NEW ZEALAND
DENTAL ASSOCIATION

Codes Review Panel
ASA Secretariat
PO Box 10675
Wellington

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Submission to the Advertising Standards Authority by the New Zealand Dental Association

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

A. Introduction

1. Thank you for the opportunity to provide this submission on the Review of the Code for Advertising to Children and the Children's Code for Advertising Food (the Codes). We are happy for this submission to be made public.

2. The NZDA would like to present an oral submission if given the opportunity. Please contact Dr. David Crum, CEO NZDA, david@nzda.org.nz

3. The New Zealand Dental Association (NZDA) is the professional association for New Zealand dentists. Almost all (98%) dentists voluntarily belong to the Association, and membership is across private and public, and generalist and specialist practice. As well as providing services for its members, the NZDA is the one body able to speak on behalf of New Zealand dentistry as a whole. The Association is committed to its motto "For the Public Weal" by supporting dentists to deliver quality oral health care in New Zealand. The NZDA continues to advocate for oral health across the population and works with many issues that affect the oral health of the public. The Association exists to promote dental and allied sciences, the oral health of the public and the interests of the dental profession. A key role of the NZDA is to promote oral health and the dental profession through education of the public, and advocacy and discussion with the broad range of organisations, companies, and public and private agencies that affect standards of oral health. In the context of this submission, the Association's most relevant policy documents on Child Oral Health and Nutrition are attached (Appendix 1).

4. The NZDA advocates for the implementation of population-wide strategies to reduce sugary drink consumption, including the mandatory regulation of marketing of sugary drinks to children, and independent monitoring and evaluation of such marketing. Hence, the NZDA **supports** the recommendations in WHO's *Report of the Commission on Ending Childhood Obesity*[1], which includes governments implement WHO's *Set of recommendations on the marketing food and non-alcoholic beverages to children.*[2]

5. Good oral health is a basic human right for all, including children.[3] The NZDA **supports** the strengthening of the Codes so that children are protected from harm and able to realise their right to healthy development. It is the NZDA's position that the review process must consider children's best interests as the paramount concern. The decisions made must be weighted in

favour of children's health and well-being, over the commercial interests of the food and marketing industries.

6. Good oral health is also a vital component of general health.[4] The NZDA considers the review as a key action in preventing diet-related disease in New Zealand children. The NZDA also recognises that the dietary risk factors for dental caries are shared by several other chronic conditions of concern for children, in particular overweight and obesity, and type 2 diabetes. Addressing the dietary factors that impact oral health will also contribute to the prevention of other diet-related conditions prevalent in children, and vice versa.

7. In this submission, we first provide a summary of the underlying health issue that underpins the NZDA's submission, that is, the prevalence of dental caries in New Zealand children. The questions in the submission document are then addressed, providing recommendations based on evidence and examples where relevant. Our submission closes with a summary of the NZDA's recommendations for the new Code.

B. Background

1. Dental caries is the most common chronic childhood disease, experienced by the majority of school-aged children worldwide.[5] Although New Zealand children's oral health has improved in recent decades, poor oral health is still a major individual and public health issue for a substantial proportion of New Zealand children. The 2014/15 annual New Zealand Health Survey reported that 29,000 children under the age of 14 years have had teeth removed due to decay, an abscess, infection or gum disease in the preceding 12 months.[6] Furthermore, Māori and Pacific children, and children from more deprived neighbourhoods, are disproportionately impacted by oral disease in New Zealand.[7]

   Treatment for dental caries is the leading cause of avoidable hospital admissions for New Zealand children aged 0-14y,[8] with one in five (20.7%) children on hospital waiting lists for such care[8]. It is not uncommon for children as young as 18 months old to be admitted to hospital in need of a general anaesthetic to have their teeth restored or removed due to decay or infection. In 2009, 5050 children aged 8 years or younger underwent these procedures in New Zealand hospitals.[9]

   Dental caries is associated with considerable morbidity.[7,10] Pain, infection, anxiety and tooth loss from dental caries can result in reduced function, notably speech and chewing; poor nutrition status; and loss of self-esteem.[11] Such consequences can negatively impact cognitive ability, education, behaviour, social functioning, children's growth and development, and ultimately, quality-of-life.[7,11,12] Fear and anxiety resulting from dental caries treatment in childhood also negatively impacts on seeking treatment later in life.[13,14]

   Oral disease is the fourth most expensive disease to treat, accounting for approximately 5-10% of public health expenditure.[10] In New Zealand in 2008, oral health care expenditure was estimated to be just over NZ$1 billion, of which NZ$178 million was funded publically, the latter portion predominately attributed to treating children.[7] It is likely expenditure has since increased.

2. Free sugars are the main dietary factor responsible for dental caries.[15] Consumption of sugar-sweetened drinks significantly increases the risk of dental caries due to their high sugar content. The sugar in such drinks also increases children's energy content without contributing any useful nutrients.[16] Other key dietary sources of sugar in New Zealand children's diets include biscuits, confectionary, cakes and muffins.[17] Sugar-sweetened beverages in particular are cheap, readily available and accessible, and are one of the most widely marketed products. [18,19]

3. Food and beverage marketing has been identified as "a significant independent determinant of children's food behaviours and health status".[18(p214)] This conclusion is supported by evidence from a number of sources.[1,18,20–22] Most recently, the *Report of the Commission on Ending Childhood Obesity* stated 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. [1(p18)]

4. Thus, based on such evidence, WHO have consistently recommended that children not be exposed to unhealthy food and beverage marketing. [1,2,23]

