

DRAFT

**Protecting children from the
harmful impact of food marketing**

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Abbreviations

ASEAN	Association of Southeast Asian Nations
Code	International Code of Marketing of Breast-milk Substitutes
EU	European Union
HSR	Health Star Rating
NCD	noncommunicable disease
SDG	Sustainable Development Goal
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive summary

Every child deserves a healthy start to life. Good nutrition and healthy diets in the first two years of life and throughout childhood set the foundation for optimal growth and development, and for health and well-being throughout life. Yet no country in the Western Pacific Region is free from malnutrition. Some countries are struggling to reduce undernutrition; others to halt the increase in childhood, adolescent and adult overweight and obesity and diet-related noncommunicable diseases. But most Member States are facing both issues at once. All forms of malnutrition threaten health, human development, well-being and economic productivity.

Countries in the Western Pacific Region have experienced some of the most rapid economic growth in the world. Along with great benefits come increasing public health challenges to ensure public health measures are commensurate with the economic situation. Rapid economic growth has changed the food system, delivering cheaper processed foods of lower nutritive value. One of the most prevalent challenges is to make healthy and affordable food choices consistent with optimal nutrition. Marketing of food products to and for children is a specific area that requires greater attention. Marketing of breast-milk substitutes, including infant formula, follow-up formula and growing-up milk to caregivers continues, undermining breastfeeding in the first six months and continued breastfeeding up to 2 years of age or beyond. More than half of food marketing in nine Western Pacific countries promotes products high in salt, free sugars, saturated fats and trans-fatty acids. Studies show exposure of children to food marketing is associated with changes in dietary consumption. Systematic reviews have reported that advertising exposure is associated with greater food intake. Violations of the *International Code of Marketing of Breast-milk Substitutes* persist. Exclusive breastfeeding rates among infants under 6 months of age remain below the global target of 50% in most countries in the Region.

Despite commitments by countries to restrict marketing, only four countries have fully implemented the *International Code of Marketing of Breast-milk Substitutes* and subsequent relevant World Health Assembly resolutions, one country has taken regulatory action based on the WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children*, while others have voluntary or self-regulatory codes.

There is growing concern among countries about marketing of food and non-alcoholic beverages to children. Global commitments and guidance on marketing of food and non-alcoholic beverages provide policy recommendations and actions to restrict marketing to children. A number of countries have partially or fully implemented these recommendations.

This report describes the impact of marketing on the change of food preferences from traditional foods to cheaper, lower nutritive value foods. It also explores various legal, regulatory and other commonly used measures towards restoring and sustaining healthy food environments. It is organized first to define and present the impact of food marketing, followed by global guidance and country experiences in restricting marketing.

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1. Introduction

1.1 Background

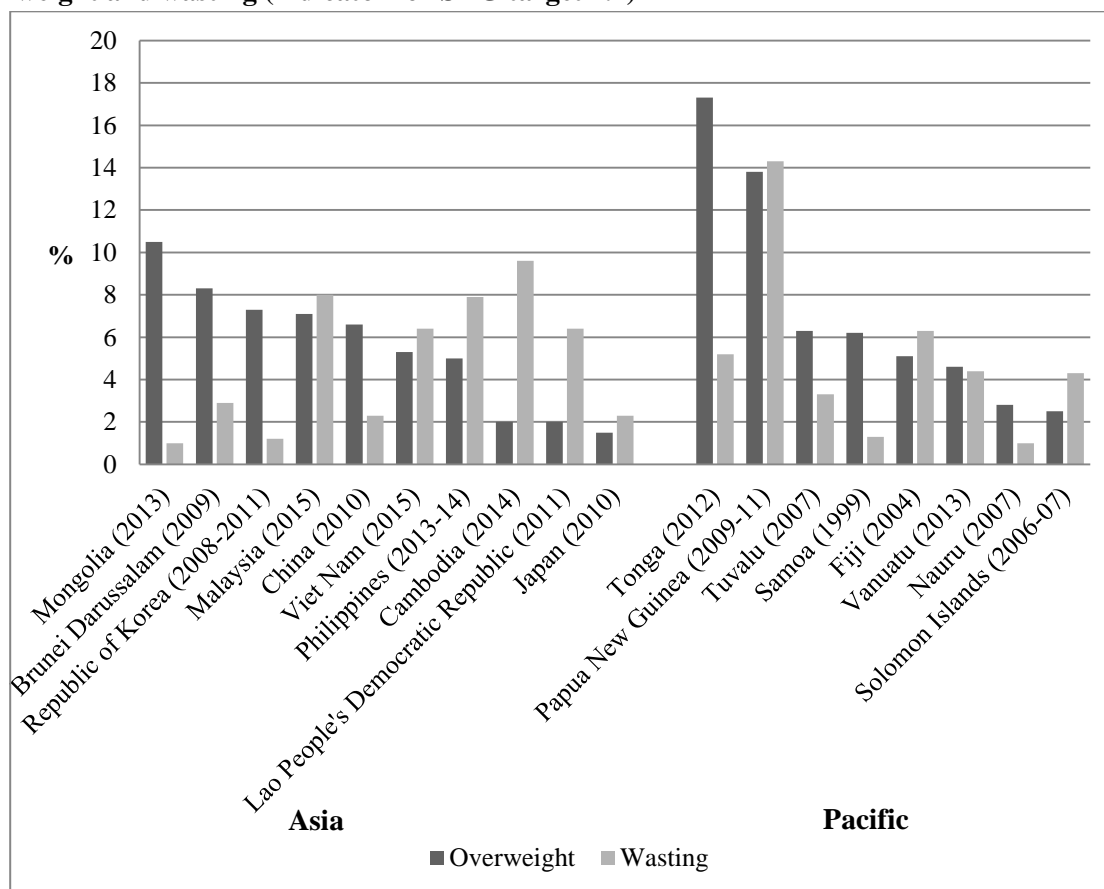
All children should have a healthy start to life: nutritious and safe food, safe drinking water, protected environment and freedom from exploitation (1). Central to a healthy start is optimal infant and young child feeding, including early initiation and exclusive breastfeeding for the first six months, continued breastfeeding to at least 2 years of age, and sufficient quality and quantity of complementary foods (2). Optimal infant and young child feeding is associated with reduced risk of death and frequency and severity of common childhood illness (e.g. diarrhoea, pneumonia, otitis media and neonatal sepsis) (3, 4). Children who were breastfed were found to have increased willingness to try new foods in infancy (5) and healthier diets (6) due to their exposure to the changing taste of breast-milk according to their mother's diet (7, 8).

No country in the Western Pacific Region is free from malnutrition (see Appendix 1 for definitions). The Region is still home to 7.5 million stunted children under 5 years of age (9). Nine countries are above the global target of 5% wasting (i.e. child weight is less than 2.5 percentile) (Fig. 1). Rates of optimal feeding are inversely related to the increase in consumption of breast-milk substitutes and energy-dense, nutrient-poor products targeted for infants and young children. Global sales of infant formula grew from US\$ 2 billion in 1987 to US\$ 40 billion in 2013 (10). The Asia and Pacific region has accounted for over US\$ 20 billion (56%) of the US\$ 36 billion global growth since 2003 (10).

Undernutrition in the first two years of life, suboptimal breastfeeding practices, recurring events of wasting and stunting all increase the risk of overweight and obesity and related noncommunicable diseases (NCDs) later in life (11).

More than 6.2 million children under 5 years of age are overweight or obese in the Region (9) (Fig. 1). No country met the global target of halting the rise of the obesity epidemic (12). Of the few countries with data in the Region, only four Member States are on track to meet the global target to halt the increase in prevalence of overweight by 2025 (13). Of these, three are still at risk of going off-course on meeting the global target. Three further countries are already off-course.

