transparency, monitoring and accountability including health impact assessments.
3. **Investing in empowered community participation in governance of the commercial determinants of health.** Investing in institutionalized empowered community participation in

governance of the commercial determinants of health, as part of whole-of-society approaches. This involves working with community-based organizations, indigenous individuals and communities, civil society, the media and health-aligned local commercial actors, youth, people living with NCDs, and academics. Actions could include:

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

4. **Strengthening governance for health in development approaches.** Building public sector capabilities to integrate economic and commercial determinants of health considerations into development strategies is essential to advance the UN Sustainable Development Goals (SDGs). This includes through financing for development, tax agreements, debt restructuring and governing common goods including land and water, common services and products including in the health sphere. Actions could include:

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

5. **Investing in triangular cooperation for action on the commercial determinants of health.**

The demonstration of political leadership and collective action between SIDS and supported by international partners levels is critical to ensure the prioritization of the commercial and social determinants of health and develop regional or SIDS-level norms and standards for the protection of policies against conflicts of interests that may adversely affect public health strategies and commitments. Action could include:

- i) Integrating commercial determinants of health considerations in implementation of the SAMOA pathway commitments;
- ii) Exploring a ONE UN approach to the commercial determinants of health; and
- iii) Considering the establishment of a SIDS Technical Network on economic and commercial determinants of health.

This Discussion Paper was prepared ahead of the SIDS ministerial conference on the prevention and control of NCDs and mental health held in Barbados in June 2023.



# 1. Introduction: the case for an economic and commercial determinants lens

## Key messages

- SIDS grapple with unique health challenges characterised by health inequities, high prevalence of NCDs and significant vulnerability to external shocks like climate-related events and natural disasters.
- Commercial activities have important impacts on health outcomes in SIDS. These commercial determinants are formed around the specific economic conditions in SIDS that underpin a number of commercially driven market failures.
- The economic vulnerabilities and dependencies of SIDS force SIDS into tough choices between servicing debt, investment in health and health determinants, or investing in disaster-preparedness infrastructure.
- Commercial determinants arising from health-harming sectors and in some cases the outsized influence of foreign commercial actors can undermine government action to tackle NCDs, injuries and violence, and mental health conditions.
- Therefore, multisectoral approaches to improve health and development in SIDS includes action on the commercial determinants through strengthened governance for health, including safeguarding against conflicts of interest.

## 1.1 SIDS face economic and health challenges characterized by unfair and avoidable health inequities

Significant health challenges remain for SIDS with over half of all people living with NCDs dying prematurely (before age 70) (2). Further action will be needed to support SIDS in achieving SDG target 3.4, by 2030, of reducing by one third premature mortality from NCDs through prevention and treatment and promotion of mental health and well-being. Premature mortality impacts negatively across national development and the other SDGs, including through loss of human potential, loss of productivity, increasing costs to health systems. These health outcomes in SIDS are directly affected by those dimensions captured by other SDGs as they target the distributions of social determinants of health: those social, economic, commercial, political and environmental conditions in which people live and that impact health and wellbeing. These determinants include:

- (i) access to nutritional and safe food, safe water, education, job opportunities and housing;
- (ii) the quality of schools, workplaces, the built environment, and community settings;
- (iii) the composition of social networks and nature of social relations and the wider set of systems shaping the conditions of daily life (3); and
- (iv) having sufficient governance capabilities to govern for health, including regulating in the public interest, fostering commercial innovation for health, tackling corruption, addressing policy incoherence and conflicts of interest.

It has been estimated that social determinants of health account for 30-55% of all health outcomes globally, exceeding the contribution of the healthcare sector (4) and therefore achieving health outcomes means acting on the social determinants. Structural inequities in the distribution of power and resources between social groups, are perpetuated through the social, economic and cultural determinants and contribute to growing health inequities in SIDS, including in both physical and mental health. Different dimensions of social identity and location, including race and ethnicity, gender, sexuality, employment socioeconomic status, disability, immigration status, population ageing, geography, and more, have an impact on differential access to opportunities for health (5).

The unequal distribution of power and resources within and between different social groups creates inequities in the immediate, visible circumstances of peoples' lives – their access to healthcare, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a safe and healthy life. These differences in circumstances affect the opportunities of individuals and communities and accumulate over the life course of individuals to lead to health inequities, within and between countries (6).

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

Small Island Developing States (SIDS) are a distinct group of countries that despite their differences, face common economic and development challenges arising from their small populations and small landmasses, their spatial dispersion and remoteness from major markets, and their high exposure to external shocks, including severe climate-related events and natural disasters. These contribute to a common set of health challenges including:

- (i) a high prevalence of NCD risk factors and disease burden;
- (ii) a higher burden of disease related to maternal, neonatal, and nutritional conditions, despite improvements in the Caribbean in particular;
- (iii) lower human, financial and medical resources in the health system impacting the capacities of the health system to respond to NCDs and other diseases;
- (iv) increased risk and severity of health emergencies, including natural disasters stemming from the effects of climate change, sea level rise and extreme weather events;
- (v) increased risk of communicable disease outbreaks associated with natural disasters;
- (vi) interactions of present and future threats from climate change with the food insecurity caused by the displacement of traditional diets with imported HFSS foods and beverages;
- (vii) urban populations particularly vulnerable to the impact of health emergencies and health security threats, due to high urban density coupled with increasing and unplanned urbanization;
- (viii) legacies of colonial practices, including reduced self-sufficiency, and increased dependency on imported capital and materials; and

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

The interlinked nature of these challenges faced by SIDS was brought to the forefront by the COVID-19 pandemic. Health systems already strained by increasing rates in diseases linked to health-harming products were demonstrated to have reduced capacity and resources to respond to the pandemic. Similarly, the risk to people living with NCDs was exacerbated as the urgency of the response to COVID-19 diverted both human and financial resources from NCDs. Although SIDS populations were identified as being at heightened risk for COVID-19 – a result of high prevalence of tobacco use, obesity and diabetes – this risk was not reflected in a prioritisation of SIDS populations for vaccine distribution: along with other low- and middle-income countries, SIDS were forced to wait while many high-income countries secured large doses of the vaccine (7). Beyond the health sector, COVID-19 also shone a spotlight on interconnected challenges, for example it revealed how food insecurity needs to feature as an important consideration within models of social protection. In addition to this, the COVID-19 pandemic intensified existing vulnerabilities related to gender-based violence, mental health issues, and childhood obesity. This impact on health status was exacerbated by the impact on the economic vulnerabilities of SIDS, with the OECD reporting that in 2020 the Gross Domestic Product (GDP) of SIDS nations dropped by 6.9%, versus 4.8% in all other LMICs (8);

The interlinked nature of challenges faced by SIDS also needs to be reflected through interlinked solutions. For example, given that SIDS food systems rely heavily on imported processed foods and beverages, reformulation of the fats, sugar and salt in these foods and beverages, and the elimination of industrially produced trans fatty acids (IP-TFAs) would deliver benefits for SIDS populations. Similarly, additional tools are needed to assist SIDS governments in protecting food and nutrition security during climate-related disasters, as well as to strengthen alcohol policies and regulation of the alcohol industry.

### 1.1.2 Tackling health inequities is critical to achieving health and development goals

In the outcome statement of the 2021 SIDS Summit for Health, the representatives of SIDS WHO Member States recognized that SIDS nations face “*acute and existential health and development threats*” (9). They also recognised the need for multisectoral, whole-of government approaches to address these threats, including action on the environmental, economic and social determinants of health (9). Among the critical influences of these factors are commercial determinants of health (CDoH), defined as the activities by commercial actors that affect people’s health positively or negatively, and the pathways through and the environments in which commerce takes place.

Underpinning economic and commercial determinants of health is an understanding that commercial actors, including large multinational companies and small- and medium enterprises, exercise broad influence on the physical, social and culture environments in which people live (10). As such, commercial actors and practices can meaningfully impact the right of every person to achieve their highest attainable level of health and well-being. This is particularly true in SIDS, where government resources and budgets are exceeded by the size and scale of multinational companies, state-owned companies, and foreign commercial actors, such as legal commercial fishing and illegal, unreported, and unregulated fishing.

Commercial actors have a critical role in ensuring commercial determinants of health have a positive impact. This impact can be expanded by SIDS governments leveraging co-benefits and partnerships to reduce NCD and injuries and promote mental health and road. This is particularly needed because the remote geography of many SIDS results in a high transactional and transport cost, no economies of scale, and a lack of price transparency and quality assurance within health systems. As a result, commercial actors could act to increase the availability of essential NCD medicines and health technologies, and support improved access to essential, high-quality, safe, effective and affordable medicines and medical products. Engagement between WHO and private sector pharmaceutical actors has included supporting SIDS nations to access prequalified medicines and health technologies (11). However, exploring the full scope and potential of commercial actors as health partners is beyond the scope of this Discussion Paper, which focuses on the points of action where commercial determinants are contributing to negative health outcomes on NCDs, injuries and violence or mental health.

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

In 2012, SIDS countries and the international community committed to safeguarding against conflicts of interest as part of strengthening governance for health and development, and increasing the involvement and accountability of commercial actors in these processes in the adoption of the Rio Political Declaration on Social Determinants of Health, and endorsed in WHA Resolution 65.8 (12):

- (i) to adopt better governance for health and development, including working across different sectors, strengthening health in development strategies and the leading role for health ministries, fostering collaborating with commercial actors while safeguarding conflicts of interest, and strengthening collaboration between countries on these topics;
- (ii) to promote participation in policymaking and implementation, including inclusive and transparent decision-making, strengthened accountability, empowering communities, governance approaches which span sectors and involve civil society and commercial actors, while safeguarding conflicts of interest;
- (iii) to further reorient the health sector towards reducing health inequities, including developing public health policies that address the social, economic, environmental and behavioural determinants of health, building public health capacity, promoting health impact assessment;
- (iv) to strengthen global governance and collaboration, including adopting coherent policy approaches, striving to ensure mutually supportive international development goals and objectives to improve health equity, implement the FCTC, implement political commitments on NCDs ensuring a focus on reducing health inequities, and fostering North-South and South-South cooperation; and
- (v) to monitor progress and increase accountability, including assessing the impacts of policies on health and societal goals to take these into account in policymaking, using intersectoral mechanisms such as Health-in-all-Policies, promote monitoring systems that

take into consideration civil society and commercial actors, with appropriate safeguard against conflict of interest.

The commitments made in the Rio Declaration acknowledge and stress the importance of safeguarding against conflicts of interest not only in health policy development, but also in the multistakeholder and multisectoral approaches needed for strengthening health in economic development approaches. Safeguarding against conflict of interest is of critical importance to SIDS and all countries in ensuring that health and health equity outcomes are not undermined by commercial interests or pressures. A 2022 study on the implementation of a subset of WHO Best Buys related to risk factors found that financial commercial actor influence is negatively associated with their implementation (10).

### 1.2.1 Economic vulnerabilities in SIDS create unaddressed negative externalities

Small, dispersed populations do not allow for sizeable domestic markets and economies of scale. This means that SIDS predominantly focus economic activity around a small number of sectors, including those with health-harming commodities such as tobacco, alcohol, sugar or in some cases fossil fuels. While a handful of other SIDS rely strongly on natural resources, the economy of most SIDS largely relies on services, particularly tourism and financial services. This concentration of economic activity increases the impacts of shocks on these sectors (13) as well as presenting a context where there may be close-knit relations between political and commercial leadership (14).

Single commodity markets and close-knit relationships between political and commercial leadership may present conflict of interests directly and indirectly relevant for health in SIDS: this is particularly true where the economic dependency is on health-harming products such as tobacco or alcohol. SIDS may face greater pressure from commercial actors due, for example, to the interconnectedness of small populations or the asymmetry in their size in relation to multinational commercial actors in the context of multinational trade (14, 15). For example, small markets with heterogeneous commercial actors dominated by single shareholders may simultaneously connect both health-harming and health-promoting goods and services - such as the use of manufacturing and bottling facilities for both water, milk, SSBs and alcohol. This creates a context where policymakers can be connected to commercial actors through personal relationships, political contributions and/or direct ownership (16, 17).

Due to their small size SIDS economies are very open to trade and reliant on a handful of trading partners. Due to their open nature, SIDS are more exposed to market fluctuations. Moreover, multilateral and bilateral trade agreements do not consistently preserve and enable health promotion and protection. Commercial drivers shape markets and financial flows, often within economic approaches that put commercial interests before health (18, 19). For instance, inadequacies in supply chains may impede the importation of cost-effective medicines and health technologies undermining their affordability for SIDS. This means that trade agreements may simultaneously increase access to unaffordable pharmaceuticals and affordable health-harming products (20, 21, 22).

SIDS that are spatially remote face challenges in access and connectivity to international markets. When taken together with their small size, this remoteness leads to high production and trading costs, limiting investment, competitiveness and the scope for integrating global value chains. This has implications for food and food sovereignty, as well as access to medicines and other essential goods and services provision.

Many SIDS are highly dependent on tourism which make up more than 30% of small island economies GDP (23) and this is significantly influenced by a small number of transnational commercial actors (24). This importance is longstanding and with both direct and indirect health impacts, including the impact of COVID-19 on tourism (25). Tourism is a driver of a shift toward increased food imports, including sugar-sweetened beverages and alcohol that meet the tastes of tourists (26, 27). It also results in environmental impacts from constructions, waste, and pollution (28). Despite being an important sector for government revenue and therefore source of financing for health-critical public expenditure (24, 29), tourism may not reach its full potential in increasing either financing for public services in SIDS, nor direct economic or employment benefits for local populations—in part due to economic leakages, including import consumption by tourists, repatriation of profits from tourism and income from land rents benefiting non-domiciled actors in SIDS (23, 25). This is particular true for certain sectors, such as enclave tourism development (land-based or cruise), which offer only restricted opportunities for local communities to benefit from tourism or sometimes no opportunities at all (24, 25).

Economic opportunities relating to tourism are not gendered neutral. Women are more often working in precarious, lower-paid employment, including subsistence farming. In the Caribbean, for example, women are generally not the beneficiaries of the specialist food production demanded for tourism (24). In the Pacific, subsistence farming in rural communities is also dominated by women, despite owning little agricultural land and facing lack of access to seed, technologies and essential financial services necessary for agricultural productivity (30). Research in the Seychelles indicates that most jobs directly or indirectly related to tourism in the private sector were mainly held by men and expatriate workers (31).

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

Small, dispersed populations entail high per capita costs in delivering essential public services (13). This creates a challenge not only for building the capacity of health systems to deliver care and the implement of health policies and interventions including on NCDs, injuries and violence and mental health conditions, but also for broader government investment in the social determinants of health such as education, social security, water and sanitation, and the governance capabilities needed to manage conflicts of interest (13). Small, dispersed populations means human and institutional capital is hard to build and maintain (13). Without the pooling of resources, SIDS are also unlikely to be able to generate significant economies of scale (25), limiting the scope both for investment from commercial actors and for effective regulation and standards-setting to support health.

Gaps in institutional and human capital mean SIDS governments may see gaps in capacity that would allow them to lever reduce the health-harming impacts of the economic and commercial determinants of health leading to of NCDs, mental ill-health, injuries and violence, and re-orient these to become health-promoting. Examples include capacity and assistance gaps for the full implementation and enforcement of the WHO Framework Convention on Tobacco Control (32), or safeguarding against conflicts of interest as part of the development and the implementation of WHO-supported NCD policies, including those related to health-harming commercial products and practices (10).

Institutional and human capital is critical for improving health and well-being and to safeguard against commercial outcomes with negative health impacts in SIDS. In part this is through economic environments where disproportionate benefit - including in human capital - accrues to commercial actors outside of SIDS (33). This is particularly the case for those commercial actors that use mechanisms to decrease their tax burden and improve corporate profitability, while socialising those financial costs and social harms that result from their business operations (e.g., rising NCD burdens, stalled living standards, biodiversity loss, environmental degradation and climate change). These uncompensated for financial burdens and social or environmental harms (so-called negative externalities (34)) then fall on the public sector, communities and individuals (35).

Negative externalities from the commercial practices on the environmental determinants of health have both direct and indirect on of NCDs, mental ill-health, injuries and violence. Biodiversity loss occurs as a persisting consequence of unsustainable commercial practices and climate change with great detrimental to the livelihoods of many in SIDS (36). Industries like fishing and tourism central to many SIDS economies rely on biodiversity to exist. Yet this disruption goes beyond the economic: natural resources have aesthetic and spiritual value for many communities in SIDS while also contributing to their food supply, water safety and protection from storm surges, beach erosion and floods (37). Climate change is a particular risk, including the climate-induced displacement of small island communities. It threatens socioeconomic and human security implications for SIDS, including physical and mental stress associated with the loss of ancestral homelands, and raising cultural, economic and social impacts of internal migration (37, 38, 39).

SIDS bear a disproportionate burden of the negative externalities of unsustainable economic arrangements and commercial practices. Despite neither making significant contributions nor receiving any of the financial benefits from these practices they now face existential and immediate risks from climate change and unfair health burdens of NCDs, injuries and violence, and mental health conditions. Economic and commercial considerations are key in designing, adopting and implementing effective multisectoral and multi-stakeholder policies and approaches needed to improve the health burdens in SIDS associated with NCDs, injuries and violence and mental health considerations. This requires institutional and human capacities to safeguard against conflicts of interest and strengthen governance of the commercial determinants of health.

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

The COVID-19 pandemic not only exacerbated the existing unique challenges faced by SIDS, including in relation to the economic and commercial determinants of health, but also continues to expose and amplify the interlinked challenges that SIDS face in mobilising the public and private resources needed to achieve sustainable and resilient development. This impacts on state capabilities which are essential for shaping what healthcare is available to whom and at what cost, as well as the investments in the social determinants of health in creating healthy and accessible environments, implementing workplace health protections, providing good quality housing, and protecting the legal right of States to regulate in the interests of health.

In SIDS, unlike in most other LMICs, these resource mobilization challenges create conditions where the external finance available is dominated by remittances and ODA, while private finance flows remain small and volatile (40). This in turn contributes to challenges relating to high fiscal deficits and public debt that create barriers to increased public expenditures and investments in

health and the determinants of health, including governance of commercial determinants (40). Collapsing revenues from an external shock also hinder essential government spending, and access to development finance, as experienced in the combination of low rates of tourism and reduction in remittances associated with COVID-19, and pressured economic markets elsewhere (41). Evidence from SIDS showed that resources including staff and government funds intended for NCDs have been redirected to support the COVID-19 response (42). While drawing attention to countries' NCD burden, as those living with NCDs are at increased risk of becoming severely ill with the virus, such disruptions are particularly problematic for those living with NCDs who need regular care (42, 43).

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

The unique economic characteristics of SIDS mean they rely on small, undiversified economies and often face high debt levels (8). Prior to the COVID-19 pandemic, eleven out of twenty-two SIDS already had solvency problems and qualified as being high risk or in debt distress – where debt servicing burdens, current account deficits and elevated levels of public debt viciously feed off each other (44). Between 2000 and 2019, the external debt of SIDS rose by 24% (of GDP), while in LMICs debt fell by 6.2% on aggregate. By 2019, external debt accounted for 62% of GDP on average in SIDS, compared with 29% for all LMICs and economies in transition (45). Levels of external debt differ significantly between SIDS, with debt-to-GDP ratio ranging from 25% to 96% in 2020 (44). These features combine to make SIDS uniquely vulnerable to economic shocks and global financial shifts (13). Consequently, the economic fallout from the COVID-19 pandemic risks further exacerbating sovereign debt and the possibility of defaults.

More broadly this means that many SIDS are forced to make choices between paying external debt, providing salaries and benefits to citizens, or investing in infrastructure in advance of potential catastrophic future weather events<sup>1</sup> (46), all of which are critical determinants of health. Although the international community reacted quickly to the liquidity problems faced by SIDS as a consequence of the pandemic, these initiatives are not sufficient for many SIDS with those with the highest debt burden remaining outside of recent global debt processes (44).