C. Response to questions in submission document

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

a. The NZDA considers the self-regulatory nature of the Codes, including the complaints system, as problematic. The Codes (i) have been developed by industry; (ii) are recommendations to be voluntarily adopted by industry members; and (iii) are not independently monitored and enforced. Although the intent of the Codes is the protection of children and a consideration of their best interests, the Codes primarily prescribe criteria for industry interests rather than children's health and well-being. Self-regulation has been shown to be ineffective in reducing the amount of unhealthy food and beverage marketing and inconsistent with health goals [24,25]. The NZDA **recommends** the mandatory regulation of marketing of sugar-sweetened beverages through independent monitoring and evaluation of food and beverage marketing, especially at times and in settings where children gather.

b. The NZDA acknowledges that the ASA incorporates provisions within the United Nations Convention on the Rights of the Child (UNCRC or the Convention) in the Codes, and that children's protection and best interests are a concern for the ASA. However, ASA's use of UNCRC is selective.[24] Children's rights are indivisible and as such are intended to be applied in totality.[3] While children have the right to information (including advertisements),[3] the primary concern must always be for children's health and well-being. The Convention provides for children's protection from harmful information, which includes such information contained in advertisements and marketing.[26]

c. The NZDA acknowledges that children aged 15-17y are provided an "extended duty of care" in the Code for Advertising Food[27] However, UNCRC defines children as any person under the age of 18.[3] The NZDA **recommends** that the Codes be extended to include the Convention's definition of a child. (See C.7).

d. The NZDA acknowledges that the current Code contains a range of marketing activities and media platforms. However, the NZDA's view is that the range is not broad enough to encompass the full range of marketing strategies that impact children (See C.4). Furthermore, although there are specific settings which are of significance to children, including home, school and sports clubs, children are exposed to food and beverage marketing in a variety of everyday settings and locations. The current Codes cover advertising, which is only one of many marketing techniques to which children are exposed. The NZDA **recommends** that they ASA Codes encompass all forms of marketing of unhealthy food and sugar-sweetened beverages, in the varied settings in which children live.

e. The NZDA considers the current Codes as ambiguous and open to interpretation. They lack clarity and specificity about the types and frequency of advertising exposures, definitions in terms of the nutrient profile of foods and sugar-sweetened beverages, marketing techniques, and the content and emotive appeals used in the advertising. The NZDA **recommends** that criteria and definitions are strengthened and clearly stated in the Code.

2. *What are the strengths and weaknesses of the current complaints process?*
   a. The current complaints system relies on the public lodging complaints about an advertisement. It is difficult to use and requires complainants to have a high level of resources in terms of time, knowledge and skill. Research in countries with similar complaints systems as New Zealand shows that parents are often unaware of the system or do not complain because they perceive the system to be futile due to its low success rate.[28–30] New Zealand research shows that even highly-skilled nutrition experts have difficulty using the system.[31]

   b. The current complaints system is also ineffective. Given the time delay between the advertisement being shown and the time the complaint has been heard, the impact and harm from the advertisement has occurred.

   c. The complaints system is industry-led and as such is subject to a conflict of interest between the commercial goals of industry and the health and well-being of children.

   d. The NZDA **recommends** that a transparent and independently monitored complaints system be implemented. Complaints should be heard by an independent body consisting of representatives from the health sector, children's representatives and a child rights advocate.

e. The NZDA **recommends** that a more efficient complaints system be implemented. In such a system, the promotion is removed immediately a complaint about it is received and not permitted to be re-aired or made public again until such time it is reviewed.

f. The NZDA **recommends** that current food and beverage marketing activities are constantly monitored for breaches of the Codes by an independent body, as described previously.

g. The NZDA **recommends** that an easy-to-use complaints system be implemented. Furthermore, children have the right to be heard in all matters that concern them.[3] The current system does not encourage children to complain about marketing that impacts them adversely. The NZDA **recommends** that a new complaints system encompass a component that is easy for children to use.

h. The NZDA **recommends** that the complaints system is regularly promoted to the public.

3. *What changes, if any, are necessary to protect the rights of children and their health / well-being?*
   a. Children's best interests must be the primary consideration of all individuals, groups and organisations in all matters that concern children.[3] The food and marketing industries have an obligation to respect and protect children's rights, and to remedy any violations of their rights.[32]

   b. Decisions made about food and beverage marketing to children must be weighted in favour of children's health and well-being. The NZDA **recommends** that all food and beverage marketing is evaluated by an independent panel consisting of nutrition, health and child rights experts before being aired. Only healthy food and beverages should be marketed. The criteria for allowable food and beverage marketing should be in line with that recommended in point C.8.

   c. The NZDA **recommends** that the health and child rights sectors have greater input into the development of the Codes, including the complaints process.

   d. The recommendations made in this submission consider the best interests as a primary concern. If made, they would protect the rights of children, and their health and well-being.

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).*
   a. WHO repeatedly state that the 'marketing' of unhealthy food and sugar-sweetened beverages should be addressed. WHO defines food and beverage marketing as

      > any form of commercial communication 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.[33(p9)]

b. Marketing techniques include:

> Advertising, sponsorship, product placement, sales promotions, cross-promotions using celebrities, brand mascots or characters popular with children, web sites, packaging, food labelling and point-of-purchase displays, e-mails and text messages, philanthropic activities tied to branding opportunities, and communication through "viral marketing", and by word-of-mouth[2(p7)]

c. The NZDA **recommends** that the Codes include the examples of marketing provided in WHO's *A Framework for the Implementation of the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* (p. 10).[33]

d. Television is a significant media format used by children, therefore it presents a significant point of marketing exposure to children[34] The industry-developed, voluntary set of guidelines for advertisers, *"Getting it Right for Children",*[35] recommends time restrictions for food advertising on free-to-air channels. However, the time limits are inconsistent across the channels (being 5pm and 5.30pm) and do not correspond with the times that the majority of children watch television. Almost a fifth of New Zealand children report watching television after 8.30pm,[34] the watershed time for adult-oriented television content. The NZDA **recommends** the time restrictions for unhealthy food and beverage marketing be extended to 9pm. Children's restrictions should also apply when a programme is expected to have an audience of more than 20% children, for example sports events and programming. This is in line with regulatory restrictions in other countries.[36]

e. Electronic media is playing an increasing role in New Zealand children's lives.[34] Such media formats currently provide an unregulated platform for food and beverage marketing, including social media sites, websites, advergaming and product placement in games and other electronic sources. Therefore, children are increasingly exposed, and unprotected against, such marketing.

