13 April 2016

Codes Review Panel
ASA Secretariat
P O Box 10675
WELLINGTON

Dear Hon Sir Bruce Robertson

Re: Submission on the Review of the Code for Advertising to Children and the Children's Code for Advertising Food

Thank you for the opportunity to provide a written submission on this consultation document.

Regional Public Health serves the greater Wellington region, through its three district health boards (DHBs): Capital & Coast, Hutt Valley and Wairarapa and as a service is part of the Hutt Valley District Health Board.

We work with our community to make it a healthier safer place to live. We promote good health, prevent disease, and improve the quality of life for our population, with a particular focus on children, Māori and working with primary care organisations. Our staff includes a range of occupations such as: medical officers of health, public health advisors, health protection officers, public health nurses, and public health analysts.

We are happy to provide further advice or clarification on any of the points raised in our written submission. If the committee determines that it will hear oral submissions, we wish to appear before the committee to speak to our written submission. The contact point for this submission is:

Clare McLennan-Kissel
Public Health Advisor
Email: clare.mclennan-kissel@wairarapa.dhb.org.nz
Tel: (06) 377 9131

Kind regards

Dr Ruth Richards
Public Health Physician

Peter Gush
Service Manager

Submission to the Advertising Standards Authority (ASA)

Review of the Code for Advertising to Children and the Children's Code for Advertising Food

1 Context

Regional Public Health (RPH) welcomes the opportunity to have input into the Advertising Standards Authority (ASA) review of the above Codes [hereafter referred to as 'the Codes']. RPH has a particular interest in preventing disease, and the prevention of childhood obesity, a major problem in New Zealand, is one of our key priorities. Marketing of foods to children has the potential to drive childhood obesity, but there is an opportunity to minimise this risk through the current review of the ASA Codes. Consequently, it is RPH's view that it is essential for the ASA to put child health and wellbeing at the centre of their considerations when reviewing the Codes for marketing to children.

RPH considers that health must play a bigger role in the regulation of advertising and marketing to children, given that the health sector has to deal with the downstream consequences of choices made throughout a child's life. "During the past 50 years, thousands of research studies have revealed that the media can be a powerful teacher of children and adolescents and have a profound impact on their health."[1] Advertising is one of the key components of media that affects the health and wellbeing of children.[2] RPH is making this submission to strengthen health considerations, including encouraging the ASA to consider whether products that are known to harm health should be advertised at all. For example, the question of which foods, beverages and other products meet that criterion of harm should be decided in collaboration with the health sector.

Using a preventative approach together allows us to work within a strengths-based environment, rather than being reactive to problems. We see prevention as a cost-effective and efficient way to resolve issues before they arise. The Ottawa Charter is a key document that guides the long term prevention and health promotion areas of our work. As stated in the Charter, public health services work to create supportive environments for health, reorient health services, develop personal skills, strengthen community action for health and contribute to healthy public policy.[3] The content of this submission is guided by the principles and intent of the Ottawa Charter.

Self regulation is naturally biased towards the views of the regulators and can influence the outcomes of public health policies and programs.[4] RPH sees a space for smart regulation that has a child- and health-centred approach. Smart regulation can be explained as a way "to modernize regulation to enhance conditions for an innovative economy while finding improved ways to meet high standards of social … protection."[5] Smart regulatory mechanisms produced through a collaborative approach between the health sector and industry (including the advertising and the food and beverage industries) would make a lasting difference to children's health and in particular address the growing obesity epidemic.

RPH **recommends** that all advertising to children that has the potential to be detrimental to health and wellbeing (harmful advertising), in particular of high fat, sugar, salt and ultra-processed foods and beverages, should be phased out. To define 'harmful advertising' we refer to the UN Convention on the Rights of the Child (UNCROC), which we discuss further below. Harmful advertising in our view is any information or material that could be injurious to a child's health and wellbeing.[6] This

includes but is not limited to any advertising that may incur harm whether through increased consumption of high fat, sugar and salt, through increased screen time or through exposure to ideas that are beyond the comprehension of a child. A Nutrient Profiling System as described in the World Health Organisation (WHO) document 'WHO Regional Office for Europe Nutrient Profile Model,'[7] would allow harmful advertising of food and beverages to be identified.

RPH suggests that a staged approach to phasing out harmful advertising, similar to that of the successful banning of tobacco advertising,[8] [9] will over time lead to a comprehensive ban on harmful advertising to children.[10] Furthermore, we see such an approach as creating an opportunity for advertisers to develop health and wellbeing conducive content that empowers healthy choices in children.

