Informal Consultation on Reducing the Harmful Impact on Children of Marketing Foods, Beverages, Tobacco and Alcohol

Manila, Philippines
25–26 September 2013
Participants of the Informal Consultation on Reducing the Harmful Impact on Children of Marketing Foods, Beverages, Tobacco and Alcohol
Manila, Philippines, 25–26 September 2013
REPORT

INFORMAL CONSULTATION ON REDUCING THE HARMFUL IMPACT ON CHILDREN OF MARKETING FOODS, BEVERAGES, TOBACCO AND ALCOHOL

Convened by:
WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Manila, Philippines
25-26 September 2013

Not for sale
Printed and distributed by:
World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

May 2014
NOTE

The views expressed in this report are those of the participants in the Informal Consultation on Reducing the Harmful Impact on Children of Marketing Foods, Beverages, Tobacco and Alcohol and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for the governments of member states in the Region and for those who participated in the Informal Consultation on Reducing the Harmful Impact on Children of Marketing Foods, Beverages, Tobacco and Alcohol, which was held in the Philippines from 25 to 26 September 2013.
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Keywords: /Marketing – legislation / Legislation, Food / Child Nutrition / Tobacco /
Alcoholic beverages /
SUMMARY

The Informal Consultation on Reducing the Harmful Impact on Children of Marketing Foods, Beverages, Tobacco and Alcohol was held from 25 to 26 September 2013 in Manila, Philippines.

The modern communication environment includes almost unlimited access by children and youths to information about all kinds of products, often via new and increasingly sophisticated types of marketing. In recent decades, the clash between commercial interests and the health of the public has become more pronounced. Unfortunately, the capacity of the public health sector to address these new risks has been limited.

The informal consultation was convened to bring together expertise from a broad range of relevant public health specialties to review lessons learnt and best practices and identify opportunities and challenges in Member States in the Western Pacific Region in the area of marketing to children. The experts were asked to: (a) present their perspectives; (b) participate in a set of breakout groups designed to maximize the cross-fertilization of ideas; and (c) collectively review a WHO Regional Office for the Western Pacific working draft of a tool for effective action through regulation and legislation to protect children from exposure to marketing that imposes health risks.

The objectives of the consultation were to:

1. present a situation analysis on risk exposure and the impact on children arising from the marketing of infant formula/breast-milk substitutes, foods and non-alcoholic beverages, alcohol, and tobacco;

2. share experiences on effective measures to reduce the harmful impacts of marketing on children; and

3. review and critique the tool for effective action through regulation and legislation to protect children from exposure to marketing that imposes health risks.

Participants included experts from Member States in the Western Pacific Region, academic institutions, intergovernmental organizations and nongovernmental organizations. The consultation was supported and guided by the expertise of the WHO Secretariat (the Regional Office for the Western Pacific and WHO headquarters).

The consultation was conducted through plenary presentations on key topics and plenary and small-group discussions on experiences, challenges and options for advancing national-level policies to reduce the harmful impact on children of marketing foods, beverages, tobacco and alcohol.

The experts reviewed, examined and critiqued a draft tool for effective action through regulation and legislation to protect children from the harmful effects of marketing of infant formula/breast-milk substitutes, unhealthy foods and non-alcoholic beverages, tobacco, and alcohol in the Western Pacific Region, referred to in this report as the “draft tool”. The meeting closed with a summary of progress, a review of current status and an elaboration of next steps.
The main conclusions from the meeting were as follows:

(1) A recognized strength of the meeting was that it created an unusual and highly creative partnership of experts working on regulations of marketing of potentially unhealthy commodities in four health areas: breast-milk substitutes, foods and non-alcoholic beverages (high in fat, sugar and salt), tobacco, and alcohol. The experts shared experiences and identified commonalities of problems and solutions that can be used to inform similar processes in countries.

(2) The health problems that arise from unregulated marketing of unhealthy products is best framed as part of an "industrial epidemic", that is to say using a disease-causation model, with non-state actors that market unhealthy products as vectors of risks, disease and premature death.

(3) The commonalities of the problems associated with unregulated marketing of these unhealthy commodities require a common approach to minimize harm. A convergence of efforts, sharply focused around advocacy to protect the health of children and adolescents has the potential to create new opportunities for mobilizing broad political support.

During the meeting, the following recommendations were made:

(1) Actions to regulate marketing of unhealthy products need to be part of comprehensive and whole-of-government approaches to protect children and society from harm from these products.

(2) The health sector plays a catalytic role in – and could itself be strengthened by – engaging the support of other experts, in particular public health lawyers, economists and media in advocacy, policy development and enforcement.

(3) Public health needs to better understand commercial interests (corporatology) and develop strategies to anticipate and counter harm. A combination of strategies ("defence" and "offence") is needed to counteract efforts of non-state actors to undermine policy-making, regulation and legislation, as well as enforcement and implementation. Lessons learnt from tobacco control, for example, can be applied to work on regulation of marketing of other unhealthy products.

(4) Harmful marketing works with and through extensive networks. The public health sector needs to work with networks as well, especially in relation to regulation of cross-border marketing. The role of civil society partners and communities in such networks is underscored.

(5) Political mapping should be undertaken towards creating political constituencies, for example, coalitions, alliances and other organized groups. Public health needs to identify other private sector players that it can work with, for example, health insurance and banking sectors, among others.

(6) The draft tool for effective action through regulation and legislation was used as an organizing framework for understanding similarities and differences for addressing marketing across four health areas: breast-milk substitutes, foods and non-alcoholic beverages, alcohol, and tobacco. Participants felt the tool has great potential to support countries in initiating and refining action against harmful marketing. The final tool should:
a. allow countries to identify the barriers and actions most salient to a given country context;

b. provide guidance to countries on how to develop effective policies, regulation and legislation;

c. be tailored to the regional context, taking the barriers and actions identified over the course of this informal consultation into account;

d. build on existing models, in particular the model adopted by Member States in the set of recommendations on the marketing of foods and non-alcoholic beverages to children; and

e. include clear reference to the need to protect public health policy-making from the interference of industry.
1. INTRODUCTION

The 21st century has been described as an "information age" characterized by easy access to information through various forms of media, including emerging platforms such as social media. The new communication environment includes almost unlimited access by children and youths to information about all kinds of products, often via new and increasingly sophisticated types of marketing. In recent decades, the clash between commercial interests and the health of the public has become more pronounced.

At no other time in history have children been more exposed to potential harm from the marketing of foods, beverages, tobacco and alcohol:

- Marketing of infant formula and other breast-milk substitutes, in breach of the WHO International Code of Marketing of Breast-milk Substitutes, is a worldwide phenomenon; it negatively affects breastfeeding practice and is harmful to infant health.

- Food marketing to children promotes food that is high in fat, salt and sugar; it influences purchasing choices and requests for particular categories and brands of foods.

- Ten years after the WHO Framework Convention on Tobacco Control (WHO FCTC) was adopted and available for ratification, youth exposure to tobacco marketing remains widespread even in countries where tobacco marketing control measures appear to be stringent. Tobacco advertising, promotion and sponsorships increase the risk that adolescents will start to smoke, while marketing through films more than doubles that risk.

- Marketing of alcohol to children and adolescents is widespread; it increases the risk that adolescents will start to drink alcohol and increases consumption among those who have already started drinking alcohol.

Unfortunately, the capacity of the public health sector to address these new risks has been limited. To address the limitations and challenges, the WHO Regional Office for the Western Pacific initiated the development of a tool for effective action through regulation and legislation to protect children from the harmful impact of marketing of foods, beverages, tobacco and alcohol. The informal consultation brought together public health experts from all four areas – food, beverages, tobacco and alcohol – to share experiences and review and provide feedback on the draft tool.

1.1 Background

The modern communication environment includes almost unlimited access to information about commercial products, including products harmful to the health of children and adults, often via new and increasingly sophisticated types of marketing. While television remains important, an increasingly multifaceted mix of marketing techniques are emerging including: advertising; sponsorship; product placement; sales promotion; cross-promotions using celebrities, brand mascots or characters popular with children; websites; packaging; labelling, point-of-purchase displays; e-mail and text messaging; philanthropic activities tied to branding opportunities; and communication through “viral marketing” and by word-of-mouth. Many of these new low-cost techniques have expanded the reach of marketers to children and other target groups.
There is robust evidence of the health risks inherent in the use of breast-milk substitutes, unhealthy diet, alcohol and tobacco. Data also strongly support the conclusion that pervasive marketing of these products amplifies these risks. Specifically:

- marketing of infant formula negatively affects breastfeeding practice;
- marketing has a direct influence on purchasing choice and requests, and influences choice of both food category and brand;
- exposure to tobacco marketing causes children to initiate tobacco use; and
- alcohol marketing increases the likelihood that adolescents will start to drink and increases drinking among those who have already commenced.

