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Asserting public health interest in acting on commercial determinants of health in sub-Saharan Africa: insights from a discourse analysis

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ABSTRACT

The actors influencing the commercial determinants of health (CDOH) in sub-Saharan Africa (SSA) have different interests and lenses around the costs and benefits of market influences in health. We analysed the views and priorities on CDOH in the discourse of global and regional agencies, SSA governments, private investors and companies, civil society and academia through a desk review of online publications post-2010, validated by purposively selected key informant interviews.

The most polarised views were between civil society and academia on one hand, focused more on harms, and private business/investors on the other, almost exclusively focused on benefits. Others had mixed messaging, encouraging partnerships with commercial actors for health benefits and also voicing cautions over negative health impacts. Views also differed between transnational and domestic business and investors.

Three areas of discourse stood out, demonstrating also tensions between commercial and public health objectives. These were the role of human rights as fundamental for or obstacle to engaging commercial practice in health; the development paradigm and role of a neoliberal political economy generating harms or opportunities for health; and the implications of commercial activity in health services. COVID-19 has amplified debate, generating demand for public sectors to incentivise commercial activity to 'modernise' and digitise health services and meet funding gaps and generating new thinking and engagement on domestic production of key health inputs.

Power plays a critical role in CDOH. Commercial actors in SSA increase their influence through discursive and agential forms of power and take advantage of the structural power gained from a dominant view of free markets and for-profit commerce as essential for well-being. As a counterfactual, we found and present options for using these same three forms of narrative, agential and structural power to proactively advance public health objectives and leadership on CDOH in SSA.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ While not always labelled commercial determinants of health (CDOH), some policy attention has been given in sub-Saharan Africa (SSA) to both harms and benefits of commercial impacts on health, particularly from harmful products and processes, and noting rising non-communicable diseases.

WHAT THIS STUDY ADDS

⇒ A discourse analysis highlights differing interests and lenses among the multiple policy actors involved; the forms of narrative, agential and structural power used to advance and contest commercial policy interests in the health sector; and how this has been intensified by COVID-19.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Public health actors and 'one health' actions need to build on current efforts to strengthen own discursive power, challenging narratives with evidence; to strengthen their agential power through institutionalising health impact assessment, regulation and control measures; and to deepen initiatives to engage with structural power through support for local producers, harmonised regional standards and engagement on global rules that constrain health promoting activity, as was done in the Trade Related Aspect of Intellectual Property Rights (TRIPS) Waiver.

⇒ Subregional and continental level organisations play a key role in enabling such actions, as does investment in SSA leadership in locally relevant innovation and production, and in links between state, academic and civil society actors to support evidence and to ensure public interests, transparency and accountability in policy decisions on CDOH.

INTRODUCTION

The WHO has defined the commercial determinants of health (CDOH) as 'the conditions, actions and omissions by corporate actors that affect health' positively or negatively.[1] The products, processes or the underlying policy conditions relating to for-profit market activities and liberalised trade may generate tensions or synergies between commercial and public health objectives.[2–4] While the term 'CDOH' has not been widely used in sub-Saharan Africa (SSA),

evidence has been noted of risks such as air pollution from industrial and transport systems, occupational hazards, tobacco, alcohol, ultra-processed foods and gambling, associated with rising non-communicable diseases (NCDs).[5–10]

SSA comprises a mix of low, lower middle and upper middle income countries that, despite rapid economic growth, have a high share of people living in poverty, raising challenges for well-being. As a key context for potentially influential commercial determinants in SSA, the African continent is pursuing free trade policies to overcome market fragmentation, liberalise trade, boost exports and expand health markets.[2] CDOHs have also been noted to become more pronounced in conditions of hyperurbanisation, rapid economic growth, rising levels of disposable income and other economic and sociocultural changes associated with globalisation in SSA.[11] The COVID-19 pandemic has intensified attention to CDOH such as intellectual property (IP) constraints to affordable health technologies[12] or food insecurity due to disrupted supply chains in liberalised trade.[13]

As Maani *et al*[14] note, the way health is framed in discourse can influence the recognition of, explanations for and responses to health challenges. We need, therefore, to understand what different stakeholders are saying, particularly those with power, to engage with and where needed develop counteracting public health narratives, given potential tensions between commercial and public health objectives.[14] With increasing global policy attention to CDOH, a discourse analysis that shows how different actors are framing commercial determinants, their consequences and priorities for action helps to make this narrative influence more transparent, highlighting synergies and indicating tensions that call for public health counter-narratives and action.[1 3 14]

Discourse analysis uses the language presented in a body of evidence to draw meaning. As a form of qualitative research, it explores how language is used to express differing viewpoints and to exert influence on issues that affect society.[15] Given the context and the absence of a shared framing of CDOH within SSA, a discourse analysis was implemented in late 2021 to better understand how the CDOHs are being similarly or differently framed, understood and articulated by seven distinct categories of actors operating in SSA that have influence in the field, namely: global/international agencies, regional agencies, governments, private investors, companies, civil society and academia. We explored what their discourses signal about tensions or synergies between commercial and public health interests and priorities and the implications for public health messaging and action. This paper presents this analysis as a contribution to policy dialogue and follow-up research on CDOH in SSA and as a regional perspective in global framings and work.

