

TECHNICAL NOTE

Background on alcohol marketing regulation and monitoring for the protection of public health

This document provides evidence for arguments supporting alcohol marketing regulation, and suggests key elements that can be considered by countries in planning, developing, implementing, and evaluating effective regulation. It also provides legislative language that can assist governments in developing or modifying existing laws and implementing monitoring mechanisms. It complements a Pan American Health Organization (PAHO) report from an exploratory meeting on alcohol regulation held in January 2015 and is firmly based in the Global Strategy to Reduce the Harmful use of Alcohol of the World Health Organization (WHO), as well as the subsequent PAHO Regional Plan of Action, but also the WHO and PAHO plans of action for the prevention and control of Non Communicable Diseases, and PAHO resolutions on Health and Human Rights and the Strategy on Health Related Law. The first draft was produced by PAHO technical staff and presented at a meeting held in July 2016, with experts and representatives from selected Member States. The final document was extensively revised by PAHO staff after the meeting, following suggestions made by participants.



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Executive summary

In the public health field, the harmful use of alcohol is one of the four most common modifiable and preventable risk factors for the major noncommunicable diseases (NCDs) and an important risk factor for several public health concerns, including violence and injury. It also has an impact on other health conditions including HIV/AIDS and tuberculosis, as well as on economic and social development.

The purpose of this note is to enhance country efforts to reduce the harmful use of alcohol by providing technical support on one potential element of a comprehensive approach to tackling this problem: the regulation of alcohol marketing. This document provides evidence for arguments supporting alcohol marketing regulation, and suggests key elements that can be considered by countries in planning, developing, implementing, and evaluating effective regulation. It also provides legislative language that can assist governments interested in developing or modifying existing laws and implementing monitoring mechanisms. This document complements a Pan American Health Organization (PAHO) report from an exploratory meeting on alcohol marketing regulation held in January 2015 and is firmly based not only on the Global Strategy to Reduce the Harmful Use of Alcohol of the World Health Organization (WHO), as well as the subsequent PAHO Regional Plan of Action, but also the WHO and PAHO plans of action for the prevention and control of NCDs, and PAHO resolutions on Health and Human Rights and the Strategy on Health Related Law.

Alcohol marketing is widespread in the Americas. Modern marketing techniques go beyond traditional print and electronic media advertisements and include branded merchandise, sponsorships of sporting teams and events, discount pricing, social media, and sales or supply at educational or health establishments.

There is now substantial evidence that associates alcohol marketing with young people's drinking behavior. Studies have found that the more they are exposed to alcohol marketing, the more likely they are to start drinking earlier, and to drink more if they are already drinking.

PAHO/WHO Member States have made several commitments, through the adoption of strategies, plans, and resolutions at regional and global levels, which mutually reinforce the role of governments in promoting and protecting health as a human right, using laws and regulations as instruments to protect public health, and regulating products which harm health – including their marketing, promotion, and sponsorship, as appropriate. They also recognize the need for multisectoral action to address the multifaceted determinants of alcohol-related harm and achieve public health aims.

PAHO/WHO Member States should adopt evidence-informed strategies to achieve their public health goals for addressing the harmful use of alcohol. This technical note provides principles for alcohol marketing regulation as well as elements that can be considered by governments in strengthening their legal and regulatory frameworks, as appropriate, to

significantly reduce or eliminate exposure to alcohol marketing. It should not be read as a prescriptive set of guidelines which countries are required to follow, as is the case with the Framework Convention on Tobacco Control, for example. As noted in the global and regional strategies, restrictions or bans on alcohol marketing techniques such as advertising, promotion, and sponsorship, as appropriate and in accordance with country constitutions or constitutional principles, can play a role in a comprehensive approach to addressing harmful alcohol use. Restrictions or bans on alcohol marketing are more effective when complemented by monitoring and evaluation, and supported by effective legislative, executive, administrative, and other regulatory measures.

Glossary of terms

Alcohol- In this document, alcohol is used as a synonym for alcoholic beverage(s). “Alcohol” or “alcoholic beverage” refers to a product that contains ethanol (ethyl alcohol) and is primarily intended for human consumption (mainly through drinking).

Alcoholic beverage- In most countries with a legal definition of “alcoholic beverage,” a threshold for content of ethanol by volume in a beverage is set at $\geq 0.5\%$ or 1.0% . Alcoholic beverages include (but are not limited to) beers, wines, and spirits, including those commercially, informally, or illegally produced for consumption [1]. Some countries apply the term “beverage of moderation” to certain alcoholic beverages, according to their volume of pure alcohol. Different approaches to regulation depending on the concentration of alcohol per volume often results in less strict regulations for products with a lower concentration of alcohol by volume. Given that the ethanol content of any beverage is the main substance causally linked to harmful effects from drinking alcoholic beverages, these “beverages of moderation” should also be included in the definition of an alcoholic beverage.

Alcohol industry or industry- Includes alcohol manufacturers, wholesale distributors, importers, and retail sellers of alcoholic beverages. This definition captures a diversity of actors, for which certain restrictions may be more relevant than others.

Alcohol marketing- Refers to any commercial communication or other action, including advertising, promotion, and sponsorship, that is designed to increase- or have the effect or likely effect of increasing- the recognition, appeal and/or consumption of alcoholic beverages and of particular new or existing alcohol brands or products. This includes the design of alcohol products, brand stretching (using an established brand for a new product in another product category), co-branding (collaboration between different brands with the same advertising goals), depiction of alcohol products and brands in entertainment media, corporate social responsibility activities undertaken by the alcohol industry, and the sale or supply of alcoholic beverages in educational and health settings. Trademarks and trade dress (label design, product configuration, and product packaging), which can serve multiple functions, are included when their goals align with those already mentioned previously.

Co-regulation- Voluntary or non-binding compliance with government-set standards.

Cross-border marketing- Refers to marketing activities that originate in one legal jurisdiction but are accessible to persons in jurisdictions different from the place of origin.

Harmful use of alcohol- As stated in the WHO Global Strategy to Reduce the Harmful Use of Alcohol, the word “harmful” refers only to public-health effects of alcohol

consumption, without prejudice to religious beliefs or cultural norms in any way. Consistent with the Global Strategy, in the context of this document, the concept of the harmful use of alcohol is broad and encompasses the drinking that causes detrimental health and social consequences for the drinker, the people around the drinker, and society at large, as well as the patterns of drinking that are associated with increased *risk** of adverse health outcomes.

Heavy episodic drinking (HED)- The proportion of a population that has consumed at least 60 grams (approximately 5 standard drinks) or more of pure alcohol on one occasion, at least once in the past 30 days. This indicator is often further specified by removing all nondrinkers (current abstainers) to get a clearer sense of the proportion of drinkers who are most likely at risk for harms caused by alcohol. Other definitions of HED are used depending on the country and/or the study.

Regulatory capacity- Qualities such as authority, governance, availability of human and financial resources, and established mechanisms, with strong legal support, for intra- and intersectoral coordination that allow the health authority to issue, enforce, and evaluate regulations (laws, acts, decrees, rules, or resolutions).

Self-regulation- Voluntary or non-binding compliance with industry-set standards.

* Italics added for emphasis.

Introduction

In the public health field, the harmful use of alcohol is one of the four most common modifiable and preventable risk factors for the major noncommunicable diseases (NCDs) and an important risk factor for several types of violence and injury [2]. There is also emerging evidence that the harmful use of alcohol contributes to the health burden caused by communicable diseases such as tuberculosis and HIV/AIDS.

Alcohol consumption contributes to more than 200 diseases and injuries. For some of these health-related outcomes, including cancer, there is no safe level of alcohol consumption, meaning no level at which individuals can be assured of no harm from alcohol use [3, 4, 5]. The population-level effect on health is overwhelmingly negative in every country of the world. Alcohol can harm drinkers directly in the form of various types of cancer, cardiovascular diseases, liver diseases, poisoning, suicides, mental disorders, and alcohol dependence. Harmful alcohol use is also associated with a number of other consequences such as traffic crashes, interpersonal and domestic violence, child abuse, insurance costs, property damage and crime, and effects on family budgets, all of which can affect drinkers and non-drinkers alike [5, 6]. The harmful use of alcohol places a burden on the social and emotional development of children, on families, on lower-resourced populations, and on national health, road safety, and criminal justice systems [7].

Alcoholic beverages are extensively promoted around the world. Several billion dollars are spent yearly on marketing (i.e. advertising, promotion, and sponsorship)[†] activities in the Region of the Americas [8, 9, 10]. Alcohol marketing is constantly evolving and utilizes multiple channels including radio, television, sport and music events, websites, social media, mobile phones, and product placements in movies and TV shows – much of which are accessible to youth. Marketers of consumer products, including alcohol, are increasingly using digital and social media, where industry innovations in producing audience engagement and brand ambassadorship have moved more quickly than regulatory and self-regulatory efforts [11].

The primary purpose of a company's alcohol marketing is to increase the sales of their alcoholic beverages. More sales mean that more alcohol is being consumed, either by more people or in greater amounts among drinkers. Any increase in consumption also increases the risk of acute and/or chronic health and social problems at the population level, even if the majority of people drink at relatively "responsible" levels.[‡] The most cost-effective policies to reduce many of the harms related to alcohol consumption are population-based and involve regulatory controls by governments, including controls on alcohol marketing – the same has been proven for other risk factors such as tobacco and ultra-processed foods [2]. The objective of alcohol marketing regulation is to substantially reduce or eliminate the

[†] See definition of "marketing" in the glossary.

[‡] The World Health Organization has not defined a limit for "responsible" or "low risk" drinking, due in part to the fact that risk varies between individuals. Additionally, there is a wide variation between countries in how to define "low risk" drinking [112].

exposure to alcohol advertising, promotion, and sponsorships as a means to reduce harms from drinking, particularly by reducing early initiation among young people and promotion of drinking to groups in conditions of vulnerability. The global nature of alcohol marketing, and the ease with which it transcends national borders, necessitates regional and global as well as national responses.

There are multiple segments of the population that are particularly vulnerable to alcohol-related harm, including young people aged 15-24 years, for whom it is the leading cause of death and disability [12] and whose brains are still in a developmental period [13]; persons with a family history of alcohol dependence; indigenous people; migrants; lesbian, gay, bisexual, and transgender individuals; pregnant women or women considering pregnancy; and persons who are impulsive, sensation-seeking, or prone to conduct disorders [14, 15, 16, 17, 18, 19, 20, 21, 22]. Women in general bear a disproportionate share of the negative consequences for the same level of alcohol consumption as compared to men because of biological differences, though they continue to drink less than men across the Americas [23]. Some of these groups may be the object of direct marketing strategies to promote drinking and acceptance of drinking as part of the social norm, though a lack of transparency by the alcohol industry regarding its marketing strategies limits research on which groups are being targeted and in which ways.

The purpose of this note is to enhance country efforts to reduce the harmful use of alcohol by providing technical support on one potential element of a comprehensive approach to tackling this problem: the regulation of alcohol marketing. This document provides evidence for arguments supporting alcohol marketing regulation, and suggests key elements that can be considered by countries in planning, developing, implementing, and evaluating effective regulation. It also provides legislative language that can assist governments interested in developing or modifying existing laws and implementing monitoring mechanisms. This document complements a Pan American Health Organization (PAHO) report from an exploratory meeting on alcohol marketing regulation held in January 2015 [24] and was produced by PAHO technical staff and reviewed by a variety of collaborators (see Annex 1) at a meeting held in July 2016.

The overall alcohol situation in the Region

Alcohol consumption in the Region of the Americas is higher on average than in most parts of the world [6, 25]. In particular, rates of heavy episodic drinking (HED) have risen in the past five years, from 4.6% to 13% among women and from 17.9% to 29.4% among men. Alcohol caused 4.7% of all deaths and 6.7% of years of life lost to death or disability in the Region in 2012 [25].

The harmful use of alcohol is increasing among young people and women around the world, including in the Region of the Americas [26]. The majority of school students aged 13 to 15 years from 30 countries in the Region reported drinking alcohol before age 14, according to the Global School Health Surveys [25]. Estimates from the World Health

Organization (WHO) indicate a high prevalence of heavy episodic drinking among 15-19 year-olds in the Region (29.3% for adolescent boys and 7.1% for adolescent girls), higher than the global average and all other WHO regions except Europe. Research has also found that the earlier young people start drinking, the more likely they are to experience alcohol-related harm [6].