WHO Member States have long recognized the need to regulate the marketing of consumable products that are harmful to children. World Health Assembly resolutions WHA34.22 adopting the International Code of Marketing for Breast-milk Substitutes, WHA56.1 adopting the WHO Framework Convention on Tobacco Control, WHA63.13 adopting the Global Strategy to Reduce the Harmful Use of Alcohol and WHA63.14 adopting a set of recommendations on the marketing of food and non-alcoholic beverages to children all point to the important role of ministries of health in protecting children and their guardians from misleading and false information about consumable products that could harm them.

Children are also afforded protections from marketing of harmful products under the human rights rubric. The Committee on the Rights of the Child notes in its General Comment No. 4 on “Adolescent health and development in the context of the Convention on the Rights of the Child”, that:

The Committee is concerned about the influence exerted on adolescent health behaviours by the marketing of unhealthy products and lifestyles. In line with article 17 of the Convention, States Parties are urged to protect adolescents from information that is harmful to their health and development, while underscoring their right to information and material from diverse national and international sources. States Parties are therefore urged to regulate or prohibit information on and marketing of substances such as alcohol and tobacco, particularly when it targets children and adolescents.

The informal consultation was convened to bring together expertise from a broad range of relevant public health specialties, from health promotion to noncommunicable disease (NCD) risk factors, to review lessons learnt and best practices and identify opportunities and challenges in Member States in the Western Pacific in the area of marketing foods, beverages, tobacco and alcohol to children. The experts were asked to: (a) present their perspectives; (b) participate in a set of breakout groups designed to maximize the cross-fertilization of ideas; and (c) collectively review the WHO Regional Office for the Western Pacific working draft of a tool for effective action to reduce the harmful impact on children of marketing foods beverages, tobacco and alcohol.

1.2 Objectives

The objectives of the consultation were to:

(1) present a situation analysis on risk exposure and the impact on children arising from the marketing of infant formula, foods, non-alcoholic beverages, alcohol and tobacco;
(2) share experiences on effective measures to reduce harmful impacts of marketing on children; and

(3) review and critique the draft tool for effective action to protect children from exposure to marketing that imposes health risks.

1.3 Participants and resource persons

The consultation was attended by experts from Member States in the Western Pacific Region, academic institutions, intergovernmental organizations and nongovernmental organizations and was supported and guided by the expertise of the WHO Secretariat (the Regional Office for the Western Pacific and WHO headquarters).

A list of participants is attached as Annex 1.

1.4 Meeting venue and agenda

The meeting was held from 25 to 26 September 2013 in Manila, Philippines. The agenda is attached as Annex 2.

2. PROCEEDINGS

2.1 Opening ceremony

The meeting was opened by Dr Susan Mercado, Director, Division of Building Healthy Communities and Populations, on behalf of Dr Shin Young-soo, WHO Regional Director for the Western Pacific.

Dr Mercado noted that marketing infant formula/breast-milk substitutes, food, beverages, tobacco and alcohol harms children, increasing the disease burden associated with these risk factors and limiting opportunities for healthy childhoods. She indicated that the World Health Assembly has taken the connection between marketing and NCDs seriously, particularly as it applies to children. A number of global resolutions, strategies and legal instruments have been adopted, including the International Code of Marketing of Breast-milk Substitutes, the set of recommendations on the marketing of foods and non-alcoholic beverages to children, the Global strategy to reduce the harmful use of alcohol (which includes policy options and interventions for national action on marketing alcoholic beverages) and the WHO FCTC (which includes provisions on banning tobacco advertising, promotion and sponsorship).

However, these obligations and guidance are often violated, in part because of the influence of and interference and tremendous pressure from affected industries.

During this meeting, the convened experts in the fields of marketing and public health will take a closer look at marketing for and to children. As a group the experts will examine evidence, share experiences and determine how to strengthen national capacity in this area. This work is important and highly relevant to strengthening health systems.

Dr Mercado emphasized that WHO can help by providing technical assistance in regional and national public health policy development and building regulatory capacity at the country
level. To this end, WHO welcomes a list of concrete steps that the Organization can take to support its Member States as one of the outcomes of this meeting.

Following participant introductions, the officers for the meeting were nominated, with Dr Rob Moodie, Professor of Public Health, Melbourne School of Population and Global Health, as Chairperson and Ms Yeong Joo Kean, Legal Adviser, International Baby Food Action Network, as Rapporteur.

2.2 Technical sessions

2.2.1 Presentation and discussion: When marketing harms children – reducing the harmful impact from marketing of infant formula, foods, beverages, tobacco and alcohol on children.

The discussion following Dr Moodie’s presentation focused on three primary areas: (a) the role of industry in regulating advertising; (b) the comparative weakness of the public health community’s networking, collective organizing and information dissemination versus that of private sector; and (c) the need for a substantial scaling up of capacity in the nexus of marketing, law and NCDs.

The utility of self-regulation, that is industry developed and imposed standards and limits, was discussed. It was noted that there is ample evidence in breast-milk substitutes and tobacco that self-regulation is, in many ways, worse than no regulation because it reduces political will and momentum. However, there is very little robust data in the other two areas considered in this consultation to indicate that self-regulation was either effective or ineffective. It was noted that many governments would prefer to pursue self-regulation to protect economic interests. Nonetheless, to avoid conflict of interest and to achieve the best public health results, it seems clear that there should be investment and promotion of government developed, adopted and implemented regulation of marketing of all relevant products. It was pointed out that government-owned monopolies present a different type of conflict of interest.

Experts were careful to clarify that regulating marketing in fields such as food is qualitatively different than regulating tobacco marketing. Specifically, it is reasonable to discuss a total ban on tobacco advertising, but to completely ban food marketing would undermine the ability of governments to promote healthy foods. There are a number of related sectors that have a more mixed profile and should not be labelled “bad”. Therefore, the approach to regulating private sector marketing activities in all cases besides tobacco (and possibly alcohol) may require a more nuanced approach.

The public is not as well informed about the harms of the breast-milk substitutes, unhealthy diet, tobacco and alcohol, nor of the negative impact of their pervasive marketing. Even within public health, NCDs have received – until recently – less attention than other health concerns. (The Millennium Development Goals, for example, do not mention NCDs.) Capacity must be built at the country level, both to review and improve current legislation and regulation and to advocate for protections from unhealthy products.

The discussion closed, noting that the private sector is extremely well organized and mutually protective. The public health community should perhaps take note and work to become similarly organized and internally cohesive.
2.2.2 Presentation and discussion: Northern Europe experiences and practice

The discussion following Ms Rehn-Mendoza’s presentation focused on three primary areas: (a) the question of how to distinguish between tobacco and alcohol on one hand and food, breast-milk substitutes and non-alcoholic beverages on the other; (b) the clear need to consider and understand the marketing power and reach of all media platforms; and (c) government opportunities to act defensively and offensively with regard to unhealthy products.

The expert group noted that while complete advertising, promotion and sponsorship bans are likely the best option, there is a misperception that it is easier to restrict tobacco and alcohol marketing, while food, non-alcoholic beverages and breast-milk substitutes have greater political and social barriers to marketing restrictions. In reconciling these commodity areas in one document, it will be important to note that best practices in one country can be adapted to other country contexts, and that – where appropriate parallels exist – lessons in one sector can and should be translated to other sectors.

Restricting marketing is becoming increasingly complicated as media fractures in to numerous platforms. It is not enough to consider only domestic television and radio; satellite and cross-border transmissions must also be considered. Social media, in particular, presents a set of new, novel opportunities and challenges. Content-based bans will become more and more important as we move away from traditional media, for which audiences could be measured and identified. It may be useful to consider the successes in tobacco in these areas, and also to look at models effectively used in even more restricted areas, like pornography. Further, it is important to consider the role not only of the industry and how it uses media, but also of the media platforms themselves.

Governments may also wish to consider combining a restriction on marketing with an increase in the airtime traditional or virtual, dedicated to positive health messaging. Additionally, there are models in which governments have combined restrictions on advertising with an increase in taxes to further drive down consumption while increasing revenue that can be earmarked for public health, as has occurred in Thailand. Approaches such as these would allow governments to be both defensive (restricting/banning advertising) and offensive (requiring airtime for positive health messaging).

2.2.3 Group work 1: What experience do we have in responding to marketing that harms children?

The experts were assigned to groups with mixed expertise to discuss the question: What experience do we have in responding to marketing that harms children?

The working groups reported back to the plenary session noting the following points in particular:

Political anxiety about trade threats is a barrier to moving forward with limiting advertising to children. Additionally, food safety and nutrition quality are parallel issues and should be considered in concert to ensure that marketing regulations are rational and promote public health. Reflecting recent successes in the Western Pacific Region – for example, the Republic of Korea where legislation requires the Government to certify ingredients used in food, and the establishment in Thailand of the Thai Health Promotion Foundation – any national marketing framework needs to empower non-industry stakeholders. The framework should also refer to the Convention on the Rights of the Child. Effective legislation needs to be based on strong evidence, which requires research and data. Many countries, at both governmental and civil society levels, lack capacity in law and public health. Also, it is critical that industry
compliance be carefully monitored, as demonstrated by breast-milk substitute marketing and tobacco marketing restrictions (even with the WHO FCTC in place).