Despite the challenges outlined above, SIDS continue to show remarkable resilience in social inclusion, well-being and resistance to dependency on others (47). Remittance transfers are important components of financial flows in SIDS and have contributed to this resilience as they are predictable, sustainable, and importantly penetrate vulnerable and hard-to-reach households (48). The impact of the COVID-19 pandemic on remittance inflows was mixed throughout 2020, with remittance inflows increasing relative to the previous year in Latin America and the Caribbean (by 6.5%) and South Asia (5.2%), but falling for East Asia and the Pacific (by 7.9%) (49). The top recipients in terms of the share of remittances in GDP in 2020 include many smaller economies such as Tonga (38 percent), Samoa (19 percent), and Marshall Islands (13 percent). (49). This had increased to 50% in Tonga and 34% in Samoa by 2022 (50).

Despite Sustainable Development Goal (SDG) target 10.C to reduce to less than 3 per cent the transaction costs of migrant remittances and eliminate remittance corridors with costs higher than 5 per cent by 2030 (51), SIDS countries continue to face variable barriers in the cost of remittance transfers, with SIDS in the Pacific experiencing remittance costs above 10% (52). Unlike other

<sup>1</sup> As noted by the UN office of the High Representative for the Least Developed Countries, Landlocked Developing Countries and Small Island Developing States (UN-OHRLLS).

natural disasters when remittance transfers remain a vital financial lifeline for those receiving them, and in many cases increase, during COVID-19, migrant and low-wage workers have borne the brunt of income losses associated with the pandemic, while also being disproportionately employed in industries where in-person services continued during the pandemic, with associated risks of exposure to the virus (53).

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

The specificities of SIDS are not well addressed through existing global governance architecture and there is insufficient consideration of where mainstream development models may not be appropriate (54). Macro-economic processes leaves SIDS susceptible to policy decisions taken elsewhere, such as the displacement of traditional diets resulting from financialization and commercial consolidation of land for tourism or agriculture, shifts in demands in international markets, market speculation in commodities, and the global production and import of cheaper HFSS products (55, 56, 57). As such, economic shocks or financial shifts, both domestic and global, can cause or exacerbate tensions between health and economic incentives within a country (58). For example, preventing financial loss to the tourism and hospitality sectors has been mobilized as a justification to oppose health policy, despite research with four CARICOM countries concluding that implementing smoke-free environments did not affect the arrival of tourists, tourism expenditure or the average length of stay (59).

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

- (i) small, dispersed populations do not allow for sizeable domestic markets and economies of scale, meaning that SIDS economic activity is predominantly focus on a small number of sectors, including health-harming commodities such as tobacco, alcohol, sugar or in some cases fossil fuels;
- (ii) long distances challenge access and connectivity to international markets. Small size and remoteness lead to high production and trading costs, limiting investment, competitiveness and the scope for integrating global value chains. This has implications for food and food sovereignty, as well as access to medicines;
- (iii) dependency on tourism with implications for employment, environmental impacts, and imports of commodities driven by the taste of tourists;
- (iv) SIDS economies broad openness to trade and reliance on a handful of trading partners exposes them to “trade fragilities” and tensions between domestic health objectives and trade. The concentration of economic activity in turns increases the impacts of shocks.
- (v) particularities in managing conflict of interests relating to both small size and the interconnectedness of small populations, but also the asymmetry in their size in relation to multinational commercial actors;
- (vi) greater challenges in mobilising the public and private finance needed to invest in health and health determinants including governance for health;
- (vii) challenges to increasing public expenditures and investments in health, health determinants and public governance relating to debt, taxation and fiscal rules;
- (viii) development approaches where the specificities of SIDS are not always considered.

This Discussion Paper reviews how economic and commercial drivers of health present in SIDS, and what that means for action to improve health in SIDS in relation to NCDs, mental health conditions, injuries and road safety (a summary of these can be found in Annex 1). In doing so, it outlines how commercial and economic drivers act as key social determinants for these health issues (Annex 2). As well as exploring the pathways by which commercial determinants affect health, it explores opportunities for SIDS to reshape economic and commercial determinants to improve health outcomes for NCDs, Mental Health conditions, injuries and road safety (a summary of existing WHO technical packages can be found in Annex 3). This includes through improved governance for health and continued innovative policy responses, leadership in economic approaches that ensure protection of health and the planet and maintaining political commitment to health and health equity (existing political commitments can be found in Annex 4).

## 2. Impact of economic and commercial determinants on health and health equity in SIDS

### Key messages

- Commercially driven risk factors contribute to the significant burden of NCDs, mental health conditions and injuries in SIDS.
- Where these economic conditions in SIDS can be both exploited and manipulated by commercial activities, there is an increased risk of subsequent negative impacts on health outcomes.
- Some commercial actors exploit their own power and market concentration in SIDS to interfere in and undermine public health policies and engage in practices harmful to human health and the environment.
- Using a commercial determinants lens, there is a need for regulatory measures to reduce demand for health-harming products, improve diets, develop safer infrastructure and lived environments, and curb air pollution.
- At the same time, there is need for further ameliorative and mitigative measures that incentivize commercial actors to support the promotion of physical activity, access to improved food environments, and to support communities affected by climate-related weather events and disasters.
- All measures need to be underpinned by action across government that protects public health objectives and prevent efforts to undermine them by commercial actors.
- This effort and overall resilience should be supported by economic diversification to reduce over-dependence on single sectors around health-harming products.

Economic and commercial determinants of health are important drivers of NCDs, mental health conditions, road safety and injuries in SIDS. Commercial determinants often disproportionately affect countries and populations that are not profiting from the product or service that causes harm to health and planet, but instead are faced with the burdens of these harms. As a result, they shape the unfair and unjust health inequities, both within and between countries, where the greatest health burden is too often concentrated in those communities that can afford it the least (60).

These negative externalities associated with the economic and commercial determinants of health include climate change, worsened nutrition environments, increased NCD incidence and greater social and economic burden on already limited funds and fragile health systems in SIDS. Health, health equity and sustainable development are mutually-reinforcing, enabling, and because SIDS face disproportionate health risks due to their economic conditions, it is imperative to examine the role of commercial actors in undermining the former through exploiting the latter.

Understanding these commercial determinants of health, the power balances inherent within them, and the critical role of global governance for improved health outcomes is an important step in supporting SIDS in their commitments to health and well-being. The commercial activity of corporations that produce health-harming products such as alcohol, tobacco and HFSS foods and

beverages have particularly detrimental influences on SIDS (22, 61). This section presents an overview of the economic and commercial drivers of NCDs, injuries and violence and mental health conditions. A summary of these can be found in Annex 1.

## 2.1 Economic and commercial drivers of tobacco use

Despite much progress, current tobacco use rates remain high in SIDS. In 2019, 23% of adults aged 15+ in all SIDS used tobacco, with a prevalence of 37% for men and of 8% for women. In some SIDS, more than half the adult male population (aged 15+) were currently using tobacco products in 2020 (such as Timor-Leste, 66%; Kiribati, 53.6% and Papua New Guinea, 55.2%) (62). Five of the top ten worst rates of adult tobacco smoking in the world are found in the Pacific region, and in 2020, adult (aged 15+) tobacco smoking rates were 39.7% in Kiribati, 45% in Nauru, and 40.5% in Papua New Guinea (62). Generally, men in SIDS smoke at approximately three times the rate of women (63). However, countries in the Pacific region have some of the highest rates of tobacco use among women in the world; estimated 44.6% of women (15+) in Nauru are current tobacco smokers, followed by 27.0% in Kiribati (62).

On the other hand, despite overall relatively low rates of tobacco use in Caribbean SIDS, rates among young people in the Caribbean are amongst the highest in the region, and novel and emerging products such as electronic nicotine and non-nicotine delivery systems (ENDS and ENND), of which electronic cigarettes are the most common prototype, and heated tobacco products (HTPs) are becoming more widely available and accessible (64). For example, according to the Global Youth Tobacco Survey conducted in Timor-Leste in 2019 showed that 30.9% of students aged 13-15 years used any tobacco products (65). Similarly, the same survey conducted in Papua New Guinea in 2016 found that 33.3% of students used any tobacco products and 19.6% of students used electronic cigarettes (66). While the major form of tobacco use is smoking, smokeless tobacco such as snuff and betel nut with tobacco is even more widespread especially in the northern Pacific with 38% of adults (18+) in Palau and 22% of adults in the Marshall Islands reported using smokeless tobacco, according to their respective national surveys (67).

Tobacco use is one of the risk factors for high prevalence of NCD-related mortality and associated societal and health sector costs in SIDS (68). Tobacco use in SIDS is shaped by market penetration and marketing of large-scale commercial actors as well as availability of easily accessible tobacco products including locally grown tobacco which are sold on the informal market. Tobacco growing and domestic manufacturing remains on some SIDS. 2020 Party reports on the implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) available in the WHO FCTC Implementation Database indicate that Kiribati, Marshall Islands, Federated States of Micronesia, Palau, Samoa, Singapore, and Tuvalu do not grow tobacco, while in Solomon Islands and Vanuatu, there is small-scale tobacco growing for personal use and sales (69, 70, 71, 72, 73, 74, 75, 76, 77, 78). In 2017, the Niue Ministry of Social Services adopted legislation prohibiting the commercial growing and manufacturing of tobacco (79).

To reduce tobacco-related death, disease and disability, different measures to reduce the demand for tobacco are introduced and applied in SIDS. For example, 13 SIDS have adopted legislation to make all indoor public places completely smoke-free (Antigua and Barbuda, Barbados, Guyana, Jamaica, Marshall Islands, Nauru, Niue, Papua New Guinea, Seychelles, Suriname, Saint Lucia, Suriname, and Trinidad and Tobago,) (67). In Kiribati, traditional community leaders have declared their maneabas (community halls and meeting places) tobacco-free, with over two-

hundred such manebas smoke-free as of 2018 (80). 13 SIDS mandate large graphic warning labels on tobacco products to warn the public about the dangers of tobacco use (Barbados, Fiji, Guyana, Jamaica, Maldives, Mauritius, Samoa, Saint Lucia, Seychelles, Solomon Islands, Suriname, Trinidad and Tobago, and Vanuatu) (67). Vanuatu has the largest graphic health warnings in the Pacific covering 90% of the display area (81). Mauritius is the only country among the SIDS, other than Singapore, to have implemented plain packaging (67, 82). 10 SIDS have put in place comprehensive bans on all forms of tobacco advertising, promotion and sponsorship (Antigua and Barbuda, Guyana, Kiribati, Maldives, Mauritius, Niue, Seychelles, Suriname, Tuvalu, and Vanuatu) (67). Only one SIDS (Mauritius) levies a share of total taxes of at least 75% of the retail price of cigarettes, as recommended by WHO (67).

The tobacco industry exploited the COVID-19 pandemic to gain influence and achieve interference in national public health policies, using government vulnerabilities such as national funding shortages, corporate social responsibility strategies and to use the political and legislative attention needed for the pandemic to detract from actions necessary for tobacco control (83, 84). By purporting to offer solutions to governments to address the pandemic, the tobacco industry further slows or impedes the development and implementation of tobacco control measures. It is important that SIDS remain alert to any efforts by the tobacco industry to undermine or subvert tobacco control efforts and stay informed of activities of the tobacco industry that have a negative impact on the tobacco control effort.

SIDS may also leverage international legal instruments to which they are Party to address climate change issues while pursuing public health objectives. For example, tobacco control and climate action are mutually reinforcing. From supply reduction measures, such as supporting alternative economic livelihoods for tobacco growers or banning tobacco sales to minors, to demand reduction measures, such as making tobacco products less affordable, smoke-free environments, warning labels, advertising bans and tobacco cessation support, WHO FCTC implementation can both contribute to positive climate outcomes and raise awareness around climate change.

## 2.2 Economic and commercial drivers of alcohol consumption

SIDS experience a wide range of health harms from alcohol, including through NCDs, injuries, violence including gender-based violence, suicide risk, crime and drowning (85, 86). As of 2019, alcohol consumption is generally lower in SIDS (4.35 litres of pure alcohol per capita in 2019 (15+)) than it is globally (5.45), although the rates for the Caribbean region (5.43 litres of pure alcohol per capita) is closer to the global average. As is the case globally, alcohol consumption in SIDS is more prevalent among men (6.96 litres of pure alcohol) than women (1.74 litres of pure alcohol) (87). The global school-based student health survey found that alcohol use rates among students aged 13-17 was found to be 32.8% in Trinidad and Tobago and 48.9% in Jamaica in 2017, and 46.3% in Saint Vincent and the Grenadines in 2018 (88, 89, 90). Alcohol consumption among young people has a negative effect on brain development, decreased educational attainment, low mental well-being, greater alcohol consumption throughout the lifespan, higher likelihood of binge drinking and increased risk of alcohol use disorders and earlier development of liver cirrhosis.

Sports sponsorships by alcohol producers are prominent in SIDS, which is a way to market alcoholic and sugar-sweetened beverages and brands to younger audiences, increasing the risk of alcohol use and dependency in adulthood (91). Sport activities sponsored by the alcohol and

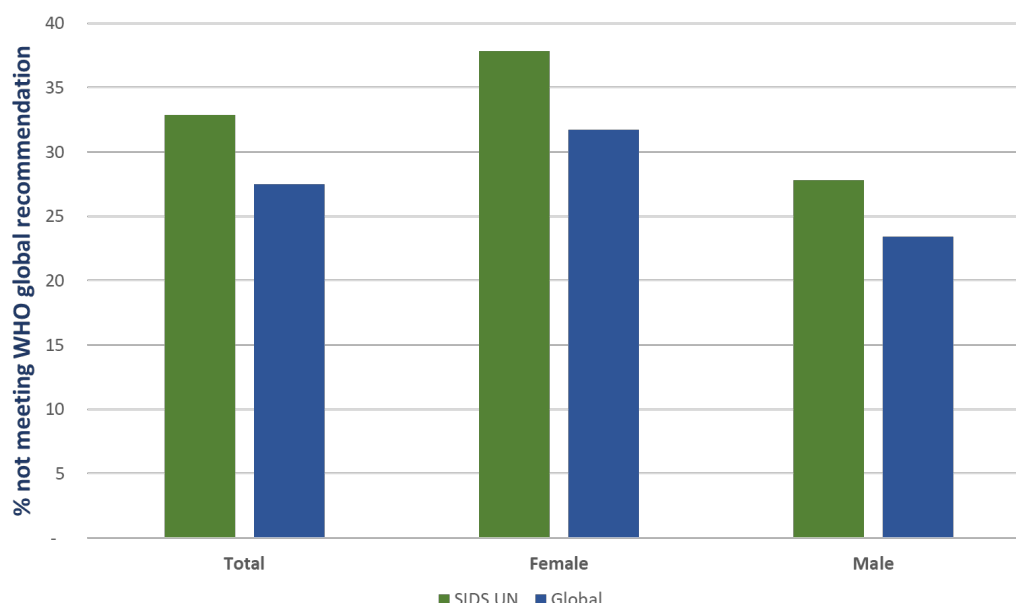
sugar-sweetened beverage industry in SIDS include those in primary and secondary schools, for elite athletes, as well as community-based sports (91). The results of a review of interventions undertaken between 2000 and 2019 (inclusive) to improve the nutrition of SIDS populations found restrictions on the availability of and increased taxation on alcohol were the most commonly reported policies that were partially or fully achieved (92). At the same time, tools are needed to assist governments in preventing the alcohol industry from exploiting times of extreme mental stress, such as during the COVID-19 pandemic, as market opportunities to increase alcohol sales and use (93, 94).

Although SIDS progress on alcohol policy implementation is comparable to global trends, alcohol sponsorship and advertising remains a policy challenge in SIDS (93). Some commercial actors from the alcohol industry have played a role undermining public health policy objectives and opposing effective alcohol policies (91). The implementation of alcohol policy for some SIDS is undertaken in the context of the links between alcohol consumption and tourism, and the role alcohol plays in their economies as an export product. In the Caribbean, industry market analysis anticipates a surpassing of 2019 total beverage alcohol volumes in 2024, positioning alcoholic beverage consumption as a commercial opportunity for SIDS in the context of COVID-19 pandemic recovery (95). Transnational alcohol corporations have concentrated the markets, with one company holding 57.2% of the market share in Latin America and the Caribbean in 2020 (91).

### 2.3 Economic and commercial drivers of physical inactivity

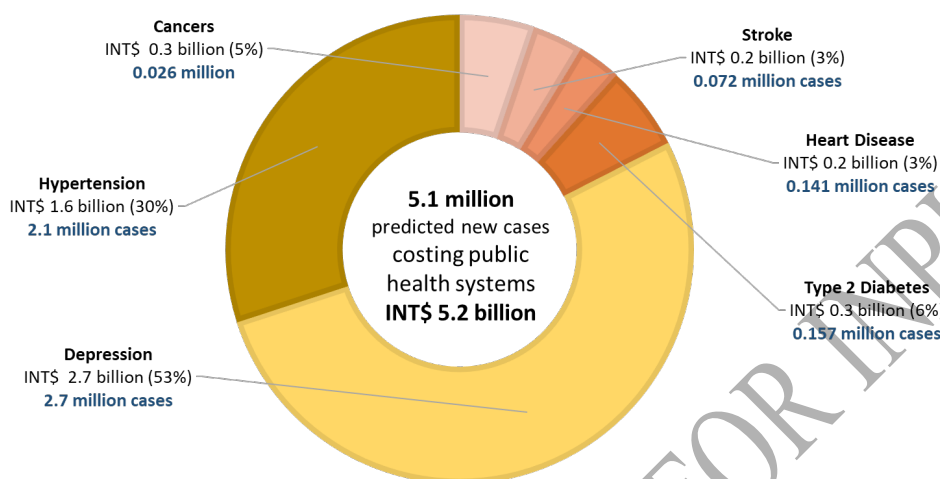
Physical inactivity is a recognised modifiable risk factor for preventing NCDs (96). Data from 2016 showed that globally, one in four adults (27%) are insufficiently physically active (97) however in SIDS, on average, one in three (33%) do not meet the global recommended level of 150 mins of moderate-intensity activity per week or equivalent (Figure 1). Levels of physical inactivity are higher in women compared with men (globally 32% in women versus 23% in men) and these differences are wider in SIDS (38% in women versus 28% in men). Women often face multiple barriers to being regularly active including fewer gender sensitive opportunities for participation in physical activity, as well as social, cultural and economic constraints (97). As of 2016, levels of physical inactivity between SIDS countries vary and are highest in The Marshall Islands (47%), Nauru (46%), Palau (45%) and Barbados (45%)(97).

**Figure 1. Levels of physical inactivity in SIDS UN countries and globally in WHO Member States**



Globally, levels of physical inactivity in adolescents are very high (81%) and highest in some SIDS. For example, data from 2020 showed that 87% of students aged 11-17 are not meeting recommended levels of regular activity in Nauru, Samoa, Tuvalu and Vanuatu, and 86% in Saint Vincent and the Grenadines (98). Of particular concern is the increasing time reported to be spent using screen-based technologies for entertainment and communications by adolescents. In these countries, for example, in 2022 students spend three or more hours per day doing sedentary activities, such as watching television, playing computer games or talking with friends when not in school (90, 99, 100, 101, 102).

Physical inactivity creates a preventable burden on primary health care services and public health care costs. New WHO estimates (Figure 2) reveal that in SIDS between 2020-2030, approximately 5.1 million new cases of NCDs and mental health conditions (such as heart disease, stroke, hypertension, diabetes, several cancers, depression and dementia) could be averted by increasing physical activity participation (103). The direct costs to the public health systems in SIDS associated with the first year of treatment of these 5.1 million cases is estimated at INT\$5.2 billion. Over half (53%) of these costs are due to new cases of depression (INT\$2.7 billion), and 30% due to hypertension (INT\$1.6 billion) followed by diabetes (INT\$0.3 billion) with the remaining costs across cancers, heart disease and stroke.