Fig. 1. Prevalence of malnutrition among children under 5 years of age disaggregated by type: overweight and wasting (indicator for SDG target 2.2)



Sources: *UNICEF/WHO/World Bank Group: Joint child malnutrition estimates 2016* and WHO Global Targets Tracking Tool (2017), latest available data (countries with available data shown).

A major cause of obesity is overconsumption of unhealthy foods. Unhealthy foods are defined as those exceeding thresholds for free sugars, saturated and trans-fats, and salt (Appendix 2 describes healthy diet while Appendix 3 provides an abridged version of the *WHO Nutrient Profile Model for the Western Pacific Region*). In 2015, unhealthy diets directly accounted for 37% of deaths and over a quarter of total disease burden (14). The annual economic costs range from €1.4 billion in Australia to €5.2 billion in China (14). In contrast, healthy diets reduce family expenditure and increase gross domestic product (15).

Evidence associating food marketing with poor nutrition and health outcomes is accumulating (16, 17).

1.2 Purpose and structure of the document

This report explores the impact of marketing on the change of food preferences from traditional foods to cheaper, lower nutritive value foods. It also explores various legal, regulatory and other commonly used measures towards restoring and sustaining healthy food environments. It is organized first to define and present the impact of food marketing, followed by global guidance and country experiences in restricting marketing.

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2. Food marketing and its impact

2.1 Definition and overview of marketing

The WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* defines marketing as “any form of commercial communication or message that is designed to, or has the effect of, increasing recognition, appeal and/or consumption of particular products and services”. It includes advertising, promotion and sponsorship (Table 1). Modern communication technologies including the Internet, social media and mobile phones increase the reach of marketing.

Table 1. The three major forms of marketing

Type	Definition	Examples
Advertising	Any form of communication, recommendation or action with the aim, effect or likely effect of advertising food products or their use either directly or indirectly.	Broadcast (television and radio), point-of-sale (e.g. pop-ups and billboards), vending machines, print (brochures, newspapers, comic books and magazines), new media (blogs, news sites, films and media clips watched online, social media such as Facebook, Twitter and Instagram), outdoor billboards, posters, moving vehicles, advergames (downloadable or Internet-based video game that advertises a brand-name product by featuring it as part of the game).
Promotion	Any form of recommendation, action or communication of messages designed to effect, persuade or encourage the purchase or consumption of a product or raise awareness of a brand, either directly or indirectly.	Free samples, tie-ins (e.g. toys), purchase incentives (e.g. competitions and collect-all) characters (e.g. brand equity characters), point-of-sale (e.g. buy and win), branding, product placement (in television shows, films, computer games), branded books (e.g. counting books for pre-schoolers), branded toys (e.g. fast-food store as playhouse), branded computer games, loyalty programmes, celebrity or health professional endorsement, cross-promotion, brand-sharing, brand-stretching and promotion through the health system. Cross-promotion is a form of promotion where customers of one product or service are targeted with promotion of a related product. Cross promotion includes packaging, branding or labelling of a product to closely resemble that of another. It can also refer to use of a particular promotional activity for one product and/or promotion of that product in a particular setting to promote another product.

Sponsorship	Any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting food products or their use either directly or indirectly.	<p>Sponsoring of school infrastructure or materials (e.g. sports facilities or books), community, sports or cultural events, training and education programmes, conferences (e.g. for health professionals), sports teams, programmes including public health campaigns and school breakfast or lunch programmes. Companies often refer to sponsorship as corporate social responsibility.</p> <p>Stakeholder marketing, another form of sponsorship, is commonly used to engage with government or other key stakeholders (by paying for social activities, from meals to participation in events and private functions).</p>
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Source: Based on *Guidelines for Implementation of Article 13 of the WHO Framework Convention on Tobacco Control (Tobacco Advertising, Promotion and Sponsorship)* (2009) and *A Framework for Implementing the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* (2012).

Marketing impact is related to the amount of marketing reaching its target audience and the power of each exposure. Exposure to marketing refers to the quantity, frequency and reach of marketing communications (18). Power is the extent to which each marketing item convinces its target audience to use the product (18). This section summarizes evidence of exposure, power and impact of food marketing on infant and young child feeding and on older children; food products such as breast-milk substitutes and foods and non-alcoholic beverages are also discussed separately.

2.2 Impact of marketing of breast-milk substitutes

Power is affected by content design, nature and execution of communication of marketing messages. Themes for marketing of breast-milk substitutes and foods for infants and young children build on the desire of caregivers to provide the best nourishment and the best start to a healthy life. Although differences exist in food marketing techniques and channels for certain products (e.g. breast-milk substitutes directly marketed through the health system), the majority of techniques and channels are common for all products from cradle to grave (18).

Internet-based marketing is evolving to include online promotions, games and groups on social media (19,20). A study in the United States of America found that 10 of 11 breast-milk substitute brands had a social media presence, primarily through Facebook, webpages, interactive features on the brands' own websites, mobile apps for new and expectant mothers, YouTube videos, sponsored reviews on parenting blogs, and other financial relationships with parenting blogs such as industry trade group's financial sponsorship of an independent blog critical of breastfeeding promotion efforts, or sponsorship of events for parenting bloggers with travel and accommodation provided to invited guests (21). Editorial content (i.e. content produced by journalists) in magazines is used to target mothers with information related to bottle-feeding or breastfeeding while cross-referencing breast-milk substitutes or feeding products. In Viet Nam, breast-milk substitutes were mentioned in almost two thirds of editorial content and about a third in Cambodia in a three-month media audit in 2015 (22).

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Company representatives have been documented to offer financial incentives to health workers to promote breast-milk substitutes in China and the Philippines (23). Health professional and hospital promotions are viewed as credible sources of information and thus are powerful channels for marketing (2, 10). Mothers to whom doctors recommended or gave prescriptions to use infant formula were found to be four times more likely to give their infants infant formula (2). The promotion types included sponsored equipment, price-related promotions (such as discounts), displays, product information materials, free-gifts and products, cross-product promotions, product samples and company representatives (24). Infant formula provided for free in maternity facilities or given in discharge packs has a negative impact of breastfeeding initiation, duration (23) and exclusivity (25, 26).

A common marketing approach is targeting a caregiver's concerns about the nutrition and health needs of their infant or young child (10, 27). A media audit in Cambodia, Indonesia, Myanmar, Thailand and Viet Nam found that common Facebook posts and conversations moderated by breast-milk substitute companies were about mothers worrying about not being able to produce enough breast milk, and questions around breast milk having sufficient energy and nutrients for newborn children. Virtually all women are physiologically able to breastfeed (28). Companies also used their Facebook pages to promote their brands and products and often gave advice about infant and young child feeding (22). Messages may suggest that ingredients added to a product improve intelligence, infer superiority to breast milk, or claim to solve digestive problems or to help an infant sleep through the night (10).

An emerging area of concern is cross-promotion of product categories. In Phnom Penh, Cambodia, 61 of the 63 (96.85%) follow-up and growing-up formulas that were recommended for the 6–24-month age range were manufactured by a company that also produced an infant formula, and 96.7% were cross-promoted (29). In Australia, a study of toddler milk advertising found most respondents (66.8%) reported seeing an advertisement for infant formula “with those who had seen non-retail advertising more than twice as likely to believe that they had seen such an advertisement as those who had only seen retail advertising” (30). Research has shown that mothers do not differentiate between categories of breast-milk substitutes, and that cross-promotion causes consumers associating advertisements of one product with all similar products produced by the same manufacturer (27).

In the Lao People's Democratic Republic, a study found that up to 89.9% of mothers reported frequent exposure to cross-border television advertisements for infant formula from Thai media (31). In Cambodia, 86% of mothers in a study reported exposure to commercial promotions of breast-milk substitutes (32). In six provinces in Cambodia, point-of-sale promotions of infant formula were found in more than half of sites (24).