In plenary, the discussion emphasized the need for technical capacity and expertise in all stages of regulating marketing – and particularly technical capacity in public health law. Countries and the public health community need to look at a serious mobilization of and increase in the public health lawyer workforce (with an emphasis on trade) across the globe, as well as access to economists, social marketing experts and other relevant trained personnel. Offensive strategies should also be considered, including using the industry itself, as per the Tobacco Master Settlement Agreement in the United States of America. This will require commitment by governments, civil society and intergovernmental agencies, for example WHO, the United Nations Children’s Fund (UNICEF) and other entities. It will also require resource mobilization.

Regulating marketing should be tied to the global human rights framework. This should be both with regard to rights protecting children from marketing, and to translate human rights language and use the United Nations human rights mechanisms (committees, etc.) as potential sources of support for monitoring implementation. There has been some success in working with the Committee on the Rights of the Child, issuing recommendations with regard to harmful marketing of breast-milk substitutes. However, these protections are often countered by arguments concerning the right of free speech and the right of mothers to choose. It is critical that governments anticipate these arguments and be ready to defend their policies.

Governments require technical support. WHO noted that it is ready to provide technical assistance at the request of any Member State, including the support for the creation of a network of lawyers with appropriate expertise who could be called on to help governments. In WHO overall, the Organization is refining its policy on interactions with non-state actors, which will provide guidance in organizational interactions with industry and clarify recruitment policy. It is anticipated that the Health Assembly will consider draft policy recommendations at its session in May 2014.

2.3 Cross-cutting themes

2.3.1 Presentations: Exposure to marketing and harnessing new media – using social media for advocacy on tobacco policy in low-resource environments.

Dr William Bellew provided an overview of exposure to marketing, providing summary statements and evidence from each of the four issue areas. He also provided examples to illustrate the concept of exposure.

Dr Stephen Hamill then presented on using social media for advocacy on tobacco policy in low-resource environments. Dr Hamill explained that global access to information sources and consumption is changing, as are target markets in low- and-middle income countries, as well as in high-income countries. Even though social media has limited reach on a per capita basis, there are still very large populations online, making social media increasingly important as a communications tool. Importantly in the context of reducing the harms of advertising, industry is using social media to reach consumers and advocates should similarly be using it to empower communities and individuals.

2.3.2 Group work 2: How do we reduce/eliminate exposure to harmful marketing?

Working again in groups with mixed expertise, the experts discussed the question: How do we reduce/eliminate exposure to harmful marketing?
The working groups reported back to the plenary session in four overarching areas:

**Measures proposed to control/regulate advertising**

The groups noted and discussed the following options with regard to measures or approaches to controlling/regulating advertising:

1. Completely ban marketing for and to children, using the tobacco model, while being sensitive to the need for governments to be able to promote healthy foods. In this regard, consideration should be given to whether a strategy is aimed to or for children.

2. Alternately, partially ban marketing, subject to strict exceptions. For example:
   a. completely ban marketing of products harmful to children;
   b. completely ban marketing breast-milk substitutes and tobacco, while partially banning the marketing of other categories of products;
   c. completely ban marketing of products with identified types of content (for example, trans fat, energy dense/nutrient poor, etc.);
   d. scale or adjust marketing bans/restrictions based on the age of the target audience; and
   e. scale or adjust marketing bans/restrictions according to different classifications of products, for example, beer and wine versus hard alcohol.

3. All types of media need to be considered in the context of banning or limiting advertising.

4. Substantial, graphic warnings should also be considered, in concert with advertising bans or restrictions.

**Approach to engaging with industry and self-regulation**

The groups reported and discussed the approach to engaging with the industry and industry self-regulation. In general, engaging with industry was considered inappropriate. In all cases, governments should take the lead role and industry should simply be excluded from public health policy discussions, particularly if policy-making is involved.

Self-regulation with regard to marketing was also considered inappropriate, and was compared to allowing a burglar to install the locks. However, these industries are powerful and can have great political influence. Also, there are countries where the industry in question is a government monopoly. Some types of self-regulation may have to be considered to allow for government regulation in others.

**Rights-based or risk-based approach to reducing the harmful impact of marketing on children**

The groups also considered and discussed the pros and cons of using rights-based and risk-based approaches to reducing the harmful impact of marketing to and for children. Both approaches have benefits and pose challenges.
The risk-based approach is more fully developed, particularly in those areas where there is robust data linking use of a product or products to health harms, for example, tobacco and alcohol. However, in food the risk-based approach may be more difficult. Regulations must clearly state what they are for and how they are going to protect children.

The rights-based approach is promising, but requires more work. The public health community needs to look at relevant international instruments to identify possible arguments and approaches. Essentially, governments need to see protecting children from marketing as their obligation, and human rights may provide the basis for that by articulating a set of agreed principles, for example, age of informed consent and the right to be informed. However, it is important to remember that there are numerous counter arguments, also based in human rights, for example, the right to free speech and the right to choose.

Common across the four issues

Lastly, the groups discussed the issues that are common across food, beverages, tobacco and alcohol with regard to restricting the harmful impact of marketing to and for children. It was agreed that many characteristics of industry behaviour and approach are similar, but that some of the barriers are different due to the fundamentally different nature of the products. Commonalities include:

1. Industry marketing techniques – all industries have learnt and continue to learn from each other’s successes and failures.

2. The power of money – money affects how the industry works, in that the mission is to maximize profits (as opposed to improving health or making a better product) and money affects how much influence, leverage and access industry has to influence politics, decision-makers and the public.

3. The industry approach to marketing regulations – in all cases, industry has objected to limits on marketing and has proposed self-regulation as the solution.

2.3.3 First panel discussion: How do we reduce/eliminate exposure to harmful marketing?

The panel, comprising four of the experts participating in the meeting, commented on the question of how to reduce or eliminate exposure to harmful marketing. The panellists reflected on feedback from the working groups, responded to issues in plenary, and introduced new ideas and perspectives, as follows:

Mr David Clark: As advocates and public health specialists, the question we should pay the most attention to is what kinds of interventions do the industry fight hardest against? We know those issues are the ones that will have genuine impact. Country compliance to codes and the ability of the industry to sway policy can be disheartening, but the data indicating that increases in regulation in countries are having an impact on breast-milk substitute sales are very inspiring.

Ms Nina Rehn-Mendoza: It is essential that countries think carefully about what they want to restrict when designing regulations and legislation. Is the goal to ban all marketing? Some marketing? As one example of how complicated the landscape can be, a number of alcohol companies also have lines of mineral water, so even if the companies cannot advertise alcohol, the same logo appears on the water.
Dr Ulysses Dorotheo: We discuss reducing and eliminating, but if something is harmful, surely we should be eliminating not reducing. It is important to first determine what “harmful” is, but having done that, harm is harm and it should be eliminated. Also, why limit this to harm to children? Why not eliminating harmful marketing to everyone? Rather than focusing on how to change people’s individual decisions or improve individual health, this is about containing aggressive, dangerous industries.

Dr Tim Gill: On the question of how to restrict exposure to food and beverage marketing, we do not yet know what best practice is. This is similar to obesity prevention. When you don’t know best practice, you focus on best process, for example, how to define unhealthy food, how to monitor exposure to advertising, how to establish good regulations and what their content should be.

2.3.4 Presentation: Power of marketing

In this presentation, Dr Bellew emphasized that marketing targeting caregivers, children and adolescents is powerful across all four health issues. To support this position, he showed evidence levels and profiles, systematic reviews and studies. Dr Bellew then provided the trigger questions for the next breakout group:

(1) Are there barriers that are currently preventing countries accessing/implementing the “best buys”? If so, what is needed to overcome these at country level?

(2) From this analysis, are there facilitative or supportive actions that WHO and Member States could/should undertake at regional level?

2.3.5 Group work 3: What are the best buys to curtail the power of marketing in the countries?

Working again in groups with mixed expertise and predicated on the outcomes of the earlier working groups, the experts discussed the question: What are the best buys to curtail the power of marketing in the countries?

The working groups reported back to the plenary session on the barriers to implementing the best buys and what actions WHO (at the regional level) and Member States should take. The following were identified as barriers:

- lack of political will;
- lack of awareness (for example, on nutrition, risks and the harms of marketing);
- lack of definitions;
- strong industry interference;
- weakness of health ministries;
- health generally and NCDs specifically, being low on government agendas;
- cross-ministerial and overlapping responsibility for these matters and a lack of integrated, cross-sectoral dialogue;
- state industry ownership and conflict of interest;
• lack of capacity (technical and financial) in government to draft, implement, monitor and enforce legislation;

• lack of capacity (technical and financial) in the civil society community;

• competing interests at the local level;

• norms that see advertising and marketing as normal;

• no clear data on what the best buys in marketing policy are;

• countries are not sharing information, so public health starts from scratch in each country, while industry is using the same successful approaches everywhere;

• powerful individual marketing;

• nongovernmental organizations limited involvement in work, need active civil society;

• level of evidence on the consequences of the power of marketing is low; and

• medical community involvement in health promotion.