**Figure 2. Cost of predicted new cases of NCDs attributable to physical inactivity in SIDS between 2020-2030**

Research shows participation in physical activity is strongly associated with various environmental as well as socio-cultural and economic factors in SIDS and globally (104). In general, more advantaged communities have better provisions of, and access to opportunities to be regularly active, whether through sport, exercise or safe walking and cycling for transport or recreation. In SIDS, only 16% of population reported in 2020 doing any physical activity in their discretionary (or “leisure”) time and this ranges from 20% in upper- and middle-income SIDS to 12% in low- and lower-income SIDS (104). At the country level, The Marshall Island and Palau reported the highest level of discretionary-time physical activity (34% in each) and Timor-Leste with the lowest (2%). Addressing the inequities in access to affordable, safe opportunities to be physically active that are appropriate to age, sex and context must be addressed.

A recent review of the barriers to and facilitators of physical activity for children and adolescents living in Oceania with Non-European, Non-Asian Ancestry found that distance between the home and sporting facilities, safety concerns on the road and within communities, food insecurity and village curfews were all key barriers to regular engagement in physical activity. In some Caribbean SIDS, unsafe and poorly maintained public spaces, such as absent or improper infrastructure for walking and cycling, water hazards and the absence of drowning prevention for recreational and water sports, are key barriers. With seasonality and extreme weather identified as a barrier to participation in physical activity (105), the changing climate of SIDS may also further impact physical activity now and into the future (106). Additionally, rural communities are often not able to access or afford the equipment and facilities to engage in physical activity during leisure time (107).

Physical activity can also be accrued through work and household-related tasks and in SIDS this domain accounts for just over half (52%) of the total reported physical activity—based on data collected between 2002 and 2019 (104). While traditional, subsistence-based work in SIDS and globally can be physically very demanding, as economies transition and with the adoption of new

technologies employment is often more sedentary (107, 108). In SIDS, the declining levels of physical activity through work must be counteracted by increased physical activity opportunities in other domains and settings.

For women in particular, working long hours, and often in predominantly sedentary employment environments, as well as being responsible for household and childcare activities are barrier for engaging in physical activity. These challenges can be further compounded by poor access to safe, inclusive and affordable opportunities for physical activity. Improving the built environment, for example through creating more public open spaces (e.g., parks) and improving the walking and cycling networks and road safety, are likely to improve physical activity, particularly for disadvantaged communities. Ensuring provision of these environments requires robust policy, legislation and regulatory requirements and enforcement (109).

Physical activity through transport (such as walking and cycling) accounted for one third (32%) of total physical activity in 2020 (104). Access to safe roads with adequate provision for walking and cycling is essential to maintaining and increasing current levels of transport-related physical activity. It also requires management of the influence from the commercial sectors such as land developers and car industry. The industry marketing of motor cars and motorbikes is aimed at encouraging a transition from “active” transport to personalised transport with the associated increased requirements on land use for roads, street design to accommodate increased traffic, and increased parking. In SIDS this is further compounded by pressures to change land-use, for example, for tourism or other commercial and housing development, which can infringe on the local communities’ access to and mobility in previously open spaces (106, 110).

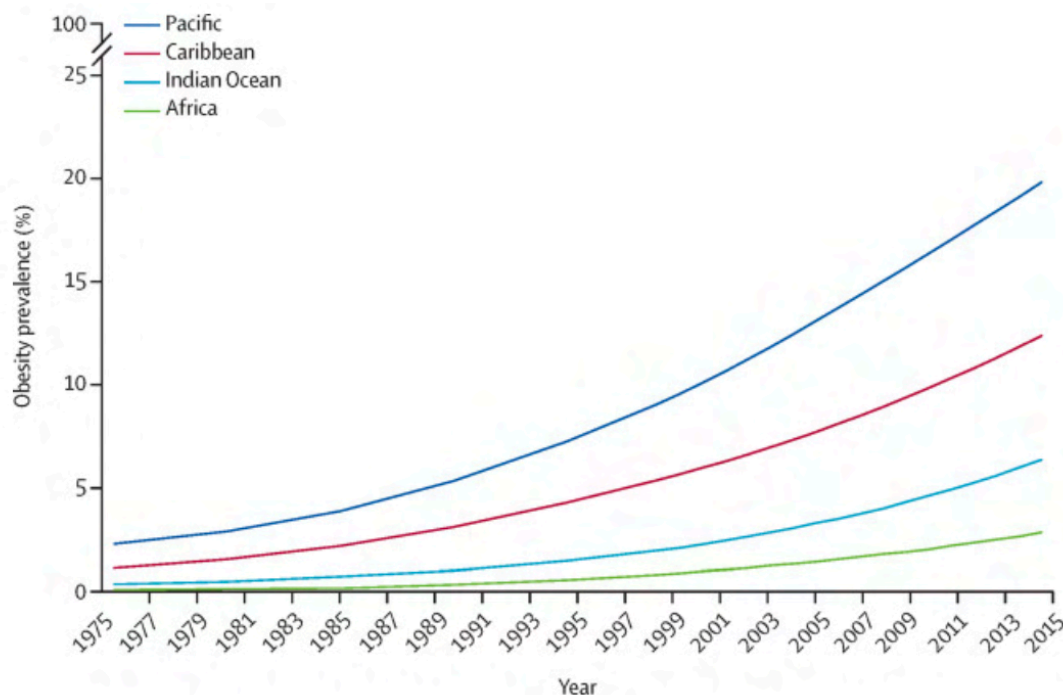
Perceptions of physical activity for specific population groups illustrates the barriers and enablers to physical activity in SIDS. This is particularly important in indigenous communities where often traditional lifestyles were more active and intrinsically embedded with engagement with the environment (107, 111). This includes values, norms, ways of life, motivations, enjoyment, family commitments and social support underpinning physical activity, and the value of integration with cultural components such as traditional dance and music, prayer, community orientation and family inclusiveness (112). Considerations of gender and cultural contexts are also particularly important to engage women and girls in structured exercise, incidental exercise, and sports, providing them with environments in which they are safe and accepted in which to exercise and play (111). Addressing the social, economic and commercial barriers in SIDS is fundamental in national and subnational efforts to effectively increase participation in physical activity and thereby improve health and wellbeing.

## 2.4 Economic and commercial drivers of unhealthy diets

Obesity rates in SIDS continue to increase, in part due to the over-availability, widespread marketing, reliance and entrenchment of importing foods and non-alcoholic beverages that are high in saturated fatty acids, trans-fatty acids, free sugars and/or sodium, and typically highly processed (HFSS foods), and their relatively high consumption, and the underlying economic, social and commercial determinants behind these trends. Five of the top 10 countries with the highest overweight and obesity rates in the world in 2016, and seven of the 10 countries with the highest rates of diabetes, are Pacific Island countries and areas (113, 114). Islands in the Western Pacific Region and the Caribbean, which represent most of small island developing states, have high levels of overweight/obesity (for example, over 60% of adults in the Caribbean, and up to

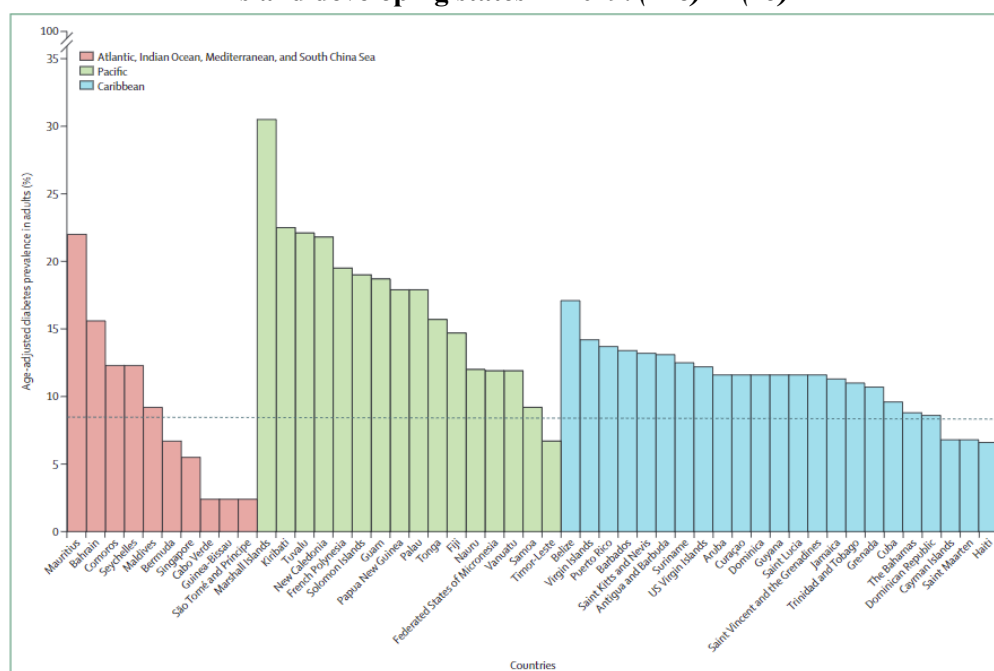
80% in some Pacific Island states) (115, 116). Childhood obesity is of particular concern in SIDS, with rates above the global average, particularly in the Pacific SIDS (Figure 3). In 2020, the average prevalence of overweight in children under five years of age in SIDS was 6.6% (compared to the global average of 5.7%), having increased since 2012 (6.3% compared to the global average of 5.6%) (117).

**Figure 3: Trends in childhood obesity prevalence in small island developing states(61)**



Many SIDS have higher diabetes prevalence rates than the global average, represented in figure four by the dashed line (Figure 4) (118) in (15).

**Figure 4: Age-adjusted comparative prevalence of diabetes in adults (20-79 years) in small island developing states in 2019. (118) in (15)**



Obesity in these contexts is primarily driven by a change in the diets of local populations from traditional, locally grown staples to imported, energy-dense, HFSS foods and beverages (15). This shift away from agricultural production has been shaped by economic and commercial factors driving this nutrition transition in SIDS, including the colonial legacy of land ownership and land division, land loss and pressures, as well as increasing migration and urbanization (120, 121, 122). It is also impacted by climate change and increasing droughts within the countries, as well as prohibitive inter-SIDS trade provision and shipping costs and other barriers, when compared to importing food internationally.

Traditional indigenous diets were fibre-rich, including seasonal fruits, legumes, nuts and seeds and cultivating endemic species plants (15). As noted in a regional UN Conference on Trade and Development (UNCTAD) meeting, fishing remains a mainstay of economic activity, but remains challenged by issues such as illegal fishing (123). Unsustainable fishing or fishing insufficiently regulated to protect local fisheries and local consumption has direct impacts on health, as depleted stocks require island fishermen to work longer hours, farther from shore, in less safe conditions (124). Research has shown that indigenous populations in rural areas of Pacific SIDS have a more varied diet which is more likely to meet WHO recommendations of consuming more than 400 g of non-starchy fruits and vegetables daily (125). In 2021, only 13 of the 38 Member States SIDS had food based dietary guidelines (FBDGs) to inform and guide policy work along the food system, and no FBDGs explicitly incorporated environmental sustainability elements.

Not only do pollution and climate-change-related extreme weather events hamper the ability of SIDS to reliably produce food, the current reliance of SIDS on imported food amplifies the risk of periodic food insecurity during natural disasters (15). For instance, fish provides 50-90% of all animal-based protein in diets in SIDS, but this key source of food may be at risk due to unsustainable fishing or fishing insufficiently regulated to protect local fisheries and local consumption (126) which have displaced traditional methods of marine stewardship. Similarly,

increased food insecurity due to climate change may force SIDS to import even more food products and have an even higher dependency on international trade in the future. Severe climate-related health events may also create opportunities in which the food industry may step in and distribute or market cheap HFSS foods at a time where consumption of high-quality foods is even more critical. Agricultural food production in SIDS is also likely to be affected by increased salinisation of aquifers associated with sea level rise and overall drought reducing water availability (127, 128). Traditionally SIDS communities utilised climate-adaptive practices to create self-sufficient food production, mostly consisting of a plant-based and minimally processed diet (15).

The State of Food Security and Nutrition in the World 2022 report, jointly prepared by FAO, IFAD, UNICEF, WFP and WHO, notes moderate or severe food insecurity was experienced in 48.9% of the total population of Small Island Developing States (in 2019-2021, compared to the global average of 28.1%) (117). Approximately 50% of SIDS import more than 80% of their food (129). This not only impacts health, but also creates a lack of food sovereignty within SIDS, resulting in food insecurity as it renders SIDS more vulnerable to disruptions in supply chains arising, including those as a result of climate change or global pandemics, as experienced during COVID-19.(130). Calls for food sovereignty have been expressed by SIDS leaders during the UN Food Systems Summit.

FAO notes that HFSS foods and beverages constitute a large proportion of SIDS imports and are often less expensive and more widely available than locally produced foods (126). This is in part facilitated by economies of scale, as larger countries can produce large amounts of food at cheaper price than locally produced food within SIDS. For example, half of all CARICOM countries import 80% of food and beverages for consumption (131) and it is generally cheaper and with fewer barriers to import foods than conduct inter-Caribbean shipping. It is also partly due to the displacement of Indigenous Peoples from their land, which increased their dependency on food imports and increased their food insecurity (122).

The availability and high accessibility of HFSS foods and beverages contributes to the global syndemic where the threats (epidemics) of climate change, obesity and undernutrition and micronutrient deficiencies coexist in the same populations (125, 132). In 2017, to reduce the high obesity rates associated with imported unhealthy food, the province of Torba in Vanuatu explored restricting imported foods in favour of domestic produce. French Polynesia imposed production and consumption taxes on products identified as imposing health risks and Tonga, which has one of the highest obesity rates in the world, is implementing import duties on meat offcuts high in saturated fats (131). Countries that apply uniform SSB tax structures include Barbados, Bermuda, Cook Islands, Dominica, Kiribati, Mauritius, Nauru, Palau, Samoa, Seychelles and Vanuatu (133, 134, 135). An evaluation of the 10% tax imposed in Barbados found that this tax led to a 4% decrease in the average weekly sales of these drinks, and an 7.5% increase in bottled water sales (133). Barbados has since increased its tax on SSBs to 20%. Seychelles introduced a sugar tax in 2019, raising SCR 44 million in 2020 (approximately 3.14 million USD) (136).

There has been mixed progress on the implementation of the WHO set of recommendations on marketing of foods and SSB beverages to children among SIDS (61). SIDS are prioritising several food policies to create a health promoting and enabling food environment including regulating

marketing of breast milk substitutes; banning the sale and marketing of unhealthy HFSS in school environments; restricting marketing of HFSS foods to which children are exposed; introducing front of pack labelling; and regulating industrially produced trans fatty acids (IP-TFAs). The regulation and implementation of marketing of HFSS food is a challenge in SIDS owing to majority of the content comes from broadcast media based in larger countries (61).

Some SIDS have implemented policies to reduce the availability of HFSS foods in schools. For example, Bermuda implemented a policy banning the sale of sugar-sweetened beverages (SSBs) in schools in 2007, with Vanuatu implementing a similar policy in 2014, and Trinidad and Tobago in 2017, and Jamaica implementing a policy restricting the sale of SSBs in schools in 2019 (137, 138). More recently, Barbados has adopted a new policy that bans the sale and marketing of sugar-sweetened beverages in and around schools in 2022 (139). While St Lucia planned to implement a ban on sugar-sweetened beverages in schools in January 2023, this has been suspended until further notice to allow for broader stakeholder engagement and information dissemination (140).

IP-TFAs are banned in almost every high-income country, but in few LMICs. The implementation of such a ban in SIDS might be made more challenging by the lack of in-country testing, which limits enforcement. In the Caribbean some countries are working directly with their commercial actors to support the removal of IP-TFAs from the food supply (141).

Improving health through better food environments is a central component of the SIDS Accelerated Modalities of Action Pathway (SAMOA Pathway) (142), as part of an integrated approach to sustainable development. A key follow-up to the SAMOA Pathway has been the Global Action Programme on Food Security and Nutrition in Small Island Developing States (GAP), which aims to create healthy food environments, transform food systems, and empower local communities (126). Similarly, the outcome statement of the 2021 SIDS Health Summit emphasizes the need to maintain healthy, sustainable and resilient food systems which deliver healthy diets while preserving biodiversity (9). Doing so will require addressing the role of some commercial actors in creating food environments that drive obesity within SIDS. As one example, a review of government consultation submissions in relation to the aforementioned 'sugar tax' in Bermuda showed how commercial actors universally opposed this measure, thereby potentially undermining the health goals that were envisioned through implementation of this tax (143). Similarly, research in Fiji has shown that the food industry tried to shape public health-related policies and programs in their favour, including by establishing relationships with the community, media and policymakers and by bringing in experts from overseas to consult with governments on public health policies (144). Similarly, an unpublished paper identified that in Barbados, representatives of multinational soda companies attempted to persuade the government not to introduce its SSB tax by instead offering assistance with promoting physical activity in the fight against NCDs (115).

Globally, challenges are posed by power imbalances, particularly with multinational companies. For example, trade challenges by more powerful stakeholders undermine the ability of lower- and middle- income countries to enact WHO recommendations, such as marketing legislation and other policy best-buys (145, 146). A case study of certain SIDS found they remain unable to implement regulations to promote, support and protect breastfeeding, in line with the International Code of Marketing of Breast-milk Substitutes (147), or enacting WHO recommended restrictions

to marketing of foods and beverages (115). WHO guidelines on "Policies to protect children from the harmful impact of food marketing" will be published in June 2023.

## 2.5 Economic and commercial drivers of air pollution

SIDS are some of the least contributing countries to CO<sub>2</sub> emissions and other pollutants, even though they are heavily impacted by the consequences of this pollution. Despite a lack of baseline data on key pollutants in SIDS (148), more work can be done to provide technical guidance for SIDS in how to address this risk factor. Air pollution remains a major challenge for SIDS, although the median annual mean concentration of fine particulate matter is estimated to be, at 9 µg/m<sup>3</sup>, much lower than in other countries (20 µg/m<sup>3</sup>), yet still above the WHO guidelines of 5 µg/m<sup>3</sup> or less (68).

Particulate matter, waste management and household air pollution are all contributing factors to this air pollution. As well as fossil fuel-driven transportation and power generation, other sources include the use of agricultural fumigants, unchecked industrial stack emissions, gas flaring, cruise ships and airplanes, rotting sargassum seaweed, inefficient waste management systems for hazardous and toxic wastes, and open pit burning, among others (148, 149). Due to a lack of alternative options, SIDS also experience heavy usage of dirty fuels for cooking in some places, poor controls of vehicle emissions and the burning of household refuse.

## 2.6 Economic and commercial drivers of injuries and violence

The way injuries manifest in SIDS varies by type of injury. SIDS face challenges relating to adequate transport infrastructure placing strains on supply chains for healthier food, water, medicines and health technologies (150). A significant proportion of the disease burden attributable to alcohol consumption arises from unintentional and intentional injuries, including those due to road traffic crashes, drowning, violence, and suicide (151).

Globally, road safety remains the main cause of injury and although this differs between SIDS, the relative burden of road traffic injuries can be important (152, 153). A 2012 population-based study into road traffic injuries in Viti Levu, Fiji found that 17% of all injury-related deaths and hospital admissions were related to road traffic injuries, making it the third most common cause of injury on Viti Levu (154). In 31 SIDS countries with data, the death rate for road traffic deaths in 2019 was 21.9, which is higher than the global average (16.9 per 100,000 population) (152).

SIDS that have had rapid economic and infrastructure development, and accompanying increased motorization, face higher rates of road injuries and death if this development has not been matched by investments into capacity and interventions to ensure road safety (152). These pathways and could benefit from considerations including strengthening public transport systems, climate-resilient transport infrastructure, import of safe vehicles, safe speeds and post-crash care.

As SIDS primarily import their vehicles, there is an important role for ensuring import standards meet international vehicle safety standards, and particularly in preventing the import of those vehicles that are unsafe or substandard, this may lead to increased road traffic injuries, as well as more pollution (155). The Global Plan for Road Safety recommends regulations for the export and import of used vehicles that are accompanied by inspections at entry and exit points, and mandatory periodic technical inspection of vehicles (153).

Increases in road transportation in SIDS places a burden on people's health not only through road traffic injuries but also through respiratory illnesses, noise, and reduced physical exercise (156). Similarly, climate change may itself be expected to have an impact on road safety, for instance when coastal erosion or floods threaten existing road networks. These impacts can be mitigated, as was shown in Anse a la Mouche, Seychelles, where the government instituted coastal protection through land reclamation in 2013, thereby protecting a main road as well as creating a local green space (157).