METHODS

The discourse analysis covered SSA as the regional grouping commonly used in United Nations frameworks, such as in reporting on the Sustainable Development Goals.[16] We identified key actors and searched sources of online evidence, manually extracted and analysed thematic features from the documents found and subjected the findings to a limited stakeholder review. The seven categories of actors noted earlier were selected for their significant and distinct roles and influence in policy and practice on CDOH in SSA. Evidence for each actor category was separately gathered and analysed to capture any diversity of discourse among them. The methods are outlined here, with further detail provided in online supplemental appendix 1 on Methods.[17]

Ethics approval

As the evidence was obtained from public domain secondary evidence from document review and stakeholder interaction was implemented after consent for review and validation, beyond external peer review of the methods noted in the acknowledgements, this process was not subject to an IRB review. Patients or the public were not involved in the design, or conduct, or reporting, or dissemination plans of our research.

Searches, data extraction, analysis and review

Searches were implemented in October 2021 using CDOH-relevant and Africa-relevant search terms, and specific terms for the different actors, detailed in the online supplemental appendix 1 on Methods.[17] Separate searches were made for each category of actor in open search engines: Google and Scielo; journal libraries: PubMed, Medline, African Journals online and Google Scholar; and institutional websites. Journal papers, reports, briefs, blogs and other media post-2010 in English were included that after review by authors were by or about the seven categories of actors, commercial determinants and health. Papers in French or Portuguese that had pertinent information in an English abstract/summary were also included and the summary information captured. The voice expressed was used to allocate papers to the specific actor category. New papers were not actively sourced after triangulation from different sources provided a saturation of information on framings, priorities, actions and actors.

Beyond the general search for SSA, to capture as feasible the diversity of country economic and social contexts, searches were also carried out and documents sourced from government websites from a sample of countries from different regions and different economic and language groups, including South Africa, Mozambique and Zambia; Kenya, Tanzania and Uganda; and Ghana, Nigeria, Sierra Leone and Democratic Republic of Congo. Further papers found in references or raised in key informant (KI) review feedback were included. A total of 300 papers were used in the full analysis and report[18] with 90 of those included cited in this paper, together with the four further papers cited on the methods.

As an exploration of discourse, the evidence was thus obtained from both peer-reviewed and non-peer-reviewed sources, with 28% from journal papers, books and theses,

Table 1 Papers sourced by actor, from searches, as assigned after text review, included in this paper, and key informants by actor

Actor	# of papers		Cited in this paper	Key informant (KI) by category*
	From searches	In category		
International/ global actors† operating in SSA	88	51	10	KI6 International technical expert with experience in SSA.
SSA continental and regional organisations‡	21	54	14	KI1 Subregional intergovernmental agency lead. KI7 Subregional public health actor.
SSA governments	25	14	7	KI8 National governmental health actor.
Banks, investors, funders, operating/investing in SSA	48	29	10	KI9 Continental finance actor.
Corporate, private for profit and business associations	43	21	5	
Civil society/social	27	42	14	KI2 Subregional trade union lead. KI4 Regional tax/finance actor.
Academia/technical	48	89	30	KI3 Continental ecology technical agency. KI5 National expert in health technology innovation.
Total	300	300	90§	

*KI number shown and used in references.
†Multilateral, bilateral, south–south, philanthropic and commercial.
‡Continental refers to Africa-wide and African Union organisations; regional organisations refer to intergovernmental and other agencies within or combining parts of east, west, central and or/southern Africa.
§Note: this excludes the four methods papers cited in this paper.
SSA, sub-Saharan Africa.

largely from academia, 66% from online reports, strategy and policy documents, from actors other than academia, and 6% from formal media, spread across all actors.[17] That inclusion of wider sources in a discourse analysis is important was supported by this evidence that only including peer-reviewed journal papers would have led to a bias towards the voice of academic actors.

Data extraction, including direct quotations, used a commonly structured data table for each actor that was revised after review for completeness, clarity and quality by all authors.[17] The data table organised evidence within areas identified from the aims of the discourse analysis, namely on: (1) the framings of CDOH and their health impacts; (2) the articulated priorities and action on CDOH; and (3) whether framed at local, national, regional or global level. A manual thematic content analysis implemented by RL and SG and reviewed by all authors identified patterns in the discourse, priorities and actions, first within each actor group, and then across actors.

Following data extraction and analysis, nine KIs were purposively selected and 45 minute semistructured discussions implemented with KI consent in November–December 2021. KIs provided stakeholder review, validation and discussion of key areas of evidence and implications raised in the discourse analysis, further detailed in the online supplemental appendix 1 on Methods.[17] Table 1 lists the papers searched and included and the KIs by actor and level.

Limitations

Given the wide nature of the field and time and resource limitations, notwithstanding the range of literature sourced, we note a number of limitations. This was not a systematic review. It does not disaggregate individual countries, nor intend to examine system or implementation issues. Together with discourse analysis of documents in other languages, these are important areas for follow-up research that this analysis may contribute useful groundwork for. Some relevant discourse, work and views of some actors and local communities may be poorly reported online or in the public domain. Inclusion of publications in English and the sampling of country-specific searches imply some linguistic and geographical exclusion. Inclusion of KIs from francophone and lusophone countries and diverse regions and actors assisted to validate findings, however, and the searches were extensive, covering all SSA subregions and actors, including those representing other sectors that impact on health, as well as membership-based movements. In its totality, the literature exposed some consistent common and contrasting views.