The Report of the Commission on Ending Childhood Obesity released earlier this year, states that

> "There is unequivocal evidence that the marketing of unhealthy foods and sugar-sweetened beverages is related to childhood obesity. Despite the increasing number of voluntary efforts by industry, exposure to the marketing of unhealthy foods remains a major issue demanding change that will protect all children equally. Any attempt to tackle childhood obesity should, therefore, include a reduction in exposure of children to, and the power of, marketing."

Furthermore, it goes on to state that

> "Settings where children and adolescents gather (such as schools and sports facilities or events) and the screen-based offerings they watch or participate in, should be free of marketing of unhealthy foods and sugar-sweetened beverages."

That children should not be exposed to harmful advertising is unequivocal from the WHO perspective. It is jointly supported by the WHO Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children, the Report of the Commission on Ending Childhood Obesity and the Global Strategy on Diet, Physical Activity and Health.[11]

The concerns regarding the impact of harmful advertising also extend further than obesity. Harmful advertising can have other impacts on the health and wellbeing of children, including sexualisation and developmental concerns, for example. Research shows that "… children and adolescents learn by observing and imitating what they see on the screen, particularly when these behaviours seem realistic or are rewarded." Furthermore, when participating in screen time, children, and adults, are engaging in anti-social behaviour, including for example, not interacting with the environment or partaking in physical activity.

There are also differing opinions about the age at which children are able to discern content and persuasion in advertisements.[12] [13] However there is growing consensus that older children and even adults have difficulty and are swayed by advertising, therefore we must implement as many protective factors for children as possible.

Taking into account international research and viewpoints, this submission calls for industry to collaborate with the health sector to ensure that the children of New Zealand are secure in their health and wellbeing for the future. Through this collaboration, the health sector can work with industry to provide expertise based on well-founded research and reputable evidence-based

practice. We see this as a 'win-win' situation for both the health sector and industry as we align our priorities to position children's health and wellbeing at the forefront.

2 The rights of children

Article 13 of the UN Convention on the Rights of the Child (UNCROC) talks about restricting the receiving and imparting of information for the protection of public health. Furthermore, Article 17 (e) "encourage[s] the development of appropriate guidelines for the protection of the child from information and material injurious to his or her well-being." RPH believes that restricting harmful advertising to children can be argued for under both Articles 13 and 17. The review of the New Zealand Codes is an opportune time to ensure that the UNCROC articles are upheld.

In a report prepared by the Health Promotion and Policy Research Unit at the University of Otago, Wellington, the authors state that

> "The New Zealand ASA system was found to be reactive, to have limited sanctions, to provide little incentive for restraint by advertisers, and to lack independent monitoring. The authors concluded that the ASA system was not protecting the rights of children by failing to enact the spirit of UNCROC and specifically, by not adequately addressing Articles 3, 6 and 13, including the right to health."[14]

RPH considers that this strengthens the argument for a collaborative approach between the health sector and industry to create smarter and targeted regulation of advertising.

3 International examples of best practice

RPH will be referring to the following international examples of advertising regulations over the course of this submission. RPH considers that the five countries referenced have robust regulatory mechanisms that can be regarded as international best practice. The WHO document on implementing recommendations on marketing to children[10] refers to these examples, among others.

The Quebec example has been shown to be particularly successful, having been regulated since 1978. Indeed, Dhar and Baylis "estimate that the [advertising] ban reduced fast-food consumption by US$88 million per year."[15] The Irish and United Kingdom examples are still relatively new and require further research to confirm their efficacy. However, they are worthy of mentioning for the specificity of their regulatory measures and for their consideration of public health. Sweden and Norway have consistently high health and wellbeing outcomes and in particular, they have much lower rates of obesity than New Zealand.[16] It is therefore valuable to examine their regulatory framework to attempt to emulate their health outcomes.

The particular points of interest in each international example RPH has selected are delineated below.