f. Product packaging is a key marketing media,[18,20,22,37,38] which is not captured by the current Codes. Marketing techniques aimed at children on food packaging include the use of cartoon and film characters, sports celebrities, promotions and premiums, and health and nutrition claims[38].

g. Sponsorship is not captured by the current Codes. The NZDA's views and recommendations on sponsorship were outlined in point C.9.

h. The NZDA **recommends** that the Codes encompass all media formats and that provision is made to incorporate new formats within the Codes as and when they are made accessible to the public.

5. *If the content of advertisements is a concern, can you please give examples and / or supporting evidence? A product name and description would be helpful so we can source the advertisements.*
    a. Marketing content impacts children's food and beverage preferences.[20,20,22,39] The persuasive techniques used are particularly concerning, as children, regardless of age, are either not able to discern the persuasive intent or unable to act on their knowledge.[39] Such techniques include, but are not limited to, premium offers, promotional characters, nutrition and health-related claims, the theme of taste, and the emotional appeal of fun[39] Sports sponsorship, and associations with sport, including product endorsement by sports personalities, has a similar impact. [40,41]

    b. Well-known athletes are perceived as heroes by children and have considerable influence on their food preferences and behaviours when used to endorse or be associated with food and beverage products .[42–45]

6. *If the placement of advertisements is a concern, can you please give examples and /or supporting evidence? For broadcast media it would be helpful to have the time/date/channel or programme, for other media, a link / publication title / outdoor location would be appreciated*
    a. The place where marketing activities are located is a key feature of the marketing mix.[46]

    b. One key location which is especially concerning is the placement of food and beverage marketing around schools, such as on bus shelters and the backs of buses used to transport school children.

Appendix 2 includes examples of concerning content and placement of marketing.

7. *The Children's Codes currently define a child as under the age of 14. Do you support or oppose this definition? Why?*
    a. The NZDA **supports** extending the Code to include persons aged less than 18y.

    b. Doing so would ensure the Code is in keeping with (i) UNCROC [3]; (ii) the WHO *Report of the Commission on Ending Childhood Obesity*[1]; (iii) the national obesity plan[47]; and (iv) *New Zealand's Food and Nutrition Guidelines for Healthy Children and Young People* (Aged 2-18 Years).[48]

    c. Research shows that although children over the age of 8y are often able to discern the persuasive intent of marketing, they do not necessarily act on this knowledge [22,49]. Brain development and cognitive reasoning is not complete until people are in their early 20s.[22] Furthermore, young children are still impacted by marketing aimed at older children and young adults,[2] for example, energy and sports drinks.

8. *Is there a role for a nutrient profiling system such as the health star rating system in the Children's Code? If yes, in what way and which system would you suggest?*
    a. The NZDA **recommends** the use of a nutrient profiling system in the Code. As noted previously, a weakness of the current system is the lack of specificity and parameters in the Codes, including the nutrient quality of the product being marketed.

    b. Nutrient profiling systems may usefully inform consumers about healthier food and beverage choices [50,51] and encourage food manufacturers to reformulate products.[51] Front-of-pack traffic light labelling systems have been shown to be the most effective interpretive labelling systems for consumers.[52] However, such systems have been opposed by food industry members, in preference for systems such as the Health Star Rating.[52]

    c. The NZDA does not recommend the use of the Health Star Rating system. The Health Star Rating system was developed as an interpretive front of pack labelling system to support consumers to make healthier food choices when selecting packaged food items. It was not developed to support the restriction of food marketing to children. The nutrient profiling system that underpins the Health Star Rating system has also been criticised as it results in healthy and unhealthy foods receiving similar ratings.[53] For example many fruits and nuts receive a three star rating while widely accepted 'junk' foods receive 2.5 stars.[53] Further, research indicates that almost 50 percent of vegetables do not receive a five star rating.[53]

    d. The NZDA **recommends** the use of the WHO Regional Office for Europe Nutrient Profile Model,[54] which has been developed specifically to underpin the regulation of food marketing to children. As such, this model could be readily applied in its current form or adapted for the New Zealand without difficulty. This system would be used to evaluate food marketing before being aired or made public.

    e. Evidence shows that placing health warnings on labels of sugary drinks improves parents' understanding of the health risks of consuming them.[55] The NZDA **recommends** the use of a sugar nutrient icon on the packaging of all sugary drinks to indicate the amount of sugar in each product in teaspoons and the use of warning labels such as "Drinking beverages with added sugar contributes to obesity, diabetes, and tooth decay" or "Intended for occasional consumption only".

9. *Do you support or oppose a specific guideline on sponsorship? Why?*
    a. The NZDA **supports** a specific guideline on sponsorship. This should be developed by members of the health sector, children's representatives and child rights advocates.

    b. Sponsorship is a key marketing strategy for companies, to increase awareness and generate brand loyalty and sales of products.[56] Unhealthy food and beverage sponsorship occurs at all levels of sport in New Zealand.[57,58] However, there is a conflict of interest between the healthy nature of sport and the generation of income for sporting organisations and food companies.[57]

c. Research demonstrates that sports sponsorship influences children's food preferences, choices, purchasing and consumption.[18,40,59–61]

d. Sport plays a significant role in New Zealand children's lives. A substantial proportion (50-90%) of children engage in sport, either as players, leadership or support roles, or as spectators of live or televised sport.[62] As such, New Zealand children are likely to be exposed to substantial levels of food-related sponsorship of sport.