RESULTS: FRAMINGS AND PRIORITIES IN CDOH

This section summarises key features of the findings, presented separately in more detail, with all 300 references.[18] Table 2 summarises the key findings on the key thematic features emerging from the discourse analysis

Table 2 Summary of findings on key areas of discourse and priorities by actor

Actor	Framings and priorities in the actor's 'voice'/discourse as found in cited sources
International/ global actors involved in SSA	Establish **rights and duties** to protect, WHO (health), International Labour Organisation (decent work), FAO (food security), UN Habitat ('right to the city') and note risks in zoonoses, antimicrobials, pollution, water and social protection deficits.[18] UN Office of the Commission on Human Rights asserts '(b)usinesses are considered to have some responsibilities with respect to human rights, although the exact nature and scope … are unclear'.[56] UN Human Rights Council is framing international rights on business duties. International finance institutions and others consider private sector as partner or 'essential' to deliver Sustainable Development Goals (SDGs) and UHC **in the health sector** through financing, technology, digital innovation and health commodities. Some urge corporate social responsibility and debt relief linked to social protection; others prioritise state support for **economic activity**, including market creation, by derisking investment and providing concessional financing.[18–20 57]
SSA continental and regional organisations	African Commission on Human and Peoples' Rights includes protections against negative impacts of private sector expansion that 'negatively impact the enjoyment of the **rights to health** and education'.[58] Concerns raised to protect biodiversity and equitable sharing of potential benefits, including in technology and digital innovation. Harmful products, processes and impacts of **liberalised trade, urbanisation agribusiness** and extractives require legal, tax and multisectoral actions to reduce risk factors. Some note private sector contribution to **health sector** funding, resources, capital, technology, IT, expertise and services to deliver UHC, and to modernise and improve quality. Others, including WHO AFRO, voice concerns over poor financial protection, public sector health worker outflows and weak service access and relevance of for-profit health services and technologies for population health burdens and low-income majorities. Regional cooperation on **standards**, tax systems, digital information systems and engagement in global treaty negotiations essential to expand health benefit distribution and coverage.[12 18 23–25 28 56–62]
SSA governments	National government strategies highlight CDOH risks linked to food quality and safety, unhealthy diets, alcohol and substance abuse, tobacco use, monocropping displacing food production, urbanisation and extractives. Concern over and rising levels of NCDs, **health service burdens**, ecological impacts and resistance to **regulation**. Common proposals are made for cross-sectoral policy, legal, tax, 'One Health' and other strategies, while noting weak enforcement capacities, and internal pressures against controling commercial actors given their **economic contribution** and influence through advertising, sponsorships and links to political actors. Concerns over commercial involvement in healthcare include inequity in access and service quality; health worker outmigration, and weak reporting from and regulation of private providers.[18 26 27 63–67]
Banks and investors operating in SSA	Most investors focus on opportunities for and returns from commercial investment in **healthcare** commodities, IT and low-cost or high-return health service models, infrastructure and digital remote care, and call for incentives in blended commercial and domestic public financing and favourable rates of returns and exit opportunities. Opportunities perceived in services for emerging middle classes, overseas business and tourists through 'boutique-hospital development' and post-COVID-19 health security and in the UHC funding gap; in an improving economic, investment and political environment; and a rapidly growing private sector. Continental investors (eg, African Development Bank) observed CDOH related to substandard housing, water and sewage systems, air pollution, industrial waste, poverty and unemployment and pose COVID-19 as a motivation for SSA policy reform towards more inclusive, equitable and sustainable **economies and services**.[18 30 31 33 68–72]
Private-for-profit business in SSA	No direct corporate voice identified negative health consequences from products or processes. Many perceived SSA **health sectors** as fertile ground for returns through technology and service innovation, given increased consumers and rapid urbanisation. Infrastructure, commodity, UHC funding, low-cost commodities, online services and medical tourism needs all seen as stimulus for commercial services in the health sector. Concerns raised that pandemic **public health regulations**, lockdowns and border closures could obstruct **economic activity and free trade**. Changes called for in government attitudes, shifting reliance on development aid to more vigorous state support to overcome business risks. One TNC advocated moving beyond short-term commercial interests to building local ownership and responsibility, although aligned to largely curative business healthcare models. SSA local enterprises voice concerned about TNCs making inadequate links to local small and medium enterprises and local contexts and encourage regionally harmonised regulation to improve business environments.[18 32–35 70 73 74]
Civil society in SSA	Civil society identifies harmful commercial commodities (eg, ultra-processed food, alcohol and tobacco) and processes (eg, extractive industries, genetic modification of foods, monocropping and agribusiness). Extractive activities, global volatility, lack of recognition of indigenous law and knowledge, corrupt power relations, conflict, declining aid, tax waivers, illicit financial flows and resources diverted from locally appropriate solutions contribute to CDOH. Rather than supporting UHC **in the health sector**, private sector financing and services are viewed as undermining equity and universalism by prioritising expensive, high-end biomedical hospital services for wealthy people and fee-charging. **Social rights** and state duties seen as key to manage commercial risks, with concerns over states relinquishing their obligations and corporations expanding their role and power. Rights violations are noted, linked to weak transparency and public accountability and commercial actors dominating health policy spaces, calling for civil society to act as a watchdog of commercial and state practice. **Neoliberal policy** related deregulation, declining tax collections, debt and state withdrawal from key services are associated with ecological damage and social deficits, falling public revenues and capacities to counter harms.[18 37 39–41 48 49 54 75–80]
Academia	CDOH and their impacts are noted to be poorly monitored, especially in marginalised communities, and 'normalised' by cultures and marketing. Risks include urban transport, air pollution, occupational hazards, tobacco, alcohol, ultra-processed and fast food, gambling, aggravating NCDs and poverty, with CDOH intensified under hyperurbanisation, rapid economic growth, increased disposable income and associated with TNC-influenced trade, investment and products that may sideline local producers. In conflicts between for-profit interests and public health goals, governments are said to often align with commercial interests. In the SDGs, 'attempting to achieve one may result in another being negatively affected'.[81] Health protection should be integrated during: economic and trade negotiations and agreements (eg, AfCFTA), and in negotiations on development aid, commercial agreements, new technologies, extractives' health duties and **health services commercialisation**. Despite benefits from funding, technology, training, R&D, innovation and expertise, directly or in public-private-partnerships (PPPs), higher-than-anticipated PPP costs to governments and weak state capacities to either manage and pay for contracted services or to fund public interest innovation weakens equitable access and financial protection. Policy coherence and accountability are needed through multisectoral action and effective preinvestment scrutiny and civil society oversight. Corporate marketing, policy lobbying and discourse framing powerfully influence **norms**, narratives and policies, adding to **neoliberal policy drivers** influencing 1980s' 'rollback' cuts in public services, wages and regulations and 1990s' 'roll-out' of private investment in commercialised services, consolidating TNC control over production and supply chains in processed food, tobacco, alcohol and other CDOH. More so than others, academic actors systematise and analyse the origins, nature and manifestations of power asymmetries affecting democracy, transparency and public interest in health and enabling commercial influence, including between corporate and public sectors, and between north and south in global policy.[2 4–11 18 42–46 51 81–86]