The following were identified as actions WHO and Member States can take:

• consider establishing health promotion funds or foundations – looking at the experience of Hong Kong (China), for example;

• require declarations of conflict of interest in government, civil society and intergovernmental organizations;

• increase industry monitoring to expose violations and malfeasance;

• require that countries report on progress, perhaps at the World Health Assembly and sessions of the regional committees);

• reach out to and integrate non-health points of view;

• determine what best practices are, then promote sharing and learning;

• work across ministries and among governments to combine evidence and share experience;

• increase awareness in government, particularly ministries of health;

• dedicate the resources necessary to develop legislation and regulation;

• develop and provide practical and effective frameworks to capture best practices;

• increase the level of empathy in government and communities for child protection; and
• support the development of a tool for effective action through regulation and legislation to protect children from the harmful impact of marketing of foods, beverages, tobacco and alcohol.

2.3.6 Second panel discussion: What are the best buys to curtail the power of marketing in the countries?

Ms Yeoug Joo Kean: Developing and implementing law is slower than marketing, so governments are always trying to catch up. Also, it is not clear what many laws, regulations and codes cover. For instance, is “follow-up milk” covered in the International Code of Marketing of Breast-milk Substitutes? One way to help protect against this is to develop legislation and regulations with broad, catch-all language. Conflict of interest in professional associations is a serious barrier to this work.

Dr Stephen Hamill: Best buys are not necessarily free; they are cost-effective. For example, counter-marketing campaigns are one of the best buys in tobacco control. They can cost millions of dollars but reach millions of people, and so have the opportunity to change the political landscape. Also, costs can be mitigated, as in Turkey where regulations require that the Ministry of Health has 30 minutes of television broadcasting during prime time each month, free of charge.

Dr Kim Cho-Il: Reducing conflict of interest is essential to reducing the harmful impact on children of marketing. It is also critical that the focus be less on individuals, and more on creating environments that are health promoting. For example, Korean legislation restricts advertising, while also promoting positive messaging and encouraging good choice making.

Professor Louise Signal: Lack of political will is a serious problem. Even in places with political will – for example, Nordic countries – there are barriers to reducing the harms of marketing on children. In particular, trade threats are a real barrier to making good policy. It becomes incumbent on advocates then to use economic arguments, as they are the most effective way to argue for policy action.

2.3.7 Presentation: Access to products

In this presentation, Dr Bellew emphasized that harmful products that are targeted at children and adolescents are readily available and increasingly affordable. He then provided the trigger questions for the next breakout group:

(1) What are the best starting points when countries may not, as yet, have had the opportunity to address this issue and progress is limited?

(2) What are the best ways to keep making progress once the initial steps have been taken?

(3) From this analysis, are there facilitative or supportive actions that WHO and Member States could/should undertake at regional level?

2.3.8 Group 4: How can countries progress along the action continuum to have measures that will limit the access (affordability, availability) of these products?

Working again in groups with mixed expertise and predicated on the outcomes of the earlier working groups, the experts discussed the question: How can countries progress along the action continuum to have measures that will limit the access (affordability, availability) of these products?
The working groups reported back to the plenary session on the best starting points, best ways to keep making progress and whether there are facilitative actions that WHO and Member States can take.

Best starting points

- Identify what is unhealthy.
- Identify appropriate civil society players.
- Gather a strong evidence base to move policy forward.
- Identify ways professional societies can help and ways they may be hindering.
- Raise taxes, which may be easier for tobacco and alcohol and harder for food and breast-milk substitutes.
- Ban unhealthy food in schools and surrounding areas.
- Reduce the size of drink containers and drinks with added sugar, for example soft drinks.
- Ban special offers, for example, “2 for 1”, on high-risk products.
- Ban playgrounds and the distribution of toys with meals at fast food outlets.
- Limit how products can be marketed.
- Reduce insurance premiums for people engaging in healthy behaviour.
- Create or enforce age limits for purchasing.
- Require that outlets be licensed, particularly those selling tobacco and alcohol.

Best ways to keep making progress

- Subsidize healthy choices and remove all subsidies, direct and indirect, for unhealthy choices.
- Build sustainable financing mechanisms for health promotion at the national level.

Facilitative actions that WHO and Member States can take

- WHO can endorse the identified best starting points.
- WHO can work with Member States to actualize the “Health-in-All-Policies” approach.
- Better integrate issues like marketing into United Nations country cooperation plans and United Nations agency collaboration.
- Improve communications and collaboration among health, trade and foreign affairs.
• Instil and implement the idea of child protection, not just child rights.
• Build capacity in and support for drafting regulations.
• Create broad partnerships by reaching outside traditional public health communities, for example, crime-reduction groups or advocates focusing on reducing drinking and driving.
• Convene meetings that allow countries to work together and foster the sense that no country is in this alone.

2.3.9 Third panel discussion: How can countries progress along the action continuum to have measures that will limit the access (affordability, availability) of these products?

The panel, comprising four of the experts participating in the meeting, commented on the question of how can countries progress along the action continuum to have measures that will limit the access (affordability, availability) of these products. The panellists reflected on feedback from the working groups, responded to issues in plenary and introduced new ideas and perspectives, as follows:

Dr Foo Ling Li: The two most important elements to progression in limiting the access of these products are robust data and appropriately trained lawyers. Until we generate enough of both resources, it will be a struggle to initiate or continue to progress in reducing the harms of marketing on children.

Ms Jo-Anne Diosana: Passing relevant legislation is necessary – this is what gives governments the authority to regulate. It is important to remember that legislation gets passed because of a combination of different factors. In the case of the Philippines’ so-called “sin tax” law, which increased taxes on alcohol and tobacco, citizens were ready, agencies collaborated closely and there was the necessary political will.

Dr Sami Schubber: WHO is uniquely placed to take a lead in developing recommendations, regulations and other international instruments. The Organization should use its convening power and the options under its Constitution to move these kinds of actions forward through its regional committees and the World Health Assembly.

Dr Godfrey Xuereb: There is a great deal of discussion about what we don’t know – what the best buys are, the exact impact of marketing, and the most effective approaches to industry engagement. However, it is essential that we are not paralyzed by the sense that we cannot move forward until we have more data. Governments must take action now, as the problems are only growing in magnitude.

2.4 Introduction of the draft tool for effective action through regulation and legislation to protect children from the harmful impact of marketing of foods, beverages, tobacco and alcohol

Dr Howard Sobel presented the draft tool for effective action through regulation and legislation, reviewing each of the seven elements: 1) develop policy/legislation; 2) strengthened regulatory capacity; 3) effective mechanisms for implementation; 4) information systems; 5) effective and efficient enforcement; 6) industry interference; and 7) role of advocacy. He indicated that the draft tool is designed to support countries in their efforts to protect children from harm from marketing of infant formula/breast-milk substitutes, unhealthy foods and non-alcoholic beverages, tobacco and alcohol. Dr Sobel asked that on Day 2 the experts identify
pathways and critical action points to achieve effective regulatory outcomes and provide a critical review of the Pathways for Effective Action through Regulation and Legislation (PEARL) approach, with an eye improving it and making it genuinely useful.

2.5 Group work: Using the seven components of the draft tool for effective action through regulation and legislation, identify the barriers, actions at country level and support required

Working now in groups of issue-specific expertise, the experts identified the barriers and actions at country level, using the seven components of the PEARL approach. The following tables summarize the outcomes of those discussions.