10. *Do you support or oppose the introduction of independent monitoring and evaluation of the code? How would this work?*
    a. The NZDA **supports** the introduction of independent monitoring and evaluation of the Code.

    b. WHO recommends transparency and accountability measures to protect children and improve health outcomes.[1]

    c. Such action would be undertaken by members of the health sector, children's representatives and child rights advocates.

11. *What is your view of the sanctions imposed by the ASA when a complaint is upheld?*
    a. The NZDA view on the sanctions imposed by the ASA when a complaint is upheld as weak.

    b. The punitive measures do not provide a significant deterrent for the food industry nor signal the importance of the issue.

    c. The NZDA **recommends** implementing sanctions that include significant monetary losses for, and transparency in identifying, those companies and organisations that have breached the Codes. Such companies should be made to compensate for the harm inflicted and financially contribute to health promotion activities.

12. *Are there environments where you consider it to be inappropriate to advertise to children?*
    a. The *Report of the Commission on Ending Childhood Obesity* states 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". [1(p18)]

    b. Settings where it is inappropriate to market to children include all educational facilities such as early-childhood centres, schools, after-school and holiday facilities; sporting facilities such as sports clubs and events; health organisations; public facilities such as libraries, recreation centres and areas; parks and halls, churches, bus stops and other transportation facilities.

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

a. The NZDA opposes combining the two Codes.

b. Given the alarming prevalence of diet-related disease in New Zealand children it is crucial that the Code for Advertising Food is maintained as a separate document to ensure that children's diet-related health is afforded the specific attention it requires.

D. Summary of NZDA's recommendations

1. The NZDA **supports** the recommendations in WHO's *Report of the Commission on Ending Childhood Obesity,*[1] which includes governments implement WHO's *Set of recommendations on the marketing food and non-alcoholic beverages to children.*[2]

2. The NZDA **recommends:**
   - the mandatory regulation of food and beverage marketing.
   - that criteria and definitions are strengthened and clearly stated in the Code.
   - that the Codes include persons aged less than 18y.
   - that the health and child rights sectors have greater input into the development of the Codes, including the complaints process.
   - that all food and beverage marketing is monitored and evaluated by an independent panel consisting of nutrition, health and child rights experts before being aired or made public, using a nutrient profiling system specifically developed for evaluating the suitability of food and sugar-sweetened beverages marketed to children.
   - that (i) an easy-to-use, efficient, and transparent and independently monitored complaints system be implemented; (ii) current food and beverage marketing activities be constantly monitored; and (iii) that a new complaints system encompass a component that is easy for children to use. Also, that the complaints system is regularly promoted to the public.
   - the time restrictions for unhealthy food and beverage marketing be extended to 9pm.
   - that the Codes encompass all media formats.
   - the use of a sugar nutrient icon on the packaging of all sugary drinks.
   - a specific guideline on sponsorship.

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Appendix 1 Relevant NZDA Policies

I. New Zealand Dental Association Position Statement on Child Oral Health

Adopted March 2013

1. Background

1.1 Our unique dental health system for children in New Zealand

Until very recently, dental care for children in New Zealand has been largely provided in school-based dental clinics by dental therapists (the School Dental Service) with support of private and hospital-based general and specialist dentists. Despite a high level of child enrollment (95%) in the service, and a very high restorative index (84% in the primary dentition of 2-11 year olds, MOH 2010) the improvements in child oral health in New Zealand have not been superior to other countries.

Early in the 21st century, the New Zealand government funded the upgrade and re-orientation of the clinical facilities in this primary care service, now known as the Community Oral Health Service. Alongside the facility changes, an opportunity arises for changes in the model of care to follow the principles of the strategic document Good Oral Health for All for Life (Ministry of Health, 2006) and the Ottawa Charter. Emphasis needs to be placed on oral health as an essential and inseparable component of general health, as well as on the promotion of good oral health and prevention of oral disease in a society and environment that supports good oral health. "Good oral health for all, for life, starts with promoting oral health for the youngest and most vulnerable members of our society" (Ministry of Health, 2006).

1.2 Oral health and general health

Oral health is a vital component of general health. Good oral health results from establishing and maintaining a nutritious diet (low in sugar and acid), and good oral hygiene practices during childhood. This is essential for individuals to enjoy good oral health for life.

Specific oral health risks arise from causes including poor food security, poor dietary choices and non-ideal oral hygiene practices. Deleterious dietary behavior includes grazing, snacking and frequent consumption of foods and drinks with high sugar and/or acid content.

Parents and caregivers are responsible for the oral health of the children in their care. Oral health and dietary advice can be given by dental professionals and appropriately trained healthcare workers.

The risk factors for poor oral health are closely aligned to those for systemic conditions such as overweight, obesity and type 2 diabetes, so efforts to improve oral health are also likely to improve the general health of New Zealand children (and adults).

1.3 Use of fluoride

Fluoride is a natural element and it works in three ways to help protect our teeth from decay:

- Fluoride helps to repair the early stages of dental caries.
- Fluoride interferes with the growth of the bacteria that cause dental caries.
- Fluoride makes teeth more resistant to dental caries by strengthening the tooth surface.

Water fluoridation has been proven to be a safe and effective public health measure to reduce dental

caries. Not all water supplies in New Zealand are optimally fluoridated. Therefore increasing the proportion of the population who can access optimally-fluoridated water will provide this oral health benefit to more of the New Zealand population.

Fluoride is also available in toothpastes, in professionally applied varnishes and gels, and in mouth rinses.

