SOCIOLOGY OF HEALTH & ILLNESS

Sociology of Health & Illness Vol. 38 No. 7 2016 ISSN 0141-9889, pp. 1026–1042
doi: 10.1111/1467-9566.12424

The post-2015 landscape: vested interests, corporate social responsibility and public health advocacy

Clare Herrick

Department of Geography, King's College London, London, UK

Abstract This paper explores the tensions between UN calls for private sector engagement in the post-2015 landscape and public health opposition to those 'harm industries' that are 'corporate vectors of disease' for the mounting global non-communicable disease burden. The UN's support for public-private partnership has provided industries with 'vested interests' in the propagation of unhealthy behaviours with new opportunities for the strategic alignment of their corporate social responsibility (CSR) endeavours with the post-2015 sustainable development agenda. This has galvanised public health advocates to place pressure on the World Health Organisation to formalise their ambiguous stance towards private sector involvement in public policy formation and the resultant 'conflicts of interest'. This paper critically examines the 'gathering storm' between this 'anti-corporate movement' and the alcohol industry in the increasingly politicised domain of CSR. Drawing on the example of SABMiller's Tavern Intervention Program, the paper argues that CSR represents a profound threat to the sanctity and moral authority of the public health worldview. Questions therefore need to be asked about whether the public health-led path of industry non-association will necessarily result in health improvements or just a further retrenchment of the ideological faultlines explored in the paper.

Keywords: alcohol/alcohol misuse, Governance, Policy analysis

Introduction

This paper explores the complex intersections between the post-2015 sustainable development agenda, the global public health movement and those industries deemed to be 'corporate vectors of disease' (Gilmore *et al*. 2011) by virtue of the significant health risks posed by their products and activities (Jahiel 2008). At a time when global political attention has finally turned to the rising global burden of non-communicable diseases (NCDs) and their four shared behavioural risk factors of diet, smoking, alcohol and physical inactivity (Marrero *et al*. 2012, World Health Organisation (WHO) 2013a), a growing band of public health advocates are also now drawing attention to the long-wave health consequences of what Freudenberg (2014) has termed the 'corporate consumption complex'. These advocates are calling for a 'new dedicated branch of public health surveillance and research capacity to … monitor and understand the activities of the unhealthy commodities industries' (Moodie 2014: 525) with regards to NCDs. Their appeals have further intensified in response to the significant corporate lobbying opportunities afforded by the 2011 United Nations (UN) High-Level Meeting on NCDs and the

Published by John Wiley & Sons Ltd., 9600 Garsington Road, Oxford OX4 2DQ, UK and 350 Main Street, Malden, MA 02148, USA

negotiations over the post-2015 Sustainable Development Goals (SDGs) (Beaglehole *et al*. 2011, Stuckler *et al*. 2011). These 'opportunity platforms' have also laid bare fundamental rifts in opinion about the involvement of the 'harm industries' (Welker *et al*. 2011) in public health policy development and implementation processes, whether this represents a conflict of interest and the extent to which such conflicts can/need to be identified and managed.

Public health advocates for the inclusion of NCDs within the SDGs have argued that industry involvement in policy negotiations represents a profound and deeply unethical conflict of interest (Lincoln *et al*. 2011, London *et al*. 2012, Richter 2014). Their unease is particularly marked in relation to the food and alcohol industries whose products and commercial activities, they argue, are antithetical to both the means and ends of public health (Casswell 2013, Stuckler and Nestle 2012). They further contend that the terms of engagement with these industries are not yet subject to the same conditions as those laid down by the Framework Convention on Tobacco Control (Bond *et al*. 2010). The level of public health concern is such that 162 public interest non-governmental and professional organisations formed the 'Conflict of Interest Coalition' (henceforth The Coalition) in 2011 and issued a 'Statement of Concern' for the attention of the President of the UN General Assembly in advance of the High-Level Meeting on NCDs (Schmitz 2015). In the statement, they highlight the risks of the kind of 'partnership' working not only advocated by a range of UN agencies, including the Global Compact (UNGC), Development Programme (UNDP) and Industrial Development Organisation (UNIDO), but also institutionalised through UNDP's Istanbul International Center for Private Sector in Development (IICPSD) and the loose collaborations between the WHO and WTO. In response to the perceived threat posed by the UN's tone of inclusivity, the Coalition called for 'an ethical framework and code of conduct to safeguard against and manage conflicts of interest in public health policy' (Conflicts of Interest Coalition 2012).

Indeed, as the language of partnership has become mainstreamed (United Nations Development Program 2012, United Nations Global Compact 2014a, United Nations Industrial Development Organization 2014); profound disjunctures have emerged between the discourses promulgated by the UN and those of the World Health Organisation (WHO) on the topic of private sector engagement in relation to health and development. This disjuncture is further compounded by the UN's current direct challenge to WHO's traditional dominance in global health governance, particularly in relation to NCDs and their manifold social, economic and environmental determinants (Garrett 2007). The widening disparity between the discourses of the two agencies also means that they increasingly hold differing interpretations of and prospective strategies for managing the conflicts of interest that, public health advocates argue, are unethical and inescapable when partnering with harmful industries with vested interests in poor health. While this gap is a source of significant frustration for public health advocates, it also represents an opportunity for the 'unhealthy commodities industries' (Stuckler *et al*. 2012) to align their corporate activities with the UN's sustainable development priorities. These processes of alignment have, in turn, leant corporate social responsibility (CSR) renewed significance as a fascinating nexus of public health disquiet and the genesis of corporate opportunity.

CSR has a long history as a business strategy that emerged 'among leading firms and business schools as a public relations tool, a way to deflect criticism, engage critics and potentially capitalise on emerging business opportunities associated with doing, and being seen to be doing, good' (Newell and Frynas 2007: 670). These activities occur (and differ markedly) across a variety of geographic contexts, but are arguably both necessary and controversial in emerging markets (Dobers and Halme 2009, Orock 2013). The deployment of CSR in countries of the south by the unhealthy commodities industries is further cause for public health concern over the innate conflicts of interest between the harm caused by their products and the platform for health policy lobbying afforded by partnership working. These conflicts of interest

have only been further entrenched, detractors argue, by the unhealthy commodities industries' strategic alignment with the Global Compact's belief in the 'centrality of private enterprise [to the] pursuit of the development agenda – and vice versa' (2014c: 3). With this in mind, this paper will critically reflect on how the post-2015 landscape offers up new legitimation opportunities for the harm industries and what this means for the concept of 'conflict of interest' in relation to the behavioural risk factors for NCDs. To do so, it first examines the debate over the relative roles and responsibilities of private industry versus that of the state in securing the promise of better health (McGoey 2014). Second, it explores CSR as 'a new global orthodoxy which claims to unite the exigencies of social well-being with the dictates of profit maximisation in the emancipatory promise of the market' (Rajak 2011: 2) with specific attention to the case of alcohol. Third, it draws on the empirical example of South African Breweries' (SAB) controversial CSR undertaking - the *Tavern Intervention Programme (TIP)* - to explore the conceptualisation and framing of conflict of interest by its public health opponents and asks whether these critiques are borne out in the programme's own evaluation. In subjecting the relationship between public health and CSR to critical analysis, the paper aims to address anthropologist Dinah Rajak's concern that too often the 'normative preoccupation with whether CSR is a force for good or a cynical corporate ploy entrenches the ideological faultlines along which the study of CSR has run' (2011: 11). In carving up the ideological faultlines underpinning public health readings of CSR, the paper argues for a geographically aware, critical social science of CSR and health that better reflects the changing demands, needs and expectations of the post-2015 global health landscape.