**Alcohol**

<table>
<thead>
<tr>
<th>Component of draft tool</th>
<th>Barriers</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate for policy using evidence and international best practices</td>
<td>• Paucity of country data (e.g., traffic accidents)</td>
<td>• Advocate/focus on existing agreements</td>
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<tr>
<td></td>
<td>• Unwillingness to accept international data</td>
<td>• Promote as health issue</td>
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<td></td>
<td>• Biased information from industry</td>
<td>• Raise awareness of water</td>
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<tr>
<td></td>
<td>• Lack of understanding of the concept and scope of conflict of interest (COI)</td>
<td>• Share awareness/data closer to home</td>
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<td></td>
<td>• Actual/existing COI</td>
<td>• Develop economic analysis</td>
</tr>
<tr>
<td></td>
<td>• Competing priorities (e.g., tobacco, HIV)</td>
<td>• Raise awareness of COI</td>
</tr>
<tr>
<td></td>
<td>• Non-medicalization of issue</td>
<td>• Multisectoral dialogue</td>
</tr>
<tr>
<td></td>
<td>• Paternalism/“nanny state”</td>
<td></td>
</tr>
<tr>
<td>Improve enforcement</td>
<td>• Lack of resources</td>
<td>• Taxes on alcohol</td>
</tr>
<tr>
<td></td>
<td>• Allocation of responsibility</td>
<td>• Public health multisectoral dialogue</td>
</tr>
<tr>
<td></td>
<td>• Transborder issues</td>
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<tr>
<td></td>
<td>• Lack of awareness regarding standards, rules (retailers)</td>
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<tr>
<td></td>
<td>• Weak sanctions</td>
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<tr>
<td></td>
<td>• “Trojan horse” (age vs. marketing)</td>
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</tr>
<tr>
<td>Develop policies/ regulations/legislation</td>
<td>• Improper/no classification standards for &quot;harmful/abuse&quot; of children</td>
<td>• Clear messages (e.g., “Even one drink has risks for young people.”)</td>
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<td></td>
<td>• Restriction on selling/buying considered enough</td>
<td>• Define/clarify terms</td>
</tr>
<tr>
<td></td>
<td>• Lack of understanding that marketing impacts children, even if not targeted at them</td>
<td>• Expose intensity, pervasiveness of drink industry marketing</td>
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<tr>
<td></td>
<td>• Lack of understanding of the need to ban alcohol in places where children congregate</td>
<td>• Encourage Member States to use models</td>
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<td></td>
<td>• Lack of capacity (legal) in ministries of health (MOH)</td>
<td>• WHO to organize workshop on legal drafting</td>
</tr>
<tr>
<td></td>
<td>• Combating social/cultural norms re: young people, children, not all</td>
<td>• Lobby lawmakers</td>
</tr>
</tbody>
</table>
### Foods and non-alcoholic beverages

<table>
<thead>
<tr>
<th>Component of draft tool</th>
<th>Barriers</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop policies/ regulations/legislation</td>
<td>• Normative and legal foundations</td>
<td>• Policy champions/advocacy</td>
</tr>
<tr>
<td></td>
<td>• Lack of ability to define problems</td>
<td>• Monitoring surveillance – problems/ issues</td>
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<tr>
<td></td>
<td>• Lack of understanding of the policy development process</td>
<td>• Research &amp; analysis – framing issue</td>
</tr>
<tr>
<td></td>
<td>• Lack of political/community will</td>
<td>• Define roles/responsibilities</td>
</tr>
<tr>
<td></td>
<td>• Lack of role clarity</td>
<td></td>
</tr>
<tr>
<td>Strengthen regulatory capacity</td>
<td>• Lack of institutional functioning structure</td>
<td>• High-level institution with resources/skills authority</td>
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<td></td>
<td>• Lack of stakeholder engagement/support</td>
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<tr>
<td></td>
<td>• Lack of commitment (understanding/funding: especially non-health agencies)</td>
<td></td>
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<td></td>
<td>• Low government priority</td>
<td></td>
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<tr>
<td></td>
<td>• Lack of skills/advocacy</td>
<td></td>
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<tr>
<td></td>
<td>• Lack of regulatory framing skills</td>
<td></td>
</tr>
<tr>
<td>Improve effectiveness of mechanisms for implementation</td>
<td>• Poor operational/communication planning</td>
<td>• Well-defined operational plan</td>
</tr>
<tr>
<td></td>
<td>• Poor infrastructure</td>
<td>• Staff development</td>
</tr>
<tr>
<td></td>
<td>• Limited skills/motivation/confidence of key staff</td>
<td>• Proper level of resourcing/support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Champions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Media training/support</td>
</tr>
<tr>
<td>Improve enforcement (together with implementation)</td>
<td>• Lack of surveillance systems</td>
<td>• Develop clear:</td>
</tr>
<tr>
<td></td>
<td>• No existing structures for enforcement</td>
<td>o roles</td>
</tr>
<tr>
<td></td>
<td>• Lack of connection between implementation and enforcement</td>
<td>o systems</td>
</tr>
<tr>
<td></td>
<td>• Roles of agencies not clearly defined</td>
<td>o processes</td>
</tr>
<tr>
<td></td>
<td>• Lack of legal expertise within health agencies</td>
<td>o network for support and legal advice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o awareness community through campaigns (on healthy diet)</td>
</tr>
<tr>
<td>Counteract interference of commercial interests in</td>
<td>• Industry lobbying power/financial resources</td>
<td>• Learn from other issues/ sectors</td>
</tr>
<tr>
<td>policy-making</td>
<td>• Perceived evidence gap</td>
<td>• Accepted international evidence assessment reports</td>
</tr>
<tr>
<td></td>
<td>• Nanny state/personal freedom/responsibility</td>
<td>• Higher priority to health on economic grounds</td>
</tr>
<tr>
<td></td>
<td>• Power/demand of consumer</td>
<td>• Shift focus onto enabling environments</td>
</tr>
<tr>
<td></td>
<td>• Lack awareness of common industry tactics</td>
<td></td>
</tr>
<tr>
<td>Additional Issue: Government focus on finance and</td>
<td>• Advocate for policy support ongoing</td>
<td>• Strong leadership - government/nongovernmental organizations/community</td>
</tr>
<tr>
<td>wealth generation</td>
<td>• Lack of sustained advocacy/interest</td>
<td>• Knowledge brokers (nongovernmental organizations)</td>
</tr>
<tr>
<td></td>
<td>• Limited access to international evidence/best practice</td>
<td>• Ongoing monitoring /</td>
</tr>
</tbody>
</table>
### Additional Issue: Framework
- Avoid multiple frameworks
- Align with existing WHO policy cycle

### Tobacco

<table>
<thead>
<tr>
<th>Component of draft tool</th>
<th>Barriers</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Advocate for policy using evidence and international best practices | • Few advocates, low expertise  
• No champions  
• Political calendar  
• Not a "hot button" issue  
• Political apathy  
• Lack of public interest/awareness  
• Local evidence gap though good best practice and international evidence  
• Anecdotal stories  
• Myths and misinformation | • Identify advocates and champions and build their capacity  
• Provide sustainable funding  
• Work with journalists/media to generate stories/campaigns  
• Be flexible: launch campaigns when opportunity strikes  
• Develop strong communications and relationships among advocates |
### Infant formula (breast-milk substitutes)

<table>
<thead>
<tr>
<th>Component of draft tool</th>
<th>Barriers</th>
<th>Actions</th>
</tr>
</thead>
</table>
| Develop policies/regulations/legislation | • Political commitment  
• Weakness at MOH  
• Commercial interference  
• Acceptance of artificial feeding as norm/superior  
• Lack of resources | • Presentation of competing evidence/arguments  
• Reiterate international commitments and obligations  
• Multisectoral cooperation  
• Document lessons learnt from tobacco and the “Code”  
• International cooperation  
• Resources |  
| Strengthen regulatory capacity           | • Lack of capacity  
• Lack of appreciation/understanding of issue among legal community  
• Limited knowledge of technical legal issues required to draft effective law  
• Commercial interference in regulation process | • Provide technical/legal capacity building – UNICEF, International Baby Food Action Network (IBFAN), WHO  
• Training  
• Support network (include law, trade, human rights, etc.)  
• Develop capacity in WHO |  
| Improve effectiveness of mechanisms for implementation | • Partial or no regulations  
• Commercial interference  
• Weak or no provisions for effective implementation mechanisms  
• Lack of stakeholder involvement during drafting process (e.g., food and drug administration) | • Identify and involve all relevant stakeholders from beginning  
• Sanctions and monitoring in implementation mechanisms  
• Sufficient empowerment of individuals and nongovernmental organizations  
• Technical assistance to develop |
2.6 Group work: Using the seven components of the draft tool for effective action through regulation and legislation, identify the barriers and actions at country level that are common across the four health areas.

Next, the issue-specific working groups identified the actions recommended common to all four of the health areas in each of the seven components of the draft tool for effective action through regulation and legislation. It was recommended that these actions should be included in the final version of the tool.

The following tables summarize the results.

### Draft tool for effective action through regulation and legislation to protect children from the harmful impact of marketing of food, beverages, tobacco and alcohol

<table>
<thead>
<tr>
<th>ACTIONS RECOMMENDED</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Develop policies, regulations and legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop and disseminate a report comprising a conceptual framework,(^1) analytic tools and their application, and a mapping of industry marketing and related strategic information for the four health areas; the target audiences for dissemination of the report include (but are not limited to) public health training institutions, health</td>
</tr>
</tbody>
</table>

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\(^1\) Infant formula/breast-milk substitutes, foods and non-alcoholic beverages, tobacco, and alcohol

professional associations, medical and public health journals and the media.