- Quebec[17] [18] [15]
  - Section 248 of the Consumer Protection Act 1978 states that "Subject to what is provided in the regulations, no person may make use of commercial advertising directed at persons under thirteen years of age."[17]

- Section 249 qualifies some circumstances in which advertising can occur17 and is applicable to both electronic and print forms of media.[15]

- Ireland[19]
  - In the Irish example of the Broadcasting Authority of Ireland (BAI) Children's Commercial Communications Code, the child- and health-centred language used is easy to read and understand.
  - The BAI Codes are required to have "particular regard to the general public health interests of children."[19]
  - The Code applies to children up to the age of 18 years.[19]
- The United Kingdom [20] [21]
  - A nutrient profile model provides a score for foods based on the nutritional value; foods that do not surpass a certain threshold cannot be advertised to children.
  - The United Kingdom Codes define a child as anyone under the age of 16. [21]
  - The United Kingdom Codes also have significantly more robust sanctioning of advertisers who do not comply and has an independent monitoring body that regulates across all media.
- Sweden[22]
  - The Radio and Television Act in Sweden states that "TV … programmes primarily aimed at children below 12 years of age may not be interrupted by advertising."[22] This includes teletext and on-demand television as well as regular broadcast television programming.
  - The complaints process is high profile and handled directly by the Consumer Ombudsman who ensures that consumer interest is protected.
- Norway[23]
  - Norwegian regulation states that "Advertisements may not be broadcast in connection with children's programmes, nor may advertisements be specifically directed at children."[23]
  - It also considers children and young people up to the age of 18 years (though some caveats apply).

4 The New Zealand system

From the extensive literature reviewed and referenced in the process of developing this submission, RPH considers that the following features of the New Zealand system of regulating advertising[24] require attention:

- The current system is one of self-regulation run by industry with little health sector input and consideration of health implications.
- Children and specifically children's health and wellbeing do not appear to be central to the Codes.
- It is a complaints-based system and the process is relatively inefficient. In regard to children, they are unlikely to complain or use a complaints process. It is up to adults to complain and without presence of a complaint, no action can be taken.
- A nutrient profiling system, to determine unhealthy foods, such as that recommended by WHO,[7] is not utilised.
- There is no independent monitoring and surveillance of advertising.
- There are limited sanctions and harm can occur before sanctions are imposed.

5 Responses to questions

RPH commends the Advertising Standards Authority for taking heed of the government's Childhood Obesity Plan and taking the initiative to review the current Children's Codes. RPH views this as an excellent opportunity for collaboration between the private and public sectors to make positive change for children.

Here RPH uses the format of the review questions to make our **recommendations**.

Please note that we are not supplying examples of content and placement as requested in questions 5 and 6. Other submitters are most likely to supply these.

1. *What are the strengths and weaknesses of the two current Children's Codes?*

    - RPH considers that the largest weakness of the two current Children's Codes is that they are suggestions, not recommendations to industry, and have been developed by industry themselves. While the intent is there, the language used in the Codes could reflect more strongly the use of 'smart regulation' that protects the health and wellbeing of our children. Therefore, RPH **recommends** that the health sector take a co-leadership role in creating smart regulations with industry, to implement a gradual phase-out of harmful advertising to children.
    - The Codes clearly cover advertising, yet advertising is just one strand of many marketing techniques that can be applied to promote products, services and brands to children. It is therefore important to see advertising in the broader context. That is, children are exposed to products not just through advertising, but through brand and product placement, through sponsorship, through point-of-sale, through packaging, [25] in every facet of their lives. It is therefore important that regulatory changes target the detrimental impacts from food, beverage and other products comprehensively and explicitly address marketing broadly which is harmful to children's health over a sustained period of exposure.

- Marketing influences children, particularly their food and beverage choices. It is both the government and industry's responsibility to work together to ensure this power is regulated to protect children's health and wellbeing. Self-regulation does not necessarily deter messages getting through that are "inconsistent with public health policy goals." Little reduction in the frequency of advertising unhealthy food has in fact been noted between 1997 and 2006. While social responsibility is referred to in the Codes, health and wellbeing outcomes do not reflect this. RPH **recommends** that social responsibility is defined and that the health sector collaborate with industry to create socially responsible, smart regulations.

2. *What are the strengths and weaknesses of the current complaints process?*

- The current process is a complaints-based system. It is not well understood and is lengthy which may have deterred individuals from making complaints. An accessible system for every citizen to understand and complete is necessary for all to be able to take control of their right to health. It is important from a public health perspective that the least harm possible is incurred from advertising; consequently a more equitable approach is needed.

- Children do not file complaints to the ASA, therefore RPH considers the system to be unsound. In order for the process to be completely transparent, child-centred and form part of a smart regulation system, children need to be able to express when they themselves perceive they are being affected by harmful advertising. RPH **recommends** implementing a more accessible complaints process that is child-friendly.