Guidelines for the safe use of fluoride in the prevention of dental disease are published on the Ministry of Health website (http://www.health.govt.nz/our-work/preventative-health-wellness/fluoridation).

1.4 Oral Health Services

All children in New Zealand are entitled to high quality oral health care including diagnosis, prevention and treatment services to improve and maintain their oral health. Children are entitled to care by dental professionals with appropriate skills and training. Equivalent services should be available throughout the country. These services should include (but not be limited to)

• Prevention and management of dental caries, erosion and periodontal disease

• Prevention and management of dental trauma

• Timely and appropriate access to specialist services including paediatric dentists and orthodontists as required

e.g. comprehensive treatment under general anaesthetic, specialist care for management dental anomalies (e.g. amelogenesis imperfecta), and management of severe malocclusion or craniofacial deformities (e.g. cleft lip and palate).

Some children may be at particular risk of developing dental disease.

Such groups include, but are not limited to:

- Children from low income families
- Maori and Pacific children
- Those living in rural or isolated communities
- Recent immigrants
- Children with special healthcare needs or developmental conditions
- Children with orofacial anomalies

These children should receive targeted enhanced, culturally appropriate, preventive dental care and appropriate treatment to aid in the reduction of oral health inequalities.

2. Policy

2.1 Parents and caregivers have the primary responsibility for the oral health of the children in their care.

2.2 Oral health and dietary advice should be readily accessible to parents, maternity & child health professionals and others involved in the care of children both inside and outside their home (such as early childhood teachers).

2.3 Nutritious foods should be accessible and affordable.

2.4 Marketing and advertising of high sugar and/or acid-containing foods and drinks should not be targeted to children, adolescents, their parents or caregivers.

2.5 Role models in New Zealand society have an obligation to promote behaviours to establish and maintain nutritious diets and optimal oral health.

2.6 High sugar and/or acid-containing processed foods should be taxed and direct advertising banned in a similar way to that of tobacco.

2.7 All children should have access to a fluoridated water supply.

2.8 All New Zealand children are entitled to high quality oral health care including diagnosis, prevention and treatment services to improve and maintain their dental health. There may be a need for targeting of these services to ensure that they can be freely accessed by those most in need, while allowing other families to access private care.

2.9 There must be a concurrent focus on prevention and treatment of dental caries and erosion in both the deciduous and permanent dentitions.

2.10 Children should receive care provided by dental professionals with appropriate skills and training.

2.11 Equivalent services should be available throughout the country.

2.12 Child oral health services should include (but not be limited to)

a) Prevention and management of dental caries, erosion and periodontal diseases

b) Prevention and management of dental trauma

c) Timely and appropriate access to specialist services as required

2.13 Children at particular risk of dental disease should receive enhanced targeted preventive dental care and appropriate treatment to aid in the reduction of oral health inequalities.

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II. New Zealand Dental Association Consensus Statement on Sugary Drinks

DRAFT FOR NZDA BOARD APPROVAL APRIL 2016

Sugary drinks, also known as sugar-sweetened beverages, are the major source of sugars consumed by children and young people in New Zealand.[1,2] These include any beverage that has added sugar such as carbonated or fizzy drinks, energy drinks, sports drinks, fruit drinks and juices, powdered drinks, cordial and flavoured waters. The consumption of sugary drinks is associated with dental caries, weight gain and obesity. Obesity is a leading risk factor for diabetes, cardiovascular disease and some cancers. Nearly two thirds of adults and one third of children are either overweight or obese in New Zealand.[3] Dental caries is a significant health problem in New Zealand. Good oral health is not only a vital component of general health but also a basic human right.[4] It is not uncommon for children as young as 18 months old to be admitted to hospital in need of a general anaesthetic to have their teeth restored or removed due to decay or infection. In 2009, 5050 children aged 8 years or younger underwent these procedures in New Zealand hospitals, making dental treatment the number one reason for admission to hospital for this age group.[5] The 2014/15 annual New Zealand Health Survey, reported that 29,000 children under the age of 14 years have had teeth removed due to decay, an abscess, infection or gum disease in the preceding 12 months.[6] The shocking rate of dental caries and tooth extractions among young New Zealanders needs immediate attention.

There is insufficient focus on reducing the dietary cause of dental caries. Free sugars are the main dietary factor responsible for dental caries.[7] The dental caries process initiated by demineralisation of enamel and dentin is caused by the presence of high levels of sugar that are metabolised by the cariogenic bacteria in the mouth. Other factors such as oral hygiene habits and use of fluorides can influence this process but these are not true aetiological factors.[7] Consumption of sugary drinks significantly increases the risk of dental caries due to their high sugar content. The sugar in these drinks also increases their energy content without any useful nutrients. Consumption of one can of soft drink per day can result in weight gain of more than 5 kilograms per year, if the excess energy gained from the soft drink is not burnt off.[8] A 600ml bottle of soft drink contains approximately 16 teaspoons of sugar and a regular 375ml can of soft drink contains about 10 teaspoons of sugar.[9] Sugary drinks are cheap, readily available and accessible, and are one of the most widely advertised products. Research shows that the majority (76%) of beverages that children identified with sports were sugary drinks.[10] Only 17 percent of beverages were from categories classified as 'everyday' drinks (water and plain milk) in the New Zealand Nutrition Guidelines. Parents and children interviewed in the study agreed that a sport-related food environment influenced children's eating habits and acted as a barrier

towards promoting positive eating habits among children. Research suggests that a ban on advertising targeted at children is effective in lowering consumption.[11]

The World Health Organisation (WHO) strongly recommends that the intake of free sugars should be reduced to less than 10 percent of total energy intake approximately 12 teaspoons per day per adult. Further reduction to less than 5 percent of total energy intake (approximately 6 teaspoons per day per adult), is recommended to help prevent dental caries in particular.[12] About 33 teaspoons of sugar per person per day is imported into New Zealand; the equivalent of 48kgs of sugar per person per year.[13] The Eating and Activity Guidelines for New Zealand adults recommend that adults replace high-sugar drinks such as fizzy and sports drinks with plain water.[14] The guidelines also recommend that adults choose foods with the lowest amount of added sugar by comparing food labels of similar foods.