2.3 Concern is growing among countries about marketing of food and non-alcoholic beverages

Children's food preferences, choices and consumption are easily influenced (33). Most children under 5 years of age cannot distinguish television advertising from regular programming, and children under 8 years believe what they see – they do not have the ability to understand its persuasive intent (34). A systematic review reported that in low- and middle-income countries, children are independent consumers, and influencers of the purchase decisions of their families and their peers (34). Parents with lower income were twice as likely to yield to a child's requests to purchase cereals than upper-

middle-income parents ($F = 23.92$, $P < 0.0001$), according to one study in Canada (35). A systematic review and meta-analysis reported a significant effect of moderate size associated with advertising exposure and increased food intake in children (standard mean difference: 0.56, $P = 0.003$) (36).

The dynamic and sophisticated nature of digital media enables marketers to directly connect and engage with their target audiences (37, 38). Viral marketing encourages children to send marketing messages to their friends (39). Emails forwarded by friends about a freebie from a website were 10 times more likely to be opened than unsolicited emails.

In 2005, Saturday morning television programming was found to have movie, cartoon, animated or costumed characters in 74% of food adverts (40). Other strategies include the use of famous sports personalities or celebrities, an offer of “free toys”, music, downloadable software, mobile telephone ringtones, and other goods and services that may appeal to children (18). Frequently deployed themes are taste, humour, action–adventure, fantasy and fun (19). Purchase incentives and the use of innovative digital technology-mediated promotions are increasing (34).

Cross-promotion is increasingly used to market foods to children and adolescents (41, 42). This also includes the use of licensed characters and celebrities to increase youth appeal of food products through association with entertainment or other properties popular with children.

2.3.1 Exposure to food and non-alcoholic beverages marketing to children

In nine countries in the Western Pacific Region where data are available, marketing of unhealthy foods ranges from 53.7% to 92% of food marketing to children (34, 43, 44). Unhealthy food advertisements on television were found to be predominant in Malaysia, with rates that increased from 1.95 food ads/hour/channel during school days to 3.5 ads/hour/channel during school holidays (45). In Singapore, 57% of food advertisements on television were for unhealthy foods such as candy, confections and fast food. In the United States, children see 12–16 ads per day for products that are high in saturated fat, sugar or sodium (34). In Mongolia and the Philippines, the density of outdoor food advertising has been found to be twice as high in the area closest to schools than in the area further from schools, and almost all advertising was for unhealthy foods and drinks (92% in Ulaanbaatar and 85% in Manila) (43). Preliminary findings of a study of food marketing to children in New Zealand were that almost half of food marketing that children were exposed to in schools were for unhealthy foods such as sugary drinks and snack foods (46). In Australia, a study found that 80% of outdoor food advertisements around primary schools in Sydney and Wollongong were for unhealthy foods (44). A 2008 United States report found spending on food marketing to children of US\$ 280 million for healthy foods versus US\$ 1.7 billion for unhealthy foods (41).

The modern communication environment provides food marketers with almost unlimited access to children, their caregivers and educators, and facilitates the use of advertising, promotion and sponsorship. Marketing to promote the consumption of foods that are high in salt, free sugars and/or fats vastly outweighs marketing of healthy foods (34, 43, 44).

Children are exposed to high levels of food marketing across a range of media, settings and events. Television remains the most popular marketing channel to children, but its dominance is waning (34). With the emergence of the Internet and new media over the past decade, there has been a shift in children’s screen time from television to the Internet (39), and marketers are increasingly using websites, digital media and social networking (47). In Australia, a study showed the top fast food, soda

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and chocolate brands used mobile applications, Facebook, and branded websites to promote their products (42). Similarly, a study in New Zealand found that a range of marketing techniques was used on food brand websites, including advertication (a combination of advertising and education using brand characters to present educational topics or working the product into an educational message) (87%), viral marketing (64%), cookies (54%), free downloadable items (43%), promotional characters (39%), designated children's sections (19%) and advergaming (13%). These techniques appeared more frequently on websites specifically targeting children and adolescents (39). In the real world environment, unhealthy food marketing is most dense where children gather, such as schools as documented in Ulaanbaatar, Mongolia and Manila, Philippines (43, 44).

In 2006, 14.5% of all food marketing expenditures in the United States targeting youth involved cross-promotion or celebrities, compared with only 4% of adult-targeted food marketing (41). A study found that two thirds of cross-promotions occurred in five food categories: cereals, fruit snacks, ready meal products, frozen desserts and candy (42). A study found six advertisements per hour for unhealthy foods in the Asia and Pacific region and 19% of food advertisements were for sugar-sweetened beverages (48).

Nine- and 10-year-old English children were found to be able to recall adverts in the past two weeks in seven different food categories (35). Eighty per cent of Chilean children aged 6–11 years were able to recall food adverts that they liked (49). Ten studies found that exposure to food promotion was associated with significant changes in children's food preferences towards foods that are high in fat, salt or sugar. Three studies found children were more likely to choose an advertised brand than a non-advertised brand of the same product type after exposure to adverts (34, 49).

Exposure to 100 incremental television ads for sugar-sweetened carbonated soft drinks and fast foods during 2002–2004 was associated with a 9.4% and 1.1% rise, respectively, in children's consumption of soft drinks and fast foods in 2004. Furthermore, fast food advertising was significantly associated with body mass index (BMI) for overweight and obese children (\geq 85th BMI percentile): a 10 000 gross rating point (GRP)¹ increase in fast food advertising was associated with a 0.01 unit increase in the BMI z-score ($p < 0.01$), an increase of 1.5% from a mean BMI score of 0.668 (50). A systematic review found 14 studies that showed a positive association between food promotion and increased snacking, increased energy intake and less healthful food choices (45). Eight cross-sectional studies indicate that food promotion can act as a significant independent determinant of children's food behaviours and health status.

Evidence from the Western Pacific Region shows that exposure to television advertising for energy-dense and nutrient-poor foods is associated with decreased intake of healthy foods such as fruits and vegetables (17).

¹ GRP is a percentage of a specific target reached by advertising for the category of interest in a specific designated market area during a certain period of time. For example, an advertising campaign that reaches 80% of a demographic group during the year on average 100 times will have a GRP of $80 \times 100 = 8000$ for that year.

3. Global guidance and country responses

3.1 Global guidance

All but one country globally have ratified the *Convention on the Rights of the Child* (CRC). The CRC includes provisions on “the right of the child to the enjoyment of the highest attainable standard of health” (Article 24). Member States also issued a general comment that “States are required to introduce into domestic law, implement and enforce internationally agreed standards concerning children’s right to health, including the International Code on Marketing of Breast-milk Substitutes ...” and “The marketing of these substances [foods that are high in fat, sugar or salt, energy-dense and micronutrient-poor, and drinks containing high levels of caffeine or other potentially harmful substances] – especially ... focused on children – should be regulated and their availability in schools and other places controlled” (1). The World Health Assembly endorsed the *International Code of Marketing of Breast-milk Substitutes* (hereinafter “the Code”) and subsequent relevant World Health Assembly resolutions including recommended actions to “translate the International Code into national legislation, regulations or other suitable measures” (Appendix 5). The Regional Committee for the Western Pacific in 2014 endorsed the *Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific Region (2015–2020)* and the *Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)*, which include provisions on full adoption, enforcement and monitoring of the Code and the *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children*.