Sources: as cited and authors from ref 18.
AfCFTA, African Continental Free Trade agreement; NCDs, non-communicable diseases; SSA, sub-Saharan Africa; TNCs, transnational corporations; UHC, universal health coverage.

by actor, with emerging key themes shown in bold. The text in this section further exemplifies for each actor the framings and specific thematic issues raised in table 2. The discussion in the next section outlines common domains of discourse that emerge across these seven actors.

Mixed discourse from international agencies

The features of international agency discourse on CDOH shown in table 2 indicate that while a number of UN

agencies use rights frameworks to engage with commercial practices, including on food, housing and health services, the common proposition by many international actors is that there is a win–win outcome between health and economic returns, particularly when commercial health services relieve financial pressures on public systems.[19] Private actors are encouraged to play a role in universal health coverage (UHC), even while observing that the different interests around social and financial returns make 'private sector participation intrinsically complicated'.[20] While corporate harms are noted, current performance standards such as the International Finance Corporation's Performance Standards on Social and Environmental Sustainability give transnational corporations (TNCs) operating in SSA leeway to voluntarily apply standards.[8] Human rights due diligence is observed to currently remain largely 'an expectation' not an obligation for commercial actors,[21] positioning the state more as facilitator than regulator of business.

A cautious discourse on CDOH risks from regional and Africa continental organisations

While some actors at Africa continental level strongly encourage expanding commercial practice as essential for health, the evidence in table 2 indicates that others are more cautious on the risks. For example, the IMF Africa Department comments that '[o]nly partnerships will help solve the health challenges the continent faces'.[22] In the face of state duties and health risks, however, others from continental and regional organisations, as noted in table 2, more explicitly raise equity and longer term consequences. A commercial focus on technologies for use in high-level services is argued to poorly address wider population health needs. Liberalised trade in the African Continental Free Trade agreement is observed to potentially enable the production and distribution of health technologies and products in SSA, but with a caution that its benefits may concentrate in wealthier corporates and countries and that reduced tariffs could diminish the public sector revenues and capacities needed to mitigate negative impacts.[23 24] Genetic engineering of vectors and genetic modification of seed and food products are criticised for carrying untested population level and ecological risk, threatening local farmer managed seed systems and crop diversity, raising risks of zoonotic-related and environmental-related disease.[25] Negotiating SSA interests in international treaties affecting CDOH, such as the post-2020 global biodiversity framework, is thus called for, including through building power outside formal negotiating processes.[25]

National governments more strongly articulate health risks and the importance of state action

National government actors in table 2 articulate an even stronger discourse on direct negative health impacts of CDOH, especially on rising NCDs, while noting the challenges facing state action. While commercial activity in the health sector is noted to contribute to UHC, here too the tone is cautious around system and equity impacts. Table 2 highlights that various governments in SSA note the importance of cross-sectoral strategies on CDOH and the challenges in applying legal, tax and other public health measures in the face of the perceived economic contribution and political influence of commercial actors. Given this, Uganda's health ministry outlines, for example, how the multisectoral nature of health risks necessitates 'a departure from traditional, vertical public health responses' towards mainstreaming human, animal and environmental protection in 'One Health' plans that cover commercial actors.[26] Cooperation between health ministries and inspectorates of commercial activities is also seen to play a role in putting law into practice.[27] Companies are generally viewed as resisting regulation, but those that see the value of mandatory standards for fair business practice are viewed as potential allies in encouraging wider business support, while early country adopters can enable regional standards.[28]