Sugary drinks are unique in that they have no nutritional value, they contribute empty calories and replace healthier beverage options. They are also extremely acidic. The New Zealand Dental Association (NZDA) recommends that adults and children switch sugary drinks to water. To reduce the intake of sugary drinks, a range of actions by government, beverage industry, schools, non-government organisations and others is urgently needed.

The NZDA calls for partner organisations to support and endorse the following actions to inform the public about the negative health impacts of sugary drinks and to advocate for population-wide strategies to reduce sugary drink consumption.

1. Joint advocacy campaign aimed at Government and the beverage industry to introduce a sugar nutrient icon on the packaging of all sugary drinks to indicate the amount of sugar in each product in teaspoons.
2. Joint advocacy campaign to introduce warning labels such as “Drinking beverages with added sugar contributes to obesity, diabetes, and tooth decay" or “Intended for occasional consumption only”.
3. Introduction of mandatory regulation of marketing of sugary drinks to children through independent monitoring and evaluation of food marketing, especially at times and places frequented by children such as children’s sports and events.
4. Introduction of daily allowance for the intake of free sugars for New Zealanders, in line with the recommendations from the WHO.
5. A nation-wide social marketing campaign, supported by partner organisations, to encourage the public to switch their sugary drinks to water.

6. Encourage schools to adopt 'water-only' policies and ban the sale of sugary drinks in and around schools.
7. Development of policies by local government to introduce 'water-only' policies at council venues and events.

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Appendix 2 Examples of inappropriate placement and content