Partnerships, the UN and WHO

Over the past two decades, businesses have shifted from being unintentional agents of development (Blowfield and Dolan 2014), to being fully fledged 'development cooperation actors' (United Nations Industrial Development Organization 2014: 18). With the ascendance of a new orthodoxy of 'sustainable development' initiated by the *Brundtland Report* in 1987, 'companies that once enacted their social responsibilities as a philanthropic side-line, and later as a risk management technique, [started to bring] sustainability into the heart of their business models' (United Nations Global Compact 2014c: 3). The shift is underpinned by a conviction that 'businesses have an inbuilt motivation to see development succeed' (United Nations Industrial Development Organization 2014: 6). As such and as the Global Compact asserts, 'corporate sustainability is effectively rearticulating the concept of responsible business, with an orientation towards the "sustainability" in sustainable development' (United Nations Global Compact 2014c: 3). This process of rearticulation is one that was propelled by the Millennium Declaration pledge to 'develop strong partnerships with the private sector and civil society organisations in pursuit of development' (United Nations 2000: http://www.un.org/millennium/declaration/ares552e.html). However, where the Millennium Declaration stopped short of setting out an express model of public-private engagement for sustainability, the UN's post-2015 process has carefully articulated a World Bank-led model of 'multi-stakeholder governance' between nation states, international organisations, civil society and the private sector (Pingeot 2014). In this model, the practice of corporate sustainability is viewed as both essential to and symbiotic with the delivery of sustainable development. Alongside this, the role of government is increasingly being reimagined as both the instigator of a necessary 'paradigm shift' and as the engineer and facilitator of an enabling 'operating environment that optimizes contributions from the private sector' (United Nations Global Compact 2014b: 3).

In recognition of the 'vested interests' of many corporations, WHO formally acknowledged the need for reflection on the nature of private sector influence in the context of the changing global burden of disease. Its 2013 report argues that 'promoting public health may necessarily involve engagement with those whose activities have the potential to do harm' (WHO 2013b: 3). There are two schools of thought in relation to how to deal with this, one side argues that 'policy is enriched by engaging with those that have different and opposing opinions', while the other asserts the need for 'a list of those groups in civil society or the private sector that should be explicitly excluded from any relationship with WHO' (WHO 2013b: 3). The draft 'Framework of engagement with non-State actors' explicitly sets out a policy of non-engagement with the tobacco and arms industries in keeping with the World Health Assembly's Resolution 65.6 Action 3(3) which mandated WHO to 'develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of programmes'. However, WHO stops short of extending the 'non-association model' to the alcohol or food industries (Daube 2014), running counter to its statement that it will 'not engage with industries making products that directly harm human health' (WHO 2014a: 3). The contradiction is further drawn out in the draft Framework which states that engaging with the private sector should be undertaken with 'caution' and will require robust instruments to identify risks and balance them with potential benefits, while also preserving WHO's integrity and reputation (WHO 2014a). Despite these promises, Daube (2014) points out that recent informal WHO consultations in Geneva included representatives from SAB and the Global Alcohol Producers Group (re-named the International Alliance for Responsible Drinking or IARD in 2015), an industry lobbying organisation set up in 2005 to engage WHO in 'constructive dialogue' (IARD 2015). For the public health lobby, this industry involvement only deepens fears of a 'gathering storm' swirling around WHO (Babor *et al.* 2013b).

The fears over WHO's integrity and reputation speak to the challenges facing the harm industries in garnering public (and political) legitimacy, especially within the NCD policy environment. While the broader post-2015 process offers a rejoinder to the private sector to recognise the 'growing overlap between public and private interests' (United Nations Global Compact 2013: 4) and, therefore the 'business case' for corporate sustainability in the context of NCDs; the precise delineation of roles and responsibilities remains both complex and contested. For example, a summary report of the 2011 UN High-Level Meeting on NCDs states that 'policy makers need to recognize that the NCD epidemic is largely preventable by government-led action in close collaboration with civil society and the private sector' (WHO 2011b: 2). The WHO's *Global Status Report on NCDs* argues that 'civil society, including the private sector, is uniquely placed to mobilize political and public awareness and support for NCD prevention and control efforts, and to play a key role in building capacity and in supporting NCD programmes' (WHO 2014c: 7). Across these two documents, governments are cast as possessing ultimate responsibility for NCD prevention, with the private sector and civil society catalysing and legitimising NCD prevention and control efforts, especially amid the funding gaps generated by the global financial crisis. The *Report* further asserts that the private sector has 'a major opportunity and responsibility in facing up to the NCD epidemic. [It] must recognize how much is at stake in both human and economic terms if the global rise in NCDs is allowed to continue' (WHO 2014c: 87). However, with the global rise in NCDs continuing unabated, questions remain as to whether the opportunities afforded by participation in the SDG processes are effacing the need to exercise corporate responsibility. This parallels the public health argument that corporate responsibility among the harm industries can only ever be an oxymoron.

The admonition to 'recognise how much is at stake in human terms' (WHO 2014c: 87) also reflects the frustrations so often expressed by public health advocates, namely the regulatory void with respect to multinational companies in general, and the harm industries in particular

(Barkemeyer *et al*. 2014). Public health anger is further exacerbated because 'the major causes of preventable death are driven by diseases related to tobacco, unhealthy diet, physical inactivity and alcohol drinking ... [yet] many of the proposals to address NCDs call for "partnerships" in these areas with no clarification of what this actually means' (Conflicts of Interest Coalition 2012). One of the main problems is that the post-2015 process has formalised a role for the private sector in advance of the adoption of any accountability mechanisms for the health and economic outcomes of their activities (Richter 2014). This gap was flagged up in a submission by the UK NCD and Development Task Force to the 'health in the post-2015 agenda' SDG thematic consultation in which the authors argued that the process should 'recognise the conflicts for all the private sector corporations whose profit-making practices result in significant externalities to society in relation to sustainable development' (The World We Want 2015 2014). These conflicts are rendered more complex by the heterogeneity of the harm industries themselves, where a tendency to conflate a diverse array of actors within the general 'industry' or 'private sector' label not only obscures significant differences in their contribution to health outcomes (Herrick 2011), but further entrenches the anti-corporate public health movement.

While public health concern about the accountability and responsibility of the private sector is important in the global north, it is arguably even more vital in countries of the global south where state capacity may be weak, corruption endemic and regulatory frameworks underdeveloped and poorly enforced (Idemudia 2011). In such contexts, vaguely-articulated references to voluntary or 'soft' approaches to corporate accountability expounded by the post-2015 documents means that 'the performance of corporate virtue' (Rajak 2011: 4) through CSR can be undertaken with relative freedom and appended to a variety of strategic ends. CSR is one of a variety of platforms or vehicles through which corporations can achieve corporate sustainability and 'represents a powerful framework through which transnational corporations gain access to new kinds of social and moral resources in pursuit of their economic goals' (Rajak 2011: 18). It must also be recognised that CSR is an inherently 'slippery' (Rajak 2011: 3) concept that is often critiqued for its lack of analytical and definitional clarity (Blowfield and Frynas 2005). This powerful definitional malleability (Rajak 2011) has meant that CSR has become a means through which the conflicts of interest inherent within the private sector's involvement in the post-2015 process can be publicly and discursively managed, if never quite mitigated. This same malleability has also enabled public health advocates to frame CSR as a paradoxical and largely hypocritical undertaking (Massin 2012, Yoon and Lam 2013), despite often lacking sufficient empirical data to fully substantiate their ideological claims (Jernigan and Babor 2015). This 'ongoing skirmishing' (Babor *et al*. 2013b, 2014a) between ideologically opposed readings of corporate sustainability is particularly marked with respect to the global alcohol industry to which this paper now turns.