Corporate voices focus on opportunities and benefits for health from commercial activities

While the evidence in table 2 shows that private investors see political, economic and post-COVID-19 opportunities for specific areas of investment, they call for measures to 'de-risk' investment. Investors from within SSA focus more on strengthening inclusive and local production capacities, cautioning about 'outsource(ing) the health security of its (Africa's) 1.3 billion people to the generosity and the benevolence of others'[29] and arguing for resource deployment to respond to equitable care for the poorest segments of society.[30] The different interests call for a 'clear policy direction and framework for public-private collaboration' within national health strategies.[31] Businesses view deficits in systems, capacities and infrastructure in SSA as fertile ground for expanding commercial activities. One corporate actor observes 'One of the great advantages Africa has over other continents …. is that there's far less legacy to get in the way than in other regions, creating a clean sheet on which companies can develop their own distinctive business models'.[32] Corporate voices calling for more vigorous state support observe that 'political risks and instability also tend to affect the healthcare sector more disproportionately compared to other sectors due to healthcare provision being perceived as a right, not an option by most African countries' and that 'the availability of cheap money in the form of aid is also a massive put off for potential for-profit investors'.[33] Some SSA domestic producers raise different concerns, perceiving inequities in markets that call for more, not less, state intervention.[34] For example, rather than seeing regulation as a barrier, SSA pharmaceutical manufacturers have welcomed strong unified regulatory systems to combat falsified and substandard medicinal products and the establishment of the African Medicines Agency, as this supports local producers of safe and innovative products.[35]

Civil society actors are more focused on harms to health from commercial activities

Civil society points more strongly than other actors to multiple areas of harm to health from commercial practices, raising in table 2 deeper drivers of these risks and linking global drivers to outcomes experienced within SSA. The interface between states and commercial forces is seen to be taking place in 'the context of colonialism and imperialism', with persistent assymetries in power relations and policy benefit, 'today still dominated by corporations headquartered in the former colonial powers'.[36] Tax waivers and loopholes in tax laws are argued to enable profit-shifting outside the region, adding to a range of illicit financial flows.[37] In Nigeria, for example, illicit flows are estimated to have led to a potential loss to public revenue 'equal to about three times the country's total health budget in 2015' as 'Elite capture of public sector policies and resources undermines the productivity of the most important sectors of the economy and prevents the fair distribution of the benefits of growth'.[38] Civil society networks in the 2020 Kampala Initiative observed that 'These social, commercial, economic and political determinants of health have been tolerated or ignored by aid, thereby reinforcing the health inequities that aid is meant to resolve'.[39] Civil society robustly asserts that for UHC '[u]niversal healthcare services funded through taxation and free at the point of access are the most effective, equitable ways of funding and delivering public health services'.[39 40] The underfunding of such services is argued to expose health workers and communities to rights violations, particularly when 'the voices of those most affected by health inequity are regularly tokenised or excluded from the conversation'.[39] The underlying neoliberal paradigm is rejected. Noting that rather than state failure or an enthusiasm for the market, privatisation has been a consequence of liberalisation-driven cuts in state spending.[18 41]

Academic actors give more focus to underlying determinants of health impacts

Academic voices had the largest share of papers, covering health promoting or harming determinants relating to commodities, goods or services; business, market and political practices that advance these commodities, goods and services; and that stem from the profit motive and are used by the private sector.[3] They locate the roots of CDOH in market-driven economies, globalisation and in power imbalances between commercial and public actors. 'Big Food' corporate strategies are argued for example, to have increased the availability, affordability and acceptability of 'nutrient-poor products such as biscuits, margarine, and oil-heavy snacks'[7] and to have enabled both commercially driven transitions from traditional foods to a 'western' diet and rising NCDs.[4] The conflict noted between for-profit interests and public health goals is observed to pose tensions between different government goals. For example, Mukanu *et al*[9] noted that while the Zambian government (in 1998) maintained a 25% excise tax on soft drinks amidst threats that Coca-Cola would pull out from the country, it later repealed this excise tax in 2015 'ostensibly for economic reasons'. The policy influence of commercial actors is identified to come from corporate marketing, policy lobbying, framing of narratives, inclusion of policy-makers as company shareholders, various forms of sponsorship and gifts through to raising trade disputes or litigating against regulatory controls.[7 42–46] Lee *et al*[43] observe in relation to sponsorship and targeted marketing of tobacco that 'many of these strategies are now illegal or severely restricted in high-income countries'.

While still unfolding at the time of the research, the COVID-19 pandemic was alluded to as both intensifying held views and the opportunities to implement them for different actors and also as generating new thinking relevant to CDOH, as shown in box 1.