- Articulate government obligations under the relevant human rights instruments and national human rights laws in relation to all four health areas; this work should be guided by the relevant General Comments of United Nations human rights treaty bodies, e.g. Committee on the Rights of the Child.
- Reiterate government/international commitments and obligations (including international human rights instruments, WHO strategies and resolutions).
- Clearly refer to United Nations guiding principles on business and human rights in the framework for policy, regulation and legislation.
- Provide technical/legal assistance and training from nongovernmental organizations, WHO, UNICEF, other United Nations agencies and from international experts.
- Increase the number of public health lawyers focused on the four health areas; develop WHO/UNICEF capacity to provide technical and legal support.
- Provide case studies of regulations that work well.
- Define and clarify terms regarding age categories for children.
- Undertake market surveillance, research and analysis to underpin policy development.
- Raise the priority of advocacy to ensure ongoing engagement of policy champions and support for policy ambassadors.
- Train lawyers in country.
- Identify appropriate national and international support.
- Provide clear, consistent messages to the public on the dangers of using these products.

**ACTIONS RECOMMENDED**

<table>
<thead>
<tr>
<th>Strengthen regulatory capacity and effectiveness mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a sustainable multisectoral regulatory structure and financing.</td>
</tr>
<tr>
<td>Ensure the involvement and empowerment of consumer groups and civil society.</td>
</tr>
<tr>
<td>Establish bilateral and/or regional support networks including expertise on intellectual property, trade and human rights law, and cross-border marketing issues.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improve effectiveness of mechanisms for implementation</th>
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</thead>
<tbody>
<tr>
<td>Establish a well-designed operational plan that identifies and involves all relevant stakeholders from the outset when designing mechanisms for implementation.</td>
</tr>
<tr>
<td>Ensure mechanisms include deterrent sanctions.</td>
</tr>
<tr>
<td>Provide examples of subnational initiatives, models and pilots to draw upon in cases where national progress stalls.</td>
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<tr>
<td>Ensure media training and engagement.</td>
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<tr>
<td>Empower individuals and nongovernmental organizations to monitor compliance and seek redress.</td>
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<tr>
<td>Identify champions at every level of implementation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establish useful information systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and implement systems to provide strategic intelligence on current and emerging marketing practices of industry across the four health areas, and building on work already undertaken in areas such as WHO FCTC Article 5.3.</td>
</tr>
<tr>
<td>Establish systematic surveillance of marketing exposure, impact and content for tobacco, alcohol, food and non-alcoholic beverages and breast-milk substitutes among children, adolescents and caregivers.</td>
</tr>
<tr>
<td>Establish a regional network on marketing surveillance and information systems involving academia, nongovernmental organizations and other appropriate partners.</td>
</tr>
</tbody>
</table>

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3 Or State as it encompasses the legislative bodies, e.g., National Assembly or Parliament
<table>
<thead>
<tr>
<th>ACTIONS RECOMMENDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve enforcement</td>
</tr>
<tr>
<td>• Use existing international/regional/national systems to institutionalize surveillance.</td>
</tr>
<tr>
<td>• Establish information on investment levels and support required for implementation.</td>
</tr>
<tr>
<td>• Establish an ongoing systematic approach to the analysis of health and economic data across the four health areas to provide current, clear and robust economic arguments underpinning policy.</td>
</tr>
<tr>
<td>ACTION RECOMMENDED</td>
</tr>
<tr>
<td>Counteract interference of commercial interests in policy-making, implementation and enforcement</td>
</tr>
<tr>
<td>• Identify existing enforcement mechanisms across the four health areas that could be adapted or added.</td>
</tr>
<tr>
<td>• Establish clear roles and responsibilities, systems and processes for</td>
</tr>
<tr>
<td>o monitoring</td>
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<tr>
<td>o adjudication</td>
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<tr>
<td>o specifying the available deterrent sanctions.</td>
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<tr>
<td>• Develop and disseminate guidelines for sanctions, including identification of the party or parties liable, applicable types and effective levels of severity.</td>
</tr>
<tr>
<td>• Enhance the use of the United Nations human rights monitoring mechanisms (e.g., Committee on the Rights of the Child) through, among other things, inclusion of information on marketing practices, their impact on children’s health and state responses, in both formal government reports and alternative reports prepared by civil society.</td>
</tr>
<tr>
<td>• Build or strengthen multisectoral dialogue and enforcement mechanisms.</td>
</tr>
<tr>
<td>ACTION RECOMMENDED</td>
</tr>
<tr>
<td>Advocate for policy using evidence</td>
</tr>
<tr>
<td>• Codify all concepts, tools, training and other resources already in place to support the implementation of WHO FCTC Article 5.3 (Protect public health policies from interference) and develop a common package across the four health areas.</td>
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<tr>
<td>• Develop models of codes of conduct for engagement with non-state actors (industries with unhealthy products).</td>
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<tr>
<td>• Expose industry malpractice, misuse of scientific evidence and creation of false evidence.</td>
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<tr>
<td>• Work in collaboration with civil society and anti-corruption advocates.</td>
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<tr>
<td>• Make use of freedom of information principles and legislation as appropriate to bring transparency.</td>
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</tbody>
</table>

3. CONCLUSIONS AND RECOMMENDATIONS

The Informal Consultation On Reducing the Harmful Impact on Children of Marketing Foods, Beverages, Tobacco and Alcohol, organized by the WHO Western Pacific Region (25–26 September 2013), brought together technical experts from in and outside the Region. The consultation objectives were to: (1) present a situation analysis on risk exposure and impact on children arising from the marketing of infant formula, foods and non-alcoholic beverages,
alcohol, and tobacco; (2) share experiences on effective measures to reduce harmful impacts of marketing on children; and (3) review and critique the draft tool for effective action through regulation and legislation to protect children from exposure to marketing that imposes health risks.

The proceedings included presentations, plenary discussions and group work and the objectives of the consultation were met.

The main conclusions from the meeting were:

(1) A recognized strength of the meeting was that it created an unusual and highly creative partnership of experts working on regulations of marketing of potentially unhealthy commodities in four health areas: breast-milk substitutes, foods and non-alcoholic beverages (high in fat, sugar and salt), tobacco, and alcohol. The experts shared experiences and identified commonalities of problems and solutions that can be used to inform similar processes in countries.

(2) The health problems that arise from unregulated marketing of unhealthy products is best framed as part of an "industrial epidemic", that is, applying a disease causation model, non-state actors that market unhealthy products are vectors of risks, disease and premature death.

(3) The commonalities of the problems associated with unregulated marketing of these unhealthy commodities require a common approach to minimize harm. Convergence of efforts, sharply focused around advocacy to protect the health of children and adolescents, has the potential to create new opportunities for mobilizing broad political support.

During the meeting, the following recommendations were made:

(1) Actions to regulate marketing of unhealthy products need to be part of comprehensive and whole-of-government approaches to protect children and society from harm from these products.

(2) The health sector plays a catalytic role in, and could itself be strengthened by, engaging the support of other experts, in particular public health lawyers, economists and media, in advocacy, policy development and enforcement.

(3) The public health sector needs to better understand commercial interests (corporatology) and develop strategies to anticipate and counter harm. A combination of strategies ("defence" and "offence") is needed to counteract efforts of non-state actors to undermine policy-making, regulation and legislation, as well as enforcement and implementation. Lessons learnt from tobacco control, for example, can be applied to work on regulation of marketing of other unhealthy products.

(4) Harmful marketing works with and through extensive networks; the public health sector needs to work with networks as well, especially in relation to regulation of cross-border marketing. The role of civil society partners and communities in such networks is underscored.

(5) Political mapping should be undertaken towards creating political constituencies, for example, coalitions, alliances and other organized groups. The public health sector needs to identify private sector players that it can work with, for example, health insurance, banking and other sectors.
The draft tool for effective action through regulation and legislation was used as an organizing framework for understanding similarities and differences for addressing marketing across the four health areas. Participants felt the tool has great potential to support countries in initiating and refining action against harmful marketing. The final tool should:

a. allow countries to identify the barriers and actions most salient to a given country-context;

b. provide guidance to countries on how to develop effective policies, regulation and legislation;

c. be tailored to the regional context, taking the barriers and actions identified over the course of this informal consultation into account;

d. build on existing models, in particular the model adopted by Member States in the set of recommendations on the marketing of foods and non-alcoholic beverages to children; and

e. include clear reference to the need to protect public health policy-making from the interference of industry.
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ANNEX 2

OBJECTIVES

To bring together stakeholders, interested parties and experts, to:

(1) present a situation analysis on risk exposure and impact on children arising from the marketing of infant formula, foods and non-alcoholic beverages, alcohol and tobacco;

(2) share experiences on effective measures to reduce harmful impacts of marketing on children; and

(3) review and critique the Framework for Action to protect children from exposure, power and access to marketing that imposes health risks.