According to the Institute of Health Metrics and Evaluation (IHME), alcohol is the leading risk factor for death and disability among people aged 15-49 years in the Americas and worldwide [12]. Estimates from WHO also indicate that the prevalence of alcohol use disorders among women in the Americas is the highest in the world [6, 25].

Given that the harmful use of alcohol is causally linked to negative health outcomes, and that there is a lack of any associated benefit among young persons and several groups in conditions of vulnerability, the promotion of alcohol consumption to these populations in particular needs to be prevented. Many marketing techniques make it difficult – if not impossible – to market to the general public without also exposing these groups to marketing. In these cases, stronger restrictions on marketing in general are the only feasible way to prevent this exposure.

Alcohol marketing in the Americas

Alcohol marketing is widespread in the Americas, appearing in many countries on roadsides, bus stops, walls, billboards, and even floors, as well as in malls, markets, and restaurants. For many consumer products, marketing practices that go beyond traditional print and electronic media advertisements are now the norm, and include branded merchandise, sponsorships of sporting teams and events, sales promotions and discount pricing, and social media. The alcohol industry's marketing of itself – reaching out to policy makers at all levels of government, funding research, and providing campaign contributions – can also create conflicts of interest [27, 28]. Corporate social responsibility activities are another arena where the alcohol industry can market itself, and the public health value of these activities has been questioned not only in regards to alcohol but also to tobacco and other harmful products [29, 30, 31, 32].

As of 2012, nearly 40% of countries in the Americas had no restrictions on alcohol marketing, according to data collected by WHO, and no country in the Region has a full comprehensive ban on all forms of marketing in all media. Only six countries reported having any statutory restrictions on the content of alcohol advertisements and less than half reported having penalties for infringements [25]. While evidence on the impact of those partial alcohol marketing restrictions is limited, the experience from tobacco marketing restrictions shows that partial bans are not effective in preventing product promotion, especially among young people [33]. Self-regulatory codes on specific marketing activities, which according to systematic reviews have proven ineffective in preventing youth exposure [34], are available in seven countries [25].

The evidence on effects of alcohol marketing and cost-effectiveness of regulation

There is now substantial evidence that alcohol marketing is associated with young people's drinking behavior, according to a recent systematic review of longitudinal studies on the association between alcohol marketing and youth consumption [35].

Twenty-one longitudinal studies that followed young people's exposure to alcohol marketing and drinking behavior over time all found that the more youth are exposed to alcohol marketing, the more likely they are to start drinking earlier, and to drink more if they are already drinking [36, 37, 38]. Other studies using different methods and selection criteria have reached mixed conclusions on the effects of alcohol marketing on drinking behavior [39, 40, 41]. However, there is widespread agreement, even reflected in alcohol industry marketing codes, that young people should be protected from exposure to and the effects of alcohol marketing [42, 43]. A common approach worldwide is the use of self-regulation programs developed by the alcohol industry or advertising organizations. However, recent reviews of research on the effectiveness of these self-regulation programs in more than 100 studies from a range of countries have concluded that voluntary (that is, not legally enforceable) efforts at controlling exposure, content, and compliance with restrictions on alcohol marketing have been ineffective in protecting young people and other groups in conditions of vulnerability [34, 44]. These themes are not unique to alcohol; the ability of marketing to encourage or discourage certain health-related behaviors has also been studied in the context of other risk factors such as tobacco and ultra-processed foods [45, 46, 47, 48].

Below is a non-exhaustive summary of results of recent studies related to the effects of alcohol marketing:

- Youth are 5 times more likely to drink alcohol brands that advertise on national television [49];
- Youth are 36% more likely to use brands that advertise in national magazines [49];
- Each additional alcohol ad seen by youth in a media market increases the number of drinks consumed in the past 4 weeks by 1% [50];
- Each additional dollar spent per capita in a media market increases the number of drinks consumed by youth by 3% [50];
- Exposure of 6th to 8th grade students (age range, 11-17 years) to alcohol ads predicted alcohol initiation 9 months later [51];
- Exposure to alcohol ads or liking alcohol ads in 7th grade (average age 12.5 years) predicted binge drinking, drinking to get drunk, neglecting responsibilities, and getting into fights in 10th grade [52];
- Youth exposed to ads containing a “party” theme were 19 times more likely to initiate drinking and ~4 times more likely to initiate binge drinking [53, 54];
- Alcohol marketing receptivity predicts the onset of drinking, binge drinking, and hazardous drinking among youth [55, 56, 57];

- Adolescents most familiar with alcohol marketing were 2 times more likely to be drinkers and have been drunk [51];
- Being able to name a favorite alcohol brand mediated the relationship between brand exposure in movies and binge drinking [58];
- There is a strong association between youth exposure to specific brands and their consumption of those brands [59];
- Longitudinal studies and systematic reviews conclude that alcohol advertising exposure is associated with a higher risk of earlier initiation of drinking and with increased drinking among youth drinkers [35, 37, 38, 60, 61, 62].

In 2004 WHO published an analysis of the cost-effectiveness of implementing advertising bans and other interventions, using a method known as CHOICE (Choosing Interventions that are Cost Effective) [63]. At the time of the analysis, the evidence available from econometric studies suggested only a modest impact from banning alcohol advertising, given the continuing presence of other alcohol marketing strategies such as product placement and event sponsorship. In their study, the authors modeled a 2-4% reduction in the incidence of hazardous alcohol use. Implementing advertising bans has a low cost of implementation (estimated between \$0.05-0.50 per capita in international dollars), mostly related to legislative activities, administration, and enforcement of laws once passed. The study showed that advertising bans are very cost-effective, even when only modest reductions in hazardous alcohol use are expected, and have an incremental benefit when coupled with taxation and restricting outlet density.

Based on these findings, restricting or banning alcohol advertising and promotions were included as very cost-effective policy options to reduce the harmful use of alcohol within the framework of preventing noncommunicable diseases [64, 65]. Other alcohol marketing strategies such as product placement or event sponsorship were not considered in the CHOICE analysis, but in the case of tobacco, a comprehensive ban on tobacco advertising, promotion, and sponsorship was found to be one of the most cost-effective interventions [66].

The WHO global strategy and regional plan for alcohol

In 2010, the World Health Assembly adopted the Global Strategy to Reduce the Harmful Use of Alcohol (WHA 63.13). Among the guiding principles of the Global Strategy, three are particularly relevant to alcohol marketing control. One is that “the protection of the health of the population by preventing and reducing the harmful use of alcohol is a public health priority;” another is the “protection of populations at high risk of alcohol-attributable harm;” and the third is that “children, teenagers, and adults who choose not to drink alcohol beverages have the right to be supported in their non-drinking behavior and protected from pressures to drink.” [67]

The WHO Global Strategy has 10 areas for policy action, including one on marketing of alcoholic beverages (area 6). For this area, policy options and interventions include:

- “(a) Setting regulatory or co-regulatory frameworks, preferably with a legislative basis, and supported when appropriate by self-regulatory measures, for alcohol marketing by:
- (i) Regulating the content and the volume of marketing;
 - (ii) Regulating direct or indirect marketing in certain or all media;
 - (iii) Regulating sponsorship activities that promote alcoholic beverages;
 - (iv) Restricting or banning promotions in connection with activities targeting young people;
 - (v) Regulating new forms of alcohol marketing techniques, for instance social media;
- (b) Development by public agencies or independent bodies of effective systems of surveillance of marketing of alcohol beverages;
- (c) Setting up effective administrative and deterrence systems for infringements on marketing restrictions [67].”

Many governments have attempted to protect young people in particular from inappropriate exposure to alcohol marketing through regulations ranging from total marketing bans to voluntary self-regulation using industry codes of practice. However, several studies indicate that current self-regulatory systems governing alcohol marketing practices are not meeting their intended goal of protecting groups in conditions of vulnerability, and could be improved if governments take on a greater role in their enforcement [36, 68, 69, 70, 71].

In 2011, PAHO’s Directing Council adopted a regional plan to help guide technical cooperation with its Member States. The resolution states that it will “implement the WHO Global Strategy to Reduce the Harmful Use of Alcohol through the Plan of Action, within the context of each country’s specific conditions, in order to respond appropriately to current and future needs in relation to underage and harmful use of alcohol” and requests the Director to “support Member States in the implementation of national and subnational plans and/or interventions to reduce the harmful use of alcohol, within the framework of their public health and social policies, taking into account the WHO Global Strategy to Reduce the Harmful Use of Alcohol.”

Under Objective 3 (to increase technical support to Member States), the plan dictated as a regional activity that PAHO “cooperate technically with countries on the development of policies, plans, and programs aimed at reducing the harmful consumption of alcohol, using evidence-based information.”

It further recommends the following national activities in relation to marketing of alcoholic beverages:

- “(a) Designate a government agency to be responsible for enforcement of marketing regulations.
- (b) Encourage statutory regulation to restrict or ban, as appropriate, the marketing of alcoholic beverages, particularly to youth and vulnerable groups.

- (c) Encourage greater responsibility among commercial interests, for example through transparent codes of conduct for the sale of alcoholic beverages and marketing practices.
- (d) Where such codes exist, establish government monitoring of industry compliance with codes of conduct [72].”

After the adoption of the regional plan, a network of focal points from ministries of health—the Pan American Network on Alcohol and Public Health (PANNAPH)—was created. Two face-to-face meetings of the network were organized, the first in Mexico City, Mexico, in 2012 (in which 30 countries were represented), and the second in Cartagena, Colombia, in 2014 (with 26 countries represented). In both meetings, recommendations were developed for priority action. One of the recommendations was that “PAHO assist in the development of a universal code of principles for the regulation of marketing of alcohol that is public health-oriented and that can be used by governments, regardless of self-regulatory codes” [73].

Human rights and health related law

It is important, as PAHO Member States have agreed, for regulatory frameworks, policies, and plans, to take into account, within the context of each country’s specific conditions, the existing international and regional human rights norms and standards [74, 75].

Alcohol marketing regulation is aligned with international and regional human rights conventions and treaties, as well as resolutions of PAHO’s Directing Council (*Health and Human Rights and Strategy on Health Related Law*) [74, 75]. The degree to which alcohol marketing affects young people and overtly seeks to increase drinking among women, the frequent objectification of women found in the content of alcohol marketing, and the threat that the harmful use of alcohol poses to young people’s and women’s health and well-being may negatively impact the enjoyment of human rights, and governments have an obligation to protect these rights.

The harmful use of alcohol has an impact on the right to the enjoyment of the highest attainable standard of physical and mental health, described in Article 12 of the International Covenant on Economic, Social, and Cultural Rights, and can have an impact on other related human rights such as the right to life, the right to personal integrity, the right to equal protection under the law, the protection of the “best interest of the child,” and the right to receive accurate information on health issues as part of freedom of expression, among others [76, 77, 78].

Various technical documents and resolutions of the World Health Assembly, the Pan American Sanitary Conference, and the PAHO Directing Council have requested Member States to “advocate,” “promote,” “protect,” and “safeguard” the human rights of members of certain groups in positions of vulnerability, especially in the context of services provided by their health agencies. Member States have been urged to formulate and adopt policies,

plans, and legislation in health to promote the well-being of certain groups in a situation of vulnerability, pursuant to the human rights instruments of the United Nations and Inter-American systems to which they are a Party.[§] Annex 2 provides a more detailed description of how a human rights strategy can be used for alcohol marketing regulation.

In line with the above, PAHO Member States have committed themselves to promote the formulation, implementation, or review of their legal and regulatory frameworks, policies, and other legal provisions, as appropriate, taking into account their national contexts, priorities, and financial and budgetary capacities. These activities require a multisectoral approach to addressing health determinants and the reduction of risk factors, among other actions, through participatory processes with communities [75].

Strengthening regulatory capacity: REGULA initiative

As a result of the commitment of PAHO Member States to prevent and control noncommunicable diseases, tackling the most relevant risk factors (namely, tobacco, alcohol, unhealthy diets, and physical inactivity) became a priority for technical cooperation in the Americas. Among the 15 highly cost-effective interventions identified in the regional Plan of Action for reducing the exposure to such risks, 10 require statutory measures in regulatory control. In common among three of the risk factors – namely alcohol, tobacco, and unhealthy diets – are taxation policies, advertising bans, and limiting access, particularly to children and adolescents [65].