Drowning rates vary across SIDS, but are generally substantially higher than non-SIDS countries. It is linked to commercial activities in tourism, fisheries and due to the important role that water transportation plays in SIDS. WHO 2019 Global Health Estimates show that, for the 31 SIDS countries for which GHE drowning rates were available, the average drowning rate was 4.5 deaths per 100,000 population whereas the average drowning rate for the 152 non-SIDS countries was 3.1 deaths per 100,000 population. All six countries with drowning rates of over 10 per 100,000 population are SIDS (158). In the Caribbean, the countries with the highest level of unintentional drowning mortality are Guyana (18.5 deaths per 100,000 population), Haiti (1.6) and Saint Vincent and the Grenadines (6.9), while Jamaica has the lowest level of unintentional drowning mortality with 0.3 deaths per 100,000 population (159). Timor-Leste reported the highest standardized drowning death rate in the South-East Asia Region in 2019 (160).

Tourism is a major commercial sector for many SIDS with implications for drowning. Tourists may be at increased risk of drowning as not all travellers have adequate water safety skills and not all tour providers are trained to ensure their clients' safety while swimming, kayaking, snorkelling or diving (161). Participating in water-based activities in unfamiliar environments can expose people to unknown dangers, particularly if signage or other forms of public information are not displayed to warn of potential risk or recommend minimum required water safety skills (162). There are opportunities to engage travel and tourism government agencies and industry stakeholders in drowning prevention initiatives, including to develop water safety messaging and training, CPR training for local businesses and accommodation providers, media awareness campaigns, water safety flyers and school education programmes (162). However, there is a lack of legislative and monitoring and evaluation roles across these sectors.

Fishing and fisheries are commercial sectors which provide livelihoods and nutrition for many communities in SIDS with implications for drowning. Risk of drowning while fishing increases during hazardous weather, at night-time when there is low visibility, and when safety equipment is not available. Safety at sea for small-scale fishers can be improved through performing routine safety inspections of vessels used for fishing, providing appropriate training for crew and regularly checking weather forecasts (163).

Drowning intersects closely with factors including the consumption of alcoholic beverages and drugs in and around the water, and a lack of swimming education, including for indigenous communities, women, ethnic minorities, First Nations people, migrants and rural residents (86, 161, 162). Across many SIDS, there is a lack of action to teach school-age children water safety skills, as well as a lack of interventions to create public awareness about drowning and alcohol use and swimming/boating (160).

Drowning is the leading cause of death in flood disasters, with climate change projected to increase the frequency and severity of flood disasters over time (164, 165). Flood disasters are a particular concern for SIDS, including those stemming from king tides, tropical cyclones and typhoons.

SIDS are taking action to prevent drowning. The Ministry of Health in Guyana has recognised drowning as a key area of focus, focusing on actions such as installing barriers to control access to water, teaching swimming, water safety and rescue skills and setting, enforcing safe boating, shipping and ferry regulations and improving flood risk management (166). Similar approaches in other SIDS could go a long way to addressing drowning risk factors including those with ties to commercial activities and making transport over water – a daily reality in many SIDS – a safer prospect. In the Maldives and Timor-Leste, multi-sectoral approaches to drowning prevention and water safety have been adopted that stakeholders in fisheries, tourism and transport (160).

In several SIDS (e.g. Haiti, Jamaica, Papua New Guinea, and Suriname) homicide is a leading cause of death in adolescent and young adult males in 2019, and a leading cause of physical injuries requiring costly emergency medical care (167, 168). Such violence is frequently associated with trade in illicit drugs, high levels of gang membership, and alcohol use. Moreover, studies covering SIDS in the South East Asia and the Pacific regions have demonstrated that child maltreatment is a leading risk factor for adult involvement in physical, sexual and emotional violence against women (169, 170).

Gender-based violence is experienced by more than 60% of women in some SIDS when the global average is one-third of women (171, 172). This is most often perpetrated by an intimate partner. Data from Kiribati in 2013 show that 68% of women have experienced physical and/or sexual violence by an intimate partner (173). Importantly, these numbers may not be an accurate representation of the burden of gender-based violence, as it has been noted that there is stigma associated with reporting this type of violence. Moreover, even when survivors are willing to report instances of violence, the appropriate systems and services may not be in place. Formal sexual and gender based violence services are largely absent in the Pacific region for example, and where they do exist, resources are scarce and inadequate to respond to the problem, particularly during disasters (173).

Climate-related and other disasters are likely to increase the prevalence of sexual and gender-based violence, through multiple pathways many of which are linked to economic and commercial drivers – including economic instability, food insecurity, mental stress, and disrupted infrastructure - both during and after disasters (174). For instance, the population of Vanuatu experienced a 300% increase in new domestic violence cases at the Tanna Women Counselling centre after two tropical cyclones hit the Tafea region in 2011, and increased rates of sexual and gender based violence were reported following the Gizo tsunami that hit the Solomon Islands in 2007 (173, 175). Concerns of women being disproportionately affected have also been raised during the COVID-19 pandemic.

Gender equity varies substantially among SIDS in terms of rights, education level, and poverty, with women often working in more precarious, lower-paid employment (150). Particularly for single parent households, and in SIDS where the ‘feminization’ of poverty has been observed,

there is a risk that economic and social disruption associated with the pandemic may worsen gender inequities, with long-tail consequences for women and children. These include pandemic-related job losses, unpaid work and risks of gender-based violence experienced disproportionately by women, and compounded effects of lack of access to education between mother and child (176).

The Women's Major Group has called for SIDS initiatives to "*recognize and redistribute the unequal and unfair burden of women and girls in sustaining societal wellbeing and economies*" (177), as well as a strengthening of action and legislative compliance to comprehensively address sexual and gender based violence (177). SIDS countries have increasingly integrated gender equality initiatives into climate action. For instance, Fiji, Grenada, Jamaica, Maldives, Papua New Guinea, St. Lucia, Tonga and Vanuatu have all integrated gender perspectives in their Nationally Determined Contributions (178).

## 2.7 Economic and commercial drivers of mental health conditions

The Global Burden of Disease Study 2019 estimates indicate mental health conditions are commonplace, with an estimated 15.2% of the population in the Caribbean and 11.2% in the Pacific having a mental disorder and standardised suicide rates disproportionately high relative to global averages (179). Estimated suicide rates vary widely across SIDS. Where some SIDS in Americas region are estimated to have suicide rates below one per 100 000, Guyana has one of the highest suicide rates in the world, with 17.4 per 100 000 for women and 63.0 per 100 000 for men in 2019 (158). Mental health conditions affect, and in turn are affected by, commercial drivers of other NCDs, and can be both a precursor and consequence of these factors. Research indicates that having a mental health condition makes a person approximately twice as likely to use tobacco products, after adjusting for other factors affecting tobacco use behaviour (180). Tobacco use increases levels of depression, anxiety and stress, attention deficit hyperactivity disorder (ADHD) and psychiatric symptoms and reduces the effectiveness of medications for mental health (180).

Mental health challenges maybe caused or exacerbated by commercial actors through several pathways, particularly through the sale of health-harming products or services, such as alcohol or gambling, that have been linked to adverse mental health risk. Through seeking to maximise sales, commercial actors play a key role in shaping the social and physical environments that lead to these health-harming outcomes. High alcohol use in particular, which is associated with direct NCD risks and gender-based violence as well as mental health conditions, occurs in particular in situations where there is high unemployment, limited leisure activities or which seek to attract tourism (169). Besides those using their products, commercial actors may also negatively impact the mental health of their workforce through poor labour conditions. In some countries the mental health burden is exacerbated by the social disruption and poverty caused by bonded labour and child labour in tobacco farming.

Research identifies an adverse relationship between over-tourism, community well-being, and economic development, with SIDS at risk of tourism models disconnected from society and the community while exacerbating ecological degradation, policy ambiguity, economic disconnectedness, institutional distrust, community discontent and social inequality (181). While a contributor to economic development, the growth of tourism in SIDS is not synonymous with the mental health benefits of poverty reduction, and may risk entrenching existing inequalities if

social sustainability is not valued alongside environmental sustainability and economic growth (182). One example is that the protection of natural environments for the purposes of tourism can undermine local well-being, by depriving local population of access to resources important for maintaining their livelihoods (182).

The COVID-19 pandemic impacted on mental health in SIDS in numerous ways, including through its impact on the workforce. SIDS health systems, including for mental health, faced additional disruptions to their existing workforce challenges, with impacts on the mental health of health workers through exhaustion, anguish and stigma (183). Service industries largely in the tourism sector were heavily affected, including cruise ships, retail and hospitality, and fear of loss of employment negatively affected mental health, though there is evidence to suggest community resilience through employment versatility and family emotional support (184). The absence of stable employment can also negatively affect mental health and well-being, perpetuate vulnerability and increase household conflict (185). People working in sectors where mitigation measures are not easy to implement were also negatively affected by anxiety and stress (186).

Conversely, in sectors such as tourism where employment practices included long hours away from families and communities, some improvements to mental well-being was reported, as a result of people's greater connection to families and communities, appreciation for and connection to the social and cultural gains that stem from a return to ancestral land, spirituality, relearning traditional knowledge, reconnecting with nature, and engaging in alternative livelihoods activities (185).

Including but not limited to the COVID-19 pandemic, prevailing dependencies on un-diverse economies, with the tourism industry as one example, has contributed to economic challenges requiring certain SIDS becoming more dependent on overseas aid and remittances (187). Further, the creation on remittance-related migration is not simply a voluntary choice to pursue employment, but is also forced by a sense of belief that remitted income is necessary for standards of living (188), and an action that may generate financial income but at the expense of domestic resource availability (189).

In addition to the threats to employment and livelihoods, there is a strong association with extreme weather events, which are increasing due to commercially driven climate change, and mental health impacts. SIDS in the Western Pacific are one of the world's most affected regions by extreme weather events, and evidence is emerging that they face disruption to *"life-support systems and population livelihoods and well-being by affecting determinant factors such as food security, malnutrition, water security, vector- and water-borne diseases and displacement affect the population's mental health/psychosocial condition"* (38). These impact on communities through fear, stress, anxiety, anger, powerlessness and exhaustion as a result of acute and slow-onset weather events, which are not only heightening, but also becoming repeated and prolonged. In addition to this, these disasters solicit grief and sadness from a reckoning of losing places of identity and culture (39). The damage to health buildings, essential supplies and transportation infrastructure during adverse weather or climate events affects their capacity to provide critical health services in emergency situations, compounding stress for those in need of acute or chronic care due to NCDs (68).

Lack of adequate mental health statistics for SIDS also makes it difficult to monitor and evaluate. Currently most countries only report on suicide rates, overlooking data such as disease burden and service activity (190). This lack of data on youth mental health in some SIDS is a significant barrier to policy action (191).

The mental health situation remains unmonitored, deprioritised and stigmatised in SIDS contexts, while a lack of mental health professionals also means that conditions are often untreated (188). Owing to the relatively small population sizes, remoteness and limited resources of the SIDS, their mental health systems face many common difficulties. These include having few mental health specialists per country, limited access to mental health services, including in schools, and stigmatization leading to underreporting. Data from 2017-2020 across 33 SIDS shows that the median number of mental health workers was 17 per 100 000, although in some SIDS, including Guinea-Bissau, Haiti, Papua New Guinea, the Solomon Islands and Vanuatu, this number was below five per 100 000 (68).

CONFERENCE DRAFT: E

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

#### Key messages

- Current economic arrangements and development approaches are insufficient to address the burden of NCDs, mental health conditions and injuries in SIDS
- These arrangements and approaches may permit and produce economic conditions and policy environments, particularly in trade, that expose SIDS to negative externalities related to the commercial determinants of health.
- This is in part because of the actions of some commercial actors to exert influence over health outcomes in SIDS through both direct means, such as lobbying and marketing, and indirect means, such as shaping knowledge and societal norms.
- A comprehensive response requires action to explore alternative economic arrangements that prioritise well-being, embrace indigenous knowledge and participation and support local businesses, people, products and services.
- It also requires action and policy coherence across sectors, such as increasing revenue through taxes on harmful products and aligning trade and broader fiscal policies with health goals.
- These efforts can be supported with the development of conflict-of-interest tools to safeguard public health policies from commercial interests, and increased community participation in decision-making and accountability mechanisms.
- At the same time, SIDS need international support in the form of more accessible development finance, assistance and debt relief as well as specific initiatives related to climate change mitigation and risk insurance and protection against biodiversity loss.

Achieving the necessary systemic and transformational change for health and wellbeing as called for by the UN 2030 Agenda, requires including progressive economic arrangements, international frameworks, government regulation, compliance mechanisms for commercial entities, regenerative business types and models that incorporate health, social, and environmental goals, and strategic civil society mobilisation, have all been identified as necessary to coherence commercial determinants with health and health equity (192).

Achievement of the SDGs in SIDS will require addressing the economic and commercial determinants of health as part of national strategies to improve outcomes for NCDs, mental health conditions, injuries and violence. Given the small size and interconnectedness of SIDS, commercial actors play critical roles in the health of their communities. Therefore, action that reduces the negative externalities from commercial products and practices and shifts the health-harming practices of economic and commercial actors to health-promoting, is essential to fulfilling the potential of economic and commercial actors with products and services that are aligned to health, to be partners for health for all. This will require a greater understanding of how

economic and commercial drivers impact on population health in SIDS, tailored approaches to safeguard against conflicts of interests, and the critical role of contextualized development approaches in shaping health outcomes in SIDS.

### 3.1 Safeguarding against conflicts of interest and strengthening community participation

Some commercial actors influence public health through lobbying, corporate social responsibility and party donations. For example, through the donations to several political parties from a tobacco company in one of only two SIDS countries to not have ratified the WHO FCTC (193, 194, 195). The WHO FCTC, and in particular Article 5.3, explicitly highlights the need to protect public health policies from commercial and other vested interests of the tobacco industry. These commercial practices have been known to incentivize politicians and political parties to align decisions to commercial interests with negative health externalities. Furthermore, some commercial actors work to influence branches of government to prevent or weaken regulation of their products and services, leading to unregulated activity, limitation of their liability, minimising their exposure to litigation risks and pre-emption of policy planning (196).

This influence extends to impacts on health policy in the domestic legal environment – with both known and undisclosed threats of legal action contesting or undermining health promotion efforts within SIDS (144, 197, 198). The influence of commercial actors also entrenches norms favourable to them leading to cross-border negative health externalities in the form of inter-state legal challenges that advance health harming commercial interests. For example, a tobacco company supported a request made by a SIDS country before the World Trade Organization (WTO) Dispute Settlement Body, alleging that Australia’s plain packaging laws breach the WTO’s General Agreement on Tariffs and Trade (GATT), Agreement on Technical Barriers to Trade (TBT) and agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) (199).

More subtly, commercial actors have been known to influence the knowledge environment, shaping how information and data are obtained and presented to populations, including to influence the research agenda, make policy decisions and shape public preferences (196, 200, 201, 202, 203, 204). Part of the challenge for policy makers remains gaps in information and monitoring of commercial practices (203). Timely, readily understandable, and accurate data about commercial actors and their practices is needed as part of public health monitoring and surveillance, programming and policy development including for tools such as health impact assessments.

Preference shaping occurs through advertising, sponsorships, marketing practices and sales promotion. This includes presenting products harmful to health as beneficial to society, or being aligned with socially desirable traits, or to counter the ‘signalling effects’ following the adoption of a public health law or policy. For example, following the introduction of the SSB tax in Barbados, some commercial actors increased advertising of “juice drinks” as healthy, despite their high levels of free sugars, misleading consumers (203). To further influence knowledge and preferences, some commercial actors found or fund other non-state actor entities such as front groups, consumer groups and think tanks, or exploit the broader perpetuation of corporate social responsibility for marketing or promotional purposes, allowing them to manufacture doubt and promote industry-favourable framings (192, 205, 206). As such, understanding the increasing role

of non-state actors in the geopolitical arena is a fundamental aspect of understanding the development of commercial determinants of health (207, 208, 209).

### 3.2 Empowering communities for participation and accountability

A key action area identified by the Rio Declaration on Social Determinants of Health and many other international commitments is empowered communities supporting action through increased and rights-based participation in building greater accountability and governance for health. The Declaration acknowledges multiple actions to do so, including inclusive and transparent decision-making, strengthened accountability, empowering communities, and governance approaches which span sectors and involve civil society and commercial actors (12). This process of community engagement and participation, coupled with mechanisms to manage and prevent conflicts of interest in political decision-making, is relevant for all efforts to address health-related issues, promote well-being, and develop more effective health interventions, programmes, services, and policies.

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

Institutionalizing meaningful participation in policy decision-making and accountability processes within SIDS is an enabling action to enhance governance and coordination to efficiently and equitably improve health and well-being, including the prevention and control NCDs, mental health conditions, injuries and violence, and their respective modifiable risk factors and determinants (22). Such objectives are already being actioned through the WHO Western Pacific Community Toolkit, in support from partners, to conduct vulnerability assessments, build mental health capacity and community-based microplanning of health decisions (210, 211, 212). In 2021, WHO published a Handbook on strengthening the participation of people, communities and civil society in health decision-making processes (213). The handbook follows through different tasks which policymakers must reflect on when strengthening participatory mechanisms, such as mitigating power imbalances, representativeness, capacity-building and policy uptake of participatory process results. More recently, WHO published a framework for meaningful engagement of people living with noncommunicable diseases, and mental health and neurological conditions (214). This framework acknowledges a core part of community participation is redressing existing institutional and power imbalances that marginalize or discriminate against lived experience perspectives in policy and programme design.

Civil society plays an important role in policy and programme development processes, as an intermediary between government and communities to voice concerns, hold commercial actors and government accountable and support the development and implementation of policies. Safeguarding against conflicts of interest and ensuring transparency and other principles of good governance is a critical component in civil society participation in public policy processes. To institutionalize meaningful participation mechanisms, SIDS countries will need to be able to

invest and sustain sufficient and stable resources, as this requires a commitment to strengthen the capacities of government and communities, ensure routine and sustained participation, and monitor and evaluate the quality of participation and the extent to which community voices inform decisions made.

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

The current burden of ill-health and health inequities in SIDS can be considered due to market failure and as a consequence of negative externalities, in part driven by the economic and commercial determinants of health. Policy and regulatory environments influence the engagement of commercial actors in health harming practices because these environments might incentivise some practices and disincentivise others (215). Therefore, action will require an integrated policy focus moving away from incentives with health-harming consequences and towards incentives that promote health that can displace them, which includes regulating commercial practices to reduce harm at the demand and supply stages. The latter will include by learning from existing efforts to protect and empower nations of all sizes from predatory marketing of breastmilk substitutes (147), from the influence of tobacco companies, from heavy marketing of alcohol, and efforts to improve the delivery of healthy diets through sustainable food systems. These incentives include regulatory incentives, fiscal incentives and trade policy. For example, to reduce the consumption of tobacco, alcohol and SSBs, consider increasing excise taxes for those who have them, introducing excises taxes for those countries that do not have them.

Trade agreements and policies, through their influences on price, availability and promotion of HFSS food products, cigarettes, and alcohol, have accelerated the transition away from traditional diets and nutrition in SIDS. Combining health, trade, and other relevant policy domains is important to identify action points, including health impact assessments (216, 217). Evidence suggests that this is particularly needed in the context of bilateral trade arrangements, which tend to have weaker provisions to support public health objectives (218), which is particularly important for SIDS given they are often dependent on fewer trading partners. Strengthening coherence between trade, health and fiscal policies more broadly present opportunities for co-benefits, for example in strengthening inter-regional trade in the Pacific region for improved food security and increased access to healthier foods (219). Given the size of government procurement in small economies, consolidating procurement for SIDS who are geographically close is an area for further consideration in relation to coherence relating to health objectives, trade and fiscal goals (220).