Box 1 Discourses in the context of COVID-19 in sub-Saharan Africa (SSA)

For international/global actors, the social protection deficits and intensifying inequalities arising from the pandemic have opened new discourse on opportunities for commercial activity in SSA, as colourfully noted by one global private sector stakeholder 'The politics is still like treacle, but the regulatory and economic blender is finally whirring'.[87] Others note that what form this takes is now debated, with economic pandemic impacts calling for SSA policy to shift from 'trading to a production based economy'.[88]

The pandemic has amplified policy debate in continental and subregional organisations on commercial determinants of health. The African Union (AU) Special Envoy to mobilise the private sector response to COVID-19 noted: 'We need a Marshall Plan for Africa's public health system…that should be jobs and enterprise driven'.[89] The AU has, however, also identified critical commercial barriers to equitable benefit, such as in the intellectual property (IP) regime, motivating its support for an IP Waiver in the Trade Related Aspects of Intellectual Property Rights Agreement.[12] In contrast, the UN Economic Commission for Africa sees the pandemic damage as requiring an even deeper engagement with 'the major players of the global economy, public and private', to reinject growth momentum into economies 'and build the foundations for recovery' including in the health sector.[90] While the Economic Community of West African States has expressed strong support for liberalised trade for population well-being,[91] a consequent shift in consumption to poor quality foods noted earlier, and food stress from supply chain disruptions during the pandemic have generated debate on more localised strategies for food security.[13 92]

COVID-19 has raised the profile of public health among SSA political actors, with perceived opportunities to strengthen public health law, inspection systems and actions to address social determinants.[27] For investors, it has intensified discourse on public–private partnerships to address 'health security' in SSA[68] and to invest in industries and technologies seen to have performed well during, or been resilient to the pandemic.[69] For academics, the pandemic is argued to have exacerbated negative impacts, such as food stress in West Africa,[13] but also to have opened new thinking, such as on greater local trade in food, on the use of digital health technologies and on rethinking monetary policy to protect citizens as high-income countries have done.[13 93 94]

DISCUSSION

As noted in the introduction, a discourse analysis can show how the different actors frame and use narratives to influence policy and action on CDOH, particularly where conflicts of interest may arise between commercial and public health objectives. The findings point to some major areas of common and divergent discourse, to tensions and synergies between public health and commercial objectives and to the role power differentials play in their interaction.

Key areas of common and divergent discourse

Within the multiple issues noted in table 2 and Results: framings and priorities in CDOH, three areas, highlighted in bold in table 2, emerge as major domains of discourse and are discussed in this section.

In the discourse on human rights in relation to CDOH, while some private actors in SSA argue for harmonised laws and standards across countries, civil society and private business/investors largely represent polar opposite views on the role of rights in managing CDOH. Civil society most strongly articulates a rights discourse, linking social rights to state duties and socioeconomic justice within countries and internationally. Civil society links the expanding power of commercial entities in areas harmful to health to states relinquishing their duties, ignoring breaches of environmental, labour and social rights. In contrast, many businesses and funders see—and some explicitly state—rights claims to be a barrier to their economic activity and prefer voluntary, 'responsibility' approaches, even while using liberal freedom of choice rights in marketing practices.

Within this, the position of international and regional agencies and states on rights is both important and variable. SSA governments, despite many including rights to health in their constitutions, make limited use of 'rights' language, but do commonly refer to regulating hazardous products, work, market practices and services. Some rights instruments and standards from UN agencies and the African Commission on Human and Peoples' Rights include duties to control commercial activity that is harmful to health. Ratification by SSA states of such international standards is seen by some to have supported domestic regulation to manage health risks. However, some international and regional agencies, particularly economic institutions, seek rather to persuade or incentivise voluntary 'good business practice', rather than enforcing it by law.

In a context of mixed messaging, the evidence suggests that SSA states navigating negotiations and regulation with powerful TNCs, and weakened by trade rules and global dispute settlement procedures, may choose less conflictual paths with corporates and economic sectors. The findings suggest that these choices are generating distrust between civil society and states, with more common reference to conflictual than alliance action between them, and of civil society protest, litigation and shadow reporting to claim rights. These tensions may be seen as counterproductive when the continent needs to advance positions grounded in equity, collective responsibility and community well-being in global platforms, such as in the global biodiversity negotiations noted earlier.[25]

A second major area of converging or conflicting discourse relates to the role of commercial activity in the health sector. All actors state commitments to UHC but with different understandings of what this implies. For civil society, numerous academic voices, and WHO, UHC depends on quality, accessible *public sector* health services. They express caution that commercial involvement will undermine equity, universalism and financial protection. Private-for-profit services are observed to focus on more profitable personal care, biomedical, hospital services, shifting resources and policy attention to these areas and leaving deficits in comprehensive primary healthcare (PHC) and population health approaches.

SSA governments and some continental actors raise similar concerns, and call for private sectors to complement public sector efforts to achieve UHC. Continental, subregional and state actors view regulation, oversight, information and mutual accountability between states and private actors as necessary to avoid negative consequences or to leverage beneficial impact from private actors in health services. They also note challenges in doing this, due to power, resource and capacity imbalances and inadequate information flows between large private actors and states.

In contrast, there is a growing and countervailing discourse, particularly from business and investors and also from some international and continental actors, proposing that private sector engagement and involvement is *essential* to attain UHC and to 'modernise' the health sector, particularly to meet funding gaps, to introduce technology and digital innovation, expertise and business models to improve quality and extend service outreach and to meet demands for pandemic-related health security.

Some SSA investors and businesses, however, raise concerns around unequal access of local and small enterprises to private investor resources, including for domestic health technology development, with consequences for equity in health services. There appears to be a potential convergence of interests between SSA domestic actors, including local producers, to build shared approaches and policy demands around health services and technologies to manage these tensions and to engage from an African lens in global processes. This has already been visible in the coalition across domestic business, governments, academia and civil society in SSA around the TRIPS Waiver and local production of vaccines and other health technologies.