CSR, alcohol and conflicts of interest

At its most basic, CSR is founded on the presumption that 'businesses have obligations to society that go beyond profit-making to include helping solve societal, social and ecological problems' (Idemudia 2011: 1). Many of these 'problems' are (or are the result of) the negative externalities of processes or products for which, many have argued, businesses should assume responsibility (Banerjee 2008). For harm industries such as food and alcohol, CSR is a polymodal enterprise that can be used to bolster corporate reputation by discursively aligning the company's products with, for example, 'healthy lifestyles' (Herrick 2009) or 'corporate oxymorons' such as 'responsible drinking' (Benson and Kirsch 2010) through sustainability

reporting, new product launches, web strategies, social media, sponsored programmes and other forms of marketing. In turn, these processes of strategic alignment have also been used as a bargaining chip and public legitimation tool ensuring that the harm industries have secured significant levels of influence in the policy-making process (Jahiel 2008). Public health advocates have argued that this 'laundering process' of 'moving money [from the sale of harmful products] into philanthropic arenas' (Benson 2014: 224), gives rise to profound conflicts of interest (Babor and Robaina 2013, Yoon and Lam 2013). Despite the promise and ubiquity of sustainability reporting, the lack of any clear definition of what constitutes a conflict of interest in relation to the harm industries has now rendered CSR a particularly lively battleground between public health advocates keen to ensure the complete elimination of corporate influences on the policy process (Gornall 2013, Herrick 2016) and the harm industries for whom the post-2015 process has reanimated CSR. It is, however, important to note that there are huge differences in the expectations and undertaking of CSR by the world's companies across their global markets. Indeed, while the CSR agenda is largely driven by northern actors who impose a series of 'universal expectations' upon on the process (see also Dobers and Halme 2009, Idemudia 2011), these may be incompatible with local realities in the global south. The outcome has often been a fractious 'disjuncture between local priorities and global expectations' (Idemudia 2011: 2) magnified because 'southern perspectives' of CSR are often neglected within CSR's very own 'field of practice' (Rajak 2011). An appreciation of the difference that scale and geographic context makes is arguably all the more important when considering CSR as 'a movement promising to harness the *global* reach and resources of transnational corporations in the service of *local* development and social improvement' (Rajak 2011: 1, emphasis in original). This has particular relevance to the harm industries where citizen and governmental expectations of corporate responsibility for health may be markedly different to those of countries of the global north.

In contrast to such specificity, public health engagements with the CSR activities of the harm industries have tended to extrapolate from the experiences of the tobacco control lobby to render 'pariah status inevitable' (Edwards 1998). This tendency reflects the huge success of the tobacco control movement in uncovering how the industry managed to co-opt science and scientists to help cast doubt on unwelcome research findings (Oreskes and Conway 2010), forge new markets in the global south through ethically problematic marketing practices, lobby national governments and international organisations to evade the threat of regulation and persistently use a variety of insidious means to deny any causal link between smoking and cancer (Fooks *et al*. 2011, Gilmore *et al*. 2015). Thus while ideological opposition to the tactics and products of the harm industries is far from new, it remains the case that 'we are not [yet] in the same place with alcohol' (Gilmore 2015: 1). However and despite the significant methodological and moral limitations to conducting research on industry activity (Babor 2016, Herrick 2016), researchers have managed to gather evidence of alcohol industry lobbying against public health policy initiatives such as minimum pricing in the UK (Gornall 2014, Hawkins and Holden 2014) and taxation in Thailand (Sornpaisarn and Kaewmungkun 2014). They have also documented emerging evidence of industry involvement in national alcohol strategy development in some African countries (Bakke and Endal 2010) amid growing concern with the 'enormous public health burden' caused by alcohol across Africa (Ferreira-Borges *et al*. 2016). However, other recent studies have failed, for example, to find definitive proof of alcohol industry manipulation of scientific studies (McCambridge and Hartwell 2014) or of CSR activities increasing alcohol availability in Africa (Babor *et al*. 2014b). Thus, while the public health 'anti-corporate movement's' (Wiist 2006) tactic of eliding the actions of the tobacco and alcohol industries plays a powerful discursive role, it has arguably also stymied critical reflection on the social, regulatory and health particularities of the alcohol industry

which render its CSR strategies a profoundly different object of analysis compared to those of tobacco.

Among many public health advocates, alcohol industry CSR activities have been framed as a kind of 'strategic encroachment' through the 'increasing involvement of the alcohol beverage industry in areas that traditionally have been the main foci of public health and academic medicine, such as scientific research, alcohol education, prevention programs, and alcohol control policies' (Babor and Robaina 2013: 206). This represents a fundamental threat to the privileged status previously afforded 'the wise council of WHO and the public health community' (Babor *et al*. 2013b: 2046). The use of CSR to transform 'what might otherwise have been depicted as a profit-driven economic entity into a palatable public health advocate' (Yoon and Lam 2013: 8) is, detractors argue, fundamentally cynical as 'the global initiatives promoted by the alcohol industry are overwhelmingly derived from approaches of unknown or minimal effectiveness or shown to be ineffective through systematic scientific research' and that, of these, 'few have been evaluated in the low and middle income countries where they are now being disseminated' (Yoon and Lam 2013: 210). The lack of evidence or evaluation may stem from the instrumental use of CSR instead to 'frame issues, define problems and guide policy debates' (Yoon and Lam 2013: 7). This creative use of CSR is often transformed into a tenuous conflation with the tactics of 'science capture' (McCambridge *et al*. 2014) with 'industry-favourable policies' cast as antithetical on all levels to 'public health initiatives' (Babor *et al*. 2013b: 2046).