The unique development challenges of SIDS create greater volatility in revenue generation and domestic public finances than in other LMICs and include their greater exposure to external shocks from natural disasters and climate change, their small and undiversified economies, vulnerability to commodity price fluctuations and their vulnerability to revenue volatility from non-tax sources such as fishing license fees, (40, 221). Finding fiscal space for critical economic and social investments is necessary for achieving the SDGs, for sustained health and human development of children and women, and for realizing human rights, particularly during health crises (222). Accordingly, health taxes can be a revenue booster as part of domestic resource mobilization in SIDS to deliver co-benefits with improving NCD, mental health, injuries, and violence outcomes.

Strengthening coherence of trade and fiscal policies with health goals relating to commercial drivers of NCDs, mental health conditions, injuries and violence is crucial to boosting fiscal space

in a matter that will deliver sustainable economic development. As emphasized in the Outcome Statement of the 2021 SIDS Health Summit, strengthening whole-of-government approaches is a governance opportunity for such policy coherence (9). Modelling with one SIDS indicated that the only way for it to achieve the SDGs within planetary boundaries required scaled increases in public investment, alongside increased taxes on consumption, trade, income, profits, and increased access and utilization of international grants in support of SDG finance (223).

The public health potential of fiscal measures would allow redress in relation to the negative externalities relating to NCDs, mental health conditions, injuries and violence (e.g., taxes on alcohol, tobacco or SSB taxes, or the repurposing subsidies across sectors, among others). The adoption or increase of taxes on tobacco and SSBs is increasingly common across SIDS, with many early global adopters of such fiscal measures (67, 92, 134). There are opportunities for further using best practice to strengthen the design of fiscal measures, for example in the threshold of sugar or ensuring they are at a level of tax that will produce measurable health effects at the population level in the short to medium term. Rebalancing fiscal revenues to reduce risks to health also relates to the levels import taxes on healthy imported products such as fresh food (115).

Since the share of tax revenues in the external financing mix for those SIDS with a GNI per capita of over USD 3 800 in 2023 is on average lower than for other LMICs at a similar level of development, appropriate policy to optimise taxation structures and domestic resource mechanisms remains a priority (44). The IMF has explored specific fiscal rules for SIDS due to their economic vulnerabilities, including fiscal rules that encompass the expected impact of external shocks on fiscal balances, and the adoption of a recurrent expenditure rule as a countercyclical policy tool to handle natural disasters, volatile resource revenues, and uncertain foreign grants (221). Other suggested opportunities for SIDS include exploring untapped tax revenue sources, strengthening uptake of tax and transparency standards, improving tax tracking and collection including with technology, formalising the informal economy and incentivising micro, small and medium enterprises (224).

To enhance the resilient and sustainable development of SIDS, the OECD recommends governments and providers of development co-operation partner to (40):

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

In addition, the OECD advises that the further use of environmentally-related taxes –including on pollution and on environmental resources – would have the advantage of both increasing domestic revenues and incentivising the more sustainable use and conservation of natural assets (40). It is

important that the above discussions relating to revenue mobilization and the respective recommendations are implemented in a manner sensitive to health and health equity.

More broadly, current revenue rules for SIDS may limit their ability to generate and spend tax revenue on the determinants of health and the necessary capabilities to safeguard against conflicts of interest and govern for health and development (221, 225, 226, 227). This could impede the ability of countries to build public capacity and instead requires an undue reliance on external aid for several public capital investments critical for improved NCD, mental health, injury and violence outcomes, such as health, education, social spending, water and sanitation and roads (35, 228, 229). Therefore, approaches to strengthen policy coherence between health and fiscal policy needs to consider the design of fiscal rules to allow for investments that are essential to improve health outcomes.

Alongside action on IMF Special Drawing Rights (SDRs) for a transition to climate mitigation and climate adaptation policies, recent calls for a proposed new UN convention on tax that aims to give low-and middle-income countries decision-making power over global tax affairs (230). In addition to this, further work to strengthen the implementation of existing commitments under the so-called Two Pillar Solution can address the economic and commercial determinants of health, specifically through the minimum tax rate of 15% as part of their approaches to plug base erosion profit shifting practices of multinationals (231, 232).

As emphasized in the Outcome Statement of the 2021 SIDS Health Summit, strengthening whole-of-government approaches is a governance opportunity (9) and the use of “*intersectoral mechanisms such as Health-in-all-Policies, promot[ing]. monitoring systems that take into consideration civil society and commercial actors with appropriate safeguard against conflict of interest*”, and “*assessing the impacts of policies on health and societal goals*”, are already existing commitments by SIDS in their endorsement of Rio Political Declaration on Social Determinants of Health (12). Further investment by SIDS in operationalizing these commitments, with a focus on to facilitating policy coherence amongst relevant policy sectors would be an important action for improving the economic and commercial determinants of health.

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

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

There are opportunities to alter the ways in which ODA is defined and distributed to benefit SIDS. Currently, some SIDS do not qualify for ODA despite the small size and precarity of their economies, while much larger emerging economies do (233). The same is true of climate finance arrangements, which not only under-delivered compared to commitments but are also often heavily skewed towards reducing emissions, which SIDS have little of, rather than financing climate change adaptation and resilience, which SIDS need (54). A significant proportion of climate finance is also currently in the form of loans and similar non-grant instruments, which is especially unappealing to SIDS who already face disproportionate debt payments. Across

environmental risks more broadly, several other underutilised finance options are available to SIDS including debt-for climate, debt-for nature, debt-for-development and debt-for-export swaps, national climate change funds, country financing roadmap, green bonds, key performance indicator (KPI) bonds such as sustainability linked bonds, ecological fiscal transfers, payment for ecosystem services, and airline and hotel taxes (234, 235, 236).

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

More immediately, in light of the COVID-19 pandemic the IMF Special Drawing Rights (SDRs) are receiving attention as an instrument that promises immediate benefits, however falling short of LMICs' financial needs (237). In addition, in October 2021, the G20 and guest countries pledged close to 45 billion USD of their SDRs towards vulnerable countries (238). This would involve high-income countries and the People's Republic of China transferring their recently allocated SDRs to low- and middle-income countries, including SIDS, to be used immediately (239). The G20 and the People's Republic of China would then cover the interest due on these SDRs with a resulting effective transfer of approximately \$441 billion (239). Without needing any of the complicated negotiations and lead-in time of creating a new mechanism, this solution will maintain and leverage the benefits of SDRs including their non-conditionality, no cost lending and low cost exchanges for currency (237, 239). Importantly, the political practicability of this option can be seen in the fact that People's Republic of China has offered to make this transfer already (240). It also mirrors a similar but more ambitious proposal by the Prime Minister of Barbados to use SDRs in the context of COP26, specifically an annual \$500 billion allocation of SDRs to finance climate mitigation and adaptation policies (241).

Research from various sources, including across several multilateral institutions, highlights how SIDS have unique governance resiliencies, capacities and needs at local, regional and international levels. These must be recognised and acted upon to improve and the mitigate adverse effects of the CDoH while improving overall health outcomes. The vulnerability of SIDS as outlined in previous sections of this Discussion Paper needs to be understood as the failure of development approaches to respond to the development needs of SIDS and a result of homogenising economic arrangements and trends that exacerbate health inequities between nations (242). Therefore, the mobilization of additional resources both nationally and internationally is essential to building the necessary capacity to act on the negative externalities and capitalize and increase the positive externalities arising from the economic and commercial determinants of health.

### 3.5 Protecting and promoting health through economic and development approaches

Fundamentally, the examples of economic and commercial determinants of health in SIDS demonstrates the failures of existing economic arrangements and development approaches, particularly with the use of gross domestic product (GDP) as a proxy measure for development, to

deliver for equitable health outcomes for populations in SIDS (243). This highlights the need for alternative economic approaches, that move beyond simple measures of GDP but rather include considerations of well-being, equity and justice, and therefore measuring what matters, to people, to the planet, and the future, as called for by the WHO Council on the Economics of Health for All in its final report (243, 244). This creates a leadership opportunity for SIDS, who have a long tradition of unconventional economic development strategies, often with great success (54). Barbados has introduced a comprehensive set of laws aiming to improve women's labour rights, as well as introducing non-discrimination, equal pay, and improved rape laws since 2019 (245). The Maldives introduced a nationwide minimum wage (245). Hawaii's feminist economic recovery plan for COVID-19, 'Building Bridges, Not Walking on Backs', is one example of a model to mitigate persisting economic marginalisation, particularly for women (246, 247).

The WHO FCTC provides an example of how the vulnerability of certain groups to harms to their health and development can be accounted. In the case of the WHO FCTC, this threat was tobacco and the response was promoting the participation of indigenous individuals and communities in the development, implementation and evaluation of tobacco control programmes that are socially and culturally acceptable (248). It is also a legal tool that further equips Parties to the Convention to contribute to the protection of the environment. Article 18 of the Convention further calls for the protection of the environment in addition to human health. Adopting economic approaches that prioritize shifting to economic alternatives to tobacco growing, in accordance with Article 17 of the Convention, can help restore biodiversity and protect land resources whilst protecting farmers from loss of livelihoods. Given the threat posed to SIDS by negative economic and commercial determinants of health, a similar approach is merited.

Exploring economic arrangements that address reducing immediate NCD risks, addressing structural determinants of health such as in Hawaii or Barbados, as well as investment in social policy such as the Maldives, offer pathways to improve the conditions for social determinants of health equity in SIDS. Including integration with a shift in policies to favour and support local businesses and local people in tourism activities, promoting local products and services (24). In acknowledgement of the disproportionate burden faced by SIDS, several UN programmes of action in relation to climate change mitigation, insurance against risk, protection against biodiversity loss, and human and social development have been initiated (249, 250, 251, 252, 253, 254).

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

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

While potential for improvements to health exist in important fields including supply chains, workplaces, products, services, road safety, access to innovations and technologies as well as many other areas of leadership and excellence by the private sector, more work is needed to prevent the negative health impacts of commercial products and practices.

In their continued commitment and leadership to improving health despite the combination of vulnerabilities and difficulties, SIDS continue to demonstrate remarkable resilience in the face of challenging circumstances.

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

### 4.1 Investment in creating policy environments that enable health.

Addressing the demand and supply side of risk factors linked to commercial practices by fostering policies that support health promoting products and regulating health-harming products and commercial practices. Example actions could include:

- i) Comprehensive best practice health taxation and enforcement to raise prices of health-harming products;
- ii) Regulation and enforcement of availability and use of health-harming products (e.g., regulate alcohol outlets; smoke-free laws);
- iii) Bans or restrictions on advertising and marketing of health-harming;
- iv) Adoption of policies for sustainable local food production and processing to support improvements in the food environment and strengthen climate-resiliency;
- v) Adoption of trade rules and excise duties that support health-promoting products including safe vehicles;
- vi) Integration of commercial determinants considerations into procurement policies;
- vii) Using health impact assessments as part of strengthening policy coherence between health and other policies with economic and commercial relevant to NCDs, injuries and violence, and mental health, such as trade, fisheries and agriculture.

### 4.2 Scaling up what works through safeguarded conflicts of interest

Safeguarding against conflicts of interest as part of adopting, implementing, and monitoring good practices, public health policies, NCD strategies and risk factor approaches as recommended by

WHO. This includes ensuring conflicts of interest are fully addressed in the as part of implementation of WHO technical packages (Annex 4). Example actions could include:

- i) Whole-of-government policies to prevent and manage conflicts of interests for commercial actors aligned with health, and those whose products and services are health-harming;
- ii) Access-to-information legislation to facilitate transparency, monitoring and accountability including health impact assessments.

#### 4.3 Investing in empowered community participation in governance of the commercial determinants of health.

Investing in institutionalized empowered and rights-based community participation in governance of the commercial determinants of health, as part of whole-of-society approaches. This involves working with community-based organizations, indigenous individuals and communities, civil society, the media and health-aligned local commercial actors, youth, people living with NCDs, and academics. Example actions could include:

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

#### 4.4 Strengthening governance for health in development approaches

Building public sector capabilities to integrate economic and commercial determinants of health considerations into development strategies is essential to advance the UN Sustainable Development Goals (SDGs). This includes through financing for development, tax agreements, debt restructuring and governing common goods including land and water, common services and products including in the health sphere. Example actions could include:

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

#### 4.5 Investing in triangular cooperation for action on the commercial determinants of health

The demonstration of political leadership and collective action between SIDS and supported by international partners levels is critical to ensure the prioritization of the commercial and social determinants of health and develop regional or SIDS-level norms and standards for the protection of policies against conflicts of interests that may adversely affect public health strategies and commitments. Examples actions could include:

- i) Integrating commercial determinants of health considerations in implementation of the SAMOA pathway commitments;
- ii) Exploring a ONE UN approach to the commercial determinants of health; and
- iii) Considering the establishment of a SIDS Technical Network on economic and commercial determinants of health.

CONFERENCE DRAFT: FOR INPUT

## References

1. United Nations Office of the High Representative for the Least Developed Countries Landlocked Developing Countries and Small Island Developing States (UN-OHRLLS). List of SIDS: UN Members/ Non-UN Members/Associate Members of the Regional Commissions 2023 [Available from: <https://www.un.org/ohrlls/content/list-sids>. Accessed 8 June 2023].
2. World Health Organization. Policy Brief - Noncommunicable diseases and mental health conditions in SIDS. World Health Organization; 2021.
3. Marmot M, Friel S, Bell R, Houweling T, Taylor S. Commission on the Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. *Lancet*. 2008;372(9650):1661-9.
4. World Health Organization. Social Determinants of Health World Health Organization: World Health Organization; 2021 [Available from: [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1). Accessed 8 June 2023].
5. Braveman P. Health disparities and health equity: concepts and measurement. *Annu Rev Public Health*. 2006;27:167-94.
6. Abdalla SM, Allotey, P., Ettman, C.K., Galea, S., Maani, N., Parsey, L., Ehule, E, Global Equity for Global Health. Think20 Italia: G20 Italia 2021; 2021.
7. Vashi AP, Coiado OC. The future of COVID-19: A vaccine review. *Journal of Infection and Public Health*. 2021;14(10):1461-5.
8. Organisation for Economic Co-operation and Development (OECD). COVID-19 pandemic: Towards a blue recovery in small island developing states. OECD; 2021.
9. World Health Organization. SIDS Summit for Health: Outcome Statement. World Health Organization, 2021.
10. Allen LN, Wigley S, Holmer H. Assessing the association between Corporate Financial Influence and implementation of policies to tackle commercial determinants of non-communicable diseases: A cross-sectional analysis of 172 countries. *Social Science & Medicine*. 2022;297:114825.
11. World Health Organization. Insulin and health technology manufacturers make commitments in support of WHO asks 2022 [Available from: <https://www.who.int/news/item/14-11-2022-insulin-and-health-technology-manufacturers-make-commitments-in-support-of-who-asks>. Accessed 8 June 2023].
12. World Health Organization. Rio Political Declaration on Social Determinants of Health. 2011.
13. Organisation for Economic Co-operation and Development (OECD). Making Development Co-operation Work for Small Island Developing States. 2018.
14. UNDP. Complexity in Small Island Developing States. 2015.

15. Marrero A, Mattei J. Reclaiming traditional, plant-based, climate-resilient food systems in small islands. *The Lancet Planetary Health*. 2022;6(2):e171-e9.
16. Robinson CJ. Corporate Ownership and Management in Small Island Developing States: Implications for Academia. *Public Policy and Management Practices*. 2017.
17. Barry RA, Hill SE, Williams S, Collin J. Challenges of conflict of interest, coordination and collaboration in small island contexts: towards effective tobacco control governance in UK Overseas Territories. *Tobacco Control*. 2022;31(Suppl 1):s39-s45.
18. World Health Organization. Valuing Health for All: Rethinking and building a whole-of-society approach - The WHO Council on the Economics of Health for all - Council Brief No. 3. 2022.
19. Eichengreen BJC, Balazs; ElGanainy, Asmaa A; Koczan, Zsoka. Financial Globalization and Inequality: Capital Flows as a Two-Edged Sword. IMF Working Paper No. 2021/004: IMF 2021.
20. Brewer TD, Andrew NL, Abbott D, Detenamo R, Faaola EN, Gounder PV, et al. The role of trade in pacific food security and nutrition. *Global Food Security*. 2023;36:100670.
21. Hinton L. Discursive Power: Trade Over Health in CARICOM Food Labelling Policy. *Frontiers in Communication*. 2022;6.
22. Healthy Caribbean Coalition. Noncommunicable Diseases and Mental Health in Small Island Developing States – A Discussion Paper by Civil Society. 2023.
23. United Nations Department of Economic and Social Affairs. The COVID-19 pandemic puts small island developing economies in dire straits. United Nations; 2020 05/2020.
24. Hampton MP, Jeyacheya JJ. Tourism and Inclusive Growth in Small Island Developing States. *The Commonwealth iLibrary*. 2013.
25. United Nations Conference on Trade and Development (UNCTAD). Building resilience in small island developing States. United Nations Conference on Trade and Development (UNCTAD). 2022.
26. OECD. Small Island Developing States - SIDS 2023 [Available from: <https://www.oecd.org/dac/financing-sustainable-development/development-finance-topics/small-island-developing-states.htm>. Accessed 8 June 2023].
27. Örnberg JC, Room R. Impacts of Tourism on Drinking and Alcohol Policy in Low-And Middle-Income Countries: A Selective Thematic Review. *Contemporary Drug Problems*. 2014;41(2):145-69.
28. Day J. Tourism, hospitality, and environmental sustainability on the Small Island Developing States. *Current Opinion in Environmental Sustainability*. 2022;59:101233.
29. Corporation IF. Twenty Reasons Sustainable Tourism Counts for Development. Tourism for Development knowledge series. Washington, DC: World Bank. 2017.

30. International Fund for International Development (IFAD). The changing role of women in the economic transformation of family farming in Asia and the Pacific. 2014.
31. Lee D, Hampton M, Jeyacheya J. The political economy of precarious work in the tourism industry in small island developing states. *Review of International Political Economy*. 2015;22(1):194-223.
32. Erik M, Evelyne de L. Exploring the implementation of the framework convention on tobacco control in four small island developing states of the Pacific: a qualitative study. *BMJ Open*. 2013;3(12):e003982.
33. Williams D. Determinants of Outward Foreign Direct Investments from Small Island Developing States. *American Journal of Economics and Business Administration*. 2009;1.
34. Pigou A. *The Economics of Welfare*: Macmillan, 1920.
35. Bertram G. Implications of Graduation from DAC Eligibility for the Cook Islands. 2016.
36. Batra G, Norheim T. Staying Small and Beautiful: Enhancing Sustainability in the Small Island Developing States. In: Uitto JI, Batra G, editors. *Transformational Change for People and the Planet: Evaluating Environment and Development*. Cham: Springer International Publishing; 2022. p. 73-91.
37. United Nations Office of the High Representative for the Least Developed Countries. *Small Island Developing States in Numbers: Biodiversity & Oceans* (2017). 2017.
38. Leal Filho W, Krishnapillai M, Minhas A, Ali S, Nagle Alverio G, Hendy Ahmed MS, et al. Climate change, extreme events and mental health in the Pacific region. *International Journal of Climate Change Strategies and Management*. 2023;15(1):20-40.
39. Clissold R, McNamara KE, Westoby R. Emotions of the Anthropocene across Oceania. *Int J Environ Res Public Health*. 2022;19(11).
40. OECD. *Recovering from COVID-19: How to enhance domestic revenue mobilisation in small island developing states*. 2022.
41. OECD. *The impact of the coronavirus (COVID-19) crisis on development finance*. 2020.
42. World Health Organization. *The impact of the COVID-19 pandemic on noncommunicable disease resources and services: results of a rapid assessment*. 2020. Report No.: 978 92 4 001029 1.
43. Luciani SA-O, Caixeta R, Chavez C, Ondarsuhu DA-O, Hennis A. What is the NCD service capacity and disruptions due to COVID-19? Results from the WHO non-communicable disease country capacity survey in the Americas region. 2023(2044-6055 (Electronic)).
44. Piemonte C. *The Impact of the COVID-19 Crisis on External Debt in Small Island Developing States*. Paris, France: OECD. 2021.
45. United Nations Conference on Trade and Development (UNCTAD). *Small island developing states need urgent support to avoid debt defaults 2021* [Available from: <https://unctad.org/news/small-island-developing-states-need-urgent-support-avoid-debt-defaults>].