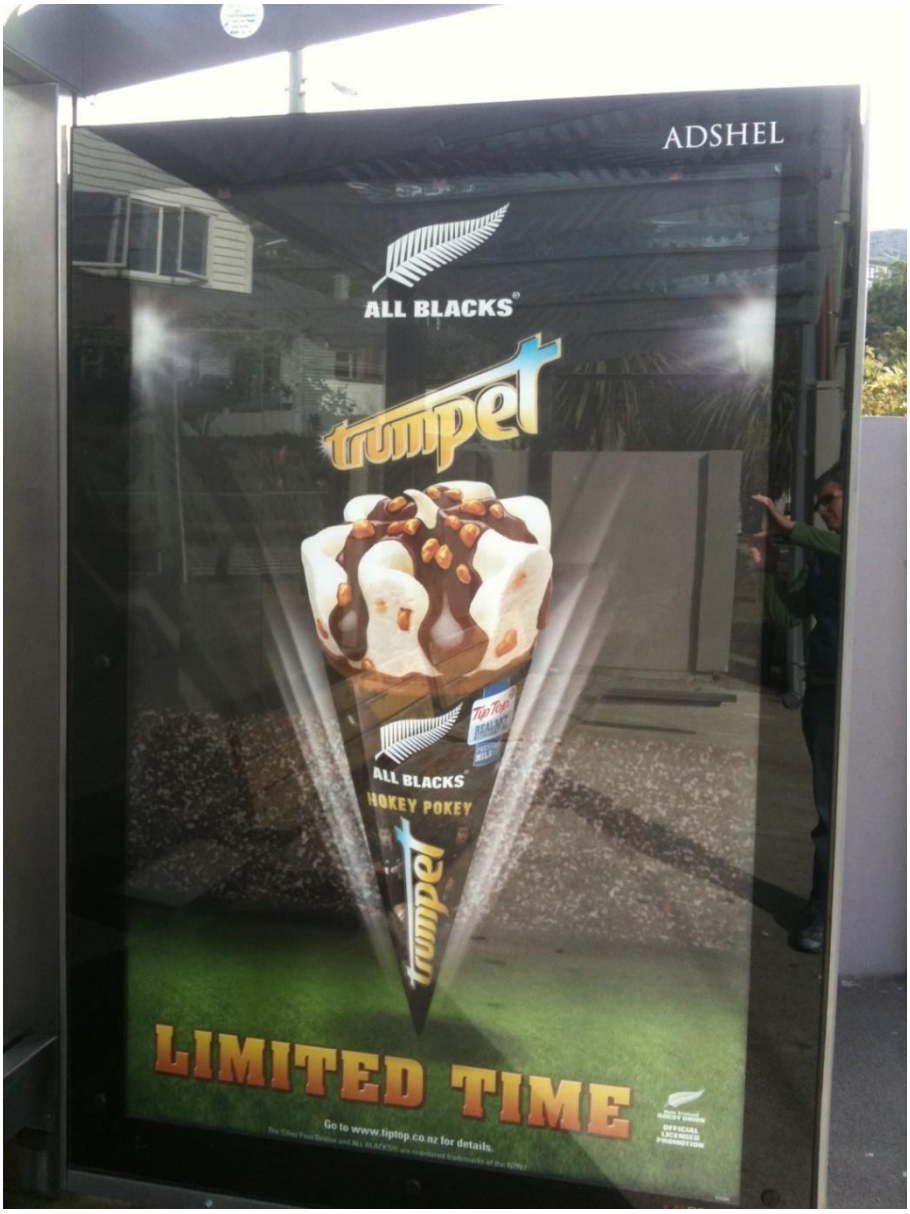


Figure 1: Bus shelter

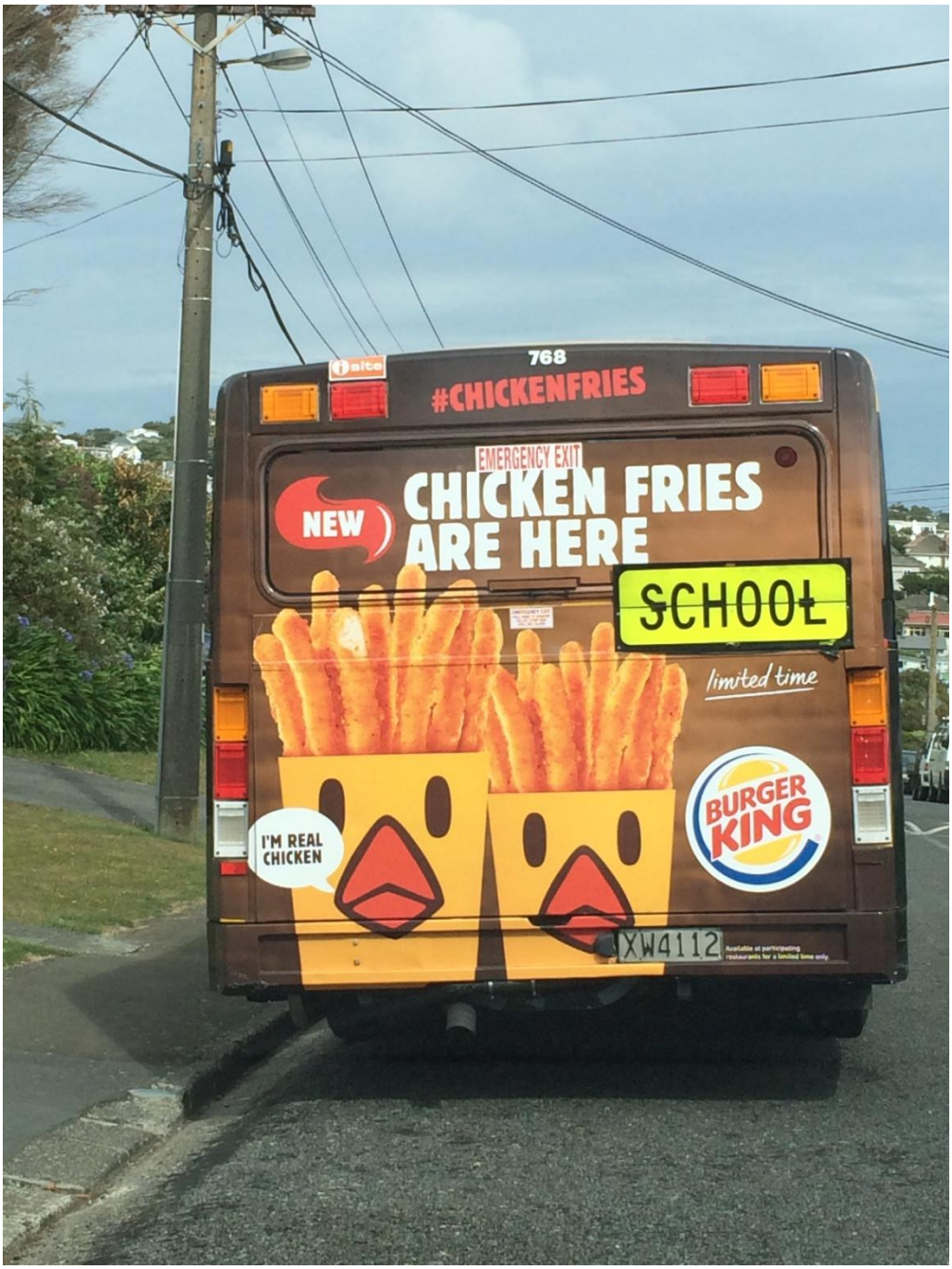


Figure 2: Back of a school bus