This 'public health scope creep' (Horn 2013: 1) may serve the purposes of advancing the anti-corporate agenda, adding further weight to calls to develop a new 'science of the effects of corporate behaviours on health' (Moodie *et al*. 2013: 1). However, in contrast to grounded and reflexive anthropological engagements with CSR (Bond *et al*. 2009, Dolan and Rajak 2011, Rajak 2011, Sharp 2006), this public health framing does little to deepen critical engagement with the evolving role of CSR in the context of NCDs, health and development in either a conceptual or empirical sense. This is largely because public health readings disembed CSR from its social practice (Welker *et al*. 2011) due to an over-reliance on methodological approaches that favour the use of secondary data in the 'textual analysis of corporations' (Miller *et al*. 2011: 464), rather than making use of the far more expositive potential afforded by fine-grained ethnographic engagements. Indeed, rather than elaborating CSR as a series of programmes that are deployed, experienced and ultimately hold the potential to be transformative (Dolan 2012, Dolan and Rajak 2011), public health accounts neglect that how CSR is received and interpreted can be just as important as what it claims to do. This is a crucial omission and one that has shaped the 'emerging conflict between the public health community and the alcohol industry' over the question of 'who owns public health in so far as alcohol policy is concerned' (Babor *et al*. 2013b: 2046). This conflict is one also being waged between 'a view supported by systematic scientific evidence and a view which is perceived by the alcohol industry as more in line with its interests' (Babor *et al*. 2014a: 1210). The problem for public health advocates is that their 'systematic scientific evidence' of commercial 'interests' is often based on little more than 'a strong suspicion, reinforced by a considerable amount of circumstantial evidence, that these activities are mainly being taken to impede the development of effective alcohol control policies advocated by the public health community that would run counter to their commercial interests' (Babor *et al*. 2013b: 2045). The prevailing tone of suspicion and paranoia has played into the hands of the global alcohol lobby, keen to frame public health advocates as pushing a 'zero-sum view about who owns public health in so far as alcohol policy is concerned' (Leverton 2014: 1214). The problem, as the negotiations over the SDGs show, is that increasingly 'no one "owns" public health' (Leverton 2014: 1214).

The 'battle between alcohol producers and public health over control of alcohol policy' (Leverton 2014: 1214) has long raged, but was given a boost in 2013 when public health lobby group the Global Alcohol Policy Alliance (GAPA) issued a Statement of Concern endorsed by 500 public health professionals and academics across 60 countries (Babor *et al*. 2013a). This was drafted in response to news that 13 of the world's major alcohol producers had issued a set of commitments to tackle alcohol related harms in the wake of WHO's *Global Strategy* on alcohol (Babor *et al*. 2013b, Babor and Brown 2013). In a rapid response to an article in the *BMJ* documenting the controversy (Gornall 2013), Margaret Chan the Director General of WHO was quick to placate the public health lobby by reassurances of the fundamental 'political job' of governments in 'improving the environment in which consumers make their choices … especially when public health interests clash with the interests of powerful economic operators, including the alcohol industry' (Chan 2013a). She later clarified that 'the development of alcohol policies is the sole prerogative of national authorities … the alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests' (Chan 2013b: 1). This statement was welcomed by members of GAPA who had expressed fears that without appropriate strategies and frameworks, 'conflicts of interest can become institutionalised as the norm, impacting on the authority of governments' (2013b). As such, the public health community is unified behind the idea that 'the role of industry CSR in public health policy needs to be subjected to closer scrutiny and that conflict of interest should be rigorously managed in any partnership working with alcohol corporations' (Yoon and Lam 2013: 8). If, as the public health lobby have argued, alcohol industry CSR is a 'fundamental and irreconcilable conflict of interest' (Yoon and Lam 2013: 87), this calls into question the purpose of a UN or WHO Framework. This tension will be further explored in relation to SAB's Tavern Intervention Programme (TIP).

Alcohol and CSR: SAB and TIP

South Africa endures a 'quadruple burden' of maternal, perinatal, infectious and chronic disease (Perez *et al*. 2013), as well as extremely high rates of interpersonal violence, road traffic accidents and injuries. Alcohol is a risk factor and direct contributor to virtually all of these public health challenges (WHO 2011c); with the country staking a claim to some of the world's highest consumption per capita and heavy episodic drinking rates. As a consequence, the WHO gives South Africa a 'pattern of drinking' and 'Years of Life Lost' score of 4 out of a possible 5 (WHO 2014b). This ranking puts the country's drinking risks on a par with other high-consumption nations including Namibia, Zimbabwe and the Ukraine. The 'scourge' of alcohol has long been a regulatory and development challenge in South Africa (South Africa Department of Social Development 2013), not least because the majority of the country's liquor is sold through an estimated 200,000 unlicensed (and therefore illegal) bars or 'shebeens' (Herrick and Charman 2013, Tsoeu 2009). Efforts to tackle the longstanding 'shebeen problem' (Lawhon and Herrick 2013) have intensified in the past 15 years as epidemiologic data have revealed the extent of alcohol-attributable harm (Schneider *et al*. 2007) and the contributory role of shebeens to these (Scott-Sheldon *et al*. 2014). To address this, the revised 2003 National Liquor Act ascribed specific responsibility to individual provinces for the regulation of the retail tier of industry. It also required companies registered as liquor producers to set out their commitments to social responsibility and responsible alcohol use. In effect, this has locked South Africa in a tense political debate over the future shape of alcohol control policies including drink driving, advertising bans, taxation and efforts to raid and close shebeens (Faull 2013, Parry *et al*. 2012). Given the reliance of SAB on shebeens as a retail

channel, the Act has also had the unintended effect of bolstering industry CSR activities deployed over an array of social and economic causes.

As one such CSR effort, TIP was initially piloted by SAB in 2008 as a partnership between SAB, the South African Business Coalition on HIV and AIDS, the national Department of Trade and Industry, the NGO Men for Development in South Africa and the Global Fund. It was one of five programmes funded through a $5 million grant from the Global Fund Workplace Program in 2011. It tackles issues related to four 'modules' – responsible alcohol consumption; HIV/AIDS, gender violence and child abuse – that represent profound and thoroughly interconnected social development challenges in South Africa. The programme uses a series of workshops and educational interventions to drive behavioural and attitudinal change amongst men identified by the police, community policing forums, provincial liquor officers, tavern owners and community leaders as persistent offenders in rural and peri-urban areas. The programme lasts for five days and takes place in a local tavern, after which its participants graduate, sign a pledge and then agree to meet as part of a 'men's support group' once a month. TIP thus aims to 'empower men with the necessary information to become ambassadors of change' for their families and communities. In so doing, it also allows SAB to argue its drive to 'be part of the solution [to alcohol-related harms] ... by targeting its source' (SAB Stories 2014: 1214). In its first phase from 2008-2012, the programme reached 2000 men across a large number of different communities. In 2014, despite the public health opposition detailed here, SAB announced the reintroduction of TIP with the goal of reaching at least 360 men in its first six months.

A 2012 round table of the *Bulletin of the World Health Organisation* explored the 'collusion' between the Global Fund and SAB as a clear and unacceptable conflict of interest (Matzopoulos *et al*. 2012). A group representing the South African Medical Research Council, the University of Cape Town's Department of Public Health and the national NGO Soul City argued that SAB's receipt of the Global Fund's Round 9 funding was problematic as it 'reflects the successful attempt of a highly profitable industry to position itself as committed to public health objectives' (Matzopoulos *et al*. 2012: 67). This strategic positioning, operationalised through partnership working, 'lend[s] legitimacy and provide[s] a platform' (Matzopoulos *et al*. 2012: 67) for the industry to lobby against the kind of policy measures – reduction of availability, taxation and marketing restrictions – that the public health community have long argued represent evidence-based, 'best buys' for alcohol control (WHO 2011a). The authors expressed a four-fold concern: the use of taverns as venues; the use of unproven educational interventions; the targeting of men alone and the use of programmes that fail to address alcohol consumption at a population level. TIP, they argue, allows SAB to 'be seen fulfilling social and legal obligations to address alcohol abuse while simultaneously ensuring that sales and profits are maintained' (Matzopoulos *et al*. 2012: 67). Moreover, they assert, in giving money to SAB's CSR initiative, the Global Fund was not only denying funds to other, under-resourced organisations, but providing SAB with 'free advertising and a mechanism to achieve its [corporate sustainability] goals' (Matzopoulos *et al*. 2012: 67). The authors argue that the Global Fund should therefore not fund any industry with 'conflicted interests' which would, in turn, place the alcohol industry strictly 'off limits'.