PROVISIONAL AGENDA

(1) Opening ceremony

(2) Presentation: When marketing harms children: reducing the harmful impact from marketing of infant formula, foods, beverages, tobacco and alcohol on children

(3) Presentation: Alcohol: Experiences in restricting marketing targeted at children – Northern Europe experiences and practice

(4) Presentation: Exposure to marketing

(5) Presentation: Power of marketing

(6) Presentation: Access to products

(7) Pathways for Effective Action I

(8) Pathways for Effective Action II

(9) Pathway for Effective Action III

(10) Pathways for Effective Action IV

(11) Conclusions and recommendations

(12) Closing
Profits and Pandemics
WPRO Meeting
25 September 2013

Rob Moodie (on behalf of my co-authors)
Melbourne School of Population and Global Health

My co-authors
- David Stuckler, Carlos Monteiro, Nick Sheron, Bruce Neal, Thaksaphon Thamarangsi, Paul Lincoln and Sally Casswell

What this talk is about
- Unhealthy commodity industries
- Role of good business
- How the TNCs operate
- The tactics they use
- Models of working with unhealthy commodity industries

Failure to prevent NCD is a political, not a technical, failure.
Action is inadequate – nationally and by development agencies and foundations.

The Lancet NCD Action Group and the NCD Alliance

"Unhealthy Commodity" Industries

There is consensus that tobacco has a conflict of interest which is irreconcilable with public health
Are the competing interests of alcohol and ultra processed food and drink industries similarly irreconcilable?
Or are they, as they claim, “part of the solution?”
GOOD BUSINESS and the HEALTHY PRIVATE SECTOR

- Creation of wealth
- Provide jobs, employees also pay taxes
- Businesses pay taxes
- No public investment without it
- The health value of a secure, worthwhile, meaningful job
- Much to learn in health from business
  - Bring a business mindset/model to global health

Transnational corporations are major drivers of NCD epidemics

And they profit from increased consumption of tobacco, alcohol and ultra-processed food and drink.

The science of the behaviour of these industries is only emerging but remains largely unstudied

- Industrial epidemics
- Industrial vectors

The expansion of the Trans National Companies into low and middle income countries

### Annual growth rate (%) of volume consumption per person in low-income and middle-income countries, and high-income countries between 1997 and 2009

<table>
<thead>
<tr>
<th></th>
<th>Low Income</th>
<th>High Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Packaged food</td>
<td>1.9%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Soft drinks</td>
<td>5.2%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Processed food</td>
<td>2.0%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Oil and fats</td>
<td>1.6%</td>
<td>–0.1%</td>
</tr>
<tr>
<td>Snacks and snack bars</td>
<td>2.4%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>2.8%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Tobacco*</td>
<td>2.0%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

*Adapted with permission from reference 7.

*Tobacco data are in retail sales per person.
### Alcohol and ultra processed food and drink industries use similar strategies to the tobacco industry to undermine effective public health policies by:

- **Biasing research findings**
- **Coopting policy makers and health professionals**
- **Lobbying politicians and public officials to oppose public regulation**
- **Influencing voters to oppose public health regulation**
- **Blatantly ignoring codes of conduct**

### Biasing research findings

- Project Whitecoat
- Food and drink companies – (Lesser et al)
- International Center for Alcohol Policies (ICAP) reports – incomplete no peer review but resembled WHO documents and supported industry positions or emphasized high levels of disagreement among scientists
- Recent studies demonstrating bias if funded by industry

### Coopting policy makers and health professionals

- US Tobacco Institute
- SAB Millers involvement in alcohol policies in sub Saharan Africa
- AFGC – introducing their own self regulatory codes
- Using the same people to run these companies

### Lobbying politicians and public officials to oppose public regulation

- $150 million spent in the US to lobby government by alcohol companies from 1999-2011
- PepsiCo contribution to pro business candidates who support Pepsi Co
- Sugar Industry threatened US government boycotts of WHO AFGC and Australian Hotels Association in Australia
- Donations to political parties
  - Chief Minister of NT

### Influencing voters and framing issues to oppose public health regulation

- Tobacco
  - Against regulation, taxation
  - Focusing exclusively on personal responsibility and parental responsibility
  - Focusing on physical activity
  - “Lifestyle” diseases versus industrial epidemics
  - Use Corporate Social Responsibility (CSR) to deflect criticism

### Blatantly abusing codes

- Coca-Cola Never Ever Markets to Kids and Is Part of Obesity Solution iPhone Edition

Download Santa’s Helper - an iPhone game produced by Coca-Cola.
Models of working with unhealthy commodity industries

- Industry self regulation
  - Preferred model of industry (and at the moment governments and UN)

- Public Private Partnerships
  - Better “inside the tent than outside”

- Public regulation
  - Acknowledging the profound conflicts of interest between protection of public health and profit from unhealthy commodities

Key messages

- Unhealthy commodity industries should have no role in the formation of national or international policy for NCD policy

- There is no evidence to support the effectiveness of self-regulation and public–private partnerships to improve public health

- Public regulation and market intervention are the only evidence-based mechanisms that can prevent harm caused by unhealthy commodity industries

Challenging the goliaths

Margaret Chan 8th Health Promotion Conference Helsinki

- “It is not just Big Tobacco anymore. Public health must also contend with Big Food, Big Soda, and Big Alcohol.

- All of these industries fear regulation, and protect themselves by using the same tactics.”
Experiences in restricting marketing targeted at children

Nina Rehn-Mendoza,
Nordic Center for Welfare and Social Issues

Contents

• Nordic experiences in restricting marketing to children
  1. case of Sweden
  2. case of Norway
• European Network on reducing marketing pressure on children
• Alcohol marketing and youth

Nordic action on marketing

Nordic countries – Nordic Council of Ministers
2. Declaration on marketing of food for children (2007)

In May 2010 the network of Nordic Ombudsmen formed a joint guidance note on marketing/sales/branding through social media (rev Dec 2012).

Main points:
• Identifiable as advertisement (no pretend consumer)
• Electronic marketing requires prior approval
• No use of advergames, i.e. games incorporated with ad
• Encouragements to buy cannot be directed at below 18 year olds (e.g. buy now, order today)
• Ad cannot encourage children to tell parents/adults to buy

Sweden experience – legal basis

Marketing Practices Act (1995) – no express rule about children, but in applying the Act there is case law that prohibits against advertising directly to below 16, no mail, sms, phone calls or e-mail addressed to anyone below 16.

Radio and TV Act (1996) – prohibition against advertising attracting the attention of children below age of 12, no advertising allowed in connection with children’s programmes, no adbreaks, no product placement, no people or characters from children’s programmes are allowed in any advertisements.

Great until commercial TV channels relocated to the UK... May come under European court of Justice shortly due to change in EU audiovisual directive.

Norway experience – legal basis

Norwegian Marketing Control Act (2009)
Covers advertising in every media, including the internet. Marketing to children more regulated than to other target groups. Explicit protection for children as they are considered particularly vulnerable. Children is defined as below 18.

Norwegian Broadcasting Act (1992) (TV and Radio)
Ads may not be broadcast in connection with children’s programmes (before or after) nor be directed at children = general ban of broadcasting ads aimed at children (targeting children is defined as: product that interests kids, timing, kids below 13 shown in the ad, animation or other presentation techniques, use of gifts/toys/games)

Norwegian Education Act (2007)
General ban on marketing (no exposure) in all primary and secondary education and training

Norway – marketing unhealthy foods

• Norwegian Action Plan on Nutrition 2007-2011: “consider restriction on advertising of unhealthy food aimed at children and young people”.
• In 2007 food industry self-regulation came into force which was evaluated by independent third party in 2010.
• The Ministry of Health and Care Services has decided that from 2015 the marketing of unhealthy foods directed at children less than 16 years old will be banned (industry fought down age from 18)
**Nutrient profiling – Norway case**

For the new ban on unhealthy foods, Norway has defined energy dense, salty and nutrient-poor foods as, e.g.:
- All chocolate and sugar confectionery
- Cereals = higher than 20 grams of total sugar per 100 grams of finished product
- Non-alcoholic beverages containing added sugar or sweeteners
- Fast food = higher than 225 kcal (950 kJ) energy, higher than 15 grams of total fat, higher than 5 grams of saturated fat, higher than 1 gram of salt (per 100 grams)
- Yoghurts and similar products = higher than 0.7 grams of fat, higher than 9 grams of total sugars

**Norway – problematic enforcement**

- Consumer Ombudsman – monitors that marketing complies with Marketing Act
- All Nordic Ombudsmen actively encourage people to file complaints about rule breaches
- Market Council – court of appeal in consumer ombudsman cases
- But, TV3 broadcasts from UK although it is in Norwegian and directed at the Norwegian market. Therefore does not need to comply with Norwegian legislation. However, the CO can continue to take action against advertisers e.g. for misleading advertising.