The United Nations General Assembly endorsed the Sustainable Development Goals (SDG2 on food and nutrition, SDG3 on health and well-being, and SDG12 on sustainable production and consumption), *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases* (2011) and the United Nations Decade of Action on Nutrition (2016–2025). The Work Programme for the United Nations Decade of Action on Nutrition contains marketing of foods and beverages to children as one of the topics for development of commitments and establishment of action networks. Additionally, the World Health Assembly has endorsed the WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children*, the *Global Strategy on Diet, Physical Activity and Health* (2004), the *Global Strategy for Infant and Young Child Feeding* (2002), the *Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition* (2014) and the final report by the Commission on Ending Childhood Obesity (2016). These further clarify recommendations to promote healthy diets and combat childhood obesity including implementing restrictions on marketing of unhealthy foods (Appendix 3).

The *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* (endorsed by the World Health Assembly in resolution WHA63.14) guides efforts by Member States to design or strengthen existing policies to reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars or salt. A *Framework for Implementing the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* was developed in response to the mandate of resolution WHA63.14 and is aimed at policy-makers wanting to apply the Recommendations. The Framework includes defining the concept of marketing and a step-by-step process for policy development, policy implementation, and establishment of a monitoring and evaluation system.

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3.2 Country responses to marketing of breast-milk substitutes

The *International Code of Marketing of Breast-milk Substitutes* has been partially or fully enacted in legislation in 135 countries. Of these, 39 countries have comprehensive legislation or other legal measures reflecting all or most provisions of the Code. However, only 32 reported having an enforcement mechanism in place and fewer were functional. Challenges were noted to include a lack of political will to legislate and enforce the Code, as well as continued interference from manufacturers and distributors in governments' efforts to initiate or strengthen Code monitoring and enforcement measures.

Despite the 1981 Code, marketing of these products continues in the Western Pacific Region (22, 51). Four countries in the Region (Appendix 4) have provisions of the Code as part of national legislative measures, but monitoring and enforcement remain challenging (52). Restriction of marketing activities, as appropriate, is one of the time-bound commitments to achieve global NCD targets (53).

In the Region, Fiji, Palau, the Philippines and Viet Nam are fully implementing the Code (52).² Mongolia has recently passed and strengthened national law on the Code for infants and young children up to the age of 24 months on marketing of breast-milk substitutes and complementary foods. The national law on the Code in the Philippines has the provision that neither the container nor the label shall have pictures or texts that may idealize the use of infant formula. The Code in Viet Nam prohibits the use of images on breast-milk substitutes similar to those on labels of milks for pregnant women. The Mongolian law includes a provision that prohibits the use of labels on complementary foods and beverages (for children up to the age of 24 months) that idealize the use of breast-milk substitutes. Hong Kong SAR (China) is currently finalizing its voluntary adaptation of the Code, and plans to collaborate with relevant nongovernmental organization and academia to conduct surveys to evaluate the effectiveness of the initiative.

Monitoring and enforcement mechanisms remain a challenge for many countries (52). However, some countries (e.g. Cambodia) have adapted a monitoring protocol on their national implementation of the Code.

3.3 Country responses to marketing of food and non-alcoholic beverages to children

Countries have also taken action to restrict marketing of food and non-alcoholic beverages to children in school settings. Vanuatu has a policy in place to restrict the marketing and sale of sugar-sweetened beverages across educational facilities. The Philippines has recently passed a policy to restrict the sale and marketing of unhealthy foods and beverages in schools. Samoa has school nutrition standards to restrict what foods are available on school grounds, thus restricting both the sale and marketing of foods that are not in line with national dietary guidelines.

Front-of-pack labelling schemes can be used to promote products that are low in salt, free sugars and/or fats, or they can warn consumers if products are high in these ingredient. Recently, a front-of-pack labelling scheme has been introduced in Association of Southeast Asian Nations (ASEAN) countries intended to promote healthier consumer choices (Appendix 4). Australia and New Zealand

² See Appendix 5 for a summary of a case study from Viet Nam.

implemented a government-led front-of-pack initiative, the Health Star Rating (HSR), in June 2014. The HSR is a nutrient profiling system that rates the nutrition content (energy, saturated fat, total sugars and sodium) of packaged foods in half-star increments from half a star (least healthy) to five stars (most healthy) displayed at the front-of-pack (54). A recently published study concluded that consumers found the HSR labels useful and easy to understand, but that the system has not had a significant effect on consumer purchase behaviour (55). The Codex Alimentarius Commission has developed science-based, internationally accepted labelling standards for nutrition labelling, health and nutrition claims, but not yet for front-of-pack labelling.

Full implementation of the WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* remains a challenge. However, globally, good practice examples are emerging, such as from the Republic of Korea (Appendix 7) and Chile (Appendix 8). In the Republic of Korea, the increase in childhood obesity has levelled off since the introduction of its law on safety management of children's diets (56). Chile's comprehensive initiative has sparked great interest in the public health community. It has a strict nutrient profiling system and extensive provisions, which include enhancing the school food environment, requiring front-of-pack labelling and regulating marketing of foods to children. Chile's law on food composition and advertising entered into force in June 2016. Evaluation is ongoing but shows initial wide recognition and support by the population.

Two WHO regions, namely the European Region and the Region of the Americas, have established guidance for developing regulatory actions. The WHO European Action Network on reducing marketing pressure on children established the *Code on Marketing Food and Non-Alcoholic Beverages to Children*. A Pan American Health Organization Expert Consultation on the Marketing of Food and Non-alcoholic Beverages to Children in the Americas recommended that marketing to children should be enforced through legal provisions. The Regional Committee for the Eastern Mediterranean endorsed resolution EM/RC54/R.9, *Food Marketing to Children and Adolescents in the Eastern Mediterranean Region: Implications for Public Health*. The resolution "URGES Member States to: 1.1 Develop appropriate multisectoral approaches and regulations to deal with the marketing of food and beverages directed at children and adolescents, including such issues as sponsorship, promotion, and advertising to involve celebrities in promoting healthy food habits; ... [and] 1.5 Establish a multisectoral mechanism to monitor the implementation of regulations regarding the marketing of food and beverages directed at children and adolescents". Evaluations were not found on the impact of the regional guidance provided.

Four necessary elements were found common to the three countries (Chile, Republic of Korea and Viet Nam) for protecting children from the harmful impact of food marketing:

- 1) require food labelling aligned with Codex Alimentarius;
- 2) develop or adapt thresholds and a classification system for salt, free sugars, saturated fats and trans-fatty acids using nutrient profiling;
- 3) develop restrictions on marketing of foods that are classified as having content above the thresholds set; and
- 4) continuously review food products sold to or commonly consumed by children.

Viet Nam, the Republic of Korea and Chile have successfully taken regulatory actions towards establishing protections for children from the harmful impact of food marketing (Appendixes 6–8).

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They first gathered information on the nutrition and health status of the population. Based on this, they defined the scope of action including type of marketing, setting and age of children, and finally either revised existing laws or drafted a new law. This required engaging partners, reviewing existing laws that may be built upon, preparing for opposition and developing enforcement mechanisms.

Countries may find voluntary action easier to implement as an intermediate step towards regulation. However, a systematic review of voluntary initiatives to “limit advertising to children” through such measures found food marketing continued with only small or no reductions (42, 57–61). In Mexico for example, companies that signed the self-regulation code focused 92.7% of their advertisements on unhealthy foods and beverages, and 23.9% of their total advertisements for foods and beverages were aimed at children and 7.1% at adolescents (62).