From a public health perspective, the Global Fund's support of TIP represents an insidious case of 'corporate capture' in which contentious industries seek to dominate the 'information environment' in order to affect policy processes (Miller and Harkins 2010). In their response, the Global Fund stresses that its status as a public-private partnership means that it 'encourages the private sector to engage in all aspects of its work' and that, moreover, partnerships with the private sector are 'critical to expanding the resources available to fight malaria, TB and HIV/AIDS' (Bampoe *et al*. 2012: 70). The Global Fund further argues that it has no 'objections to

collaborating' with any industries (other than tobacco, arms and pornography) that support 'evidence-based, effective interventions' (Bampoe *et al*. 2012: 70). In contrast to Matzopoulos and colleagues' assertion that shebeens represented an inappropriate venue for interventions, the Global Fund response cites evidence in which brief interventions for HIV risk reduction were conducted in shebeens (Kalichman *et al*. 2008, Morojele *et al*. 2006) rendering them 'viable and dynamic locations for intervention' (Bampoe *et al*. 2012: 70). Indeed, there remains a largely intractable divide between the Global Fund's view of the partnership between the South African government and SAB as 'innovative' and the public health perspective of it being a 'cause for concern' (Matzopoulos *et al*. 2012: 67). This is emblematic of the profound 'culture clash' between public health and the harm industries documented by Munro and de Wever (2008).

In a final rejoinder to the round table, Gilmore and Fooks (2012: 71) admonish both the South African government and the Global Fund for their 'apparent failure' to 'recognise and adequately address the potential conflict between corporate interests and public health'. Amid this conflict, CSR strategies such as TIP – which are held up as perfectly legitimate by the UN – are viewed as one of a number of deeply unethical routes for the harm industries to achieve public legitimacy and policy influence (Casswell 2013, London *et al*. 2012, Moodie *et al*. 2013). In this pervasive public health narrative, the alcohol industry is critiqued for its support of 'ineffective and potentially counter-productive' (Gilmore and Fooks 2012: 71) educational interventions to effect behaviour change and risk reduction as well as using CSR as a legitimacy platform for government dialogue and policy lobbying. To its critics, TIP is yet another industry CSR activity that ignores 'science' in pursuit of its ideological and commercial goals, signifying an urgent need for 'robust rules for managing potential conflicts of interest' (Gilmore and Fooks 2012: 71). This debate is also profoundly shaped by the very cracks, gaps, contradictions and uncertainties that characterise alcohol control science itself (Herrick 2016) and their uneasy co-existence with the belief in evidence-based policy.

It is noteworthy that the accusation of TIP's inefficacy was published in advance of an evaluation of the TIP programme's effect on participant knowledge, attitudes and behaviours by the Health Economics and HIV and AIDS Research Division, University of KwaZulu-Natal. The evaluation was undertaken with a sample of 455 men in Gauteng province in three stages – pre, post and six months post-intervention. The study compared those receiving the intervention with a control group who only received courses on cancer, diabetes, heart disease, obesity and sexuality (Govender and George 2013) and had a 24 per cent retention rate by the six month post-intervention stage. The evaluation used a mixed-methods approach comprising linked behavioural surveys at all three stages, focus groups with participants at time 2 and 3, as well as interviews and focus groups with stakeholders. With respect to the responsible alcohol use module in particular, the evaluation noted 'significant improvements' in the 'knowledge of the effects of the harmful use of alcohol' as well as 'for scores on the AUDIT scale, suggesting a decrease in risky drinking behaviours' (Govender and George 2013: 17). The report noted, however, that the intervention did 'not impact on high risk drinkers', leading the authors to ask how this group might be better accommodated in future iterations of the programme. The qualitative findings suggest a shift in responsible drinking behaviours among participants such as alternating drinks with water and eating while drinking, as well as a greater degree of reflexivity over the impact of drinking upon others, including family and community. In contrast to the concerns expressed by Matzopoulos *et al*. (2012), the authors also report that participants considered the tavern to be an important venue as one of the few 'public' spaces available in poor communities with the potential to offer a 'relatively neutral and rational space' for the discussion of difficult issues.

The report concludes that the TIP intervention does 'exhibit efficacy in improving participant knowledge, with significant improvement ... regarding the effects of alcohol consumption' (Govender and George 2013: 29). Moreover, it asserts that the qualitative research demonstrates that participants were 'beginning to demonstrate positive attitude shifts towards the themes addressed during the TIP', even if they concede that 'programme efficacy in terms of actual behaviour change yielded inconsistent results' (Govender and George 2013: 29). The authors conclude that this is consistent with similar studies in which it is easier to measure knowledge and attitudes than to demonstrate sustained behaviour change. This is due to the inextricability of behaviour from broader structural factors, the subjective nature of self-reporting and the problem of social desirability bias (Davis *et al*. 2010). The report consequently recommends that, where possible, future evaluation should include the 'gold standard' of biological markers: possible for HIV incidence, but more problematic for alcohol consumption. The invocation of the need for 'gold standard' evaluation protocols also points to a deep tension within the study of alcohol which has, perhaps unsurprisingly, become elided with the conflict of interest debate. The parameters, standards and expectations of what constitutes evidence – and therefore 'efficacy' – in CSR-led interventions are difficult to attain in real world settings (Adams 2013), but it is in these real world settings that conflicts of interest arguably matter most. It is also in these real world (and often vastly under-resourced) settings that CSR strategies and partnerships are increasingly being deployed. When public health critiques ignore the possibility that CSR might be 'a force for good', as the TIP evaluation haltingly suggests, in favour of casting it as a 'cynical corporate ploy' (Rajak 2011: 12), it suggests that the 'gathering storm' becomes more about protecting the 'integrity' of the public health endeavour (London *et al*. 2012) than any critical refection on how CSR might be productively harnessed in a post-2015 era.

Conclusion: whose conflict of interest?

Drawing on the example of a particularly contentious alcohol industry CSR endeavour in South Africa, this paper has explored the extent to which the public health reading of the 'harm industries' is in tension with the post-2015 notion of multi-dimensional and multi-sectoral 'issue platforms'. This approach chimes with Horton's (2012) assertion that, 'although health still retains a place of importance, it is no longer the dominant idea underpinning the way we see human progress'. It is certainly the case that post-2015 processes have provided new platforms to legitimate the harm industries' claims that they should be active participants in policy formation. However the gap between the stances of the UN and WHO explored here has also meant that CSR has become something of a synecdochal referent for the emerging battle between two versions of moral authority. On one hand stand corporations 'as agents of progress and development, [who can assert] their commitment to a global economic order governed by the supposedly amoral, asocial and secular logic of "the market"' (Rajak 2011: 239). On the other hand, the moral and ethical authority of a scientific, evidence-based, rational and objective public health put to the service of the public interest. Conflicts of interest can be between the corporate requirement to deliver profit to shareholders and the public health burden of the products they sell, but it can also be between competing visions of rights, responsibilities and duties with respect to health. As such, there is a profound conflict of interest between the means and ends of industry and those of public health in which, perhaps most crucially, the activities of the former represent a profound threat to the sanctity of the latter. When health is so embroiled with social acts of consumption, culturally significant spaces such as shebeens, questions of freedom and individual livelihoods, it becomes clear why the alcohol

control landscape is now more conflicted than ever before. It also hints at why public health-led alcohol control policies often have difficulty gaining traction with either politicians or voters and why anti-corporate lobbying for food and alcohol has yet to find the same widespread public support as past campaigns against tobacco, sweatshops or infant formula in the global south.