- RPH further **recommends** that the complaints process is streamlined to enable all complaints to be acted upon urgently and efficiently. RPH **recommends** establishing a process whereby when a complaint is made the advertisement is pulled from broadcast or publication within 24 hours and not returned to air either: until such a time as the complaint is resolved; or if the complaint is upheld, will remain withdrawn. RPH also **recommends** that increased promotion of how to make a complaint is required, as the Broadcasting Standards Authority is mandated to do regularly.[26]

- Additionally, further transparency and accountability in the complaints process is required. For example, making the composition and interests of the complaints board members available would be an initial step that RPH **recommends**.

3. *What changes, if any, are necessary to protect the rights of children and their health / wellbeing?*

- As mentioned, RPH considers it necessary to have collaboration between the health sector and industry present in the regulation of advertisements to protect the rights of children and their health and wellbeing.

- Given the far-reaching impacts that advertising in all its forms can have on the health and wellbeing of children, it is important that broad public health efforts to prevent the

onset of non-communicable diseases including obesity include comprehensive and far-reaching policies and smart regulation. Indeed,

> "There are good data that show that advertising does increase consumer spending by children and the products most advertised to children may not be the healthiest for them (e.g., junk food and fast food), whereas other products are woefully underadvertised (eg, healthy food, contraceptives)."

- Currently, broadcast advertisements must go through an industry led Commercial Approvals Bureau (CAB) to be able to be broadcast. CAB is reliant on the ASA Codes to regulate the appropriate content of advertisements. With the recommended gradual phase-out of harmful advertising to children, RPH envisages a regulatory approvals system, led by a collaboration between the health sector and industry, that supports and shapes advertising for broadcast or publication. This suggested approvals agency would work with advertisers to create advertisements directed at children that will improve health and wellbeing of children, e.g. public service announcements as are allowed in Quebec.[15]

- While the "Getting it Right for Children" document[27] details viewing time restrictions on free-to-air channels, there is little consistency. "There is a misalignment between children's programme times as defined by broadcasters and actual viewing times of children." Most stations stop restrictions at 5:00pm or 6:00pm yet the Broadcasting Standards Authority "Code of broadcasting practise states that the normally accepted viewing time for children is usually up to 8:30pm." It is understood that many children are watching beyond these restricted times, thus building an argument for extending restrictions on advertising to children. In the Irish example, children's viewing time stops at 9:00pm. However, if a show broadcast after 9:00pm and before 10:00pm has an expected audience where 50% of people are under age 18, then the children's restrictions apply.

- As mentioned, Article 17 of UNCROC affirms the protection of children from injurious material. Encouraging consumption of energy-dense foods and beverages and over consumption is leading to 'injurious' effects of overweight and obesity in children at an epidemic level. We refer again to the Irish example of advertising regulation that states "they should not encourage an unhealthy lifestyle or unhealthy eating or drinking habits such as immoderate consumption, excessive or compulsive eating."[19] The current NZ Codes allow a wide range of products to be advertised. In order to truly prioritise the health and wellbeing of the child, RPH **recommends** that the Codes should be created and led by collaboration between the health sector and industry.

- Once harmful advertisements (marketing) have been identified (as per the WHO framework and in concordance with UNCROC), a gradual phasing out of harmful advertising to children is **recommended**. A suggested schedule for phasing out harmful advertising is:

    - By end of 2017, phase-out harmful advertisements to children initially during existing children's viewing times.

- By end of 2018, extend children's viewing times to reflect actual viewing times and implement phase-out of harmful advertisements to children to reflect new times.
- By end of 2020, implement phase-out of harmful advertisements to children on all other media formats (print media, internet and social media, bus stops etc.).
- By end of 2021, harmful advertisements to children will be phased out on all media, all of the time.

- The Public Health sector focusses on equitable access to services and equitable outcomes for our most vulnerable populations. These are RPH's guiding principles. As the WHO stated in the Ending Childhood Obesity report this year, "Governments should ensure equitable coverage of interventions, particularly for excluded, marginalised or otherwise vulnerable population groups, who are at high risk of malnutrition in all its forms and of developing obesity." This argument further contributes to our case for increased collaboration between the health sector and industry to jointly regulate advertising to children.

- While children are not recommended any screen time under two years of age,[28] the reality is that many children start watching earlier, the average age being nine months. This means they are being influenced by screen content from a very young age. Potential effects of screen time include decreased parent-child interaction, reduced attention span and reduced visualisation. Additionally, there are studies showing that excessive exposure to screen time in infants can lead to language delay and poor visual development.[29]

- RPH also **recommends** regular reviews of the Codes to ensure that new societal trends and pressures that are predictors of health and wellbeing are covered within the scope of the regulations to protect child's rights.