The impact of self-regulatory or voluntary codes is limited by the extent of uptake by food companies (60) or participation by child-oriented food marketers (63). Lack of impact was reportedly related to weak nutritional standards for defining healthy foods employed by industry (63), permissive definitions of foods considered inappropriate for marketing, inadequate definitions for when and where food marketing to children can occur (59), or codes covering only some types of marketing (20). One study found that commitments and nutritional criteria of companies that signed on to the European Union (EU) pledge for responsible marketing of food and beverages to children varied considerably and lacked transparency (64). Another study reported that 90% of products marketed to children from EU pledge signatory companies do not meet the criteria set by WHO (62). In Australia, a study of food advertisements to children found that 61% failed the Australia and New Zealand nutrient profiling criteria and that 68% of advertisements by companies signatory to the Responsible Children’s Marketing Initiative failed (64). The continued marketing of unhealthy foods in countries with self-regulatory or voluntary codes indicates that such measures in their current form do not adequately protect children. Voluntary actions are the first choice for action in some countries.

4. Summary

This report described the harmful impact of food marketing to children and how countries have responded. Marketing of unhealthy foods to children alters food preferences and consumption, thereby contributing to unhealthy diets. Despite international commitments and guidance to mitigate the negative impact, marketing of breast-milk substitutes as well as food and non-alcoholic beverages remains. This report also explored various legal, regulatory and other commonly used measures towards restoring and sustaining healthy food environments.

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Appendix 1. Glossary

Advertising

Any form of communication, recommendation or action with the aim, effect or likely effect of advertising food products or their use either directly or indirectly.

Breast-milk substitutes

Any food or beverage being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose (1). A breast-milk substitute should be understood to include any milks (or products that could be used to replace milk, such as fortified soy milk), in either liquid or powdered form, that are specifically marketed for feeding infants and young children up to the age of 3 years (including infant formula, follow-up formula and growing-up milks).

Commercial complementary food

Complementary food and drink products that are manufactured, packaged and sold commercially. These products are marketed as suitable for feeding children up to 3 years of age. This age definition is in line with the relevant Codex Alimentarius guidelines and standards on foods for infants and young children that refer to young children up to the age of 3 years (2).

Complementary food

Any food or beverage, whether manufactured or locally prepared, suitable as a complement to breast-milk or breast-milk substitutes when either becomes insufficient to satisfy the nutritional needs of the infant (1).

Cross-promotion

A form of promotion where customers of one product or service are targeted with promotion of a related product. Cross promotion includes packaging, branding or labelling of a product to closely resemble that of another. It can also refer to use of a particular promotional activity for one product and/or promotion of that product in a particular setting to promote another product.

Double burden of malnutrition

Refers to the burden of undernutrition (wasting, stunting, low birthweight and micronutrient deficiencies, including among those of normal weight or the overweight) along with the burden of overweight and obesity linked to a rise in noncommunicable diseases (3).

Follow-up formula

Sometimes also referred to as follow-up milk or follow-on milk, this includes milk or milk-like formulation commonly marketed for babies from 6 months of age and prepared in accordance with relevant international or national standard. The upper age indication on the product label varies from country to country but is usually between 12 and 24 months.

Food

Any non-alcoholic substance intended for human consumption. This definition includes breast milk, all breast-milk substitutes, all complementary foods, foods and non-alcoholic beverages such as sugar-sweetened beverages.

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Food and non-alcoholic beverages

Any type of food or beverage not containing alcohol. This definition includes all processed and unprocessed food products and beverages.

Food environment

The range of foods available, affordable, convenient and desirable to people. Food market environments constrain and signal consumers what to purchase; wild and cultivated food environments also can provide availability and convenience of foods (4).

Food system

Gathers all the elements (environment, people, inputs, processes, infrastructures, institutions, etc.) and activities that relate to the production, processing, distribution, preparation and consumption of food, and the outputs of these activities, including socioeconomic and environmental outcomes (4, 5).

Free sugars

All monosaccharides and disaccharides added to foods by the manufacturer, cook or consumer, plus sugars naturally present in honey, syrups, fruit juices and fruit concentrates. The definition does not cover intrinsic sugars in, for example, fruits and vegetables (6).

Growing-up formula

Sometimes also referred to as growing-up milk, toddler milk or formulated milk. This product is targeted at infants and young children aged between 1 year (sometimes younger) and 3 years. Often, the product name is similar to a company's infant formula products, with a figure "3" added on.

Infant formula

Includes milk or milk-like formulation that can be fed to infants from birth and prepared in accordance with relevant international or national standard. The upper age indication on the product label varies from country to country but is usually between 6 months and 12 months. There is a variety of infant formulas. This includes "special" formula such as soy formula, lactose-free formula, low-birthweight/premature formula and therapeutic milks.

Malnutrition

Refers to the body not getting the right balance of nutrients and calories needed to sustain good health and development. It arises mainly as a result of inadequate or unbalanced diets, but is also caused by poor nutrient absorption or loss of nutrients due to illness. The causes of malnutrition are directly related to inadequate dietary intake as well as disease, but are directly related to many factors, including household food security, maternal and child care, health services, environment and other factors. Malnutrition thus includes undernutrition (wasting, stunting and low birthweight), micronutrient deficiencies (including among those of normal weight or overweight) and overweight/obesity (3).

Marketing

Refers to any form of commercial communications or message that is designed to, or has the effect of, increasing the recognition, appeal and/or consumption of particular products and services. It comprises anything that acts to advertise or otherwise promote a product or service (7).

Noncommunicable diseases

Diseases not passed from person to person. They are of long duration and generally slow progression. The four main types of noncommunicable diseases (NCDs) are cardiovascular diseases (e.g. heart disease), cancers, chronic respiratory diseases (e.g. asthma and chronic obstructed pulmonary disease) and diabetes. Tobacco use, physical inactivity, unhealthy diets and the harmful use of alcohol are the major risk factors for most NCDs (3).

Promotion

Any form of recommendation, action or communication of messages designed to effect, persuade or encourage the purchase or consumption of a product or raise awareness of a brand, either directly or indirectly.

Sponsorship

Any form of contribution to any event, activity or individual with the aim, effect or likely effect of promoting food products or their use either directly or indirectly.

Stakeholder marketing

A form of sponsorship commonly used to engage with government or other key stakeholders (by paying for social activities, from meals to participation in events and private functions).

Sugar-sweetened beverages

Any beverages containing free sugars. These include carbonated or non-carbonated soft drinks, fruit/vegetable juices and drinks, liquid and powder concentrates, flavoured water, energy and sports drinks, ready-to-drink tea, ready-to-drink coffee and flavoured milk drinks. Free sugars cover monosaccharides (such as glucose or fructose), disaccharides (such as sucrose or table sugar) and high-fructose corn syrup added by the manufacturer, cook or consumer during processing or preparation, or free sugars naturally present in honey, syrups, fruit juices and fruit concentrates. This definition does not include beverages with non-sugar sweeteners or any form of breast-milk substitutes (8).

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Appendix 2. Healthy diet

Key facts

- A healthy diet helps protect against malnutrition in all its forms, as well as noncommunicable diseases (NCDs), including diabetes, heart diseases, stroke and cancer.
- Unhealthy diet and lack of physical activity are leading global risks to health.
- Healthy dietary practices start early in life – breastfeeding fosters healthy growth and improves cognitive development, and may have longer-term health benefits, like reducing the risk of becoming overweight or obese and developing NCDs later in life.
- Energy intake (calories) should be in balance with energy expenditure. Evidence indicates that total fat should not exceed total energy intake to avoid unhealthy weight gain with a shift away from saturated fats to unsaturated fats, and towards the elimination of industrial trans fats.
- Limiting intake of free sugars to less than 10% of total energy intake is part of a healthy diet. A further reduction to less than 5% of total energy is suggested for additional health benefits.
- Keeping salt intake to less than 5 g per day helps prevent hypertension and reduces the risk of heart disease and stroke in the adult population.