In reality, the 'poisonous partnerships' between the harm industries, government and civil society may not always be completely ineffectual, as the evaluation of TIP demonstrates. Yet while even Adams *et al*. (2012: 585) concede that such 'initiatives may have desirable outcomes for health', they still express the conviction that the 'visible co-engagement of public good agencies and addictive consumption industries can have unintended and perverse consequences' (Adams *et al*. 2012: 585). In order to avoid this possibility, they advise that 'the non-association model is a pragmatic response to the risks of becoming divided, dominated and subsumed by industry and government sector alliances … and safeguards the integrity and voice of the health sector from being reprocessed according to the broader economic interests of government and industry' (Adams *et al*. 2012: 588). They assert that without any frameworks for managing the conflicts of interest discussed here, partnership is impossible and non-association the only 'prudent' form of engagement. It is unsurprising then that public health narrations of industry CSR are laced with notions of siege in which the alcohol control policy priorities of public health (WHO 2011a) and its practitioners are under perennial threat from the harm industries and their 'performance of corporate virtue' (Rajak 2011: 2). As such, *The Lancet's* (2013: 17) welcoming of 'private sector entities that … are demonstrably committed to promoting public health and are willing to participate in public reporting and accountability frameworks' to the post-2015 table only ignites public health fears of encroaching 'moral jeopardy' (Adams *et al*. 2012: 587). Here then it is worth remembering Laurie Garrett's words: 'public health wars are rarely won; they are merely pushed to low level stalemates with the enemies' (Garrett 2013: 21). As the situation of stalemate explored in this paper deepens, we need to ask if we will ultimately be any healthier for it.

Address for correspondence: *Clare Herrick, Department of Geography, King's College London Strand, London WC2R 2LS. E-mail: clare.herrick@kcl.ac.uk*

Acknowledgments

Thank you to the two anonymous reviewers for their helpful comments and feedback. The research support for this paper was provided by ESRC–DFID grant number RES-167-25-0473. All opinions expressed in the paper are the author's own.

References

Adams, V. (2013) Evidence-based global public health: subjects, profits, erasures. In Biehl, J. and Petryna, A. (eds) *When People Come First: Critical Studies in Global Public Health*. Princeton University Press: Princeton.

Adams, P., Buetow, S. and Rossen, F. (2012) Vested interests in addiction research and policy: poisonous partnerships: health sector buy-in to arrangements with government and addictive consumption industries, *Addiction*, 105, 4, 585–90.

Babor, T.F. (2016) Commentary on Savell *et al*. (2016): Alcohol producers as problem inducers, *Addiction*, 111, 1, 33.

Babor, T.F. and Brown, K. (2013) Statement of Concern About the Global Alcohol Producers, *Journal of Groups in Addiction and Recovery*, 8, 4, 238–9.

Babor, T.F. and Robaina, K. (2013) Public Health, Academic Medicine, and the Alcohol Industry's Corporate Social Responsibility Activities, *American Journal of Public Health*, 103, 2, 206–14.

Babor, T., Brown, K.D.J., Mbona Tumwesigye, N., Hastings, G., *et al*. (2013a) *Statement of Concern: The international public health community responds to the global alcohol producers' attempts to implement the WHO Global Strategy to Reduce Harmful Use of Alcohol. Statement issued 8 February 2013*. London: GAPA.

Babor, T., Hall, W., Humphreys, K., Miller, P., *et al*. (2013b) Who is responsible for the public's health? The role of the alcohol industry in the WHO global strategy to reduce the harmful use of alcohol, *Addiction*, 108, 12, 2045–7.

Babor, T., Hall, W., Humphreys, K., Miller, P., *et al*. (2014a) Addiction editors respond to Mr Leverton, *Addiction*, 109, 7, 1209–11.

Babor, T., Robaina, K. and Jernigan, D. (2014b) The influence of industry actions on the availability of alcoholic beverages in the African Region, *Addiction*, 110, 4, 561–71.

Bakke, Ø. and Endal, D. (2010) Vested interests in addiction research and policy alcohol policies out of context: drinks industry supplanting government role in alcohol policies in sub-Saharan Africa, *Addiction*, 105, 1, 22–8.

Bampoe, V., Clancy, A., Sugarman, M., Liden, J., *et al*. (2012) Response from the Global Fund, *Bulletin of the World Health Organization*, 90, 1, 70–1.

Banerjee, S. (2008) Corporate social responsibility: the good, the bad and the ugly, *Critical Sociology*, 34, 1, 51–79.

Barkemeyer, R., Holt, D., Preuss, L. and Tsang, S. (2014) What happened to the 'development' in sustainable Ddevelopment? Business guidelines two decades after Brundtland, *Sustainable Development*, 22, 1, 15–32.

Beaglehole, R., Bonita, R., Alleyne, G., Horton, R., *et al*. (2011) UN high-Level meeting on non-communicable diseases: addressing four questions, *The Lancet*, 378, 9789, 449–55.

Benson, P. (2014) Corporate paternalism and the problem of harmful products, *PoLAR: Political and Legal Anthropology Review*, 37, 2, 218–30.

Benson, P. and Kirsch, S. (2010) Corporate oxymorons, *Dialectical Anthropology*, 34, 1, 45–8.

Blowfield, M. and Dolan, C.S. (2014) Business as a development agent: evidence of possibility and improbability, *Third World Quarterly*, 35, 1, 22–42.

Blowfield, M. and Frynas, J.G. (2005) Setting new agendas: critical perspectives on corporate social responsibility in the developing world, *International Affairs*, 81, 3, 499–513.

Bond, L., Daube, M. and Chikritzhs, T. (2009) Access to confidential alcohol industry documents: from big tobacco to big booze, *Australasian Medical Journal*, 1, 3, 1–26.

Bond, L., Daube, M. and Chikritzhs, T. (2010) Selling addictions: similarities in approaches between big tobacco and big booze, *Australasian Medical Journal*, 3, 6, 325–32.

Casswell, S. (2013) Vested interests in addiction research and policy. Why do we not see the corporate interests of the alcohol industry as clearly as we see those of the tobacco industry?, *Addiction*, 108, 4, 680–5.

Chan, M. (2013a) *Support for strong alcohol policies. Opening address at the Global Alcohol Policy Symposium, Istanbul, Turkey* Geneva: WHO.

Chan, M. (2013b) WHO's response to article on doctors and the alcohol industry, *British Medical Journal*, 346, f2647.

Conflicts of Interest Coalition (2012) Conflicts of Interest Coalition Statement of Concern. Available at http://coicoalition.blogspot.co.uk/ (last accessed 1 May 2015).

Daube, M. (2014) Protecting their paymasters, *Addiction*, 109, 4, 526–7.