4. *Please comment on any concerns you have with different media formats in relation to advertising to children (for example: magazines, television, social media, websites).*

- Research shows that regulating the internet is challenging and that parents and families need to be cognisant of the amount of time children are using the internet, social media and all other media formats. It should be noted that Facebook "advertisements must be age- and country-targeted and must comply with all locally required or recommended industry codes, guidelines, notice and warnings, licenses and approvals." Given that social media is ubiquitous in almost all young people's lives, alongside "the new potential of digital advertising to reach an increasingly younger audience, it seems vital to establish appropriate advertising ethics for what can and cannot be advertised to certain age groups." Therefore RPH **recommends** that a section on electronic and social media must be included in the Codes as one of the key methods used to reach children.

- It is clear that so called 'junk food' advertising affects "children's food beliefs and preferences" and the internet now provides another realm of concern with increased

food- and beverage-related content online. Furthermore, school-age children and adolescents are extremely likely to be affected by advertising of unhealthy food and "perceptions of ideal body image." Both physical and mental effects of harmful advertising on children must be considered when configuring the regulatory framework for advertising.

- RPH believes that examples of international regulatory approaches from Quebec, Ireland, the United Kingdom, Sweden and Norway show that regulatory measures can be applied to different media and require government regulation and impetus. RPH refers again to the example of tobacco advertising and how successful the phasing out of that has been in New Zealand.

7. *The Children's Codes currently define a child as under the age of 14. Do you support or oppose this definition? Why?*

- RPH **recommends** increasing the age to 18 years old to be in agreement with the UNCROC, WHO Ending Childhood Obesity Commission, and the New Zealand Obesity Plan. [30] This aligns with the Ireland Code which applies to all children up to the age of 18.[19]

- Research shows that brain development is not complete until children reach their 20s, and that cognitive reasoning is not fully developed.[1] "Marketing targeted at teenagers and young adults often reaches children" therefore it is advisable that the age limit is raised at least to the age of 18 to reduce this spread. These arguments largely refer to television advertising, but with increasing internet usage and capacity, it must also be applied to social and print media.[31] [25]

8. *Is there a role for a nutrient profiling system such as the health star rating system in the Children's Codes? If yes, in what way and which system would you suggest?*

- On packaged foods there is certainly a role for displaying the ingredients in a transparent and accessible way, together with the healthiness of the product. In the United Kingdom model, a nutrient profiling system has been implemented. [21] It is worthwhile to note however, that these systems do not apply to any food that is not packaged.

- Despite its limitations, RPH **recommends** the introduction of a nutrient profiling system to give weight to the identification of 'harmful advertising.' Once harmful advertising has been defined and identified, it can then be phased out as outlined in question 3.

- RPH considers that the Codes need to focus on what is being advertised, as well as how it is being advertised. RPH **recommends** that the review refers to the European model, published by WHO in 2015 as an example of a robust nutrient profiling system. This will clearly classify 'harmful' foods and beverages that should not be advertised to children.

9. *Do you support or oppose a specific guideline on sponsorship? Why?*

- RPH **supports** a specific guideline on sponsorship. We envisage that a gradual phase-out of harmful advertisements to children includes a phase-out of sponsorship.

- When community groups rely on sponsorship for funding to undertake their core business, often an ethical dilemma occurs. The lack of funding in the community puts undue pressure on organisations to continue to function with sponsorship from industry or organisations that contradict their ethos.[32] RPH considers therefore that sponsorship can be more insidious and harmful than advertising by itself. RPH **recommends** any sponsorship that aligns with the definition of harmful advertising is phased out rapidly.

- Similarly, regarding food industry sponsorship of sport or sporting organisations that occurs in New Zealand, some incongruence exists between the intentions of the sport and the ethics of having industry products that are harmful to health sponsoring the sport.[33] Being able to gauge what harmful sponsorship is must rely on a combination of the WHO nutrient profiling system, such as that mentioned above and the independent monitoring body as discussed in question 10. RPH therefore **recommends** that sponsorship that has a detrimental effect on health and wellbeing of children, both directly and indirectly, is phased-out more quickly than advertising generally.

10. *Do you support or oppose the introduction of independent monitoring and evaluation of the codes? How would this work?*

- RPH considers that having independent monitoring and evaluation of the Codes is of utmost importance to the success of a regulatory approach that protects and promotes the health and wellbeing of children. Indeed, the WHO acknowledges that transparency and independent accountability mechanisms are vital in improving childhood obesity outcomes.