In November 2014, PAHO launched a new initiative, called REGULA, aimed at strengthening the institutional capacity of Member States' health authority to regulate these risk factors. As a result, a technical reference document was developed, in which regulatory capacity was identified as an essential public health function along with surveillance, health promotion, and social participation [79]. Additionally, several activities were undertaken including the systematization and legal analysis of the existing laws related to taxation, availability, and marketing of tobacco, alcohol, ultra-processed foods, and sugary beverages in 19 countries of Latin America. In two countries, Chile and Honduras, an in-depth analysis of the institutional capacity to regulate these products was also carried out.

Preliminary findings from the legal analysis of the laws and some institutions involved in regulatory control in the Region indicate a wide diversity of national approaches and the predominance of little or no effective regulation of alcohol marketing (the same was found for other policy areas as well). While results are not yet available, the interest in the

[§] Technical document CD50/12 refers to several Inter-American and universal human rights treaties, conventions and protocols that protect the right to health and other related human rights and can be used to review/reform/formulate national laws and regulations. Some of these instruments are the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination against Women; the International Covenant on Economic, Social, and Cultural Rights; the Convention on the Rights of the Child; the Convention on the Rights of Persons with Disabilities; the American Convention on Human Rights and its Additional Protocol in the Area of Economic, Social and Cultural Rights.

REGULA initiative by several countries, as well as the gaps in legislation already identified, indicate that countries in the Region would benefit from information on more effectively regulating the advertising, promotion, and sponsorship of alcoholic beverages.

Related work on marketing regulation of other consumer products

PAHO/WHO has done extensive work towards regulatory control of marketing of tobacco, breast-milk substitutes, ultra-processed foods, and sugary beverages, and there are lessons to be learned from these efforts in regards to alcohol marketing control.

Article 13 of the Framework Convention on Tobacco Control (FCTC) states that “Each Party shall, in accordance with its constitution or constitutional principles, undertake a comprehensive ban on all tobacco advertising, promotion, and sponsorship (TAPS) within the period of five years after entry into force of this Convention of the Party.” It also specifically recognizes the need to “facilitate the elimination of cross-border advertising.” [45]

A WHO guideline for implementing FCTC Article 13 reaffirms the concept that a ban on TAPS can only be effective if it is total. If only a partial ban is implemented, the industry “inevitably shifts its expenditures to other advertising, promotion, and sponsorship strategies, using creative, indirect ways to promote tobacco products and tobacco use, especially among young people” and that “Therefore, the effect of a partial advertising ban on tobacco consumption is limited” [33].

Similar logic can be applied to alcohol marketing restrictions: only a comprehensive ban on all alcohol advertising, promotion, and sponsorship would be sufficient to achieve a significant reduction or elimination of exposure to alcohol marketing.

Of additional relevance to alcohol marketing control, PAHO organized an expert meeting in 2011 on the marketing of foods and non-alcoholic beverages to children. The scope of the meeting was to develop recommendations for Member States on designing new and/or strengthening existing statutory regulations on the marketing of these products to youth and other groups in conditions of vulnerability. The report provides background on the extent, nature, and effects of food marketing to children; explores the effectiveness of various policies; and offers recommendations on policy, process, and procedure, and on how to define “marketing food to children [47].” In 2014, these recommendations were approved by PAHO’s Directing Council as part of the regional Plan of Action for the Prevention of Obesity in Children and Adolescents [80].

Recent work on alcohol marketing regulation

In line with the above, PAHO organized an exploratory meeting on 12-13 January 2015 with international researchers to discuss the situation in the Americas and globally and consider possibilities for moving forward in assisting Member States. Because of the global nature of alcohol marketing, participants from several regions of the world came together. The objectives of the meeting were to summarize the research on the effects of alcohol marketing on young people; review existing statutory and self-regulatory codes on marketing and examine their effectiveness; consider the implications of international trade agreements and other treaties on alcohol marketing regulation; describe the experience of countries where new legislation has been recently enacted or proposed; and discuss lessons learned from existing codes and other products. The participants reached consensus on nine key messages concerning planning, developing, implementing, and evaluating effective alcohol marketing regulation. The results of this meeting informed the eventual development of this technical note. The results of the 2015 meeting are available in the document titled PAHO Meeting on Alcohol Marketing Regulation: Final Report [24]. See Box 1 for the key concepts that were discussed during the meeting.

In July 2016, PAHO held another meeting with participants from some of its Member States as well as research institutes to discuss the scientific evidence on the effects of alcohol marketing and the impact of self-regulatory codes, review current existing statutory regulations of alcohol marketing from the Americas, and consider the use of human rights instruments and the strengthening of legal and regulatory frameworks for alcohol marketing control. A draft version of this technical note was also reviewed by participants (see Annex 1 for the final list of contributors).

Box 1. Key concepts from 2015 PAHO Meeting on Alcohol Marketing Regulation [24]

- (a) Governments should protect groups in conditions of vulnerability from exposure to alcohol marketing, particularly children and adolescents.
- (b) Governments should prioritize the passage of a comprehensive ban on alcohol marketing.
- (c) Governments should put into force legal statutory requirements to enhance their regulatory capacity, accompanied by well-resourced mechanisms for enforcement and adjudication, including the ability to levy meaningful sanctions for violations.
- (d) Given the conflicts of interest between public health goals and the alcohol industry's commercial interests, governments should develop marketing regulations that are independent of the industry.
- (e) Governments should ensure that all health messages about the use of alcohol are developed by a body independent of the alcohol industry, and should be evidence-informed, scientifically evaluated, and free of ambiguous expressions such as "responsible drinking."
- (f) Governments should require and regularly collect information from the alcohol industry about its marketing activities, including expenditures and areas of activity. This information should be made publicly available.
- (g) Governments should ensure that global trade agreements do not compromise the ability of national governments to regulate and restrict the marketing of alcoholic beverages.
- (h) When developing legislation on alcohol marketing controls, governments should consider global, regional, and national lessons from existing marketing regulations on tobacco, breast-milk substitutes, ultra-processed food, and nonalcoholic sugary beverages because of the similarities in purpose (commercial interest), scope, and pervasiveness.
- (i) PAHO/WHO should develop evidence-informed guidelines and principles for alcohol marketing regulation to assist countries in the development of appropriate legislation and other mechanisms to implement and monitor regulatory controls on alcohol marketing.

Summary

All people should live in an environment in which accurate information about the health and safety consequences of alcohol use is not undermined by alcohol marketing. As indicated in the developments reviewed above, PAHO/WHO Member States have made several commitments relevant to alcohol marketing through the adoption of strategies, plans, and resolutions at regional and global levels. These commitments are mutually reinforcing in terms of the role of governments in promoting and protecting health as a human right, using laws and regulations as instruments for public health, and regulating products which harm health – including their marketing, promotion, and sponsorship. To continue the progress that has been made, the remainder of this technical note describes a set of principles and regulatory elements, based on approved regulations and experience with other risk factors or in one or more countries, which can be used by Member States to develop a comprehensive plan for the regulation of alcohol marketing in accordance with the guidance and evidence included in this technical note.

Principles for regulatory control

The following principles can be used by those looking to adopt statutory measures to protect present and future generations from the devastating health, social, environmental, and economic consequences of the harmful use of alcohol, including the exposure to alcohol marketing.

- (a) A comprehensive legally-binding ban on all alcohol marketing is the only means to eliminate the risk of any exposure to alcohol marketing for those most in need of protection, such as youth and other groups in conditions of vulnerability. Partial bans are more limited in scope given that the industry can shift to more indirect, unregulated, or new forms of marketing.
- (b) From a public health standpoint, there is no rationale for applying different regulations to alcoholic beverages of varying alcohol content by volume or type of beverage. Alcohol marketing regulation should include all alcoholic beverages regardless of their strength.
- (c) Regulatory capacity to develop, implement, enforce, and monitor restrictions on alcohol marketing is an essential public health function and therefore should be addressed in legislative measures and allocation of resources to monitor the implementation of these restrictions.
- (d) Cross-border alcohol marketing can undermine governments' efforts to protect their populations from exposure to alcohol marketing if not subjected to the same regulatory measures as those applied to marketing originating from within a State.
- (e) Civil society not affiliated with the alcohol industry can participate in developing, supporting, and monitoring effective measures for regulating alcohol marketing, if given a clear mandate and resources for doing so.
- (f) The alcohol industry has commercial and other vested interests, which, in accordance with national laws, can be used to disqualify its participation in setting countries' public health policies with respect to alcohol marketing.
- (g) Multilateral and bilateral international agreements can protect national public health interests. In some cases, there are provisions already included that can be used to protect national or subnational regulations in the context of public health and safety. In other cases, explicit provisions can be made.

Regulatory elements for consideration as part of a comprehensive ban

Below is a list of regulatory elements that can be considered by countries for incorporation into their respective legal frameworks to implement and monitor regulatory controls for alcohol marketing for the protection of public health.

Legal and regulatory strengthening, implementation, enforcement, and reporting

- (a) Revise the country's laws and regulations to include a total and comprehensive ban to eliminate exposure to alcohol marketing, including advertising, promotion, and sponsorship, in accordance with country constitutions or constitutional principles, with the vision to address the harmful use of alcohol.
- (b) Designate a public agency or independent body that is free from conflict of interest to implement, monitor, enforce, and report on compliance with the law. Ensure the body has the requisite authorities and resources to carry out these functions.
- (c) Incorporate a process for monitoring compliance with the law and for the timely adjudication and enforcement of all violations. Impose penalties sufficient to deter non-compliance. Consider applying a portion of penalties to strengthen enforcement efforts or otherwise promote the achievement of the law's objectives. Consider the sectors that should be responsible for compliance and to which these penalties should be applied: alcohol industry, advertising agencies, media and communication companies, etc.
- (d) Regularly evaluate and report on (i) compliance and enforcement and (ii) the effectiveness of the law in achieving its public health objectives.
- (e) Promote independent monitoring by civil society, academia, and others at the national or subnational levels, by establishing a system for receiving complaints. Consider awarding a portion of penalties to the complainant organization.

Cross-border advertising and promotion

- (f) Include both inbound and outbound advertising and promotion within the comprehensive legally binding ban.
- (g) Cooperate in the development of technologies and other means necessary to monitor and facilitate the control of cross-border alcohol marketing.
- (h) Elaborate regional, multilateral or bilateral agreements establishing a comprehensive ban on such marketing.

Non-exhaustive list of techniques

- (i) Provide an indicative (non-exhaustive) list of alcohol marketing techniques that a comprehensive ban should encompass, but avoid providing lists of prohibited activities that are, or could be understood to be, exhaustive. While it can be useful to provide examples of prohibited activities, when legislation does so it should make clear that they are only examples, using terms like “including but not limited to” and “or any other form of alcohol marketing.”
 - (i) Communication through audio, visual, or audiovisual means: print (including newspapers, magazines, pamphlets, leaflets, flyers, letters, billboards, posters, signs), television and radio (including terrestrial, satellite, and streaming), films, DVDs, songs, videos and CDs, games (computer games, video games, or online games), other digital communication platforms (including the Internet and mobile phones) and theater or other live performance;
 - (ii) Brand-marking, including in entertainment venues and retail outlets and on vehicles, equipment, or clothing (e.g. by use of brand colors or schemes of colors, logos, or trademarks);
 - (iii) Point-of-purchase advertising displays, and other in-store marketing tools;
 - (iv) Product placement (i.e. the inclusion of, or reference to, an alcohol product, service, or trademark in the context of communication (see above), in return for payment or other consideration);
 - (v) Provision of gifts or discounted products with the purchase of alcoholic beverages (e.g. key rings, t-shirts, baseball hats, etc.);
 - (vi) Supply of free samples of alcoholic beverages, including in conjunction with marketing surveys and taste testing;
 - (vii) Incentive promotions or loyalty schemes (e.g. redeemable coupons provided with the purchase of alcoholic beverages or with other products promoting the purchase of alcoholic beverages);
 - (viii) Competitions associated with alcoholic beverage products or services or brand names, whether requiring purchase of such a product or service or not;
 - (ix) Direct targeting of individuals with promotional (including informational) material, such as direct mail, telemarketing, “consumer surveys,” or “research”;
 - (x) Promotion of discounted products or services (such as happy hours, ladies’ nights, all-you-can-drink specials, bulk discounting, etc.);
 - (xi) Sale or supply of toys or sweets that resemble alcoholic beverages or related products (such as trucks, branded animals, etc.);
 - (xii) Payments or other contributions to retailers to encourage or induce them to sell alcoholic beverages or to do so exclusively or prominently, including retailer incentive programs (e.g. rewards to retailers for achieving certain sales volumes), or to promote alcoholic beverages through awnings, sunshades, umbrellas, and the like;

- (xiii) Sales, supply, placement, or display of products at educational or health establishments;
- (xiv) Cross-promotions, including character licensing and co-branding;
- (xv) Celebrity endorsements (teams and individuals);
- (xvi) Indirect marketing, including branding of non-alcoholic products and promotional materials to extend alcoholic brand reach;
- (xvii) Provision of financial or other support to events, activities, individuals, or groups (such as sporting or arts events, individual sportspeople or teams, individual artists or artistic groups, welfare organizations, politicians, political candidates, or political parties), whether or not in exchange for publicity, including corporate social responsibility activities;
- (xviii) Industry-initiated or encouraged word-of-mouth and viral marketing strategies, and Internet, mobile, or other digitally-based strategies to encourage brand loyalty or consumption;
- (xix) Other communications or actions that aim at promotion or actions that have or are likely to have a promotional effect, including corporate social responsibility programs, social aspects organizations, designated driver campaigns with the support of the alcohol industry, educational programs to children and youth sponsored by the alcohol industry, educational campaigns on responsible drinking sponsored by the alcohol industry.