Davis, C.G., Thake, J. and Vilhena, N. (2010) Social desirability biases in self-reported alcohol consumption and harms, *Addictive Behaviors*, 35, 4, 302–11.

Dobers, P. and Halme, M. (2009) Corporate social responsibility and developing countries, *Corporate Social Responsibility and Environmental Management*, 16, 5, 237–49.

Dolan, C. (2012) The new face of development: the 'bottom of the pyramid' entrepreneurs, *Anthropology Today*, 28, 4, 3–7.
Dolan, C. and Rajak, D. (2011) Introduction: ethnographies of corporate ethicizing, *Focaal*, 60, special issue, 3–8.
Edwards, G. (1998) Should industry sponsor research? If the drinks industry does not clean up its act, pariah status is inevitable, *British Medical Journal*, 317, 7154, 336–7.
Faull, A. (2013) Policing taverns and shebeens: Observation, experience and discourse, *SA Crime Quarterly*, 46, 35–48.
Ferreira-Borges, C., Rehm, J., Dias, S., Babor, T., *et al*. (2016) The impact of alcohol consumption on African people in 2012: an analysis of burden of disease, *Tropical Medicine and International Health*, 21, 1, 52–60.
Fooks, G.J., Gilmore, A.B., Smith, K.E., Collin, J., *et al*. (2011) Corporate social responsibility and access to policy élites: an analysis of tobacco industry documents, *PLoS Med*, 8, 8, e1001076.
Freudenberg, N. (2014) *Lethal But Legal: Corporations, Consumption, and Protecting Public Health*. New York: Oxford University Press.
Garrett, L. (2007) The challenge of global health, *Foreign Affairs*, 14, 1, 14–39.
Garrett, L. (2013) *Existential Challenges to Global Health*. New York: New York University Center on International Cooperation.
Gilmore, I.T. (2015) Should the drinks industry have a role in establishing public health policy to reduce alcohol-related harm?, *International Journal of Evidence-Based Healthcare*, 13, 1, 1–2.
Gilmore, A.B. and Fooks, G. (2012) Global Fund needs to address conflict of interest, *Bulletin of the World Health Organization*, 90, 1, 71–2.
Gilmore, A., Savell, E. and Collin, J. (2011) Public health, corporations and the new responsibility deal: promoting partnerships with vectors of disease?, *Journal of Public Health*, 33, 1, 2–4.
Gilmore, A.B., Fooks, G., Drope, J., Bialous, S.A., *et al*. (2015) Exposing and addressing tobacco industry conduct in low-income and middle-income countries, *The Lancet*, 385, 9972, 1029–43.
Global Alcohol Policy Alliance (2013) *Statement of Concern*. London: GAPA.
Gornall, J. (2013) Doctors and the alcohol industry: an unhealthy mix?, *British Medical Journal*, 346, f1889.
Gornall, J. (2014) Under the influence: 1. False dawn for minimum unit pricing, *British Medical Journal*, 348, f7435.
Govender, K. and George, G. (2013) *An evaluation of the SAB Ltd Tavern Intervention Programme (TIP)*. Durban: Health Economics and HIV and AIDS Research Division, University of KwaZulu-Natal.
Hawkins, B. and Holden, C. (2014) 'Water dripping on stone'? Industry lobbying and UK alcohol policy, *Policy and Politics*, 42, 1, 55–70.
Herrick, C. (2009) Shifting blame/selling health: corporate social responsibility in the age of obesity, *Sociology of Health & Illness*, 31, 1, 51–65.
Herrick, C. (2011) Why we need to think beyond the 'industry' in alcohol research and policy studies, *Drugs: Education Prevention, and Policy*, 18, 1, 10–5.
Herrick, C. (2016) Alcohol, ideological schisms and a science of corporate behaviours on health, *Critical Public Health*, 26, 1, 14–23.
Herrick, C. and Charman, A. (2013) Shebeens and crime: The multiple criminalities of South African liquor and its regulation, *South African Crime Quarterly*, 45, 25–33.
Horn, L. (2013) Powers and Faden's theory of social justice applied to the problem of foetal alcohol syndrome in South Africa, *Public Health Ethics*, 6, 1, 3–10.
Horton, R. (2012) Offline: What kind of world do you want post-2015?, *The Lancet*, 380, 9849, 1214.
IARD (2015) About IARD. Available at http://www.iard.org/about/ (last accessed 2 October 2015)
Idemudia, U. (2011) Corporate social responsibility and developing countries: moving the critical CSR research agenda in Africa forward, *Progress in Development Studies*, 11, 1, 1–18.
Jahiel, R. (2008) Corporation-induced diseases, upstream epidemiologic surveillance, and urban health, *Journal of Urban Health*, 85, 4, 517–31.

Jernigan, D.H. and Babor, T.F. (2015) The concentration of the global alcohol industry and its penetration in the African region, *Addiction*, 110, 4, 551–60.

Kalichman, S., Simbayi, L., Vermaak, R., Cain, D., *et al*. (2008) Randomized trial of a community-based alcohol-related HIV risk-reduction intervention for men and women in Cape Town South Africa, *Annals of Behavioral Medicine*, 36, 3, 270–9.

Lawhon, M. and Herrick, C. (2013) Alcohol control in the news: the politics of media representations of alcohol policy in South Africa, *Journal of Health Politics, Policy and Law*, 38, 5, 989–1025.

Leverton, M. (2014) Letter from the Global Alcohol Producers Group, *Addiction*, 109, 7, 1209.

Lincoln, P., Rundall, P., Jeffery, B., Kellett, G., *et al*. (2011) Conflicts of interest and the UN high-level meeting on non-communicable diseases, *The Lancet*, 378, 9804, e6.

London, L., Matzopoulos, R., Corrigall, J., Myers, J., *et al*. (2012) Conflict of interest: a tenacious ethical dilemma in public health policy, not only in clinical practice/research, *South African Journal of Bioethics and Law*, 5, 2, 102–8.

Marrero, S.L., Bloom, D.E. and Adashi, E.Y. (2012) Noncommunicable diseases: a global health crisis in a new world order, *JAMA*, 307, 19, 2037–8.

Massin, S. (2012) Is harm reduction profitable? An analytical framework for corporate social responsibility based on an epidemic model of addictive consumption, *Social Science and Medicine*, 74, 12, 1856–63.

Matzopoulos, R., Parry, C.D., Corrigall, J., Myers, J., *et al*. (2012) Global Fund collusion with liquor giant is a clear conflict of interest, *Bulletin of the World Health Organization*, 90, 1, 67–9.

McCambridge, J. and Hartwell, G. (2014) Has industry funding biased studies of the protective effects of alcohol on cardiovascular disease? A preliminary investigation of prospective cohort studies, *Drug and Alcohol Review*, 34, 1, 58–66.

McCambridge, J., Kypri, K., Drummond, C. and Strang, J. (2014) Alcohol harm reduction: corporate capture of a key concept, *PLoS Med*, 11, 12, e1001767.

McGoey, L. (2014) The philanthropic state: market–state hybrids in the philanthrocapitalist turn, *Third World Quarterly*, 35, 1, 109–25.

Miller, D. and Harkins, C. (2010) Corporate strategy, corporate capture: food and alcohol industry lobbying and public health, *Critical Social Policy*, 30, 4, 564–89.