46. United Nations Office of the High Representative for the Least Developed Countries Landlocked Developing Countries and Small Island Developing States (UN-OHRLLS). Vaccinations and COVID-19 Funding for Small Island Developing States: United Nations; 2021 [Available from: <https://www.un.org/ohrls/content/covid-19-sids>. Accessed 8 June 2023]
47. Ooi C-S, de Waegh R, Trifan C, Zhang Y. Islands and Resilience: Experiences from the Pandemic Era 2023.
48. Corno VS, J; Hills, J. Assessing Remittances Potential to Build Climate Resilience in the Pacific 2022 [Available from: <https://sdg.iisd.org/commentary/guest-articles/assessing-remittances-potential-to-build-climate-resilience-in-the-pacific/>. Accessed 8 June 2023]
49. The World Bank. Defying Predictions, Remittance Flows Remain Strong During COVID-19 Crisis. 2021.
50. The World Bank. Remittances Grow 5% in 2022, Despite Global Headwinds 2022 [Available from: <https://www.worldbank.org/en/news/press-release/2022/11/30/remittances-grow-5-percent-2022>. Accessed 8 June 2023]
51. United Nations Sustainable Development Goals. Goal 10: Reduce inequality within and among countries 2015 [Available from: <https://www.un.org/sustainabledevelopment/inequality/>. Accessed 8 June 2023]
52. World Bank Group. Migration and Development Brief 37. 2022.
53. OECD. OECD Employment Outlook 2020: Worker Security and the COVID-19 Crisis. OECD2020.
54. Bishop M, Bouhia, R., Carter, G., Corbett, J., Lindsay, C., Scobie, M., Wilkinson, E. Towards sustained development in Small Island Developing States: why we need to reshape global governance. London: Overseas Development Institute; 2021.
55. Food and Agricultural Organization of the United Nations. The land market in Latin America and the Caribbean: concentration and foreignization. Santiago, Chile; 2014.
56. Underhill SJR, Singh-Peterson L. Improving non-communicable disease remediation outcomes in Tonga: the importance of domestic fruit production systems: an analysis. *Journal of Agriculture and Rural Development in the Tropics and Subtropics*. 2017;118(1):91-103.
57. United Nations Economic and Social Commission for Asia and the Pacific (ESCAP). Sustainable agriculture and food security in Asia and the Pacific. 2009.
58. Williams A. Cheston T, Coudouel A, Subran, L. Tailoring Social Protection to Small Island Developing States : Lessons Learned from the Caribbean. Social Protection & Labor Discussion Paper; No. 1306. World Bank. 2013.
59. González-Rozada M, Prieto-Lara E, Sandoval GA. Effect of comprehensive smoke-free legislation on the tourism industry in countries of the Caribbean Community. *Rev Panam Salud Publica*. 2022;46:e146.

60. World Health Organization Regional Office for Europe. Commercial determinants of health 2023 [Available from: <https://www.who.int/news-room/fact-sheets/detail/commercial-determinants-of-health>. Accessed 8 June 2023]
61. Sobers N, Samuels TA. Diet and childhood obesity in small island developing states. *The Lancet Child & Adolescent Health*. 2019;3(7):445-7.
62. World Health Organization. WHO global report on trends in prevalence of tobacco use 2000-2025, fourth edition. Geneva 2021.
63. World Health Organization. Small Island Developing States: Health and WHO. World Health Organization; 2017.
64. Pan American Health Organization. Report on Tobacco Control for the Region of the Americas. 2022.
65. World Health Organization. Global youth tobacco survey (GYTS), Timor-Leste 2019. 2019.
66. World Health Organization. 2016 GYTS Fact Sheet Papua New Guinea 2016 [Available from: <https://www.who.int/publications/m/item/2016-gyts-fact-sheet-papua-new-guinea>. Accessed 8 June 2023]
67. World Health Organization. WHO report on the global tobacco epidemic 2021: addressing new and emerging products 2021.
68. World Health Organization. Noncommunicable diseases and mental health in small island developing states: Report of the High-level technical meeting on NCDs and mental health. 2023.
69. Tobacco Tactics University of Bath. Western Pacific Region 2021 [Available from: <https://tobaccotactics.org/article/western-pacific-region/> Accessed 8 June 2023]
70. WHO Framework Convention on Tobacco Control Secretariat. Kiribati Core Questionnaire of the Reporting Instrument of the WHO FCTC Geneva: WHO Framework Convention on Tobacco Control Secretariat. 2020.
71. WHO Framework Convention on Tobacco Control Secretariat. Marshall Islands Core Questionnaire of the Reporting Instrument of the WHO FCTC Geneva: WHO Framework Convention on Tobacco Control Secretariat. 2018.
72. WHO Framework Convention on Tobacco Control Secretariat. Micronesia (Federated States of) Core Questionnaire of the Reporting Instrument of the WHO FCTC Geneva: WHO Framework Convention on Tobacco Control Secretariat. 2020.
73. WHO Framework Convention on Tobacco Control Secretariat. Palau Core Questionnaire of the Reporting Instrument of the WHO FCTC Geneva: WHO Framework Convention on Tobacco Control Secretariat. 2020.
74. WHO Framework Convention on Tobacco Control Secretariat. Samoa Core Questionnaire of the Reporting Instrument of the WHO FCTC Geneva: WHO Framework Convention on Tobacco Control Secretariat. 2020.

75. W HO Framework Convention on Tobacco Control Secretariat. Singapore Core Questionnaire of the Reporting Instrument of the WHO FCTC Geneva: WHO Framework Convention on Tobacco Control Secretariat. 2020.
76. WHO Framework Convention on Tobacco Control Secretariat. Tuvalu Core Questionnaire of the Reporting Instrument of the WHO FCTC Geneva: WHO Framework Convention on Tobacco Control Secretariat. 2020.
77. WHO Framework Convention on Tobacco Control Secretariat. Solomon Islands Core Questionnaire of the Reporting Instrument of the WHO FCTC Geneva: WHO Framework Convention on Tobacco Control Secretariat. 2020.
78. WHO Framework Convention on Tobacco Control Secretariat. Vanuatu Core Questionnaire of the Reporting Instrument of the WHO FCTC Geneva: WHO Framework Convention on Tobacco Control Secretariat. 2020.
79. World Health Organization Regional Office for the Western Pacific. Niue recognized for world-leading efforts to reduce tobacco use 2019 [Available from: <https://www.who.int/westernpacific/about/how-we-work/pacific-support/news/detail/30-05-2019-niue-recognized-for-world-leading-efforts-to-reduce-tobacco-use>. Accessed 8 June 2023]
80. Pacific Community. Tobacco and manufactured tobacco substitutes: levels and trends of imports and interventions taken to control use in selected Pacific Island countries and territories. 2022.
81. WHO Framework Convention on Tobacco Control Secretariat. Vanuatu: record size pictorial health warnings required 2016 [Available from: <https://untobaccocontrol.org/impldb/vanuatu-record-size-pictorial-health-warnings-required/>. Accessed 8 June 2023]
82. World Health Organization. Tobacco plain packaging: global status 2021 update. Geneva: World Health Organization,; 2022.
83. Burki TK. Tobacco industry capitalises on the COVID-19 pandemic. *The Lancet Respiratory Medicine*. 2021;9(10):1097-8.
84. Pan American Health Organization. PAHO Member State officials, researchers, and civil society advocates gather in Washington D.C. to share achievements, challenges, and future strategies to further tobacco control in a post-COVID19 context 2022 [Available from: <https://www.paho.org/en/news/18-7-2022-paho-member-state-officials-researchers-and-civil-society-advocates-gather>]
85. Kessaram T, McKenzie J, Girin N, Roth A, Vivili P, Williams G, et al. Alcohol use in the Pacific region: Results from the STEPwise approach to surveillance, Global School-Based Student Health Survey and Youth Risk Behavior Surveillance System. *Drug Alcohol Rev*. 2016;35(4):412-23.
86. Stacey MW-P, Richard Charles F, Peter AL, Sue D. Identifying a gap in drowning prevention: high-risk populations. *Injury Prevention*. 2020;26(3):279.

87. World Health Organization. The Global Health Observatory. Alcohol, total per capita (15+) consumption (in litres of pure alcohol) (SDG Indicator 3.5.2) 2023 [Available from: [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/total-\(recorded-unrecorded\)-alcohol-per-capita-\(15-\)-consumption](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/total-(recorded-unrecorded)-alcohol-per-capita-(15-)-consumption). Accessed 8 June 2023].
88. World Health Organization. 2017 GSHS Fact Sheet Trinidad and Tobago 2017 [Available from: <https://www.who.int/publications/m/item/2017-gshs-fact-sheet-trinidad-and-tobago-trinidad>. Accessed 8 June 2023].
89. World Health Organization. 2017 GSHS Fact Sheet Jamaica 2017 [Available from: <https://www.who.int/publications/m/item/2017-gshs-fact-sheet-jamaica>. Accessed 8 June 2023].
90. World Health Organization. 2018 GSHS Fact Sheet Saint Vincent and the Grenadines 2018 [Available from: <https://www.who.int/publications/m/item/2018-gshs-fact-sheet-saint-vincent-and-the-grenadines>. Accessed 8 June 2023].
91. Robaina K, Babor T, Pinsky I, and Johns P. The alcohol industry's commercial and political activities in Latin America and the Caribbean: Implications for public health. NCD Alliance, Global Alcohol Policy Alliance, Healthy Latin America Coalition, and Healthy Caribbean Coalition. 2020.
92. Brown CR, Rocke K, Murphy MM, Hambleton IR. Interventions and policies aimed at improving nutrition in Small Island Developing States: a rapid review. *Rev Panam Salud Publica*. 2022;46:e33.
93. Centre for Social and Health Outcomes Research and Evaluation, World Health Organization Regional Office for the Western Pacific. Alcohol Marketing in the Western Pacific Region. 2006.
94. Alafia Samuels T. Alcohol industry actions in the English Caribbean and the role of civil society in fighting back. Presentation. 2020.
95. IWSR. Investments in tourism infrastructure will help beverage alcohol recovery in the Caribbean islands 2023 [Available from: <https://www.theiwsr.com/investments-in-tourism-infrastructure-will-help-beverage-alcohol-recovery-in-the-caribbean-islands/> Accessed 8 June 2023].
96. World Health Organization. Global action plan on physical activity 2018–2030: more active people for a healthier world. 2018.
97. Guthold R, Riley L, Bull F. Worldwide trends in insufficient physical activity from 2001 to 2016: a pooled analysis of 358 population-based surveys with 1·9 million participants. *Lancet Glob Health*. 2018;Vol 6:e1077-e86.
98. Guthold R, Riley L, Bull F Global trends in insufficient physical activity among adolescents: a pooled analysis of 298 population-based surveys with 1·6 million participants. *Lancet Child Adolesc Health*. 2020;Vol 4:23-35.
99. World Health Organization. Global School-based Student Health Survey, Fact Sheet Nauru. Geneva: World Health Organization. 2011.

100. World Health Organization. Global School-based Student Health Survey, Fact Sheet Samoa. Geneva: World Health Organization. 2011.
101. World Health Organization. Global School-based Student Health Survey, Fact Sheet Tuvalu. Geneva: World Health Organization. 2013.
102. World Health Organization. Global School-based Student Health Survey, Fact Sheet Vanuatu. Geneva: World Health Organization. 2016.
103. Costa Santos A, Meheus F, Ilbawi A, Bull F. The cost of inaction on physical inactivity to public health-care systems: a population-attributable fraction analysis. *Lancet Glob Health*. 2023;Vol 11:e32-e9.
104. Strain T, Garcia L, Cowan M, Guthold R, Brage S, Bull F. Levels of domain-specific physical activity at work, in the household, for travel and for leisure among 327 789 adults from 104 countries. *BMJ Sports Medicine*. 2020;54:1488-97.
105. Tucker P, Gilliland J. The effect of season and weather on physical activity: a systematic review. *Public Health*. 2007;121(12):909-22.
106. UN-Habitat. Urbanization and Climate Change in Small Island Developing States. Nairobi: UN-Habitat. 2015.
107. Thompson SL, Chenhall RD, Brimblecombe JK. Indigenous perspectives on active living in remote Australia: a qualitative exploration of the socio-cultural link between health, the environment and economics. *BMC Public Health*. 2013;13(1):473.
108. Ulijaszek SJ. Body size and physical activity levels of adults on Rarotonga, the Cook Islands. *Int J Food Sci Nutr*. 2001;52(5):453-61.
109. World Health Organization. Fair play: building a strong physical activity system for more active people. Geneva: World Health Organization. 2021.
110. Parra DC, Monteiro CA, Freudenberg F. Automobile, construction and entertainment business sector influences on sedentary lifestyles. *Health Promotion International*. 2016;33(2):239-49.
111. Singh KN, Sendall MC, Crane P. Understanding Sociocultural Influences on Physical Activity in Relation to Overweight and Obesity in a Rural Indigenous Community of Fiji Islands. *Journal of Racial and Ethnic Health Disparities*. 2023;10(3):1508-17.
112. Heard EM, Auvaa L, Conway BA. Culture X: addressing barriers to physical activity in Samoa. *Health Promotion International*. 2017;32(4):734-42.
113. World Health Organization. The Global Health Observatory. Prevalence of obesity among adults, BMI  $\geq 30$  (age-standardized estimate) (%) 2023 [Available from: [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-adults-bmi-30-\(age-standardized-estimate\)-](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-adults-bmi-30-(age-standardized-estimate)-)]. Accessed 8 June 2023]
114. World Health Organization. The Global Health Observatory. Prevalence of obesity among adults, BMI  $\geq 30$  (crude estimate) (%) 2023 [Available from:

[https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-adults-bmi=-30-\(crude-estimate\)-\(-\).](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-obesity-among-adults-bmi=-30-(crude-estimate)-(-).) Accessed 8 June 2023]

115. Foster N, Thow AM, Unwin N, Alvarado M, Samuels TA. Regulatory measures to fight obesity in Small Island Developing States of the Caribbean and Pacific, 2015 - 2017. *Rev Panam Salud Publica*. 2018;42:e191-e.
116. Food and Agricultural Organization of the United Nations. Food Security and Nutrition in Small Island Developing States (SIDS). Food and Agricultural Organization (FAO). 2014.
117. Food and Agricultural Organization of the United Nations. The State of Food Security and Nutrition in the World 2022. Rome, Italy. 2022.
118. International Diabetes Federation. Diabetes estimates (20-79 y). Age-adjusted comparative prevalence of diabetes, %. 2019. 2021 [Available from: <https://diabetesatlas.org/data/en/indicators/2/>. Accessed 8 June 2023].
119. Placeholder for removal.
120. Hawkes C. Uneven dietary development: linking the policies and processes of globalization with the nutrition transition, obesity and diet-related chronic diseases. *Globalization and Health*. 2006;2(1):4.
121. Connell J, Lowitt K, Ville A, Hickey G. Food Security and Sovereignty in Small Island Developing States: Contemporary Crises and Challenges. 2020. p. 1-23.
122. Fuller S, Ngata T, Borrelle SB, Farrelly T. Plastics pollution as waste colonialism in Te Moananui. *Journal of Political Ecology*. 2022;29(1).
123. Small island developing states in the Pacific explore ways to make fisheries and other oceans economic sectors more sustainable [press release]. 10/8/2015 2015.
124. Borovnik M. Occupational health and safety of merchant seafarers from Kiribati and Tuvalu. *Asia Pacific Viewpoint*. 2011;52(3):333-46.
125. Vogliano C, Raneri JE, Maelaia J, Coad J, Wham C, Burlingame B. Assessing Diet Quality of Indigenous Food Systems in Three Geographically Distinct Solomon Islands Sites (Melanesia, Pacific Islands). *Nutrients*. 2020;13(1):30.
126. Food and Agricultural Organization of the United Nations. Global Action Programme on Food Security and Nutrition in Small Island Developing States. 2017.
127. Martyr-Koller R, Thomas A, Schleussner C-F, Nauels A, Lissner T. Loss and damage implications of sea-level rise on Small Island Developing States. *Current Opinion in Environmental Sustainability*. 2021;50:245-59.
128. Campbell J. Development, global change and traditional food security in Pacific Island countries. *Regional Environmental Change*. 2014;15:1-12.
129. United Nations Department of Economic and Social Affairs. The COVID-19 pandemic puts small island developing economies in dire straits. 2020.

130. Food and Agricultural Organization of the United Nations. Small Island Developing States Response to COVID-19. Food and Agricultural Organization of the United Nations. 2020.
131. Healthy Caribbean Coalition. NCDs and Trade Policy in the Caribbean. 2017.
132. Swinburn BA, Kraak VI, Allender S, Atkins VJ, Baker PI, Bogard JR, et al. The Global Syndemic of Obesity, Undernutrition, and Climate Change: The Lancet Commission report. *The Lancet*. 2019;393(10173):791-846.
133. Alvarado M, Unwin N, Sharp SJ, Hambleton I, Murphy MM, Samuels TA, et al. Assessing the impact of the Barbados sugar-sweetened beverage tax on beverage sales: an observational study. *International Journal of Behavioral Nutrition and Physical Activity*. 2019;16(1).
134. World Health Organization. WHO manual on sugar-sweetened beverage taxation policies to promote healthy diets. 2022.
135. Teng A, Snowdon W, Win Tin ST, Genç M, Na'ati E, Puloka V, et al. Progress in the Pacific on sugar-sweetened beverage taxes: a systematic review of policy changes from 2000 to 2019. *Australian and New Zealand Journal of Public Health*. 2021;45(4):376-84.
136. Details of Public Revenues - Seychelles [Internet]. [cited 31 January 2023]. Available from: <https://stats.oecd.org/Index.aspx?DataSetCode=REVSYC>.
137. Healthy Caribbean Coalition. Rapid Assessment of the School Nutrition Policy Environment In Select Caribbean Countries: November 2019. 2019.
138. Ministry of Education. Sweet Drinks Policy. Vanuatu: Ministry of Education and Ministry of Health; 2014.
139. Global Health Advocacy Incubator. Combating Diet-Related Non-Communicable Diseases in the Caribbean 2023 [Available from: <https://www.advocacyincubator.org/featured-stories/2023-03-06-combating-diet-related-non-communicable-diseases-in-the-caribbean>. Accessed 8 June 2023].
140. St. Lucia Times. Saint Lucia Suspends Ban On Sugar-Sweetened Beverages In Schools 2023 [Available from: <https://stluciatimes.com/150271/2023/01/saint-lucia-suspends-ban-on-sugar-sweetened-beverages-in-schools/>. Accessed 8 June 2023].
141. Ministry of Health & Wellness The Government of Jamaica. Jamaica moves towards eliminating trans-fats from local food supply 2022 [Available from: <https://www.moh.gov.jm/jamaica-moves-towards-eliminating-trans-fats-from-local-food-supply/>. Accessed 8 June 2023].
142. United Nations Economic Commission for Latin America and the Caribbean. Synthesis of the Caribbean subregion midterm review report of the Small Island Developing States (SIDS) Accelerated Modalities of Action (SAMOA) Pathway. ECLAC SUBREGIONAL HEADQUARTERS FOR THE CARIBBEAN; 2020.
143. Williams S, Hill SE, Oyebode O. 'Choice should be made through... educated decisions not regressive dictates': discursive framings of a proposed 'sugar tax' in Bermuda: analysis of submissions to a government consultation. *Globalization and Health*. 2022;18(1):89.