Regulatory elements for consideration for countries not in a position to implement a comprehensive ban

There are a number of reasons why countries may not be in a position to implement a comprehensive ban: in certain cases, the constitution may not allow it; in others, a lack of political will may be a temporary barrier to implementing more stringent regulations. In those cases, the following regulatory elements can be considered as they apply in the country's current context.

- (a) Begin with a comprehensive ban, and then provide minimal exceptions to that ban, to the extent required by national law.^{***††}
- (b) Include in the law a comprehensive ban giving a transitional time frame (medium or long term, or progressive).^{‡‡}
- (c) Consider the following intermediate measures, as appropriate given constitutional constraints:
 - (i) Assessing the human and other costs of delaying or not implementing a comprehensive ban;
 - (ii) Requiring and prescribing a process for the timely disclosure to relevant governmental authorities of expenditures by the alcohol industry on alcohol marketing, which, subject to national law, would be made available to the public;
 - (iii) Requiring and prescribing a process for the timely submission of all marketing materials, such as radio, TV, print, and billboard ads, and social media campaigns, to the State, to be placed in a depository to facilitate public health surveillance and enforcement, including after-the-fact assessment of compliance with existing restrictions and penalties as appropriate;
 - (iv) Requiring that health or other appropriate warnings or messages, prescribed by an appropriate government public health authority and updated as needed on an annual basis, accompany all alcohol advertising and, as appropriate, other forms of alcohol marketing, be of a size or length that is commensurate with that of the rest of the advertising, and incorporate messages developed by a body free of conflict of interest, with language that is clear and simple, research-based, scientifically evaluated, factual in nature, and without ambiguous concepts such as “responsible drinking;”
 - (v) Mandating counter-advertising, possibly funded by a levy on alcohol sales, designed and tested by an appropriate government or other public health

^{**} A Member State with strong constitutional protections for speech and expression may consider narrow exceptions regarding factual information such as the name, price, and origin of the beverage.

^{††} See the 1991 version of France's Loi Evin as an example. The document *PAHO Meeting on Alcohol Marketing Regulation: Final Report* (2016) provides some detail on this law [24].

^{‡‡} Legally referred to as *vacatio legis*.

- authority, proportional to the amount of product advertising, and updated as needed on an annual basis;
- (vi) Developing and disseminating public health messages to the population regarding the harmful use of alcohol, and possibly funded by a levy on alcohol sales;
 - (vii) Banning all forms of alcohol marketing and sponsorship that promote an alcohol product or service by any means that are false, misleading, deceptive, or likely to create an erroneous impression about its characteristics, health effects, or hazards;
 - (viii) Banning all forms of alcohol marketing and sponsorship that promote an alcohol product or service by any means that is connected with activities that reach or are likely to reach young people or other groups in conditions of vulnerability, such as sports events; musical events; cultural events; endorsements by public figures such as artists, athletes, and other people who are commonly recognized by young people and other groups in conditions of vulnerability.
- (d) Consider the magnitude of marketing practices and media, to ensure as broad a range of partial restrictions as possible. These measures may include:
- (i) Content-specific restrictions (e.g. prohibiting marketing that targets minors; associates alcohol with activities requiring a high degree of alertness; makes health claims; associates alcohol with athletic, social, or sexual success; or, on the contrary, allowing descriptions only of product quality);
 - (ii) Time-specific restrictions (e.g. no alcohol marketing between certain hours when youth are most likely to be exposed);
 - (iii) Audience-specific restrictions (e.g. permitting marketing only in media where youth are not the primary audience);
 - (iv) Beverage-specific restrictions (e.g. beer, wine, spirits, “alcopops”);
 - (v) Medium- or channel-specific restrictions (e.g. prohibiting marketing in media such as national television, private or commercial television, national radio, private or commercial radio, points of sale, cinemas, billboards, internet, newspapers, magazines, etc.);
 - (vi) Restricting advertising in “new media” (e.g. stricter “age verification” procedures for people to access alcohol industry content online);
 - (vii) Location-specific restrictions (e.g. prohibiting marketing in places where young people are likely to gather such as schools, playgrounds, or churches; residential neighborhoods; public property; or, on the contrary, allowing marketing only in the interior of outlets);
 - (viii) Event-specific restrictions (e.g. prohibiting marketing for sporting events, cultural events, rock concerts, college/university events).

References

- [1] D. Lachenmeier, B. Sarsh and J. Rehm, "The composition of alcohol products from markets in Lithuania and Hungary, and potential health consequences: a pilot study," *Alcohol and Alcoholism*, vol. 44, no. 1, pp. 93-102, 2009.
- [2] WHO, "Global status report on noncommunicable diseases 2010," World Health Organization, Geneva, 2011.
- [3] WHO, "WHO expert committee on problems related to alcohol consumption: Second report," World Health Organization, Geneva, 2007.
- [4] T. Stockwell, J. Zhao, S. Panwar, A. Roemer, T. Naimi and T. Chikritzhs, "Do "moderate" drinkers have reduced mortality risk? A systematic review and meta-analysis of alcohol consumption and all-cause mortality," *Journal of Studies on Alcohol and Drugs*, vol. 77, no. 2, pp. 185-98, 2016.
- [5] IARC, "World cancer report," International Agency for Research on Cancer, Lyon, 2014.
- [6] WHO, "Global status report on alcohol and health 2014," World Health Organization, Geneva, 2014.
- [7] J. Sacks, K. Gonzales, E. Boucher and et al., "2010 national and state costs of excessive alcohol consumption," *American Journal of Preventive Medicine*, vol. 49, no. 5, pp. e73-e79, 2015.
- [8] AdAge, "Global marketers 2011," in *Advertising Age*, New York, Advertising Age, 2012.
- [9] CAMY, "State laws to reduce the impact of alcohol marketing on youth: Current status and model policies," Center on Alcohol Marketing and Youth, Baltimore, MD, 2012.
- [10] "Self-regulation in the alcohol industry: Report of the federal trade commission," United States Federal Trade Commission, 2014.
- [11] D. Jernigan and A. Rushman, "Measuring youth exposure to alcohol marketing on social networking sites: Challenges and prospects," *Journal of Public Health Policy*, vol. 35, no. 1, pp. 91-104, 2014.
- [12] IHME, "Global burden of disease study," Institute of Health Metrics and Evaluation, Seattle, 2013.
- [13] S. Hiller-Sturmhofel and H. S. Swartzwelder, "Alcohol's effects on the adolescent brain," *Alcohol Research & Health*, vol. 28, no. 4, pp. 213-21, 2004/2005.
- [14] M. Brucks, G. M. Armstrong and M. E. Goldberg, "Children's use of cognitive defenses against television advertising: A cognitive response approach," *Journal of Consumer Research*, vol. 14, no. 4, p. 471-82, 1988.
- [15] "Alcohol problems: A growing threat to health," *WHO Chronicle*, vol. 36, no. 6, p. 222-5, 1982.
- [16] M. D. Slater, D. Rouner, F. Beauvais, K. Murphy, M. Domenech-Rodriguez and J. Van Leuven, "Adolescent perceptions of underage drinkers in TV beer ads," *Journal of Alcohol and Drug Education*, vol. 42, no. 1, pp. 43-55, 1996.

- [17] R. Magri, J. Hutson, H. Miguez, H. Suarez, A. Menendez and V. Parodi, "Advances in the determination of alcohol and other drug consumption during pregnancy: A study of 900 births in Montevideo, Uruguay," *Contemporary Drug Problems*, vol. 34, no. 3, pp. 445-76, 2007.
- [18] L. H. de Souza, M. C. dos Santos and L. C. de Olivera, "Padrão do consumo de álcool em gestantes atendidas em um hospital público universitário e fatores de risco associados," *Revista Brasileira de Ginecologia e Obstetrícia*, vol. 34, no. 7, pp. 296-303, 2012.
- [19] K. J. Sher, E. R. Grekin and N. A. Williams, "The development of alcohol use disorders," *Annual Review of Clinical Psychology*, vol. 1, pp. 493-523, 2005.
- [20] M. B. Sobell and L. C. Sobell, *Problem drinkers: Guided self-change treatment*, New York: Guilford Press, 1993.
- [21] J. E. Cassisi, M. Delehant, J. S. Tsoutsouris and J. Levin, "Psychophysiological reactivity to alcohol advertising in light and moderate social drinkers," *Addictive Behaviors*, vol. 23, no. 2, pp. 267-74, 1998.
- [22] S. F. Tapert, E. H. Cheung, G. G. Brown, L. R. Frank, M. P. Paulus and A. D. Schweinsburg, "Neural response to alcohol stimuli in adolescents with alcohol use disorder," *Archives of General Psychiatry*, vol. 60, no. 7, pp. 727-35, 2003.
- [23] PAHO, "Infographic: Health impacts of women's alcohol consumption," 11 July 2016. [Online]. Available: <http://bit.ly/29uEYk>. [Accessed 3 August 2016].
- [24] PAHO, "PAHO meeting on alcohol marketing regulation: Final report," Pan American Health Organization, Washington, DC, 2016.
- [25] PAHO, "Regional status report on alcohol and health in the Americas," Pan American Health Organization, Washington, DC, 2015.
- [26] K. D. Shield, M. Monteiro, M. Roerecke, B. Smith and J. Rehm, "Alcohol consumption and burden of disease in the Americas in 2012: Implications for alcohol policy," *Pan American Journal of Public Health*, vol. 38, no. 6, pp. 442-9, 2015.
- [27] E. Savell, G. Fooks and A. Gilmore, "How does the alcohol industry attempt to influence marketing regulations? A systematic review," *Addiction*, vol. 111, no. 1, pp. 18-32, 2016.
- [28] A. Vendrame, "When evidence is not enough: A case study on alcohol marketing legislation in Brazil," *Addiction*, vol. 112, no. 1360-0443, pp. 81-85, 2017.
- [29] D. Pantani, R. Sparks, Z. Sanchez and I. Pinsky, "'Responsible drinking' programs and the alcohol industry in Brazil: Killing two birds with one stone?," *Social Science & Medicine*, vol. 75, no. 8, pp. 1387-91, 2012.
- [30] O. Belt, K. Stamatakos, A. Ayers and et al. , "Vested interests in addiction research and policy. Alcohol brand sponsorship of events, organizations and causes in the United States, 2010–2013," *Addiction*, vol. 109, no. 12, pp. 1977-85, 2014.
- [31] A. Biglan, "Corporate externalities: A challenge to the further success of prevention science," *Prevention Science*, vol. 12, no. 1, pp. 1-11, 2011.
- [32] T. Calvacante, M. Carvalho Ade and E. C. Rangel, "Social responsibility argument for the tobacco industry in Brazil," *Salud Pública de México*, vol. 48, no. Suppl 1, pp. S173-