Miller, P., de Groot, F., Mckenzie, S. and Droste, N. (2011) Alcohol industry use of social aspect public relations organizations against preventive health measures, *Addiction*, 106, 9, 1560–7.

Moodie, A.R. (2014) Big alcohol: the vector of an industrial epidemic, *Addiction*, 109, 4, 525–6.

Moodie, R., Stuckler, D., Monteiro, C., Sheron, N., *et al*. (2013) Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries, *The Lancet*, 381, 9867, 670–9.

Morojele, N.K., Kachieng'a, M.A., Mokoko, E., Nkoko, M.A., *et al*. (2006) Alcohol use and sexual behaviour among risky drinkers and bar and shebeen patrons in Gauteng province, *South Africa, Social Science and Medicine*, 62, 1, 217–27.

Munro, G. and de Wever, J. (2008) Culture clash: alcohol marketing and public health aspirations, *Drug and Alcohol Review*, 27, 2, 204–11.

Newell, P. and Frynas, J.G. (2007) Beyond CSR? Business, poverty and social justice: an introduction, *Third World Quarterly*, 28, 4, 669–81.

Oreskes, N. and Conway, E. (2010) *Merchants of Doubt: How a Handful of Scientists Obscured the Truth on Issues from Tobacco Smoke to Global Warming*. London: Bloomsbury.

Orock, R. (2013) Less-told stories about corporate globalization: transnational corporations and CSR as the politics of (ir)responsibility in Africa, *Dialectical Anthropology*, 37, 1, 27–50.

Parry, C., Harker Burnhams, N. and London, L. (2012) A total ban on alcohol advertising: presenting the public health case, *South African Medical Journal*, 102, 7, 602–4.

Perez, A.M., Ayo-Yusuf, O.A., Hofman, K., Kalideen, S., *et al*. (2013) Establishing a health promotion and development foundation in South Africa, *South African Medical Journal*, 103, 3, 147–9.

Pingeot, L. (2014) *Corporate Influences in the Post-2015 Process*. Aachan: Bischofliches Hilfswerk MISEREOR e.V.

Rajak, D. (2011) *In Good Company: An Anatomy of Corporate Social Responsibility*. Stanford: Stanford University Press.

Richter, J. (2014) Time to turn the tide: WHO's engagement with non-state actors and the politics of stakeholder governance and conflicts of interest, *British Medical Journal*, 348, g3351.

SAB Stories (2014) SAB reintroduces intervention programme for men in local taverns. Available at http://www.sab.co.za/sablimited/content/en/sab-press-releases-archive-2014?oid=123999&sn=Detail&pid=117316 (last accessed on 3 February 2015).

Schmitz, H.P. (2015) The global health network on alcohol control: successes and limits of evidence-based advocacy, *Health Policy and Planning*, doi:10.1093/heapol/czu064.

Schneider, M., Norman, R., Parry, C., Bradshaw, D., *et al*. (2007) Estimating the burden of disease attributable to alcohol use in South Africa in 2000, *South African Medical Journal*, 97, 8, 664–72.

Scott-Sheldon, L.A.J., Carey, K.B., Carey, M.P., Cain, D., *et al*. (2014) Alcohol use disorder, contexts of alcohol use, and the risk of HIV transmission among South African male patrons of shebeens, *Drug and Alcohol Dependence*. 140, 198–204.

Sharp, J. (2006) Corporate social responsibility and development: an anthropological perspective, *Development Southern Africa*, 23, 2, 213–22.

Sornpaisarn, B. and Kaewmungkun, C. (2014) Politics of alcohol taxation system in Thailand: behaviours of three major alcohol companies from 1992 to 2012, 3, 3, 210–8.

South Africa Department of Social Development (2013) Central Drug Authority ready to implement National Drug Masterplan. Available at http://www.cda.gov.za/ (last accessed 3 March 2015).

Stuckler, D. and Nestle, M. (2012) Big food, food systems, and global health, *PLoS Med*, 9, 6, e1001242.

Stuckler, D., Basu, S. and McKee, M. (2011) Commentary: UN high level meeting on non-communicable diseases: an opportunity for whom?, *British Medical Journal*, 343, 5336, 1–3.

Stuckler, D., McKee, M., Ebrahim, S. and Basu, S. (2012) Manufacturing epidemics: the role of global producers in increased consumption of unhealthy commodities including processed foods, alcohol, and tobacco, *PLoS Med*, 9, 6, e1001235.

The Lancet (2013) Health and the post-2015 development agenda, *The Lancet*, 381, 9868, 699.

The World We Want 2015 (2014) Noncommunicable diseases in the post-2015 agenda. Available at https://www.worldwewant2030.org/ (last accessed 4 March 2015).

Tsoeu, M. (2009) *A value chain analysis of the formal and the informal economy: a case study of South African Breweries and shebeens in Soweto Faculty of Humanities*. Johannesburg: University of the Witwatersrand, p. 216.

United Nations (2000) *Millennium Declaration*. New York: United Nations.

United Nations Development Program (2012) *Strategy for working with the private sector*. New York: UNDP.

United Nations Global Compact (2013) *Building the post-2015 business engagement architecture*. New York: United Nations.

United Nations Global Compact (2014a) *Partnerships: impementing the post-2015 develpment agenda*. New York: UN Global Compact.

United Nations Global Compact (2014b) *UN Global Compact briefing series: issue paper 4: post-2015 agenda and related sustainable development goals. Issue focus: the role of business in improving health*. New York: United Nations.

United Nations Global Compact (2014c) *White paper: the role of business and finance in supporting the post-2015 agenda*. New York: United Nations Global Compact.

United Nations Industrial Development Organization (2014) *Series of dialogues on means of implementation of the post-2015 development agenda. Engaging with the private sector in the post-2015 agenda. Consolidated report of the 2014 consultations*. New York: UNIDO and the UN Global Compact.

Welker, M., Partridge, D.J. and Hardin, R. (2011) Corporate lives: new perspectives on the social life of the corporate form: an introduction to supplement 3, *Current Anthropology*, 52, S3, S3–16.

Wiist, W.H. (2006) Public health and the anticorporate movement: rationale and recommendations, *American Journal of Public Health*, 96, 8, 1370–5.

World Health Organisation (WHO) (2011a) *From burden to 'best buys': Reducing the economic impact of NCDs in low- and middle-income countries*. Geneva: WHO.
World Health Organisation (WHO) (2011b) *UN high-level meeting on NCDs: summary report of the discussions at the round tables*. Geneva: WHO.
World Health Organisation (WHO) (2011c) *South Africa country profile: alcohol*. Geneva: WHO.
World Health Organisation (WHO) (2013a) *Global action plan for the prevention and control of noncommnicable diseases 2013–2020*. Geneva: WHO.
World Health Organisation (WHO) (2013b) *WHO governance reform*. Report by the secretariat, Geneva: WHO.
World Health Organisation (WHO) (2014a) *Framework of engagement with non-State actors*. Geneva: WHO.
World Health Organisation (WHO) (2014b) *Global status report on alcohol. Country profile: South Africa*, Geneva: WHO.
World Health Organisation (WHO) (2014c) *Global status report on non-communicable disease*. Geneva: WHO.
Yoon, S. and Lam, T.-H. (2013) The illusion of righteousness: corporate social responsibility practices of the alcohol industry, *BMC Public Health*, 13, 1, 630.