**European Network on reducing marketing pressure on children**

- Network established in 2008, with Norwegian Directorate of Health as the secretariat and leader (WHO-EURO facilitated setup of network)
- Technical experts from 20 European countries as of 2011, plus observers: World Health Organization, the European Commission, the United Nations Standing Committee on Nutrition, the Food and Agriculture Organization of the United Nations, the International Obesity TaskForce and Consumers International
- 8 network meetings, last in May 2013
- All meeting reports and documents are available on-line

**Objectives of the European Network**

- Identify and demonstrate specific actions to protect children against pressure from marketing of energy-dense, micronutrient-poor foods and beverages
- Share experiences and best practices in monitoring exposure to marketing
- Discuss alternative approaches to regulation
- Discuss nutrient profiling as a tool in restricting marketing of food and beverages
- Report to various international meetings (WHA and WHO-EURO)

**Key issues and challenges ahead**

- Regulatory approach?
- Self-regulation/voluntary codes
- Statutory regulation
- Combination
- What should be regulated?
- All marketing to children, all food marketing to children, marketing of unhealthy foods to children?
- How to define “unhealthy food” – nutrient profiling feasible?
- Age limits
- 18, 16, 12 years?
- Marketing techniques to be covered?
- All types of marketing?

**Alcohol marketing to children and young people**

With permission some slides presented are from Professor David Jernigan at the Center for Alcohol Marketing to Youth (CAMY)
Consequences of youth drinking

Young people who begin drinking before age 15 are five times more likely to develop alcohol problems later in life than those who wait until they are 21. (OSG, 2007)

They are:
- Four times more likely to develop alcohol dependence (Grant and Dawson 1997)
- Six times more likely to be in a physical fight after drinking
- Greater than six times more likely to be in a motor vehicle crash because of drinking
- Almost five times more likely to suffer from other unintentional injuries after drinking (Hingson et al. 2009)

Every year approximately 5,000 people under age 21 die from alcohol-related injuries resulting from underage drinking. (OSG, 2007)

Brain activity in two 15 year-olds during a memory task

Addressing Alcohol’s Appeal to Youth: Alcohol Advertising

≥15 longitudinal studies
- Followed groups of young people over time, monitoring alcohol marketing exposure and drinking behavior
- Find increased exposure to alcohol advertising and marketing is associated with drinking initiation and increased consumption and greater risk of problems, even after controlling for wide range of other variables

Forms of alcohol advertising and marketing that predict drinking onset among youth
- Alcohol advertisements in magazines
- Beer advertisements on television
- Alcohol advertisements on radio
- Alcohol advertisements on billboards
- In-store beer displays and sports concessions
- Alcohol use in movies
- Ownership of alcohol promotional items

Greater exposure predicts youth alcohol consumption by brand

Youth were three times more likely to consume a brand if exposed to its advertising

Analysis controlled for:
- Demographic characteristics
- Magnitude of alcohol consumption
- Parental drinking
- Risk-taking behavior
- Media use patterns
- Autonomy of brand choice
- Brand-specific prices
- Overall brand market share
Importance of Monitoring at Brand Level

A small percentage of alcohol brands is responsible for half of youth exposure.

<table>
<thead>
<tr>
<th>Medium</th>
<th>Year</th>
<th>Total number of brands advertising</th>
<th>Brands responsible for half of youth exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magazines</td>
<td>2008</td>
<td>333</td>
<td>16 (5%)</td>
</tr>
<tr>
<td>Television</td>
<td>2009</td>
<td>151</td>
<td>12 (8%)</td>
</tr>
<tr>
<td>Radio</td>
<td>2009</td>
<td>77</td>
<td>3 (4%)</td>
</tr>
</tbody>
</table>

How does advertising affect young people’s drinking decisions?

- Youth are drawn particularly to elements of music, characters, story and humor.
- Young people who liked the ads believed that:
  - positive consequences of drinking were more likely
  - their peers drink more frequently
  - their peers approve more of drinking
- These beliefs interact to produce greater likelihood of drinking, or of intention to drink within the next year.
- Causal arrows all in one direction – that is, positive expectancies do not predict greater liking of ads: assumptions of peer drinking do not predict greater liking of ads.

Challenges of Monitoring Youth Exposure

Monitoring is dependent on consumer self-reports of exposure
Survey data is not available on brand-specific youth alcohol consumption
Spending alcohol advertising on digital media is rapidly increasing
  - Internet advertising: 90% increase from 2010 to 2011
  - Internet advertising is only a small part of digital marketing
    - Facebook, YouTube
    - Mobile applications (“apps”), etc.

Science today

“Proof” is impossible in social science research
Science is iterative – the science is steadily improving
Preponderance of evidence is that alcohol advertising and marketing exposure increases youth drinking
Given nature of advertising response function, the more thorough the ban the more protective it will be

What does it look like today?
**Alcopops**

- Industry spokespersons have described alcopops as designed for "entry-level drinkers" and those who do not like the taste of beer.
- Even though most of them have distilled spirits in them, the industry claimed they were made from beer, so that they could be:
  - Taxed lower, sold in convenience stores, advertised on TV
  - Most popular with youngest drinkers

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**The Latest in Alcopops:**

**High Alcohol Flavored Malt Beverages**

- Fruit flavored, sugary alcoholic drinks that come in colorful non-traditional packaging
- Also known as "malternatives", "FABs", "cheerleader beer", "chick beer"
- New industry term "progressive adult beverages"
- First alcopops contained 5-6% alcohol and came in 12 oz bottles
- Second generation products contain up to 12% alcohol and come in 16 – 24 oz cans
  - "Binge in a Can" = 5 beers, sold as a single serving
**High Alcohol Flavored Malt Beverages**

![Image of High Alcohol Flavored Malt Beverages]

**Product Placement**

- Many examples:
  - Kahlua in Catwoman
  - Coors in Scary Movie 3
  - Carlsberg in Spiderman
  - Heineken ($10 million) in Matrix Reloaded


**Beer Institute Advertising and Marketing Code**

Models and actors employed to appear in beer advertising and marketing materials should be a minimum of 25 years old, substantiated by proper identification, and should reasonably appear to be over 21 years of age.

![Image of Beer Institute Advertising and Marketing Code]

**DISCUS Code of Responsible Practices**

Beverage alcohol advertising and marketing materials should not contain the name of or depict Santa Claus.

![Image of DISCUS Code of Responsible Practices]

**What is an ad? Conversations With Joose**

Yesterday, we asked about your first time... with JOOSE. Now we want to hear about the morning after... JOOSE. Walk of shame anyone? Tell us a speed morning after story with JOOSE.

December 23, 2010 at 11:13am

John Wade: Ahhh yes, the morning after. When you woke up to see you brought home two empty cans of Joose from the bar with you, and there's a text from your friend waiting for you stating ' Dude, do you have any clue how ****ed up you were last night, and do you have any more of a clue as to what you did?'.

December 23, 2010 at 11:28am

JOOSE LDI: What did you do?!

December 23, 2010 at 11:32am

Adam Hood: In the past 6 years I've made spaghetti two times. One of the best Joose nights ever! I woke up naked on my couch with a full plate of spaghetti and half a Joose in front of me. Trashed the spaghetti, finished the Joose.

December 23, 2010 at 11:42am
Conversations With Joose (continued)

JOOSE Should have saved the spaghetti for the inevitable fourth meal cravings! And... how did half a Joose get you kissed on the couch?!
December 23, 2010 at 11:48am

Adam Rood Let’s just say the “half Joose” wasn’t Joose #1 of the night...
December 23, 2010 at 11:49am - @1 person

Jesleme Joose Neon green pours out of me the next morning.
December 23, 2010 at 1:06pm

JOOSE is that why your tongue is greenish blue in your profile picture?
December 23, 2010 at 1:11pm

Tyler Jamison Duncan midnight vomit all over the wall and not knowing about it till the next day and having to clean it up with a major hangover.
December 23, 2010 at 3:46pm

Conversations With Joose (continued)

JOOSE EW @Tyler! LOL, I once had someone tell me they threw up underneath their bed and didn’t know about it until months later!
December 23, 2010 at 4:02pm

Tyler Jamison Duncan lol! it’s not as bad as drinking an entire bottle of vodka, and not knowing that vodka kicks in later and falling between your desk and bed not able to get up profusely vomiting red vines and blacking out and coming to while vomiting lol. Worst night of my life.
December 23, 2010 at 4:37pm

Aaron Shoemaker This has happened a couple of times: woke up to find that there was a JOOSE unfinished. So I had it for breakfast.
December 23, 2010 at 6:48pm
“Binge in a can” with natural Brazilian healing powers

Antioxidant beer

“Beer plus” – a smart choice

Even the can is slim

No carbs – even better
What is to be done?

Effective marketing regulations

Best option: complete ban
2nd best: French model "Loi Evin 1991" also referred to as ban on lifestyle marketing
3rd best: Restrictions/bans specifically reducing youth exposure
Content bans are difficult to enforce
The clearer and more complete the ban, the greater the effect (partial bans lead to substitution to other media)
No evidence to support effectiveness of industry self-regulatory codes such as limiting advertising when youth are 30% of audience

Case study – new marketing restrictions expected in Finland

First attempt to regulate marketing in social media:
- Companies cannot use consumer generated materials (text or pictures)
- No competitions, games or raffles allowed (no apps)
- No materials such as videoclips produced that consumers can share
- In addition; TV/radio ban 7am – 10pm and outdoor ads banned