- 82, 2006.
- [33] WHO, "Framework convention on tobacco control. Guidelines for the implementation of Art. 13," World Health Organization, Geneva, 2008.
 - [34] J. Noel, T. Babor and K. Robaina, "Industry self-regulation of alcohol marketing: A systematic review of content and exposure research," *Addiction*, vol. 112, no. 1360-0443, pp. 28-50, 2017.
 - [35] D. H. Jernigan, J. K. Noel, J. Landon, N. Thornton and T. Lobstein, "Alcohol marketing and youth alcohol consumption: A systematic review of longitudinal studies published since 2008," *Addiction*, vol. 112, no. 1360-0443, pp. 7-20, 2017.
 - [36] T. Lobstein, J. Landon, N. Thornton and D. Jernigan, "The association between alcohol marketing and youth alcohol consumption: A systematic review for Public Health England," UK Health Foundation, London, 2015.
 - [37] P. Anderson, A. De Bruijn, K. Angus, R. Gordon and G. Hastings, "Impact of alcohol advertising and media exposure on adolescent alcohol use: A systematic review of longitudinal studies," *Alcohol and Alcoholism*, vol. 44, no. 3, pp. 229-243, 2009.
 - [38] L. Smith and D. Foxcroft, "The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: Systematic review of prospective cohort studies," *BMC Public Health*, vol. 9, no. 51, 2009.
 - [39] N. Siegfried, D. Pienaar, J. Ataguba, J. Volmink, T. Kredon, M. Jere and C. Parry, "Restricting or banning alcohol advertising to reduce alcohol consumption in adults and adolescents," *Cochrane Database of Systematic Reviews*, vol. Nov 4, no. 11, 2014.
 - [40] J. Nelson, "What is learned from longitudinal studies of advertising and youth drinking and smoking? A critical assessment," *International Journal of Environmental Research and Public Health*, vol. 7, no. 3, 2010.
 - [41] G. Wilcox, E. Kang and L. Chilek, "Beer, wine, or spirits? Advertising's impact on four decades of category sales," *International Journal of Advertising*, vol. 34, no. 4, 2015.
 - [42] Beer Institute, "Advertising and marketing code," Beer Institute, Washington, DC, 2011.
 - [43] Distilled Spirits Council of the United States, "Code of responsible practices for beverage alcohol advertising and marketing," 2011.
 - [44] J. Noel, Z. Lazzarini, K. Robaina and T. Babor, "A brief history of alcohol marketing self-regulation codes," A brief history of alcohol marketing self-regulation codes, Farmington, CT, 2015.
 - [45] WHO, "Framework convention on tobacco control," World Health Organization, Geneva, 2003.
 - [46] National Cancer Institute, "The role of the media in promoting and reducing tobacco use. Tobacco Control Monograph No. 19 (NIH Pub. No. 07-6242)," U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, Bethesda, MD, 2008.
 - [47] PAHO, "Recommendations from a Pan American Health Organization expert consultation on the marketing of food and non-alcoholic beverages to children in the Americas," Pan American Health Organization, Washington, DC, 2011.

- [48] S. Tanski, M. Stoolmiller, M. Gerrard and J. Sargent, "Moderation of the association between media exposure and youth smoking onset: Race/ethnicity, and parent smoking," *Prevention Science*, vol. 13, no. 1, pp. 55-63, 2012.
- [49] M. Siegel, C. S. Ross, A. B. Albers, W. DeJong, C. King III, T. S. Naimi and D. H. Jernigan, "The relationship between exposure to brand-specific alcohol advertising and brand-specific consumption among underage drinkers - United States, 2011-2012," *American Journal of Drug and Alcohol Abuse: Encompassing All Addictive Disorder*, vol. 42, no. 1, pp. 4-14, 2016.
- [50] L. B. Snyder, F. Milici, M. Slater, H. Sun and Y. Strizhakova, "Effects of alcohol advertising exposure on drinking among youth," *Archives of Pediatrics & Adolescent Medicine*, vol. 160, no. 1, pp. 18-24, 2006.
- [51] M. Morgenstern, B. Isensee, J. Sargent and R. Hanewinkel, "Attitudes as mediators of the longitudinal association between alcohol advertising and youth drinking," *Archives of Pediatrics & Adolescent Medicine*, vol. 165, no. 7, pp. 610-6, 2011.
- [52] J. Grenard, C. Dent and A. Stacy, "Exposure to alcohol advertisements and teenage alcohol-related problems," *Pediatrics*, vol. 131, no. 2, pp. e369-79, 2013.
- [53] M. Morgenstern, Z. Li and et al., "The party effect: Prediction of future alcohol use based on exposure to specific alcohol advertising content," *Addiction*, vol. 112, no. 1, pp. 63-70, 2017.
- [54] M. Morgenstern, F. Schoeppe, J. Campbell and et al., "Content themes of alcohol advertising in U.S. television—Latent class analysis," *Alcoholism: Clinical and Experimental Research*, vol. 39, no. 9, pp. 1766-74, 2015.
- [55] M. Morgenstern, J. Sargent, H. Sweeting, F. Faggiano, F. Mathis and R. Hanewinkel, "Favourite alcohol advertisements and binge drinking among adolescents: A cross-cultural cohort study," *Addiction*, vol. 109, no. 12, pp. 2005-15, 2014.
- [56] B. Primack, A. McClure, Z. Li and J. Sargent, "Receptivity to and recall of alcohol brand appearances in U.S. popular music and alcohol-related behaviors," *Alcoholism: Clinical and Experimental Research*, vol. 38, no. 6, p. 1737-1744, 2014.
- [57] S. E. Tanski, A. C. McClure, Z. Li and et al, "Cued recall of alcohol advertising on television and underage drinking behavior," *JAMA Pediatrics*, vol. 169, pp. 264-71, 2015.
- [58] A. McClure, M. Stoolmiller, S. Tanski, R. Engels and J. Sargent, "Alcohol marketing receptivity, marketing-specific cognitions, and underage binge drinking," *Alcoholism: Clinical & Experimental Research*, vol. 37, no. s1, pp. e404-13, 2012.
- [59] C. Ross, E. Maple, M. Siegel and et al, "The relationship between brand-specific alcohol advertising on television and brand-specific consumption among underage youth," *Alcoholism: Clinical and Experimental Research*, vol. 38, no. 8, pp. 2234-42, 2014.
- [60] E.-Y. Lin, S. Caswell, R. Q. You and T. Huckle, "Engagement with alcohol marketing and early brand allegiance in relation to early years of drinking," *Addiction Research & Theory*, vol. 20, no. 4, pp. 329-38, 2012.
- [61] A. de Bruijn, R. Engels, P. Anderson, M. Bujalski, J. Gosselt, D. Schreckenber, J. Wohtge and R. de Leeuw, "Exposure to Online Alcohol Marketing and Adolescents'

- Drinking: A Cross-sectional Study in Four European Countries," *Alcohol and Alcoholism*, 2016.
- [62] T. Lobstein, J. Landon, N. Thornton and D. Jernigan, "The commercial use of digital media to market alcohol products: A narrative review," *Addiction*, vol. 112, no. 1360-0443, pp. 21-27, 2017.
- [63] D. Chisholm, J. Rehm, M. Van Ommeren and M. Monteiro, "Reducing the global burden of hazardous alcohol use: A comparative cost-effectiveness analysis," *Journal of Studies on Alcohol*, vol. 65, no. 6, pp. 782-93, 2004.
- [64] WHO, "Global action plan for the prevention and control of noncommunicable diseases 2013-2020," World Health Organization, Geneva, 2013.
- [65] PAHO, "Plan of action for the prevention and control of noncommunicable diseases in the Americas 2013-2019," Pan American Health Organization, Washington, DC, 2014.
- [66] K. Shibuya, C. Ciecierski, E. Guindon and et al, "WHO framework convention on tobacco control: Development of an evidence based global public health treaty," *BMJ*, vol. 327, no. 19 July, pp. 154-7, 2003.
- [67] WHO, "Global strategy to reduce the harmful use of alcohol," World Health Organization, Geneva, 2010.
- [68] J. Noel and T. Babor, "Does industry self-regulation protect young persons from exposure to alcohol marketing? A review of compliance and complaint studies," *Addiction*, vol. 112, no. 1360-0443, pp. 51-56, 2017.
- [69] J. Noel, T. Babor and K. Robaina, "Industry self-regulation of alcohol marketing: A systematic review of content and exposure research," *Addiction*, vol. 112, no. 1360-0443, pp. 28-50, 2017.
- [70] J. Noel, T. Babor, K. Robaina and et al., "Alcohol marketing in the Americas and Spain during the 2014 FIFA World Cup Tournament," *Addiction*, vol. 112, no. 1360-0443, pp. 64-73, 2017.
- [71] J. Noel, Z. Lazzarini, K. Robaina and A. Vendrame, "Alcohol industry self-regulation: Who is it really protecting?," *Addiction*, vol. 112, no. 1360-0443, pp. 57-63, 2017.
- [72] PAHO, "Plan of action to reduce the harmful use of alcohol," Pan American Health Organization, Washington, DC, 2011.
- [73] PAHO, "Summary report and recommendations: PANNAPH First Regional Meeting; 2012 Aug 21-23; Mexico City, Mexico," in *Pan American Health Organization*, Washington, DC, 2012.
- [74] PAHO, "Resolution CD50.R8 Health and Human Rights," Pan American Health Organization, Washington, DC, 2010.
- [75] PAHO, "CD54/14, Rev. 9 Strategy on Health-related Law," Pan American Health Organization, Washington, DC, 2015.
- [76] UNCESCR, "General Comment No. 14: The right to the highest attainable standard of health," UN Committee on Economic, Social, and Cultural Rights, New York, 2000.
- [77] A. Chapman, "Can human rights standards help protect children and youth from the detrimental impact of alcohol beverage marketing and promotional activities?," *Addiction*, vol. 112, no. 1360-0443, pp. 117-121, 2017.

- [78] UNICEF, "Convention on the rights of the child," UNICEF, New York, 2000.
- [79] PAHO, "Noncommunicable disease risk factors in the Americas: Considerations on the strengthening of regulatory capacity: REGULA technical reference document," Pan American Health Organization, Washington, DC, 2015.
- [80] PAHO, "Plan of action for the prevention of obesity in children and adolescents," Pan American Health Organization, Washington, DC, 2014.
- [81] WHO, "Global status report on alcohol and health," World Health Organization, Geneva, 2014.
- [82] WHO, "Global strategy to reduce the harmful use of alcohol," World Health Organization, Geneva, 2010.
- [83] PAHO, "Regional Status Report on Alcohol and Health in the Americas," Pan American Health Organization, Washington, DC, 2015.
- [84] PAHO, "Alcohol and Public Health in the Americas: A Case for Action," Pan American Health Organization, Washington, DC, 2014.
- [85] T. Babor, R. Caetano, S. Griffith Edwards and et al, *Alcohol: No Ordinary Commodity: Research and Public Policy*, New York: Oxford University Press, 2010.
- [86] K. Robaina and T. Babor, "Influence of the Alcohol Industry in Latin American and the Caribbean: Implications for Public Health," Draft report prepared for the Pan American Health Organization, Washington, DC, 2015.
- [87] T. Babor, K. Robaina and J. Noel, "Vulnerability to alcohol-related problems: A policy brief with implications for the regulation of alcohol marketing," *Addiction*, vol. 112, no. 1360-0443, pp. 94-101, 2017.
- [88] CDC, "Youth Exposure to Alcohol Advertising on Television – 25 Markets, United State, 2010," vol. 62, no. 44, pp. 877-90, 2013.
- [89] PAHO, "CD50.R8: Health and Human Rights," Pan American Health Organization, Washington, DC, 2010.
- [90] PAHO, "CD54/14: Strategy on Health-related Law," Pan American Health Organization, Washington, DC, 2015.
- [91] H. Selin and J. Vasquez, "Secondhand Tobacco Smoke in the Americas: A Human Rights Perspective," Pan American Health Organization, Washington, DC, 2009.
- [92] PAHO, "CD50/12 Health and Human Rights: Concept Paper," Pan American Health Organization, Washington, DC, 2010.
- [93] CESCR, "General Comment No. 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights, U.N. Doc. E/C.12/2000/4, para. 48," United Nations Human Rights Office of the High Commissioner Committee on Economic, Social and Cultural Rights, 2000.
- [94] A. Chapman, "A Human Rights Approach to Health Care Reform," Georgetown University Press, Washington, DC, 1994.
- [95] A. Chapman and B. Carbonetti, "Human Rights Protections for Vulnerable and Disadvantaged Groups: The Contribution of the UN Committee on Economic, Social, and Cultural Rights," *Human Rights Quarterly*, vol. 33, pp. 682-732, 2011.