144. Mialon M, Swinburn B, Wate J, Tukana I, Sacks G. Analysis of the corporate political activity of major food industry actors in Fiji. *Globalization and Health*. 2016;12(1):18.
145. Barlow P, Stuckler D. Globalization and health policy space: Introducing the WTOhealth dataset of trade challenges to national health regulations at World Trade Organization, 1995–2016. *Social Science & Medicine*. 2021;275:113807.
146. Barlow P, Labonte R, McKee M, Stuckler D. Trade challenges at the World Trade Organization to national noncommunicable disease prevention policies: A thematic document analysis of trade and health policy space. *PLoS medicine*. 2018;15(6):e1002590.
147. World Health Organization. Marketing of breast milk substitutes: national implementation of the international code, status report 2020. World Health Organization; 2020.
148. Shah K. Air Pollution in Small Island Developing States: A Growing but Avoidable Challenge Requiring Multilevel Interventions. *SSRN Electronic Journal*. 2021.
149. World Health Organization. Air quality and health: Type of pollutants 2023 [Available from: <https://www.who.int/teams/environment-climate-change-and-health/air-quality-and-health/health-impacts/types-of-pollutants>. Accessed 8 June 2023].
150. Adeoti T, Fantini, C., Morgan, G., Thacker, S., Ceppi, P., Bkikhoo, N., Kumar, S., Crosskey, S., O'Regan, N., . Infrastructure for Small Island Developing States. United Nations Office for Project Services; 2020.
151. World Health Organization. Alcohol Fact Sheet 2022 [Available from: <https://www.who.int/news-room/fact-sheets/detail/alcohol>. Accessed 8 June 2023].
152. Martinez S, Sanchez R, Yañez-Pagans P. Road safety: challenges and opportunities in Latin America and the Caribbean. *Latin American Economic Review*. 2019;28(1).
153. World Health Organization. Global Plan for the Decade of Action for Road Safety 2021–2030. Geneva: World Health Organization; 2021.
154. Herman J, Ameratunga S, Wainiqolo I, Kafoa B, McCaig E, Jackson R. The case for improving road safety in Pacific Islands: a population-based study from Fiji (TRIP 6). *Australian and New Zealand Journal of Public Health*. 2012;36(5):427-9.
155. United Nations Environment Programme (UNEP). Addressing the Used Vehicles Market. Nairobi: United Nations Environment Programme (UNEP); 2019.
156. World Health Organization. Road safety in the Western Pacific Region : call for action.: World Health Organization Western Pacific Region; 2009.
157. Nieuwenhuijsen M, Khreis H. Green space is important for health. *The Lancet*. 2017;389(10070):700.
158. World Health Organization. Global Health Estimates (2000-2019) 2021 [Available from: <https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates>. Accessed 8 June 2023].

159. Pan-American Health Organization. The burden of unintentional drowning in the Region of the Americas, 2000-2019 2021 [Available from: <https://www.paho.org/en/enlace/burden-unintentional-drowning>. Accessed 8 June 2023].
160. World Health Organization Regional Office for South-East Asia. Status of drowning in South-East Asia: Country reports. 2022.
161. Cortés LM, Hargarten SW, Hennes HM. Recommendations for Water Safety and Drowning Prevention for Travelers. *Journal of Travel Medicine*. 2006;13(1):21-34.
162. World Health Organization Regional Office for the Western Pacific. Regional status report on drowning in the Western Pacific 2021.
163. Food and Agricultural Organization of the United Nations BoBP-IOB-I. Safety at sea for small-scale fishers 2020.
164. Doocy S, Daniels A, Murray S, Kirsch TD. The human impact of floods: a historical review of events 1980-2009 and systematic literature review. *PLoS Curr*. 2013;5.
165. Field CB, V. Barros, T.F. Stocker, D. Qin, D.J. Dokken, K.L. Ebi, M.D. Mastrandrea, K.J. Mach, G.-K. Plattner, S.K. Allen, M. Tignor, and P.M. Midgley (Eds.), editor. *Managing the Risks of Extreme Events and Disasters to Advance Climate Change Adaptation*. Cambridge, United Kingdom: Cambridge University Press; 2012.
166. NEWSROOM. 'Let us strive to end deaths by drowning' - Health Minister 2021 [Available from: <https://newsroom.gy/2021/07/25/let-us-strive-to-end-deaths-by-drowning-health-minister/>. Accessed 8 June 2023].
167. Lakhani SW, Alys M. Trends in crime and violence in Papua New Guinea. Research and dialogue series no. 1. Washington, DC.: World Bank; 2014.
168. Pan American Health Organization. The Health of Adolescents and Youth in the Americas. Implementation of the Regional Strategy and Plan of Action on Adolescent and Youth Health 2010-2018 2018.
169. Setoya Y, Kestel D. WHO Mental Health Gap Action Programme implementation in the Small Island Development States: experience from the Pacific and English-speaking Caribbean countries. *BJPsych Int*. 2018;15(2):27-30.
170. Fulu E, Jewkes R, Roselli T, Garcia-Moreno C. Prevalence of and factors associated with male perpetration of intimate partner violence: findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific. *Lancet Glob Health*. 2013;1(4):e187-207.
171. World Health Organization. Policy Brief - Noncommunicable diseases and mental health conditions in SIDS. World Health Organization; 2021.
172. World Health Organization. Violence Against Women Prevalence Estimates, 2018. Geneva: World Health Organization; 2021.
173. UN Women Fiji. Climate change disasters and gender based violence in the Pacific. 2014.

174. van Daalen KR, Kallesøe SS, Davey F, Dada S, Jung L, Singh L, et al. Extreme events and gender-based violence: a mixed-methods systematic review. *The Lancet Planetary Health*. 2022;6(6):e504-e23.
175. OHCHR. Protecting the Human Rights of Internal Displaced Persons in Natural Disasters: Challenges in the Pacific. 2011.
176. The World Bank. The Poverty Podcast: Gender and COVID-19 [Internet]: World Bank Group; 2022. Podcast. Available from: <https://www.worldbank.org/en/news/podcast/2022/06/21/gender-and-covid-19>. Accessed 8 June 2023.
177. Women's Major Group. Gender Equality And Women's Human Rights: Essential In Achieving Sustainable Development In Small Island Developing States, And Globally. 2013.
178. The Commonwealth. Gender Integration for Climate Action: A Review of Commonwealth Member Country Nationally Determined Contributions. 2021.
179. IHME. Global Burden of Disease (GBD) 2019 2022 [Available from: <https://www.healthdata.org/gbd>. Accessed 8 June 2023].
180. WHO Regional Office for Europe. Tobacco Use and Mental Health Conditions: A Policy Brief. World Health Organization Regional Office for Europe; 2020.
181. Peterson RR. Over the Caribbean Top: Community Well-Being and Over-Tourism in Small Island Tourism Economies. *International Journal of Community Well-Being*. 2020.
182. Scheyvens R, Momsen JH. Tourism and Poverty Reduction: Issues for Small Island States. *Tourism Geographies*. 2008;10(1):22-41.
183. Brolan CE, Körver S, Phillips G, Sharma D, Herron L-M, O'Reilly G, et al. Lessons from the frontline: The COVID-19 pandemic emergency care experience from a human resource perspective in the Pacific region. *The Lancet Regional Health - Western Pacific*. 2022;25:100514.
184. Arjona-Fuentes JM, Radic A, Ariza-Montes A, Han H, Law R. Fear and poor mental health among workers during the global cruise tourism crisis: Impact of low employability and family support. *International Journal of Hospitality Management*. 2022;106:103276.
185. Scheyvens RA, Movono A, Auckram S. Pacific peoples and the pandemic: exploring multiple well-beings of people in tourism-dependent communities. *Journal of Sustainable Tourism*. 2023;31(1):111-30.
186. International Labour Organization. The future of work in the tourism sector: Sustainable and safe recovery and decent work in the context of the COVID-19 pandemic. 2022.
187. Connell J. The two cultures of health worker migration: A Pacific perspective. *Social Science & Medicine*. 2014;116:73-81.
188. Kelman I, Ayeb-Karlsson S, Rose-Clarke K, Prost A, Ronneberg E, Wheeler N, et al. A review of mental health and wellbeing under climate change in small island developing states (SIDS). *Environmental Research Letters*. 2021;16(3):033007.

189. Gibson J, McKenzie D, Stillman S. The Impacts of International Migration on Remaining Household Members: Omnibus Results from a Migration Lottery Program. *The Review of Economics and Statistics*. 2011;93(4):1297-318.
190. Walker IF, Asher L, Pari A, Attride-Stirling J, Oyinloye AO, Simmons C, et al. Mental health systems in six Caribbean small island developing states: a comparative situational analysis. *International Journal of Mental Health Systems*. 2022;16(1):39.
191. UNICEF Eastern Caribbean Area Office. *Generation Unlimited: well-being of young people in the Eastern Caribbean*. 2021.
192. Friel S, Collin J, Daube M, Depoux A, Freudenberg N, Gilmore AB, et al. Commercial determinants of health: future directions. *The Lancet*. 2023;401(10383):1229-40.
193. PMI. Political Contributions 2016 2016 [Available from: [https://web.archive.org/web/20200225133806/https://www.pmi.com/resources/docs/default-source/pmi-our-company/political-contributions-2016.pdf?sfvrsn=794a83b5\\_8](https://web.archive.org/web/20200225133806/https://www.pmi.com/resources/docs/default-source/pmi-our-company/political-contributions-2016.pdf?sfvrsn=794a83b5_8). Accessed 8 June 2023].
194. PMI. Political Contributions 2011 2011 [Available from: [https://web.archive.org/web/20200225135343/https://www.pmi.com/resources/docs/default-source/our\\_company/political-2011.pdf?sfvrsn=67cb1b5\\_0](https://web.archive.org/web/20200225135343/https://www.pmi.com/resources/docs/default-source/our_company/political-2011.pdf?sfvrsn=67cb1b5_0). Accessed 8 June 2023].
195. Tobacco Tactics University of Bath. Latin America and Caribbean Region 2023 [Available from: <https://tobaccotactics.org/article/latin-america-and-caribbean-region/>. Accessed 8 June 2023].
196. Madureira Lima J, Galea S. Corporate practices and health: a framework and mechanisms. *Globalization and Health*. 2018;14(1):21.
197. Japan Tobacco Inc. v. Administrator-General, 38 FLR 20 (1992). (1992).
198. Jamaica Gleaner. Wisynco withdraws court action over campaign against sugary drinks 2018 [Available from: <https://jamaica-gleaner.com/article/news/20180501/wisynco-withdraws-court-action-over-campaign-against-sugary-drinks>. Accessed 8 June 2023].
199. Tobacco Tactics University of Bath. Philip Morris International 2022 [Available from: <https://tobaccotactics.org/article/philip-morris-international/>. Accessed 8 June 2023].
200. Bennett E, Topp SM, Moodie AR. National Public Health Surveillance of Corporations in Key Unhealthy Commodity Industries – A Scoping Review and Framework Synthesis. *International Journal of Health Policy and Management*. 2023.
201. Atli Gunnarsson J, Ruskin G, Stuckler D, Steele S. Big food and drink sponsorship of conferences and speakers: a case study of one multinational company's influence over knowledge dissemination and professional engagement. *Public Health Nutr*. 2023;26(5):1094-111.
202. Gómez EJ. The politics of ultra-processed foods and beverages regulatory policy in upper-middle-income countries: Industry and civil society in Mexico and Brazil. *Global Public Health*. 2022;17(9):1883-901.

203. Alvarado M, Penney TL, Unwin N, Murphy MM, Adams J. Evidence of a health risk ‘signalling effect’ following the introduction of a sugar-sweetened beverage tax. *Food Policy*. 2021;102:102104.
204. Hunt D. How food companies use social media to influence policy debates: a framework of Australian ultra-processed food industry Twitter data. *Public Health Nutr*. 2021;24(10):3124-35.
205. Lacy-Nichols J, Marten R, Crosbie E, Moodie R. The public health playbook: ideas for challenging the corporate playbook. *The Lancet Global Health*. 2022;10(7):e1067-e72.
206. Lacy-Nichols J, Nandi S, Mialon M, McCambridge J, Lee K, Jones A, et al. Conceptualising commercial entities in public health: beyond unhealthy commodities and transnational corporations. *The Lancet*. 2023;401(10383):1214-28.
207. Patay D, Ralston R, Palu A, Jones A, Webster J, Buse K. Fifty shades of partnerships: a governance typology for public private engagement in the nutrition sector. *Globalization and Health*. 2023;19(1):11.
208. Suzuki M, Webb D, Small R. Competing Frames in Global Health Governance: An Analysis of Stakeholder Influence on the Political Declaration on Non-communicable Diseases. *Int J Health Policy Manag*. 2021;11(7):1078-89.
209. Kentikelenis A, Rochford C. Power asymmetries in global governance for health: a conceptual framework for analyzing the political-economic determinants of health inequities. *Globalization and Health*. 2019;15(1):70.
210. World Health Organization Regional Office for the Western Pacific. Western Pacific Community Engagement Toolkit: Empowering Communities Through Microplanning in the Federated States of Micronesia 2020 [Available from: <https://who-wpro.ctb.ku.edu/plan/empowering-communities-through-microplanning-in-the-federated-states-of-micronesia/>].
211. World Health Organization Regional Office for the Western Pacific. Western Pacific Community Engagement Toolkit: Household Vulnerability Assessments Across Villages in the Samoan Islands 2020 [Available from: <https://who-wpro.ctb.ku.edu/assess/household-vulnerability-assessments-across-villages-in-the-samoan-islands/>].
212. World Health Organization Regional Office for the Western Pacific. Western Pacific Community Engagement Toolkit: Building Community Capacity to Promote and Protect Mental Health in Papua New Guinea 2020 [Available from: <https://who-wpro.ctb.ku.edu/engage/building-community-capacity-to-promote-and-protect-mental-health-in-papua-new-guinea/>].
213. World Health Organization. Voice, agency, empowerment - handbook on social participation for universal health coverage. Geneva 2021.
214. World Health Organization. WHO framework for meaningful engagement of people living with noncommunicable diseases, and mental health and neurological conditions. 2023.
215. Gilmore AB, Fabbri A, Baum F, Bertscher A, Bondy K, Chang HJ, et al. Defining and conceptualising the commercial determinants of health. *Lancet*. 2023;401(10383):1194-213.

216. Friel S, Hattersley L, Townsend R. Trade Policy and Public Health. *Annual Review of Public Health*. 2015;36(1):325-44.
217. Hirono K, Haigh F, Gleeson D, Harris P, Thow AM, Friel S.. Is health impact assessment useful in the context of trade negotiations? A case study of the Trans Pacific Partnership Agreement. *BMJ Open*. 2016;6(4):e010339.
218. Abdalla SM, Ofefi L, Maani N, Galea S. 28. Commercial Determinants of Health in Low- and Middle-Income Countries. In: Maani N, Petticrew M, Galea S, editors. *The Commercial Determinants of Health*: Oxford University Press; 2022. p. 0.
219. Thow AM, Ravuvu A, Ofa SV, Andrew N, Reeve E, Tutuo J, et al. Food trade among Pacific Island countries and territories: implications for food security and nutrition. *Globalization and Health*. 2022;18(1):104.
220. Nurse K. *Dynamic Trade Policy for Small Island Developing States* 2016.
221. Nakatani R. A Possible Approach to Fiscal Rules in Small Islands — Incorporating Natural Disasters and Climate Change. 2019.
222. Ortiz IC, A; Durán Valverde, F; Muzaffar, T; Urban, S. *Fiscal Space for Social Protection. A Handbook for Assessing Financing Options*: International Labour Organization; 2019.
223. Allen C, Metternicht G, Wiedmann T, Pedercini M. Modelling national transformations to achieve the SDGs within planetary boundaries in small island developing States. *Global Sustainability*. 2021;4.
224. Canada GA. Improving development impact in Small Island Developing States: Implementing effectiveness principles. 2022.
225. Asian Development Bank. *ADB Support for Public Sector Reforms in the Pacific: Enhance Results through Ownership, Capacity, and Continuity*. 2009.
226. Inter-American Development Bank. *Fiscal Rules: Towards a New Paradigm for Fiscal Sustainability in Small States*. 2017.
227. Gupta SS, M; Yousefi, R. *Expenditure Conditionality in IMF-supported Programs*: International Monetary Fund; 2018.
228. United Nations Conference on Trade and Development (UNCTAD). *The Least Developed Countries Report 2019*. 2019.
229. Trade and Development Board Investment, Enterprise and Development Commission. *Expert Meeting on Revisiting Development Strategies for Small Island Developing States in the Post-Pandemic Competitive Landscape. Revisiting development strategies for small island developing States in the post-pandemic competitive landscape. Note by the UNCTAD secretariat*, (2022).
230. OHCHR. Human rights experts support call for UN tax treaty 2022 [Available from: <https://www.ohchr.org/en/press-releases/2022/11/human-rights-experts-support-call-un-tax-treaty>. Accessed 8 June 2023].

231. OECD. Statement on a Two-Pillar Solution to Address the Tax Challenges Arising from the Digitalisation of the Economy – 8 October 2021 2021 [Available from: <https://www.oecd.org/tax/beps/statement-on-a-two-pillar-solution-to-address-the-tax-challenges-arising-from-the-digitalisation-of-the-economy-october-2021.htm>. Accessed 8 June 2023].
232. OECD. Tax Challenges Arising from Digitalisation of the Economy – Global Anti-Base Erosion Model Rules (Pillar Two). 2021.
233. Guillaumont P. Assessing the Economic Vulnerability of Small Island Developing States and the Least Developed Countries. *The Journal of Development Studies*. 2010;46(5):828-54.
234. United Nations Office of the High Representative for the Least Developed Countries Landlocked Developing Countries and Small Island Developing States (UN-OHRLLS). Finance For Development For Small Island Developing States Report - Advance Unedited.
235. UNFCCC. COP27 Decision, Funding arrangements for responding to loss and damage associated with the adverse effects of climate change, including a focus on addressing loss and damage. United Nations Framework Convention on Climate Change (UNFCCC); 2022.
236. UNFCCC. Conference of the Parties. Twenty-seventh session. Sharm el-Sheikh Implementation Plan. Sharm el-Sheikh: United Nations Framework Convention on Climate Change; 2022.
237. ECLAC. Special Drawing Rights (SDRs) and the COVID-19 crisis. 2022.
238. G20 to channel 45 billion US dollars to help vulnerable countries, aiming for 100 billion globally [press release]. 2021.
239. Center for Economic and Policy Research. Special Drawing Rights: The Right Tool to Use to Respond to the Pandemic and Other Challenges. 2022.
240. Finance for Development Lab. Options Paper for Channeling China’s SDRs to Africa. 2023.
241. Reuters. Barbados' Mottley says IMF must help finance the fight against climate change 2021 [Available from: <https://www.reuters.com/markets/us/barbados-mottley-says-imf-must-help-finance-fight-against-climate-change-2021-12-03/>. Accessed 8 June 2023].
242. Narayan D. Empowerment and Poverty Reduction: A Sourcebook. Washington DC: World Bank; 2002.
243. United Nations. Policy Brief 4. Valuing What Counts: Framework to Progress Beyond Gross Domestic Product. 2023.
244. World Health Organization. Health for All: Transforming economies to deliver what matters. 2023.
245. Walker J, Martin M, Seery E, Abdo N, Kamande A, Lawson M. The Commitment to Reducing Inequality Index 2022. Oxfam, DFI; 2022.
246. Hawai'i State Commission on the Status of Women. Building Bridges, Not Walking on Backs: A Feminist Economic Recovery Plan for COVID-19 Hawai'i State Commission on the Status of Women; 2020.