Healthy diet for infants and young children

In the first 2 years of a child's life, optimal nutrition fosters healthy growth and improves cognitive development. It also reduces the risk of becoming overweight or obese and developing NCDs later in life. Advice on a healthy diet for infants and children is similar to that for adults, but the following elements are also important:

- Infants should be breastfed exclusively during the first 6 months of life.
- Infants should be breastfed continuously until 2 years of age and beyond.
- From 6 months of age, breast milk should be complemented with a variety of adequate, safe and nutrient dense complementary foods. Salt and sugars should not be added to complementary foods.

Currently there is no dietary recommendation of global utility available for children and adolescents.

However, individuals and populations are advised to:

- increase the consumption of fruit and vegetables, as well as legumes, whole grains and nuts;
- limit the energy intake from total fats and shift fat consumption away from saturated fats to unsaturated fats; and
- limit the intake of sugars.

Source: Extracts from World Health Organization. Healthy diet [Internet]. 2015. Available from: <http://www.who.int/entity/mediacentre/factsheets/fs394/en/>

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Appendix 3. WHO Nutrient Profile Model for the Western Pacific Region

This is an abridged version of the *WHO Nutrient Profile Model for the Western Pacific Region: A Tool to Protect Children from Food Marketing* (2016). The model consists of a total of 18 food categories. The nutrients covered and for which thresholds are set are: total fat, total sugar, added sugar, non-sugar sweetener, energy, saturated fat and sodium. These thresholds are used to determine where marketing to children should be restricted (Table A3.1). Marketing is prohibited if thresholds exceed per 100 grams.

Table A3.1. Thresholds beyond which WHO recommends marketing be restricted

Food category	Total fat (g)	Saturated fat (g)	Total sugars (g)	Added sugars (g)	Non-sugar sweetener	Sodium	Energy (kcal)
1 Chocolate and sugar confectionery, energy bars and sweet toppings and desserts	Not permitted						
2 Cakes, sweet biscuits and pastries, other sweet bakery products, dry mixes for making such	Not permitted						
3 Savoury snacks				0		0.04	
4 Beverages							
a) Juices			5		0		
b) Milk drinks	4			0	0		
c) Energy drinks, tea and coffee	Not permitted						
5 Edible ices	4		10		0	0.08	
6 Breakfast cereals	10		15		0	0.64	
7 Yogurts, sour milk, cream, other similar foods	4		10		0	0.08	
8 Cheese	20	20				0.52	
9 Ready-made and convenience foods and composite dishes	10	4	10			0.4	225
10 Butter and other fats and oils		20		0	0	0.56	
11 Bread, bread products and crisp breads	10		10			0.48	
12 Fresh or dried noodles, pasta, rice and grains	10		10			0.48	
13 Fresh and frozen meat, poultry, fish and similar	20						
14 Processed meat, poultry and similar	20						
15 Fresh and frozen fruit, vegetables and legumes	20					0.68	
16 Processed fruit, vegetables and legumes	5		10	0		0.4	
17 Products made from soya	12		10	0		0.4	
18 Sauces, dips and dressings	10			0		0.4	

Appendix 4. Implementation of policies to protect children from the harmful impact of food marketing in the Western Pacific Region

The table below summarizes the implementation of policies to protect children from the harmful impact of food marketing in the Western Pacific Region.

Legal action	A green cell implies that some type of legislation (legally enforceable measure) is in place. Refer to A, B and C below the table for further classification/explanation.
Voluntary action	A yellow cell implies that some type of voluntary action is in place. This might include voluntary pledges, voluntary initiatives by the government, self-regulations or voluntary industry codes.
No action	A red cell implies that no action is taken.
No information	A blank cell implies that no information is available.

Member States and areas	COLUMN 1	COLUMN 2		COLUMN 3	COLUMN 4	COLUMN 5
	International Code of Marketing of Breast-milk Substitutes	Marketing of foods for infants and young children covered up to 36 months		Marketing of foods and non-alcoholic beverages to children	Nutrition labelling (especially nutrient declaration)	Front-of-pack labelling
		Milk products	Complementary foods			
American Samoa						
Australia						
Brunei Darussalam						
Cambodia	B	(24)				
China	C	(4)				
Commonwealth of the Northern Mariana Islands						
Cook Islands						
Federated States of Micronesia						
Fiji	A	(6)	(24)			
French Polynesia						
Guam						
Hong Kong SAR (China)						
Japan						

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Kiribati						
Lao People's Democratic Republic	C	(24)	(24)			
Macao SAR (China)						
Malaysia						
Marshall Islands						
Mongolia	B	(24)	(24)			
Nauru						
New Caledonia						
New Zealand		(12)				
Niue						
Palau	A	(36)	(12)			
Papua New Guinea	C					
Philippines	A	(36)	(24)			
Pitcairn Islands						
Republic of Korea	C					
Samoa						
Singapore						
Solomon Islands	C					
Tokelau						
Tonga						
Tuvalu						
Vanuatu						
Viet Nam	A	(24)	(24)			
Wallis and Fortuna						

Column 1

This column pertains to national adaptation of the *International Code of Marketing of Breast-milk Substitutes* (hereinafter “the Code”) and subsequent relevant World Health Assembly resolutions. Data in this column are obtained from the WHO/UNICEF/IBFAN status report with regard to regulatory measures (1) and the IBFAN status report 2016 with regard to voluntary measures (2). Data were confirmed through consultations with Member States. While voluntary policies are present in some

Member States in the Western Pacific Region, only legally enforceable policies (legislation) are marked green in this table. The table has three categories of legislation (A, B or C).

- A. Full provisions in law: legislation enacted or regulations adopted, decrees or other legally binding measures encompass all or nearly all provisions of the Code and subsequent World Health Assembly resolutions.
- B. Many provisions in law: Member State has enacted legislation or adopted regulations, decrees or other legally binding measures encompassing many provisions of the Code and subsequent World Health Assembly resolutions.
- C. Few provisions in law: Member State has enacted legislation or adopted regulations, directives, decrees or other legally binding measures covering few of the provisions of the Code or subsequent World Health Assembly resolutions.

Column 2

This column pertains to national implementation of World Health Assembly resolution WHA69.9 (3) welcoming the *Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children (4)*, which targets all foods and beverages marketed as suitable for feeding infants and young children aged 6–36 months. For the purpose of this table, the implementation of the Guidance is shown separately to highlight the gaps that still exist in full implementation of the Code. The data in this column are obtained from a 2016 status report on Code implementation (1), or through consultations with Member States.

If a reference exists to an age group (in any policy to regulate or restrict marketing of food for infants and young children), this has been noted in the respective cells (in months of age).

Column 3

This column pertains to national implementation of policies to restrict or regulate marketing of food and non-alcoholic beverages to children, building on the WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children (5)*. While voluntary policies are present in some Member States in the Western Pacific Region, only legally enforceable policies (legislation) are marked green in this table.

Column 4

This column pertains to national implementation of policies on nutrition labelling (specifically nutrient declaration) aligned with Codex Alimentarius guidelines (CAC-CL2-1985, last update 2016). As recommended by Codex Alimentarius, nutrition labelling should include energy (calories), protein, carbohydrate, fat, saturated fat, sodium (salt) and sugars using metric units and/or as a percentage of the nutrient reference value (NRV) provided.

Column 5

This column pertains to national implementation of policies on front-of-pack labelling. Front-of-pack labelling is an addition to nutrient declaration, which makes it easier for consumers to be aware of the nutrient status of a food product. An example of a voluntary policy is the Health Star Rating in Australia and New Zealand.