- [96] UNGA, "Universal Declaration of Human Rights, Res. 217 A (III, UN Doc. A/810 at 17," United Nations General Assembly, New York, 1948.
- [97] UNGA, "International Covenant on Economic, Social and Cultural Rights. Res. 2200 A, 21 U.N. GAOR Supp. (No 16) 49, U.N. Doc. A/6316 , 993 U.N.T.S. 3, entered into force on 3 January 1976.," United Nations General Assembly, 1966.
- [98] UNGA, "International Covenant on Civil and Political Rights. Res. 2200 A (XXI) , 21 U.N. GAOR Supp. (no. 16) 52, U.N. Doc. A/6316, 999 U.N.T.S. 171, entered into force 23 March 1976," United Nations General Assembly, 1966.
- [99] Human Rights Committee, "General comment No. 6: article 6 (Right to life), Sixteenth session, para 5," United Nations Human Rights Office of the High Commissioner, 1982.
- [100] UNGA, "International Convention to Eliminate All Forms of Racial Discrimination Res. 2106 A (XX), entered into force in 1969," United Nations General Assembly, 1965.
- [101] UNGA, "Convention on the Elimination of All Forms of Discrimination Against Women, Res. 34/180, U.N. GAOR Supp. (No. 16) 49, U.N. Doc. A/34/46," United Nations General Assembly, 1979.
- [102] UNGA, "Convention on the Rights of the Child. Res.44/25 on 20 November 1989. Entered into force on 2 September 1990, Article 24," United Nations General Assembly, 1989.
- [103] UNGA, "Convention on the Rights of Persons with Disabilities. U.N. Doc. A/RES/61/106, entered into force 2008.," United Nations Human Rights Office of the High Commissioner, 2006.
- [104] OAS, "American Declaration of the Rights and Duties of Man. Approved by the Ninth International Conference of American States on 2 May. Resolution XXX, Pan American Union, Final Act of the Ninth Conference, 38-45.," Organization of American States, 1948.
- [105] OAS, "Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, "Protocol of San Salvador," OAS Treaty Series No. 69. OEA/Ser. L.V/II.82 doc 6 rev. 1 at 67 (1992), came into effect 1999," Organization of American States, 1988.
- [106] K. Mechlem, "Treaty Bodies and the Interpretation of Human Rights," vol. 42, no. 905, 2009.
- [107] R. Khosla and P. Hunt, "Human Rights Responsibilities of Pharmaceutical Companies in Relation to Access to Medicines," in *Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility*, Toronto, University of Toronto Press, 2012.
- [108] J. Ruggie, "Report of the Special Representative of the Sec.Gen. on the issue of human rights and transnational corporations and other business enterprises: Guiding Principles on Business and Human Rights: Implementing the UN "Protect, Respect and Remedy" Framework," 2011.
- [109] "United Nations Global Compact," [Online]. Available: www.unglobalcompact.org/. [Accessed August 23 2016].

- [110] Committee on the Rights of the Child, "General comment No. 16 on State obligations regarding the impact of the business sector on children's rights, IV. Nature and Scope of State Obligations," 2013.
- [111] STAP, "Strengthening Regulation to Protect Young People: Conclusions and recommendations of the ELSA Project," National Foundation for Alcohol Prevention in the Netherlands, 2007.
- [112] A. Kalinowski and K. Humphreys, "Governmental standard drink definitions and low-risk alcohol consumption guidelines in 37 countries," *Addiction*, vol. 111, no. 7, pp. 1293-8, 2016.

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Annex 2: A conceptual framework for alcohol marketing regulation based on human rights

Executive summary

The World Health Organization (WHO) has identified alcohol consumption as one of the major contributors to the global disease burden as both a risk factor for and a direct cause of a variety of health problems. Globally, alcohol ranks fifth as a risk factor for death and disability. Moreover, alcohol consumption is high in the Latin American and Caribbean region (LAC) and the prevalence of drinking among youth is increasing. Also compared to other geographic regions, LAC has the highest percentage of total deaths attributed to alcohol usage. The alcohol industry is actively promoting demand for alcohol products through a number of channels including advertising and sponsorship of sports and other events, which few countries in the region have enacted regulation to control.

This concept paper explores the use of human rights law to limit the exposure to alcohol advertising and promotion of groups in a situation of vulnerability. A series of international and regional human rights instruments, ratified by most countries in LAC, recognize the right to the enjoyment of the highest attainable standard of health (“right to health”). Countries which ratify these instruments assume the legal obligation to implement their provisions and to protect their populations from violations by the state, third parties, and other relevant stakeholders. To protect the health of children, the United Nations (UN) Committee on the Rights of the Child has directed states to adopt preventive measures such as effective regulation and monitoring of advertising and marketing by industries, particularly those involved in the manufacture and distribution of products like alcohol and cigarettes that are injurious to the health of children. Moreover, the Pan American Health Organization (PAHO) has previously used a human rights approach in its work, including a concept paper (CD50/12) and resolution (CD50R8) on health and human rights and strategy on health-related law (CD54R9), as well as a publication exploring human rights implications to protect individuals and communities from exposure to secondhand tobacco smoke.

The final section of the document sets forth a number of suggestions on ways countries can utilize human rights norms and law to regulate or eliminate alcohol beverage marketing and promotional activities, and the capacity building needed facilitate the use of human rights instruments in the context of alcohol control measures.

Background

The World Health Organization (WHO) has identified alcohol consumption as one of the major contributors to the global disease burden. Alcohol plays a role in the global burden of disease in two ways: as a risk factor for and as the direct cause of a variety of health problems. Globally, alcohol ranks fifth as a risk factor for death and disability. In 2012, 139 million disability-adjusted life years (DALYs), or 5.1% of the global burden of disease and injury, were attributable to alcohol consumption. In that year about 3.3 million deaths,

or 5.9% of all global deaths, were attributable to alcohol consumption. This figure corresponds to one in every 20 deaths in the world (7.6% for men and 4.0% for women) which is greater than the proportion of deaths from HIV/AIDS, tuberculosis, or violence. Moreover, alcohol consumption often causes death relatively early in life. Major alcohol use disorders, which are 100% attributable to alcohol, include alcohol dependence, liver diseases (liver cirrhosis), and fetal alcohol syndrome. In addition, alcohol plays a role in about 4% to 25% of the global disease burden attributable to specific cancers and also contributes to about 10% of the disease burden due to tuberculosis, epilepsy, and hypertensive heart disease [1]. WHO's concerns with the deleterious impact of alcohol led to the development of the Global Strategy to Reduce the Harmful Use of Alcohol to address this problem. This document proposes a number of evidence-based policies including taxation and pricing policies, availability restrictions, and regulation of the promotion and marketing of alcoholic beverages [2].

Alcohol consumption is particularly high in the Latin American region (LAC) and the rate of use is increasing. Compared to other geographic regions, LAC also has the highest percentage of total deaths attributed to alcohol usage. Rising rates of alcohol consumption, increased drinking among young people, and heavy episodic drinking* patterns have contributed to alcohol's role as the leading risk factor for death and disability in the region [3].

The increase in alcohol consumption in LAC likely is due at least in part to the active promotion of alcohol products by the alcohol industry. In Latin America, as elsewhere, the alcohol industry's core business goal is to increase alcohol sales so as to raise profits for its shareholders. The industry uses marketing and advertising to increase the public's exposure to its products and to promote drinking as socially desirable, usually while ignoring the negative effects of alcohol on health [4]. Greater alcohol promotion often translates into increased per capita consumption which in turn results in a higher prevalence of alcohol-related harms [5]. A recent study of the alcohol industry in LAC indicates that the industry is actively involved in promoting demand for alcohol products utilizing advertising on youth radio, television, websites, social media, mobile phones, sponsorship of sport and music events, and product placement in movies and television shows. Currently, promotional activities are increasingly moving to digital and social media. The scale of these advertising campaigns is suggested by the quantity spent: in 2011 five alcohol companies reported spending \$5.5 billion in traditional advertising venues alone [6].

One component of the alcohol industry's marketing and advertising strategy is to promote drinking to new market segments, which in the case of LAC include women and youth [6]. In recent years alcoholic beverage marketers have intensified their targeting of young drinkers by introducing an array of inexpensive products designed to appeal to young people and tailoring marketing activities to reach them through contests, games, cartoons

* Consumption of 60 grams (approximately 5 standard drinks) or more of pure alcohol on one occasion, at least once in the past 30 days.

on web pages; employing popular music and issuing alcohol branded CDs; and sponsoring sporting events [4]. These initiatives contravene industry guidelines for responsible advertising practices, which acknowledge that groups in a situation of vulnerability, such as children and pregnant women, should be protected from targeted advertising by alcoholic beverage producers. Youth, particularly young persons who have already initiated alcohol use, and youth and adults who have developed a syndrome of alcohol dependence, have been shown to be more susceptible to the promotional messages in alcohol advertising and therefore both can be considered groups in a situation of vulnerability [7]. For example, a study by the United States Centers for Disease Control and Prevention concludes that exposure to alcohol marketing increases the likelihood youths will initiate drinking and drink at higher levels [8]. In addition, women's lower body weight, smaller liver capacity to metabolize alcohol, and higher proportion of body fat contribute to women achieving higher blood alcohol concentrations than men for the same amount of alcohol intake, making them more vulnerable to alcohol-related harm. Women who drink during pregnancy, especially during the early stages when they may not even realize they are pregnant, also expose their sensitive developing fetus to serious alcohol-related harms [7].

Although most countries in the region have some form of marketing regulation, only 12 percent have statutory bans to limit the marketing of alcohol beverages. Two-thirds of countries in LAC have no restriction on TV, radio, print media, and billboards, including El Salvador, Uruguay, and Suriname. Others regulate the timing and placement of advertisements or rely on industry self-regulation. Moreover, there is little in the way of regulatory efforts related to the increasingly frequent use of digital and social media [6].

The human rights perspective

Benefits of a human rights strategy

The use of human rights law (norm and standards), and other laws related to the right to health offers a potential strategy to facilitate the formulation and/or review of regulations to restrict advertising and promotional activities related to alcohol products. It is noteworthy that PAHO is currently using a human rights approach in several areas of health. In 2010, PAHO Member States adopted a resolution on health and human rights that included objectives related to “strengthening the technical capacity of the health authority to provide support for the formulation of health policies and plans consistent with the applicable international human rights instruments related to health; supporting PAHO’s technical cooperation in the formulation, review and, if necessary, reform of national health plans and legislation, incorporating the applicable international human rights instruments, especially those related to the protection of groups in vulnerable situations; formulating and, if possible, adopting legislative, administrative, educational, and other measures to disseminate the applicable international human rights instruments on protecting the right to the enjoyment of the highest attainable standard of health and other related human rights among the appropriate personnel in the legislative and judicial branches and other governmental authorities [9].”

In 2015, Member States adopted the Strategy on Health-Related Law, which includes among its objectives “promoting the formulation, implementation, or review of legal and regulatory frameworks that address health determinants, health promotion through a life-course, the reduction of risk factors, and the prevention of disease, through a multisectoral approach and strengthening the technical capacity of Member States’ health authority to facilitate coordination and collaboration with the legislative branch and other sectors [10].”

Additionally, a PAHO report addressing secondhand tobacco smoke stated that “international human rights law provides governments with a useful legal framework to facilitate the implementation of effective laws and educational campaigns to protect the public [11].” The same can be said of the potential application of human rights law to protect individuals and the public from the deleterious impacts of alcohol advertising and promotional activities.