A third area where views differ between actors, which also underlies the first two, is how CDOHs relate to overall economic and development paradigms. All actors see wider development conditions as relevant, but differently. Here too, the widest divergence in expressed views is between civil society and corporates or investors.

Corporates express no harms at all in their own activities and, in contrast, identify benefit from their products, models and economic activity. For corporates and investors, the continent is fertile ground for market opportunities and commercial operations, with primary concerns around decreasing risk. Civil society, some continental/subregional organisations and states and many academics, in contrast, raise and seek to make visible multiple areas of harm to health from CDOH in SSA, such as in chronic and zoonotic disease risk, pollution, obesogenic environments, food insecurity, ecological degradation and deficits in key inputs to health and social protection. They propose multisectoral 'One Health' responses, participatory health impact assessments, financial and regulatory measures and more comprehensive, updated public health laws, backed by strengthened public sector capacities. They also give more focus to deeper drivers in liberalised trade, loss of tax revenue, financial outflows and extractive, agribusiness systems and urbanisation, depleting natural and public resources and distorting or weakening public services. Associated with this was a call for greater investment in local research and development and production of health-related technologies; for regional harmonisation of tax policies to avoid a 'race to the bottom' in attracting investment; and for a more critical discourse, including from finance ministers on global IP, tax and biodiversity rules that do not serve SSA policy goals.[14 37 47 48]

Underlying this divergence in lens are differences in the political economy paradigm driving policy. Some see liberalised trade, capital accumulation and enhanced global integration as essential for economic activity, with indirect but ultimate benefit for health and ecological well-being, notwithstanding transitional harms. Others critique this model as generating poverty, inequality, public sector decline and degradation of natural resources, undermining health, both in the immediate and long term. SSA actors, including some business voices, identify inequity in benefit from the current global political economy as pertinent to CDOH, arguing for inclusive economic policies, such as investment in domestic and small scale producers, to improve health. A focus on CDOH inherently opens a deeper discussion on these political economy debates, one that box 1 indicates the COVID-19 pandemic has also fostered. It implies choices on whether to focus on health protections within current economic policies or whether health, together with other socioeconomic and ecological challenges, motivates more radical thinking on development. Commercial interests and power are influential CDOH in these policy debates, as discussed later.

Tensions/synergies between commercial and public health objectives

The findings in table 2, exemplified in Results: framings and priorities in CDOH, suggest some areas of tension and potential synergy between commercial and public health objectives in SSA.

There are different values applying in commercial markets and public health activities. The discourses raise in various ways the collective, social and economic rights framings in public health, the expectation of equity, redistributive justice, transparency and informed participation; the duties to do no harm to health that apply to all, including corporate entities; and the precautionary principle that implies protection of public health in the face of uncertainty. These values contrast with the liberal, individual freedoms and the profit and value for money goals in commercial market activity.

There is an apparent synergy noted in the production of commodities that contribute to health, particularly when production systems and products avoid health risks and ecological damage. Even in the production of potentially health promoting commodities such as food, there is a risk to health in market investment in ultra-processed or genetically modified foods and falling local food production and consumption, when tax, trade, marketing and pricing policies favour commercial over health objectives. There are also tensions between commercial and public health goals in the model of healthcare adopted. Private sector health services and PPPs are noted to favour biomedical, personal and hospital care and to avoid less profitable population health, PHC, 'One Health' and cross-sectoral interventions that reach lower-income communities. These are left for public sector and not-for-profit actors to invest in, despite these services being essential to manage key health burdens and for equity and universalism. Hence, while there is a wide articulation of commitments to health across all actors, there are also contrasting expectations of what rights and laws take precedence when there is conflict between public health and commercial interests. This is evident in IP debates, or when regulatory controls of TNC practices that are harmful to health unleash trade disputes. These competing values need to be recognised and explicitly addressed in negotiations between health and commercial interests. While the longer term impact of COVID-19 is still unfolding in SSA, including through conditions applied to debt relief and economic support, it has provoked dialogue on economic models and raised the profile of public health. This suggests opportunities for strengthened health-promoting values and approaches and building synergies, but the opposite may also be the case, further deepening tensions between commercial and public health objectives.

Such tensions draw attention to governance and implementation issues. While multisectoral action and coordination across government is called for to manage CDOH, as for example in 'health in all policy' (HiAP) approaches, there are also differences noted across sectors in how to address CDOH, particularly in relation to regulation and tax measures. How these differences are resolved in policy decisions and practice relates in part to evidence, but moreso to the relative capacities and power of public health and commercial actors, the rules and procedural systems in policy, including on information disclosure,

and whether key public-interest civil society actors access policy platforms.[49] Policy setting on CDOH is thus a fluid space that merits attention, particularly in relation to commercial influences in policy decision making, and the power asymmetries in these interactions.

Engaging with the inequitable distribution of power in interactions on CDOH

As for other social determinants, tackling the inequitable distribution of power emerges as essential to address CDOH.[50] A power analysis can help frame strategic thinking on this interaction of different interests and identify levers that can be used by public health advocates.[50 51] Power increases through mechanisms of discursive power (rarely questioned ideas and narratives); agential power (active interventions); and structural power (actions undertaken by governments and advocated by influential bodies).[51 52] Applying this analysis to the evidence points to areas of commercial power and countervailing power levers for public health objectives.