- Government (i.e. the health sector) could have an overseeing role to ensure that programmes are implemented, monitored and evaluated as to their success. "The role of government is crucial in achieving lasting change in public health."

- RPH **recommends** that an independent monitoring and evaluation system is introduced. We envisage that a group of people comprised of health sector and industry representatives would perform regular scans of all forms of advertising present in the community. This would reduce the reliance on complaints for the ASA to act and therefore reduce harm. The group could then raise concerns more regularly by identifying potential Code violations, rather than relying on individual complaints to detect potential harm. The monitoring process should also be able to refer advertisements to the complaints board and move the system away from the individual consumer complaints-based process.

11. *What is your view of the sanctions imposed by the ASA when a complaint is upheld?*

- Currently, the sanctions imposed are limited and take some time to be implemented. Harm often occurs before sanctions are imposed. Harm starts when an advertisement is aired. If an advertisement that is injurious to the health and wellbeing of children is broadcast or published and not removed once a complaint is made, the penalties introduced are small compared to the harm done.

- Simply having the advertisement removed is not sufficient penalty. Financial infringement in addition to curbing ability to continue advertising, i.e. a short-term ban for the company, organisation or industry, is **recommended** to support compliance with the Codes. It is worthwhile to look at the high profile complaints process in Sweden as an example of a highly government regulated model.[22]

- RPH considers that it is crucial that the complaints board consider health and wellbeing at every step of the complaints process. RPH **recommends** that any sanctions applied as a penalty, should contribute to remedy the harm caused, such as contribution to health promotion campaigns, sponsorship or the suggested monitoring body. This could be compared to the gambling profits that are required to contribute to gambling harm reduction.[34]

12. *Are there environments where you consider it to be inappropriate to advertise to children?*

- Anywhere that children may gather or be present is not appropriate to advertise to children. This includes both the content and placement of advertisements in the environment.

- RPH considers that the following list includes, but is not limited to, the environments where advertising to children is inappropriate: schools, early childhood centres, education support services, health organisations, bus stops, sports games, sports facilities, shared community areas i.e. parks and halls, churches, retail areas, community noticeboards.

13. *Do you support or oppose combining the two current codes? Why?*

- Whether or not the Codes remain separate or are joined, RPH **recommends** that both Codes implement a gradual phase-out of harmful advertising to children, which is collaboratively overseen by the health sector and industry and supported by independent monitoring. For us, it is vital that the review of the Codes places the child at the centre in order to promote and protect their health and wellbeing.

- Since food advertising and obesity both have a high profile currently, if the Codes are amalgamated the emphasis on food advertising should not be lost.

6 Summary of RPH's recommendations

- RPH **recommends** enhanced collaboration between industry and the health sector to produce smart regulation that will benefit both industry and long-term health outcomes and ensure that all advertisements protect the rights, health and wellbeing of children. (Question 1)

- RPH **recommends** a gradual phase-out of harmful advertisements to children (a stepwise implementation approach) which will eventually become a comprehensive ban of harmful advertising to children across all media. RPH **recommends** enhanced health sector and industry collaboration in the advertising approvals process to facilitate this phasing out. (Questions 3 and 13)

- RPH **recommends** that the review panel refer to the WHO document "A Framework for implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children" for different ways of implementing these approaches. (Questions 1, 3 and 12)

- RPH **recommends** implementing an independent monitoring and evaluation group with representatives from health and industry which can uphold the intent of the reviewed advertising codes to reduce harm from advertising to children and have the power to submit advertisements to the Complaints Board. (Question 10)

- RPH **recommends** that the complaints based process is streamlined and advertised widely. (Questions 2 and 11)

- RPH **recommends** implementing increased sanctions on advertisers in case of Code violation that would

    - provide significant financial and other penalties to the infringer, and

    - directly benefit health promotion efforts to reduce harm caused by allocating the finances recouped to health promotion, sponsorship or monitoring.

  (Question 11)

- RPH **recommends** expanding the definition of children to include any person up to the age of 18. (Question 7)

- RPH **recommends** specific guidelines on sponsorship that will lead to a rapid phase-out of unhealthy and harmful sponsorship. (Question 9)

- RPH **recommends** the adoption of a nutrient profiling system to help identify harmful advertising. (Question 8)

- RPH **recommends** specifically addressing the use of electronic and social media in the Codes. (Question 4)

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