Annex

References

1. WHO, UNICEF, IBFAN. Marketing of breast-milk substitutes: national implementation of the international code – status report 2016. Geneva: World Health Organization; 2016.
2. IBFAN-ICDC. State of the Code by country. Penang: International Code Documentation Centre, part of the global International Baby Food Action Network; 2016.
3. World Health Organization. World Health Assembly resolution WHA69.9: Agenda item 12.1. Ending inappropriate promotion of foods for infants and young children [Internet]. 2016. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_R9-en.pdf
4. World Health Organization. Maternal, infant and young child nutrition: guidance on ending the inappropriate promotion of foods for infants and young children [Internet]. 2016. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_7Add1-en.pdf
5. World Health Organization. Set of recommendations on the marketing of foods and non-alcoholic beverages to children. Geneva; 2010.

Appendix 5. International Code of Marketing of Breast-milk Substitutes and subsequent relevant resolutions

The table below covers all subsequent relevant resolutions to the *International Code of Marketing of Breast-milk Substitutes* (hereinafter “the Code”) with special emphasis on marketing practices, complementary feeding and/or complementary foods. Summaries of resolutions comprise direct wording from the specific resolutions and/or paraphrased sentences with respect for the original message and diction.

YEAR	RESOLUTION	SELECTED RESOLUTION HIGHLIGHTS AND FEATURES
1981	WHA34.22	<p>The Code was adopted by the World Health Assembly (118 in favour, 1 no, 3 abstentions).</p> <p>Stressed that adoption and adherence to the Code is a minimum requirement.</p> <p>Urged Member States to implement the Code into national legislation, regulations and other suitable measures.</p>
1982	WHA35.26	<p>Recognized that commercial promotion of breast-milk substitutes contributes to an increase in artificial feeding and calls for renewed attention to implement and monitor the Code at national and international levels.</p>
1984	WHA37.30	<p>Requested that the WHO Director-General work with Member States to implement and monitor the Code and to examine the promotion and use of foods unsuitable for infant and young child feeding.</p>
1986	WHA39.28	<p>Urged Member States to ensure that small amounts of breast-milk substitutes needed for the minority of infants are made available through normal procurement channels and not through free or subsidized supplies.</p> <p>Directed attention of Member States to the following:</p> <ul style="list-style-type: none"> - Any food or drink given before complementary feeding is nutritionally required may interfere with breastfeeding and therefore should neither be promoted nor encouraged for use by infants during this period. - Practice of providing infants with follow-up milks is not necessary.
1988	WHA41.11	<p>Requested the WHO Director-General to provide legal and technical assistance to Member States in drafting or implementing the Code into national measures.</p>
1990	WHA43.3	<p>Highlighted the WHO/UNICEF statement on “protection, promoting and supporting breastfeeding: the special role of maternity services” which led to the Baby-Friendly Hospital Initiative (BFHI) in 1992.</p> <p>Urged Member States to ensure that the principles and aim of the Code were given full expression in national health and nutrition policy and action.</p>

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YEAR	RESOLUTION	SELECTED RESOLUTION HIGHLIGHTS AND FEATURES
1992	WHA45.34	<p>Urged Member States to:</p> <ul style="list-style-type: none"> - encourage and support all public and private health facilities providing maternity services so that they become “baby-friendly”; - take measures appropriate to national circumstances aimed at ending the donation or low-priced sale of supplies of breast-milk substitutes to health-care facilities providing maternity services; and - draw upon the experiences of other Member States in giving effect to the Code.
1993	WHA46.7	<p>Endorsed the World Declaration and Plan of Action for Nutrition adopted by the International Conference on Nutrition.</p> <p>Urged Member States by the year 2000 to:</p> <ul style="list-style-type: none"> - reduce substantially the prevalence of starvation and widespread chronic hunger; undernutrition, especially among children, women and old people; iron deficiency anaemia; foodborne diseases; and social and other impediments to optimal breastfeeding; - remedy inadequate sanitation and poor hygiene; and - contain and reduce the rate at which the prevalence of diet-related diseases and of conditions related to them is rising.
1994	WHA47.50	<p>Urged countries to foster appropriate complementary feeding practices from the age of about 6 months.</p> <p>Reiterated earlier calls in 1986, 1990 and 1992 to end free or low-cost supplies and extends the ban to all parts of the health care system (effectively superseding the provisions of Article 6.6 of the Code).</p>
1996	WHA49.15	<p>Called on Member States to ensure that:</p> <ul style="list-style-type: none"> - complementary foods are not marketed for or used to undermine exclusive and sustained breastfeeding; - financial support to health professionals does not create conflicts of interests; and - Code monitoring is carried out in an independent, transparent manner free from commercial interest.
2001	WHA54.2	<p>Moved global recommendation of exclusive breastfeeding from 4 months to 6 months of age.</p> <p>Emphasized that, to meet evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods, while breastfeeding continues for up to 2 years or beyond.</p>

YEAR	RESOLUTION	SELECTED RESOLUTION HIGHLIGHTS AND FEATURES
2002	WHA55.25	<p>Endorsed the Global Strategy for Infant and Young Child Feeding. Recognized that infant and young child mortality can be reduced with nutritionally adequate and safe complementary feeding through introduction of safe and adequate amounts of indigenous foodstuffs and local foods.</p> <p>Recognized the role of optimal infant feeding in reducing the risk of obesity.</p> <p>Alerted that micronutrient interventions should not undermine exclusive breastfeeding.</p> <p>Urged Member States to ensure that the introduction of micronutrient interventions and marketing of nutrient supplements do not replace or undermine support for sustainable practice of exclusive breastfeeding and complementary feeding.</p>
2005	WHA58.32	<p>Asked Member States to:</p> <ul style="list-style-type: none"> - ensure that nutrition and health claims for breast-milk substitutes are not permitted unless national or regional legislation specifically allow this; - be aware of the risks of intrinsic contamination of powdered infant formulas and to ensure this information be conveyed through label warnings; and - ensure that financial support and other incentives for programmers and health professionals working in infant and young child health do not create conflicts of interest.
2006	WHA59.11	<p>Asked Member States to make sure the response to the HIV pandemic does not include non-Code compliant donations of breast-milk substitutes or the promotion thereof.</p>
2006	WHA59.21	<p>Commemorated the 25th anniversary of the adoption of the Code. Welcomed the 2005 Innocenti Declaration.</p> <p>Asked WHO to mobilize technical support for Code implementation and monitoring.</p>
2007	WHA60.23	<p>Requested the WHO Director-General to promote responsible marketing including the development of a set of recommendations on the marketing of foods and non-alcoholic beverages to children in order to reduce the impact of foods high in saturated fats, trans-fatty acids, free sugars or salt, in dialogue with all relevant stakeholders, including private sector partners, while ensuring avoidance of potential conflict of interest.</p>
2008	WHA61.20	<p>Urged Member States to scale up efforts to monitor and enforce national measures and to avoid conflicts of interest.</p> <p>Investigated the safe use of donor milk through human milk banks for vulnerable infants, mindful of national laws, cultural and religious beliefs.</p>

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YEAR	RESOLUTION	SELECTED RESOLUTION HIGHLIGHTS AND FEATURES
2010	WHA63.23	<p>Recognized that the promotion of breast-milk substitutes and some commercial foods for infants and young children undermines progress in optimal infant and young child feeding.</p> <p>Expressed deep concern over persistent reports of violations of the Code by some infant food manufacturers and distributors.</p> <p>Urged Member States to:</p> <ul style="list-style-type: none"> - develop and strengthen legislative and regulatory measures to control the marketing of breast-milk substitutes to give effect to the Code and resolutions; - end all forms of inappropriate promotion of foods for infants and young children and to ensure that health and nutrition claims not be permitted on these foods; and - ensure that required breast-milk substitutes in emergency responses are purchased and distributed according to strict criteria.
2012	WHA65.6	<p>Requested the WHO Director-General to provide clarification and guidance on the inappropriate promotion of foods for infants and young children cited in resolution WHA63.23, taking into consideration the ongoing work of the Codex Alimentarius Commission (CAC).</p>
2014	WHA67(9)	<p>Requested the WHO Director-General to provide clarification and guidance by end of 2015 on the meaning of “ending inappropriate promotion of food for infants and young children” as cited in resolution WHA63.23 on infant and young child nutrition.</p>
2016	WHA69.9	<p>Welcomed the technical guidance on ending the inappropriate promotion of foods for infants and young children (up to 36 months)</p> <p>Urged Member States to continue to implement the Code and WHO recommendations on the marketing of foods and non-alcoholic beverages to children.</p> <p>WHA69.9 was “noted” but not endorsed.</p>