The relevance of human rights norms and laws for the protection of health and thereby to regulate alcohol advertising and promotional practices derives from a number of factors. Human rights law is predicated on the fundamental principle of the inherent dignity and equal worth of every human being. Consistent with this principle, it sets out minimum conditions for a dignified life in the form of rights or entitlements. To frame a moral claim as a human right implies that it is of special importance and that its realization has a high priority. Beyond a moral argument, there is also a legal argument to establish legal obligations related to health for States Party to human rights treaties. As explored by Jonathan Mann, violations of human rights have a negative impact on health; laws and policies more effectively protect health if they incorporate human rights norms and standards based on constitutional agreements and treaties negotiated by governments [12]. As a result, human rights both confer specific entitlements on rights-holders and necessitate correlative duties for governments to take positive measures to protect and realize the obligations they encompass.

Importantly, in the past sixty years, health status, health protection, and access to health care have been recognized as the subject matter of human rights.[†] A series of international and regional human rights instruments which have been ratified by most countries in the LAC region recognize the right to the enjoyment of the highest attainable standards of health (known as “the right to health”). These instruments are listed in the following section with a brief summary of key relevant provisions. Countries which ratify these instruments assume the legal obligation to implement their provisions. The protection of health as a human right is also enshrined in 19 of the 35 PAHO Member States’ constitutions.[‡]

[†] See, for example, the initial Report of the Special Rapporteur for the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, to the Commission on Human Rights (2003) E/CN.4/2003/58, available at www.un.org/womenwatch/ods/E-

[‡] Bolivia, Brazil, Cuba, Chile, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Uruguay, Venezuela

All human rights give rise to three types of government obligations: the duties to respect, protect, and fulfill these rights. Of relevance here, obligations to protect include the duties of states to take measures to safeguard persons within their jurisdiction from infringements of recognized rights by third parties. According to the authoritative interpretation of the right to health drafted by the UN Committee on Economic, Social, and Cultural Rights, violations of the right to health can occur through the direct action of states or alternatively other entities insufficiently regulated by states. Violations of the obligation to protect include such omissions as the failure to regulate the activities of individuals, groups, or corporations so as to prevent them from violating the right to health, but also all other rights, such as the right to life, personal integrity, equal protection under the law, education, work, access to information, due process in law, non-discrimination, healthy environment, and healthy working conditions, among others [13].

Interpretations of what a right to health entails by UN human rights treaty bodies overseeing implementation of specific human rights instruments[§] make clear that the right to health is not to be understood as a right to be healthy but instead the provision of specific entitlements by the state. Indeed given genetic factors, individual susceptibility to ill health, and the possible adoption of unhealthy or risky lifestyles, good health cannot be ensured by a state. According to the Committee on Economic, Social, and Cultural Rights, entitlements related to the right to health include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health. The Committee also interprets the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health. The Committee identifies the underlying determinants of health to include access to safe and potable water and adequate sanitation, an adequate supply of safe feed, nutrition, housing, healthy occupational and environmental conditions, and access to health-related education and information [13]. By extension, a safe and healthy environment would be one without alcohol advertising and promotional activity. It also requires that health-related education and information should cover the harms of drinking alcohol which ultimately can affect even the right to life and personal integrity.

Also relevant, one of the hallmarks of a human rights approach is the commitment to protecting the rights of individuals and groups in a situation of vulnerability or disadvantage. As a universal standard, the implementation of a human rights entitlement is measured particularly by the degree to which it benefits those who hitherto have been the most disadvantaged and vulnerable and brings them up to mainstream standards [14]. Concern with the status of those in a situation of vulnerability and disadvantage in the human rights community comes from the realization that in virtually all societies there are individuals and groups of persons who systematically lack enjoyment of a wide range of human rights. Many of these groups experience discrimination, social exclusion, stigmatization, and/or deprivation of protections and entitlements on an ongoing basis. They may be subject to human rights violations by the state, by others in the society, or by institutions. Structural barriers, social dynamics, and/or economic forces can also result in

[§] Particularly the Committee on Economic, Social, and Cultural Rights

human rights violations particularly affecting groups in a situation of vulnerability [15]. As noted above, youth, women- especially those who are pregnant- and individuals with a history of alcohol dependence may be considered especially vulnerable in relationship to alcohol promotion activities and susceptible to alcohol harms.

Relevant health related international and regional human rights instruments

Beginning with the Universal Declaration of Human Rights [16],** a series of international and regional declarations and instruments have enumerated a right to health, or as articulated in Article 12 of the International Covenant on Economic, Social, and Cultural Rights, †† “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health [17].” As in the International Covenant on Economic, Social, and Cultural Rights, the right to health is often to be achieved progressively, subject to the availability of resources. Other human rights instruments, for example the International Covenant on Civil and Political Rights, †† have recognized a right to life and interpreted it broadly as requiring positive measures for health protection and medical care, as for example to reduce infant mortality and increase life expectancy [18, 19].

The following international and regional human rights instruments, which all have an explicit recognition of a right to health, are relevant because most, or in some cases all, LAC member countries have ratified the document:

Universal Declaration of Human Rights: article 25 states that everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, medical care, and necessary social services [16]. As a declaration, the Universal Declaration of Human Rights is not legally binding but it is widely acknowledged to be the foundation of international human rights law and has common law standing.

International Covenant on Economic, Social, and Cultural Rights: as noted above, article 12 recognizes the right of everyone to the highest attainable standard of physical and mental health achieved progressively, subject to the availability of resources. Article 12 directs States Party (the countries which have ratified the Covenant) to undertake a series of steps. These include those necessary for the reduction of infant mortality and for the healthy development of the child; the improvement of all aspects of environmental and industrial hygiene; the prevention, treatment, and control of epidemic, endemic, occupational, and other diseases; and the creation of conditions which would assure all medical services in

** As a declaration, no states are called on to ratify this instrument.

†† The following countries in LAC have ratified this instrument and are therefore legally bound by its provisions: Argentina, Bahamas, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Trinidad and Tobago, Uruguay, and Venezuela.

‡‡ The following states in LAC have ratified this covenant and are therefore legally bound by its provisions: Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Trinidad and Tobago, Uruguay, and Venezuela.

the event of sickness [17]. The most authoritative interpretation of the right to health, which is a 2000 general comment adopted by the U.N. Committee on Economic, Social, and Cultural Rights, expands on this conception of what the right to health entails and the concomitant obligations of States Party [13].

International Convention on the Elimination of All Forms of Racial Discrimination: article 5 stipulates that States Party prohibit, eliminate, and prevent discrimination in the field of health and guarantee enjoyment without distinction of both a right to public health and medical care [20].

Convention on the Elimination of All Forms of Discrimination Against Women: article 12 directs States Party to take all appropriate measures to eliminate discrimination against women in the field of health and mandates States Party to ensure equality of access to health care services, including those related to family planning, pregnancy, confinement, and post-natal period, and to grant free services where necessary [21].^{§§}

Convention on the Rights of the Child: which has been ratified by 190 countries, the most of any human rights instrument, recognizes the right of the child to the enjoyment of the highest standard of health. Article 24 directs States Party to take appropriate measures to implement this right in order to diminish infant and child mortality; ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; combat disease and malnutrition; ensure appropriate pre-natal and post-natal health care for mothers; develop preventive health care guidance for parents; and to provide access to education about child health and nutrition [22].^{***}

Convention on the Rights of Persons with Disabilities: recognizes that persons with disabilities have a right to enjoy the highest attainable standard of health and directs States Party to take all appropriate measures to ensure that persons with disabilities have access to health services that provide the same range, quality, and standard of free or affordable health care and programs as well as to provide health services needed specifically by persons because of their disabilities, including those providing early identification and intervention. It also prohibits discrimination against persons with disabilities in the provision of health and life insurance [23].^{†††}

^{§§} The following states in LAC have ratified this convention, often referred to by the acronym CEDAW: Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Trinidad and Tobago, Uruguay, and Venezuela.

^{***} This is the most widely ratified international human rights instrument. All states in LAC have ratified this instrument.

^{†††} The following states in the LAC Region have ratified this human rights instrument: Argentina, Bahamas, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Grenada, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Vincent and the Grenadines, Trinidad and Tobago, Uruguay, and Venezuela.

American Declaration of the Rights and Duties of Man: Article 11 states that every person has the right to the preservation of his health through sanitary and social measures including food, clothing, housing, and medical care to the extent permitted by public and community resources [24].^{###}

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, “Protocol of San Salvador”: article 10 recognizes the right to health as a public good and instructs States Party to undertake a series of measures to ensure that the right is implemented, including making primary or essential healthcare available to all; extending the benefits of health services to all individuals subject to the State’s jurisdiction; providing universal immunization against the principal infectious diseases; preventing and treating endemic, occupational, and other diseases; educating the population on the prevention and treatment of health problems; and addressing the health needs of the highest risk groups and those whose poverty makes them the most vulnerable [25].

In addition, the constitutions of many countries in LAC have health provisions, though not necessarily in the form of an explicit legal entitlement. Some constitutions have a provision addressing health or health care as a programmatic statement, for example, as a directive for state policy. The establishment of a constitutional right to health appears primarily in newer constitutions of emerging democracies.

Human rights standards addressing the regulation of deleterious corporate activity

The Convention on the Rights of the Child has the most relevant provisions to protect members of a group in a situation of vulnerability, in this case the child, from the deleterious effects of alcohol promotion and advertising. The preamble to the Convention explicitly identifies children as a group in a situation of vulnerability requiring special protection, care, and assistance. Article 17 addresses the important function performed by the mass media and encourages the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being. Further, Article 32 states that children have the right to be protected from economic exploitation [22]. In addition, Article 33 directs States Party to take all appropriate measures, including legislative, administrative, social, and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances.

UN human rights treaty bodies develop general comments to interpret provisions of their respective conventions and to address significant thematic issues. While these documents do not have the same binding legal force that human rights instruments have for States Party, the general comments that address important issues and are convincingly argued can be quite influential [26]. Therefore it is notable that a general comment prepared by the UN Committee on the Rights of the Child to interpret the requirements of Article 24 of the Convention specifies that all business enterprises have an obligation to identify,

^{###} Since it is a declaration, there are no formal state ratifications.

prevent, and mitigate their negative impact on children's right to health across their business relationships and within any global operations. These requirements are further elaborated in another general comment the Committee on the Rights of the Child prepared on state obligations regarding the impact of the business sector on children's rights. In that document the Committee identifies the ways in which the activities and operations of business enterprises can impact a child's inherent right to life and to health. It warns that the marketing to children of products such as cigarettes and alcohol can have a long-term impact on their health. To protect the child, the Committee directs states to adopt preventive measures such as effective regulation and monitoring of advertising and marketing industries and to create an enabling environment for business to respect children's right to life and health. The general comment goes on to state that legislation and regulation are essential instruments for ensuring that the activities and operations of business enterprises do not adversely impact on or violate the rights of the child. It specifically mentions the problematic role the mass media may have on children and the need to regulate the media to protect children from harmful information. Additionally, according to the general comment, states are required to implement and enforce internationally agreed standards concerning children's rights, health, and business [22].

The provisions of the Convention on the Rights of the Child noted here and the general comments of the Committee on the Rights of the Child can provide the basis for PAHO and WHO to work with the Committee on the Rights of the Child to train legislators and judges, review legislation, and collaborate with the Inter-American Commission on Human Rights on the impact of alcohol marketing and promotion and to develop effective monitoring and legislative guidelines, as has been done in other technical areas. The Committee on the Rights of the Child regularly holds meetings, which it terms a Day of General Discussion, in conjunction with its sessions to review States Party reports. Some Days of General Discussion are used to provide the background to draft a general comment on a specific subject. PAHO can offer to assist the Committee with preparing a general comment or a statement of concerns relating to alcohol advertising and promotional activities, as it has done on other topics such as drafting the General Comment 15 on the right to the enjoyment of the highest attainable standard of health (Committee on the Rights of the Child), the General comment on the right to sexual health (Committee on Economic, Social, and Cultural Rights), and on the right to live in the community (in collaboration with the UN Committee on the Rights of Persons with Disability). It should also be noted that PAHO is also collaborating with the UN Special Rapporteur on the Right to Health on thematic reports and technical support during country visits.