247. Prakash I, Meghrajani T. LSE Blogs 2021. [cited 2022]. Available from: <https://blogs.lse.ac.uk/gender/2021/03/22/a-cursory-glance-at-hawaiis-economic-revival-policy-the-intersection-of-feminist-economics-and-good-governance/>. Accessed 8 June 2023].
248. WHO Framework Convention on Tobacco Control, (2003).
249. UNEP. Secretariat of the Pacific Environment Programme - The SPREP Convention 2023 [Available from: <https://www.unep.org/explore-topics/oceans-seas/what-we-do/working-regional-seas/regional-seas-programmes/pacific>. Accessed 8 June 2023].
250. UNEP. The Caribbean Environment Programme and Cartagena Convention Secretariat 2023 [Available from: <https://www.unep.org/cep/>. Accessed 8 June 2023].
251. UNFCCC. Climate change, small island developing States. Issued by the CLIMATE CHANGE SECRETARIAT (UNFCCC). Bonn, Germany.; 2005.
252. United Nations Conference on Trade and Development. Climate action: Initiatives for Action 2023 [Available from: <https://www.un.org/en/climatechange/climate-action-coalitions>. Accessed 8 June 2023].
253. UNESCO. World Heritage Programme for Small Island Developing States (SIDS) 2023 [Available from: <https://whc.unesco.org/en/sids/>. Accessed 8 June 2023].
254. SDG Knowledge Exchange. BPOA (1994) - Barbados Programme of Action 1994 [Available from: <https://sustainabledevelopment.un.org/conferences/bpoa1994>.
255. World Health Organization. ACTIVE: a technical package for increasing physical activity 2018.
256. World Health Organization. More ways, to save more lives, for less money: World Health Assembly adopts more Best Buys to tackle noncommunicable diseases 2023 [Available from: <https://www.who.int/news/item/26-05-2023-more-ways--to-save-more-lives--for-less-money---world-health-assembly-adopts-more-best-buys--to-tackle-noncommunicable-diseases>. Accessed 8 June 2023].
257. World Health Organization. The Global Breast Cancer Initiative 2021 [Available from: <https://www.who.int/initiatives/global-breast-cancer-initiative>. Accessed 8 June 2023].
258. World Health Organization. Cervical Cancer Elimination Initiative 2018 [Available from: <https://www.who.int/initiatives/cervical-cancer-elimination-initiative>. Accessed 8 June 2023].
259. World Health Organization. The Global Initiative for Childhood Cancer 2018 [Available from: <https://www.who.int/initiatives/the-global-initiative-for-childhood-cancer>. Accessed 8 June 2023].
260. World Health Organization. Climate change and health in Small Island Developing States: a WHO special initiative, Pacific island countries and areas. 2017.
261. WHO Framework Convention on Tobacco Control. Guidelines for implementation of Article 5.3. 2013.

262. World Health Organization. HEARTS: Technical package for cardiovascular disease management in primary health care: Risk-based CVD management 2020.
263. Pan American Health Organization. HEARTS in the Americas: Guide and Essentials for Implementation 2022. 53 p.
264. World Health Organization. INSPIRE Handbook: action for implementing the seven strategies for ending violence against children 2018. 297 p.
265. Ghebreyesus TA. The WHO Special Initiative for Mental Health (2019-2023) Universal Health Coverage for Mental Health. World Health Organization; 2019.
266. World Health Organization. MPOWER 2023 [Available from: <https://www.who.int/initiatives/mpower>. Accessed 8 June 2023].
267. World Health Organization. WHO package of essential noncommunicable (PEN) disease interventions for primary health care. 2020.
268. World Health Organization. REPLACE trans fat: an action package to eliminate industrially-produced trans-fat from the global food supply: trans fat free by 2023. 2018.
269. World Health Organization. Save lives: a road safety technical package 2017.
270. World Health Organization. The SAFER initiative: a world free from alcohol related harm 2018 [Available from: <https://www.who.int/initiatives/SAFER>].
271. World Health Organization. The SHAKE technical package for salt reduction 2016.
272. World Health Organization. SIDS High-level technical meeting on NCDs and mental health 2023 [Available from: <https://www.who.int/news-room/events/detail/2023/01/17/default-calendar/sids-high-level-technical-meeting-on-ncds-and-mental-health>. Accessed 8 June 2023].
273. World Health Organization. Summary of the first gathering of the Global Group of the Heads of State and Government for the Prevention and Control of NCDs on 21 September 2022 [Available from: <https://www.who.int/news-room/events/detail/2022/09/21/default-calendar/summary-of-the-first-gathering-of-the-global-group-of-the-heads-of-state-and-government-for-the-prevention-and-control-of-ncds-on-21-september-2022>. Accessed 8 June 2023].
274. A/RES/77/186, §31. Agriculture development, food security and nutrition (2022).
275. Political declaration of the 3rd High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases : resolution / adopted by the General Assembly, (2018).
276. Outcome document of the High-Level Meeting of the General Assembly on the Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-communicable Diseases : draft resolution / submitted by the President of the General Assembly, (2014).

277. Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases : draft resolution / submitted by the President of the General Assembly, (2011).
278. United Nations. Addis Ababa Action Agenda of the Third International Conference on Financing for Development (Addis Ababa Action Agenda). 2015.
279. World Health Organization Regional Office for the Western Pacific. 2015 Yanuca Island Declaration on health in Pacific island countries and territories. 2015.
280. World Health Organization Regional Office for the Western Pacific. Yanuca Island Declaration. 1985.
281. United Nations Office of the High Representative for the Least Developed Countries Landlocked Developing Countries and Small Island Developing States (UN-OHRLLS). The SAMOA Pathway. 2014.
282. Pan American Health Organization. Declaration of Port-of-Spain: Uniting to Stop the Epidemic of Chronic NCDs. 2007.
283. United Nations Office of the High Representative for the Least Developed Countries Landlocked Developing Countries and Small Island Developing States (UN-OHRLLS). Small Island Developing States Global Business Network 2023 [Available from: <https://www.un.org/ohrlls/sids-gbn>. Accessed 8 June 2023].
284. OHCHR. United Nations Forum on Business and Human Rights 2023 [Available from: <https://www.ohchr.org/en/hrc-subsiary-bodies/united-nations-forum-business-and-human-rights>. Accessed 8 June 2023].
285. OHCHR. About the Regional Forums on Business and Human Rights 2023 [Available from: <https://www.ohchr.org/en/special-procedures/wg-business/about-regional-forums-business-and-human-rights>. Accessed 8 June 2023].
286. OHCHR. Working Group on Business and Human Rights 2023 [Available from: <https://www.ohchr.org/en/special-procedures/wg-business>. Accessed 8 June 2023].
287. World Health Organization. SEVENTY-FOURTH WORLD HEALTH ASSEMBLY. WHA74.16. Agenda item 22.1. Social determinants of health. 2021.
288. World Health Organization. The Geneva Charter for Well-being 2021 [Available from: <https://www.who.int/publications/m/item/the-geneva-charter-for-well-being>.
289. World Health Organization. SIXTY-SECOND WORLD HEALTH ASSEMBLY. WHA62.14. Agenda item 12.5. Reducing health inequities through action on the social determinants of health. 2009.

## Annexes

### Annex 1: Summary of economic and commercial drivers of the risk factors for NCDs, injuries and road safety and Mental Health conditions

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

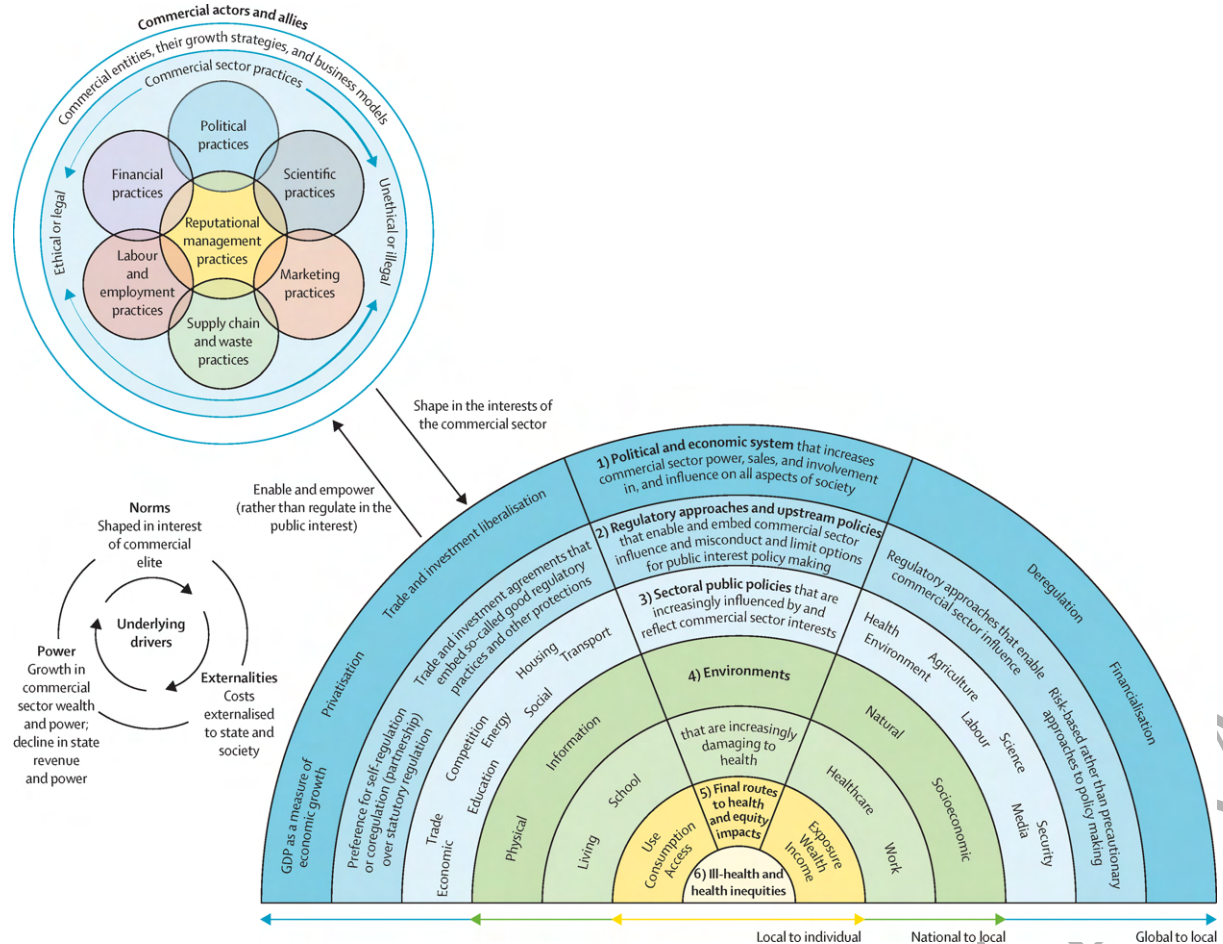
Unhealthy diets	<ul style="list-style-type: none"> <li>• SIDS have some of the highest overweight and obesity rates in the world, with up to 80% of adults in some Pacific Island states and over 60% in the Caribbean being obese/overweight. Childhood obesity rates in SIDS in the Caribbean are increasing at 1% / year, primarily driven by the high availability of imported, affordable and heavily marketed, energy-dense and highly processed foods, as approximately 50% of all small island economies import over 80% of their food.</li> <li>• More than 85% of adults do not consume recommended 400 grams of fruits and vegetables each day.</li> <li>• In 2021, only 13 of the 38 Member States SIDS had food based dietary guidelines (FBDGs) to inform and guide policy work along the food system, and no FBDGs explicitly incorporated environmental sustainability elements.</li> <li>• Improving health through nutritional environments is a central component of the SIDS Accelerated Modalities of Action (SAMOA) pathway and a key policy option for SIDS who have taken measures such as imposing taxes on sugar-sweetened beverages and other unhealthy products.</li> <li>• Industrially produced trans fats (IP-TFAs) are banned in almost every high-income country, but in few LMICs. It requires legislation which is a challenge for SIDS with limited human resources.</li> <li>• Domestic food security is undermined by a reliance on imported processed products including ultra-processed foods and beverages.</li> <li>• Regulation of marketing through television is very difficult as most broadcast content available in SIDS originates from larger countries.</li> </ul>
Physical inactivity	<ul style="list-style-type: none"> <li>• The average prevalence of insufficient physical activity in SIDS (27%) is similar to the global level (28%).</li> <li>• The unhealthy relationship between sport and the health-harming products' industries is a challenge globally and exacerbated in SIDS where funding sources are limited, and 'sport' from primary school through to secondary school and amongst elite athletes, is often funded/sponsored by the alcohol and UPFB industries normalizing their consumption from childhood and indirectly undermining benefits gained from physical activity.</li> <li>• Considering perceptions and barriers to physical activity for specific population groups requires an understanding of values, norms, ways of life, motivations, enjoyment, family commitments, social support, and integration with cultural components such as traditional dance and music, prayer, community orientation and family inclusiveness.</li> <li>• Considerations of gender and cultural contexts are also particularly important to engage women and girls in structured exercise, incidental exercise, and sports, providing them with environments in which they are safe and accepted in which to exercise and play.</li> </ul>
Air pollution	<ul style="list-style-type: none"> <li>• SIDS are some of the least contributing countries to CO<sub>2</sub> and other polluting emissions, though they are some of the most impacted countries.</li> <li>• SIDS experience heavy usage of dirty fuels for cooking in some places, poor controls of vehicle emissions and the burning of household refuse due to lack of alternative options. As well as fossil fuel-driven transportation and power generation, other pollutant sources include the use of agricultural fumigants,</li> </ul>

	<p>unchecked industrial stack emissions, gas flaring, cruise ships and airplanes, rotting sargassum seaweed, inefficient waste management systems for hazardous and toxic wastes, and open pit burning, among others.</p> <ul style="list-style-type: none"> <li>• Air pollution remains a major challenge for SIDS, although the median annual mean concentration of fine particulate matter is estimated to be, at 9 µg/m<sup>3</sup>, much lower than in other countries (20 µg/m<sup>3</sup>), yet still above the WHO guidelines of 5 µg/m<sup>3</sup> or less (68). Particulate matter, waste management and household air pollution are all contributing factors to this air pollution.</li> <li>• With a lack of baseline data on key pollutants in SIDS, more work can be done to provide technical guidance for SIDS in how to address this risk factor.</li> </ul>
<b>Compounding Challenges</b>	
Climate change	<ul style="list-style-type: none"> <li>• As temperatures increase, sea levels rise, drought and extreme weather events become more common, climate change presents an existential threat for SIDS communities.</li> <li>• Biodiversity and access to natural resources, which are threatened by climate change, are central to economic, cultural and spiritual life for SIDS.</li> <li>• Extreme events disrupt supply chains deepening vulnerability and creating insecurity as it relates to foods, medicines, etc. and create the conditions for commercial actors including those in the health-harming industries to expand and exploit vulnerable market opportunities.</li> </ul>
Fishing	<ul style="list-style-type: none"> <li>• One key challenge that SIDS face are illegal and unsustainable fishing and the resulting depleted fish stocks, which risk a key food source.</li> <li>• Fisheries face further risk of depletion due to the threat of climate change, posing a challenge to livelihoods and nutrition.</li> <li>• Plastics, sewage and agricultural and industrial pollutants are major threats to environmental sustainability, both on land and in the sea.</li> <li>• The Caribbean Sea has one of the highest levels of plastic pollution globally, and microplastic pollution is widespread.</li> </ul>
Agriculture	<ul style="list-style-type: none"> <li>• Local food production continues to be challenged by the distinct vulnerability SIDS face to the impacts of climate change. This is further compounded by ongoing gender-based barriers to land access, fisheries resources, tools and credit which impact the agricultural and fishery workforce, as well as the global overexploitation of oceanic resources which have threatened SIDS blue economy and rich aquatic resources. This is impacting availability and affordability of healthy foods.</li> </ul>
Access to medicines	<ul style="list-style-type: none"> <li>• The pharmaceutical industry intersects with CDoH in many ways, from the provision of essential medicines and technologies to COVID-19 related and other vaccine inequity arising from single source supply chains and paying disproportionately higher cost as a percentage of health expenditure for the cost of vaccinating populations.</li> <li>• Small size means a lack of economies of scale and high costs for imports which cannot come by land.</li> <li>• Purchasing of small amounts of pharmaceuticals means higher unit prices.</li> </ul>

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

## Annex 2: Conceptual model of the commercial determinants of health

In Gilmore, A., et al. Defining and conceptualising the commercial determinants of health. *Lancet*. 2023 Apr 8;401(10383):1194-1213. doi: 10.1016/S0140-6736(23)00013-2. Epub 2023 Mar 23. (2/5)



### Annex 3: Summary of select WHO implementation guides, technical and policy packages relevant to SIDS

**ACTIVE: a technical package for increasing physical activity (255)**

Physical activity

**Appendix 3 of the WHO global action plan for the prevention and control of noncommunicable diseases 2013–2030 (256)**

Updated NCD ‘best buys’

**The Global Breast Cancer Initiative (257, 258)**

Cancer

**Cervical Cancer Elimination Initiative**

Cancer

**The Global Initiative for Childhood Cancer (259)**

Cancer

**Special Initiative on Climate Change and Health in Small Island Developing States (SIDS) (260)**

Climate change

**Preventing drowning: an implementation guide (261)**

Drowning prevention

**HEARTS: Technical package for cardiovascular disease management in primary health care: Risk-based CVD management (262), including complementing HEARTS in the Americas Initiative (263)**

Cardiovascular diseases

**INSPIRE Handbook: action for implementing the seven strategies for ending violence against children (264)**

Violence

**The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health (265)**

Mental health

**MPOWER measures, to assist in the country-level implementation of effective interventions to reduce the demand for tobacco, contained in the WHO FCTC (266)**

Tobacco control

**WHO package of essential noncommunicable (PEN) disease interventions for primary health (267)**

Noncommunicable diseases

**REPLACE trans fat: an action package to eliminate industrially-produced trans-fat from the global food supply: trans fat free by 2023 (268)**

Industrially-produced trans fat

**Save lives: a road safety technical package (269)**

Road safety

**The SAFER initiative (270)**

Alcohol control

**The SHAKE technical package for salt reduction (271)**

Salt reduction

CONFERENCE DRAFT: E

## Annex 4: Relevant milestones and commitments

### NCDs and SIDS

**SIDS High-level Technical Meeting on NCDs and Mental Health, prior to a Ministerial Conference in June 2023 (272)**

WHO, PAHO, Government of Barbados (2023)

**WHO Global NCD Compact and first annual gathering of a Heads of State and Government Group for the Prevention of NCDs (273)**

WHO, Government of Ghana, Government of Norway (2022)

**Agriculture development, food security and nutrition (A/RES/77/186) (274)**

WHO (2022)

**SIDS Summit for Health: Outcome Statement (9)**

WHO (2021)

**Political declaration of the 3rd High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases : resolution / adopted by the General Assembly (275)**

WHO (2018)

**Outcome document of the High-Level Meeting of the General Assembly on the e Comprehensive Review and Assessment of the Progress Achieved in the Prevention and Control of Non-communicable Diseases : draft resolution / submitted by the President of the General Assembly, (2014) (276)**

WHO (2014)

**Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases : draft resolution / submitted by the President of the General Assembly, (2011) (277)**

WHO (2011)

**Political Declarations of the UN High-level Meetings on the Prevention and Control of NCDs in 2011, 2014 and 2018 (275, 276, 277)**

WHO (2018)

**Special Initiative on Climate Change and Health in Small Island Developing States (SIDS) (260)**

WHO, UNFCCC (2017)

**2015 Addis Ababa Action Agenda of the Third International Conference on Financing for Development (278)**

UN (2015)

**Yanuca Island Declaration and the Healthy Islands approach (279, 280)**

WHO, Pacific Community (1985, reaffirmed in 2015)

**SIDS Accelerated Modalities of Action Pathway (SAMOA Pathway) (281)**

UN-OHRLLS (2014)

**Declaration of Port-of-Spain: Uniting to Stop the Epidemic of Chronic NCDs (282)**

CARICOM (2007)

**WHO Framework Convention on Tobacco Control (FCTC) (248)**

WHO FCTC (2003)

**Business and human rights in SIDS**

**Small Island Developing States Global Business Network (283)**

UN-OHRLLS

**United Nations Forum on Business and Human Rights**, Working Group on the issue of human rights and transnational corporations and other business enterprises (284, 285, 286)

OHCHR (various)

**Regional Forums on Business and Human Rights** (Latin America and the Caribbean; Pacific; Africa; South Asia; and Eastern Europe and Central Asia) (204, 205)

OHCHR (various)

**Economic and commercial dimensions of the social determinants of health**

**Seventh-Fourth World Health Assembly Resolution WHA74.16 on Social Determinants of Health (287)**

WHO (2021)

**Geneva Charter for Well-being (288)**

WHO (2021)

**Rio Political Declaration on Social Determinants of Health (12)**

WHO (2011)

**Sixty-Second World Health Assembly Resolution WHA62.14 on Reducing health inequities through action on the social determinants of health (289)**

WHO (2009)

**Sustainable development**

**UN 2030 Agenda for Sustainable Development**

UN (2015)