Appendix 6. Viet Nam: Decree on the trading in and use of feeding products for infants, feeding bottles and teats (Decree No. 100/2014/ND-CP)

Gathering the facts

A review of the national implementation of the *International Code of Marketing of Breast-milk Substitutes* (entitled Decree 21) in Viet Nam revealed that mothers and families were not protected from inappropriate and inaccurate marketing of breast-milk substitutes. Parents and babies were left vulnerable to commercial pressures. Exclusive breastfeeding rates in Viet Nam are among the lowest in the Western Pacific Region – only one in four infants are exclusively breastfed.

Defining the scope of action

To better protect children from the harmful impact of marketing, a decision was made to enhance alignment of the former Decree 21 with the *International Code of Marketing of Breast-milk Substitutes*. The new Decree 100 regulates marketing (including the provision of information, education, communication and advertising), trading and the use of feeding products for infants, as well as feeding bottles, teats and pacifiers, and covers all infants and young children under the age of 24 months. The scope of Decree 100 is to reduce malnutrition.

Drafting the law

Engage partners: The Ministry of Health took the lead in the process. Collaboration with multiple partners and line ministries beyond the Ministry of Health was essential. It was critical to build partnerships with, and obtain consensus among, the right stakeholders and to leverage their comparative advantages. The United Nations Children’s Fund (UNICEF) and Alive & Thrive helped build and lead a coalition of government, multilateral and nongovernmental organization partners to advocate strengthening the former Decree 21 (to become Decree 100).

Review and build on existing laws: The revised decree is based on a number of existing decrees, namely the Law on Child Protection, Care and Education, the Law on Advertising, the Law on Food Safety and the Commercial Law. It was critical to understand the legal environment to facilitate policy coherence. In 2012, the National Assembly voted in favour of Decree 100.

Prepare for opposition: Throughout the process it was important to anticipate and plan for strong resistance, and to monitor and follow up each phase of the process, including through risk assessments.

Develop enforcement and monitoring mechanisms: Building on existing structures for enforcing food regulations, the responsible agency for enforcement is the Viet Nam Food Administration (Health Inspection Unit). Penalties for violations have been defined.

Decree 100 on the trading in and use of feeding products for infants, feeding bottles and teats was signed by the Prime Minister in November 2014.

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Appendix 7. Republic of Korea: Special Act on the Safety Management of Children's Dietary Life

Gathering the facts

A stark increase in obesity among children was observed between 1998 and 2005, rising from 6.6% to 10.2%. In the same time period, the consumption of sugar-sweetened beverages increased. A national forum on children's diet and health was held with experts and key stakeholders to discuss the urgency for action. Foods for which marketing and sales restrictions were put in place included children's "preferred" foods. Restrictions are based on a food classification system, which includes thresholds for energy, saturated fat, sodium and free sugars (food categories are defined in the Food Code and the Livestock Code).

Defining the scope of action

To determine the main components of the Act, the food environment was assessed in collaboration with academia and research institutes. Priority measures identified were regulating the sale and marketing of foods frequently consumed by children, in areas where children gather and eat (in and around schools, through a "Green Food Zone" and restaurants) and during programmes children view on television. The Act covers all children under the age of 19 years.

Drafting the law

Engage partners: The Ministry of Food and Drug Safety took the lead in advancing regulatory action in line with the Presidential declaration of 2003 as the first "Year of Children's Safety", and expanded it to children's safe food environments. The Ministry of Education was involved as a key partner. The Korean Food and Drug Administration launched a task force entitled SAFENET (on the "safety control of children's dietary life"), now led by the Ministry of Food and Drug Safety. The Ministry identified key partners, which included high-level members of the National Assembly. Involvement of local governments was important to ensure healthier food environments at the local level (and to support local evaluation every three years). Academia and civil society groups, especially groups with mothers, provided strong and steady support for the regulation.

Review and build on existing laws: A number of existing laws had to be taken into consideration, including the Child Welfare Act, Food Sanitation Act, Education Act, School Meals Act, Infant Care Act, Broadcasting Act and the Early Childhood Education Act. It was critical to understand the legal environment to facilitate policy coherence. With opposition of not only the food industry but also the advertising industry, the regulation was forced to settle for a limited time period (17:00 to 19:00 daily, initially for three years under the "sunset rule") for restriction of television advertising. Considering that the Act has to be renewed every three years, interference occurs on a regular basis.

Prepare for opposition: Engagement with civil society as well as monitoring and evaluation of the Act are critical to counter any possible interference.

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Develop enforcement and monitoring mechanisms: Officers from the Ministry of Food and Drug Safety are designated to monitor the Green Food Zones. An online tool was developed for citizens to report violations, and children themselves were made “safety sheriffs”. Penalties that include up to three years’ imprisonment were defined.

The *Special Act on the Safety Management of Children’s Dietary Life* was implemented in 2009.

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Appendix 8. Chile: Law on Nutrition Composition of Food and Advertising

Gathering the facts

Data on obesity among children and adults revealed that 27.1% of girls and 28.6% of boys aged 5–17 years were obese in 2011. Studies showed that 1 of every 11 deaths in Chile was attributable to overweight and obesity. Few people in Chile were consuming diets that were in line with the country’s food-based dietary guidelines. A food classification system was developed to determine which foods were “unhealthy” and for which marketing should be restricted. Thresholds were defined for foods and beverages.

Defining the scope of action

The Government proposed several actions to: tackle obesity, including regulatory measures to protect breastfeeding (implementation of the *International Code of Marketing of Breast-milk Substitutes*); regulate marketing of foods and non-alcoholic beverages to children (building on the WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children*); implement front-of-pack warning labels; and restrict the sale and marketing of unhealthy foods in schools. The Law covers children under the age of 14 years.

Drafting the law

Engage partners: The Ministry of Health took the lead in advancing regulatory action by identifying key high-level partners, which included senators, the Senate Health Committee and local government social leaders. Training was conducted with social leaders, and citizens were engaged in dialogue. Information was disseminated and discussions held at national health forums. Various ministries were consulted and involved in the process, including education, agriculture, and trade and industry. The Ministry of Education was a key partner and had responsibility for the measures proposed for schools. To strengthen support, the Senate convened the first International Summit on Health and Nutrition attended by national and global experts. There was collaboration with academia and research institutes to conduct initial assessments of the situation and provide overall support to the process.

Review and build on existing laws: The cross-sectoral nature of the proposed policies required a review of the legal environment. For example, any proposed bill had to be aligned with the existing Law on Labelling and Advertising as well as the Sanitary Code. The proponents of the bill worked with public interest lawyers to strengthen their legal position and better understand existing trade and investment agreements.

Prepare for opposition: From the beginning, the food industry declared their “full opposition” to the bill. The active participation of academia and civil society was considered important to advance the bill and counter pressure. The support from the public interest lawyers was critical.

Develop enforcement mechanisms: Building on existing structures for enforcement of other food-related regulations, Chile used its “sanitary authorities”, which have regional monitoring and control systems in place. They defined penalties for violators of the law.

Chile passed its *Law on Nutrition Composition of Food and Advertising* (Law 20.606) in June 2016.