United Nations Global Compact

Under international human rights law as traditionally formulated, non-state actors, including transnational corporations, do not have binding legal obligations. In the human rights paradigm, it has been the obligation of States/governments to regulate private sector actors to encourage them to act consistently with human rights norms and to prevent them from committing human rights violations [13]. Recently however, many human rights advocates have argued that corporations do indeed have human rights responsibilities. For example, a recent article coauthored by Paul Hunt, the first Special Rapporteur for the right

to health, states that: “A consensus is emerging that business enterprises, like all actors in society, have some legal and ethical human rights responsibilities.” When serving as the Special Rapporteur he developed human rights guidelines for pharmaceutical companies in relation to access to medicines [27]. However, when the issue of their human rights responsibilities is raised, corporations have usually argued that their primary or sole responsibility is to their shareholders.

John Ruggie, who served as the UN Secretary-General’s special representative on the issue of human rights and transnational corporations, initially took the position that no binding international law presently placed duties on corporations, but in his later UN reports altered his view, affirming that corporations do hold duties to respect human rights and not to infringe on the rights of others. His final report providing Guiding Principles on Business and Human Rights proposes a “protect, respect, and remedy” framework. Its components are (1) the state’s duty to protect against human rights abuses by third parties, including business enterprises, through appropriate policies, regulation, and adjudication; (2) the corporate responsibility to act with due diligence to avoid infringing the rights of others and to address adverse impacts with which they are involved; and (3) the need for greater access by victims to an effective remedy, both judicial and non-judicial [28].

The United Nations Global Compact, a UN initiative to encourage businesses to adopt socially responsible policies, including respect for human rights, incorporates these principles. The UN reports that there are over 8,000 corporate participants in the Global Compact [29]. The corporations that have joined the Global Compact are listed on the UN site, and include several multinational alcohol producers, among them Anheuser-Busch, InBev, Asahi, Bacardi, Carlsberg, Diageo, Heineken, Krin, Pernod Richard, and SABMiller. It would be possible to check whether other alcohol producers operating in LAC have also subscribed to the initiative.

Strategies to protect individuals and communities

Like other human rights, the right to health requires that States Party have a continuing obligation to move as expeditiously and effectively as possible towards the full realization of their obligations. According to the Committee on Economic, Social, and Cultural Rights, obligations include the duties of states to adopt legislation or to take other measures to protect all groups of society in a situation of vulnerability or marginalization [13].

Similarly, the Committee on the Rights of the Child has declared that states have an obligation to protect the rights guaranteed under the Convention on the Rights of the Child against infringements by third parties and that this duty is of primary importance when considering states’ obligations with regards to the business sector. The Committee’s General Comment addressing state obligations regarding the impact of the business sector on children’s rights specifies that such measures can and should encompass the adoption of appropriate policies, the passing of laws and regulations, their monitoring and enforcement, and investigation of their potential violations. Furthermore, “A State is therefore responsible for infringements of children’s rights caused or contributed to by business enterprises where it has failed to undertake necessary, appropriate, and

reasonable measures to prevent and remedy such infringements or otherwise collaborated with or tolerated the infringements [30].”

Realizing that business enterprises increasingly operate on a global scale through complex networks of subsidiaries, contractors, suppliers, and joint ventures, as is the case with many companies involved with the production, marketing, and promotion of alcohol products, the Committee on the Rights of the Child specifies that while states have a primary responsibility to respect, protect, and fulfill children’s rights in their own jurisdiction, states also have obligations to engage in international cooperation for the realization of children’s rights beyond their territorial boundaries. They must ensure that all business enterprises, including transnational corporations which are operating within their borders, are adequately regulated so that they do not adversely impact on the rights of the child and/or aid violations in foreign jurisdictions [30].

Human rights norms and law regarding the right to health and the rights of the child require the effective implementation of regulatory measures to protect children and other groups in a situation of vulnerability from exposure to alcohol marketing and promotion so as to reduce alcohol use and the consequent deleterious impact of alcohol products. Given the difficulty of shielding groups in a situation of vulnerability from alcohol advertising and promotion, the most effective protection would be a total ban on all forms of alcohol advertising and promotion, in line with the WHO Strategy to Reduce the Harmful Use of Alcohol, or the imposition of comprehensive restrictions, particularly when states cannot impose a total ban due to constitutional principles.

However, states within the Americas generally fail to undertake measures to protect groups in a situation of vulnerability from alcohol advertising, promotion, and sponsorship. As noted previously, only 12 percent of the 35 Member States have statutory bans to limit the marketing of alcohol beverages, and two-thirds of countries in the Region have no restriction on TV, radio, print media, and billboard advertising.

A project on alcohol marketing in Europe aiming to strengthen regulation to protect young people had a number of relevant recommendations, despite the fact that it did not consider any specific human rights conventions and obligations. It proposed that alcohol marketing restrictions at European and country levels should address the advertising and promotion of alcohol products through all media and the sponsorship of arts, cultural, musical, and sporting events. It recommended that European and country based regulations be strengthened in order to (1) restrict the placement of alcohol marketing to reduce exposure to young people; (2) limit alcohol marketing that is misleading about the characteristics or effects of alcohol; (3) prohibit alcohol marketing that appeals to minors and other groups in a situation of vulnerability; and (4) require information that alcohol is not a risk-free product. In addition, it recommended that these objectives may be realized by restricting marketing to information about the product and only referring to the origin, composition, strength (% alcohol), and means of production. The guidelines called for the establishment of systems to provide sustainable monitoring and surveillance of alcohol marketing [31].

While these measures provide a good starting point, they are too general to be truly useful. There is a need for much greater specificity. For example, what exactly does it require to restrict the placement of alcohol marketing to reduce exposure to young people? Does it apply to specific types of alcoholic beverages, media, time periods, and/or ads that would attract and appeal to young people? Also what ages does the term “young people” encompass? Similarly, it would be helpful to have a list of all the types of alcohol marketing that might appeal to minors and other groups in a situation of vulnerability. Does it include all sponsorships of sporting events and product placements in youth-related programs and activities?

In contrast with the work on tobacco control, there has not been an international or regional framework instrument with guidelines for implementation to underlay and support initiatives to regulate alcohol advertisement and promotion. The drafting of such an instrument on the model of the WHO Framework Convention on Tobacco Control would be the most effective way to protect the health of individuals and communities in a situation of vulnerability from the detrimental impact of alcohol beverage marketing and promotional activities. Should it not be possible to proceed with a framework convention on alcohol marketing, it would still be useful to draft a comprehensive human rights based document setting forth measures to restrict alcohol advertising and promotion that would at least provide guidance to sympathetic governments, civil society organizations, and human rights oversight and monitoring bodies committed to protecting children and youth from alcohol advertising and promotional activities. In the interim, capacity building initiatives at the country level linking human rights commitments to the problems raised by alcohol use and exposure to alcohol marketing, particularly children and other groups in a situation of vulnerability, would increase awareness of various sectors of society of the need to take further measures to protect and promote the right to health and other related human rights of these groups.

References Annex 2

- [1] WHO, "Global status report on alcohol and health," World Health Organization, Geneva, 2014.
- [2] WHO, "Global strategy to reduce the harmful use of alcohol," World Health Organization, Geneva, 2010.
- [3] PAHO, "Regional Status Report on Alcohol and Health in the Americas," Pan American Health Organization, Washington, DC, 2015.
- [4] PAHO, "Alcohol and Public Health in the Americas: A Case for Action," Pan American Health Organization, Washington, DC, 2014.
- [5] T. Babor, R. Caetano, S. Griffith Edwards and et al, *Alcohol: No Ordinary Commodity: Research and Public Policy*, New York: Oxford University Press, 2010.
- [6] K. Robaina and T. Babor, "Influence of the Alcohol Industry in Latin American and the Caribbean: Implications for Public Health," Draft report prepared for the Pan American Health Organization, Washington, DC, 2015.
- [7] T. Babor, K. Robaina and J. Noel, "Vulnerability to alcohol-related problems: A policy brief with implications for the regulation of alcohol marketing," *Addiction*, vol. 112, no. 1360-0443, pp. 94-101, 2017.
- [8] CDC, "Youth Exposure to Alcohol Advertising on Television – 25 Markets, United State, 2010," vol. 62, no. 44, pp. 877-90, 2013.
- [9] PAHO, "CD50.R8: Health and Human Rights," Pan American Health Organization, Washington, DC, 2010.
- [10] PAHO, "CD54/14: Strategy on Health-related Law," Pan American Health Organization, Washington, DC, 2015.
- [11] H. Selin and J. Vasquez, "Secondhand Tobacco Smoke in the Americas: A Human Rights Perspective," Pan American Health Organization, Washington, DC, 2009.
- [12] PAHO, "CD50/12 Health and Human Rights: Concept Paper," Pan American Health Organization, Washington, DC, 2010.
- [13] CESCR, "General Comment No. 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights, U.N. Doc. E/C.12/2000/4, para. 48," United Nations Human Rights Office of the High Commissioner Committee on Economic, Social and Cultural Rights, 2000.
- [14] A. Chapman, "A Human Rights Approach to Health Care Reform," Georgetown University Press, Washington, DC, 1994.
- [15] A. Chapman and B. Carbonetti, "Human Rights Protections for Vulnerable and Disadvantaged Groups: The Contribution of the UN Committee on Economic, Social, and Cultural Rights," *Human Rights Quarterly*, vol. 33, pp. 682-732, 2011.
- [16] UNGA, "Universal Declaration of Human Rights, Res. 217 A (III), UN Doc. A/810 at 17," United Nations General Assembly, New York, 1948.
- [17] UNGA, "International Covenant on Economic, Social and Cultural Rights. Res. 2200 A, 21 U.N. GAOR Supp. (No 16) 49, U.N. Doc. A/6316 , 993 U.N.T.S. 3, entered into force on 3 January 1976.," United Nations General Assembly, 1966.

- [18] UNGA, "International Covenant on Civil and Political Rights. Res. 2200 A (XXI) , 21 U.N. GAOR Supp. (no. 16) 52, U.N. Doc. A/6316, 999 U.N.T.S. 171, entered into force 23 March 1976," United Nations General Assembly, 1966.
- [19] Human Rights Committee, "General comment No. 6: article 6 (Right to life), Sixteenth session, para 5," United Nations Human Rights Office of the High Commissioner, 1982.
- [20] UNGA, "International Convention to Eliminate All Forms of Racial Discrimination Res. 2106 A (XX), entered into force in 1969," United Nations General Assembly, 1965.
- [21] UNGA, "Convention on the Elimination of All Forms of Discrimination Against Women, Res. 34/180, U.N. GAOR Supp. (No. 16) 49, U.N. Doc. A/34/46," United Nations General Assembly, 1979.
- [22] UNGA, "Convention on the Rights of the Child. Res.44/25 on 20 November 1989. Entered into force on 2 September 1990, Article 24," United Nations General Assembly, 1989.
- [23] UNGA, "Convention on the Rights of Persons with Disabilities. U.N. Doc. A/RES/61/106, entered into force 2008.," United Nations Human Rights Office of the High Commissioner, 2006.
- [24] OAS, "American Declaration of the Rights and Duties of Man. Approved by the Ninth International Conference of American States on 2 May. Resolution XXX, Pan American Union, Final Act of the Ninth Conference, 38-45.," Organization of American States, 1948.
- [25] OAS, "Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, "Protocol of San Salvador," OAS Treaty Series No. 69. OEA/Ser. L.V/II.82 doc 6 rev. 1 at 67 (1992), came into effect 1999," Organization of American States, 1988.
- [26] K. Mechlem, "Treaty Bodies and the Interpretation of Human Rights," vol. 42, no. 905, 2009.
- [27] R. Khosla and P. Hunt, "Human Rights Responsibilities of Pharmaceutical Companies in Relation to Access to Medicines," in *Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility*, Toronto, University of Toronto Press, 2012.
- [28] J. Ruggie, "Report of the Special Representative of the Sec.Gen. on the issue of human rights and transnational corporations and other business enterprises: Guiding Principles on Business and Human Rights: Implementing the UN "Protect, Respect and Remedy" Framework," 2011.
- [29] "United Nations Global Compact," [Online]. Available: www.unglobalcompact.org/. [Accessed August 23 2016].
- [30] Committee on the Rights of the Child, "General comment No. 16 on State obligations regarding the impact of the business sector on children's rights, IV. Nature and Scope of State Obligations," 2013.
- [31] STAP, "Strengthening Regulation to Protect Young People: Conclusions and recommendations of the ELSA Project," National Foundation for Alcohol Prevention in the Netherlands, 2007.

Acknowledgments Annex 2

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