All three forms of corporate power are being engaged with around CDOH in SSA, and commercial actors are viewed as more agile and proactive in doing so than states.[28] Examples of corporate discursive power are narratives of 'private is best' and 'failing' public sectors or that controls on businesses can lead to social and economic decline. Agential power is applied in political engagement, coalition building, information management, sponsorship and welfare-related interventions described in our findings. Commercial structural power is supported by a dominant neoliberal global paradigm, national and global processes and rule systems legitimising corporate interests and ensuring enabling environments for commercial activity in health, potentially reducing the need to exercise narrative or agential power.[51]

Beyond an academic understanding of the different forms of power, this raises a question of how to engage with these power levers to proactively advance public health objectives and leadership in engaging on CDOH?

There were numerous examples in SSA of challenges to narratives that weaken public health, and of countervailing *discursive power*, such as in the exposure of harmful practices; positioning public sector systems as essential for UHC; or showing the health, socioeconomic and biodiversity benefit from local food production systems. Information systems that monitor commercial actors and health impact assessment of commercial projects help to institutionalise evidence for public health narratives. Promotion of healthy local foods and participatory, consultative public health approaches counter narratives promoting harmful practices, particularly when backed by relevant enforced controls on marketing, labelling and false messaging.

The findings show *agential power* for public health in the regulation of alcohol and tobacco company sponsorships, disclosures of conflicts of interest, active measures to meet public funding commitments and provide accessible, affordable quality universal *public sector* health services and investments in key areas of health that are visible to and matter to the public, like reliable safe water and waste management, particularly where this involves communities and internalises social protection in corporate policies.[49] The disconnect and distrust between states and civil society and the marginalisation voiced by local producers in the findings suggest a current loss in agential power by not bringing these groups together around shared public health goals.

Leveraging *structural power* implies engaging on local to global economic policies and rules systems that weaken the policy coherence, policy spaces and capacities to claim, protect and promote rights to health and public health within commercial practice and to advance production and consumption alternatives that align better to health objectives. With tax losses from corporate practices in low-income countries estimated at equivalent to nearly 52% of health budgets, for example, African Union, SSA finance ministries and civil society have highlighted public revenue losses due to outflows relating to TNC-related tax rules and illicit financial flows and called for action to strengthen economic governance and reform global rules. While regional harmonisation of tax laws through the African Tax Administrative Forum is proposed to avoid a 'race to the bottom', they also propose reform to global rules enabling tax outflows, including for tax revenue to be assigned to where revenues are produced.[37 53 54] While there is report of TNC resistance to regulation, tax, pricing and policy tools that lie within the power of states to promote public health, and pressure to involve commercial actors given weakened public sectors, such engagement shows the more affirmative use of structural power to promote public health, also noted in the engagement on the TRIPS Waiver, on biodiversity or on fair benefit from sharing of genetic material.

CONCLUSION

The health impacts of expanded commercial interest and activity in SSA highlight a clear need for proactive and comprehensive policy attention on CDOH, such as in relation to harmful products; the health impact of extractive activities and urbanisation; trade liberalisation and food systems; and commercialisation in health systems. The findings suggest the need to influence discourse and strengthen agency to advance public health objectives in such areas of CDOH.

Discourse can be influenced, and inclusive, transparent decision making strengthened through use of evidence from cross-disciplinary and citizen science research; institutionalised strategic health impact assessment; strengthened monitoring, surveillance and information systems; private sector disclosure duties; and public domain reporting.

Agency can be strengthened through protecting rights and standards on CDOH, updating public health

law, domesticating relevant international standards and harmonising regional standards. Implementation of standards calls for investment in inspection and enforcement mechanisms and engagement of TNCs on their duties, including through litigation in SSA and source countries.[55] SSA leadership can be built in areas of commercial benefit to health, particularly for population health measures in communities and frontline services, with increased SSA investment in local research, development, proof of concept and domestic production of health-related technologies, challenges to IP/trade rules that limit this and 'mining' IP and expired patents to support reverse engineering.[47] This implies strengthened coherence, capacities and action across sectors, through HiAP, with CDOH also embedded in enhanced and widely implemented 'One Health' actions and systems.

Engaging on structural power calls for alliances within and across regional and continental bodies, and initiatives to track and engage on health consequences of global trade, tax, biodiversity, IP and debt rules and to monitor and promote accountability on claims and commitments, including for their impact on equity.

Action on CDOH does not lie only at the doorstep of actors in SSA, however, particularly given the global level influences. WHO's unequivocal statement on the central role of public sector health systems in UHC supports those with concerns on the negative equity impacts of for-profit health services to resist UHC being used as a springboard for expanding commercialisation of health services in SSA. In a terrain where power currently advantages TNCs, global actors and particularly WHO are expected to use their own power to stand for health rights in CDOH debates and to articulate where public health values and norms take precedence.

The findings highlight many areas of action. The expansion of commercial impacts in SSA suggests, however, that piecemeal interventions on CDOH, while necessary, may be insufficient. This paper proposes understanding, negotiating and facilitating strategic and converging policy dialogue and action on the *multiple* levers of power that influence CDOH outcomes. Engaging on CDOH opens a debate that is critical to both prevent a deepening erosion of public policy space and to identify ideas and policies that better support synergies between social, ecological and economic well-being.

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