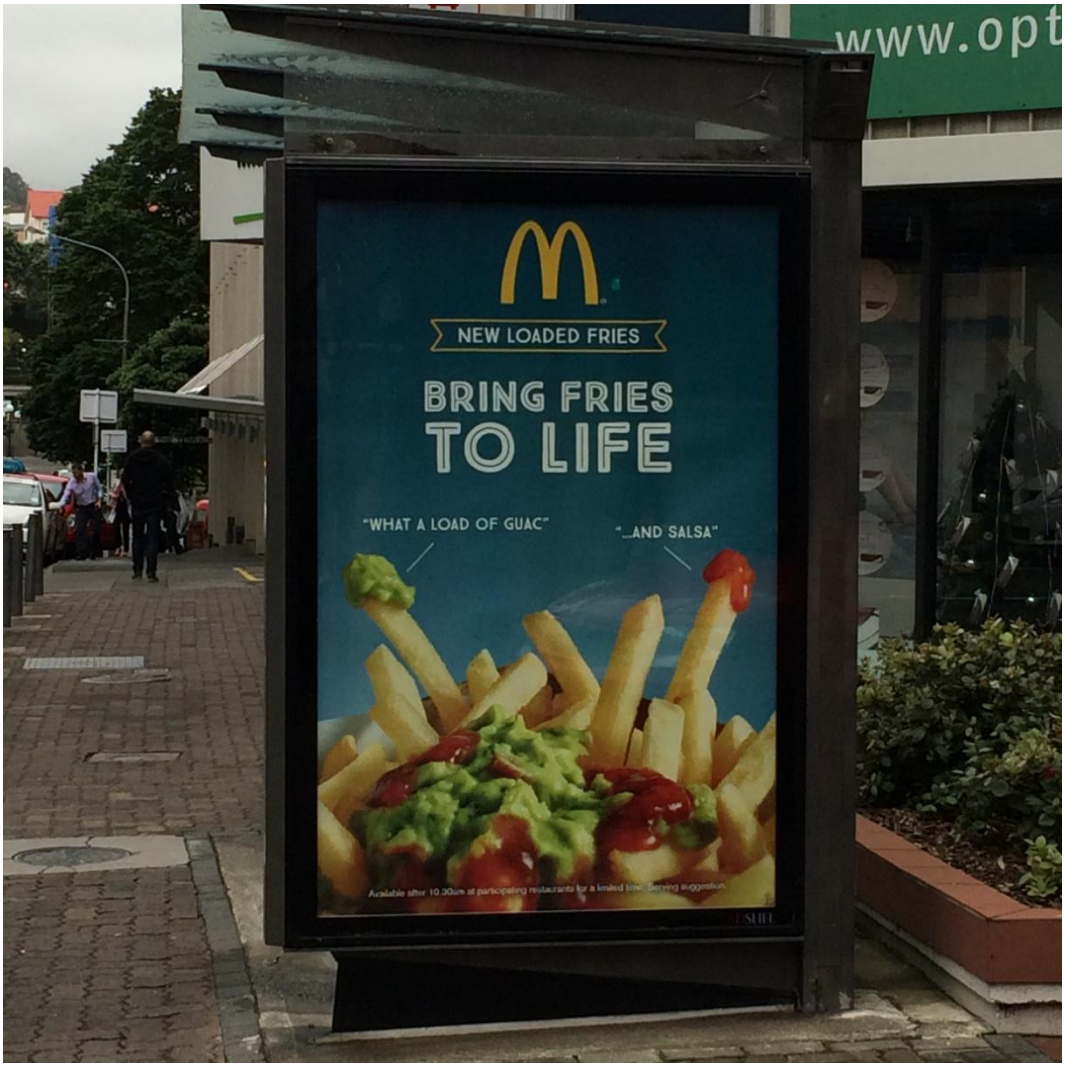


Figure 3: Bus shelter

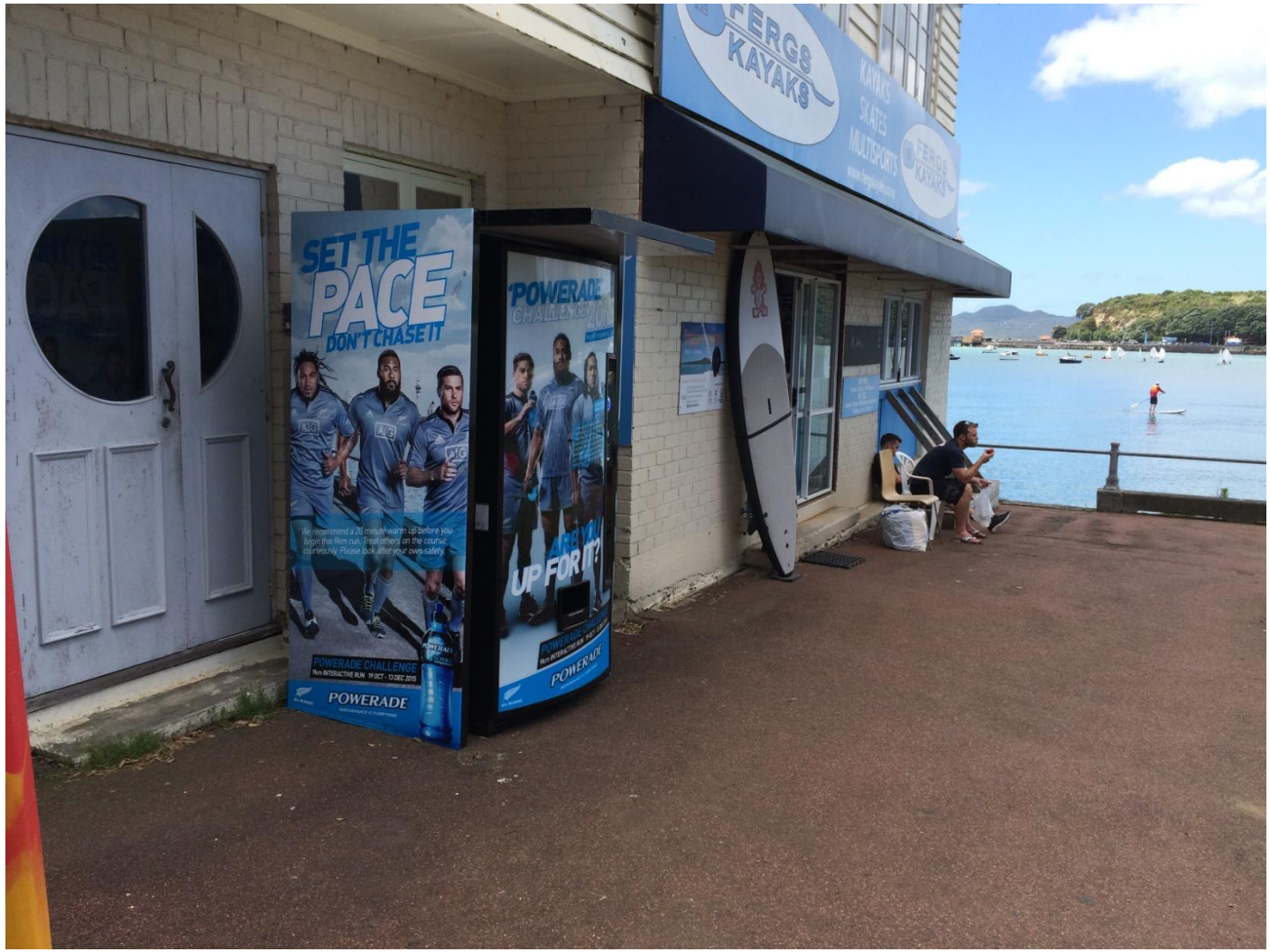


Figure 4: Waterfront Auckland - public space

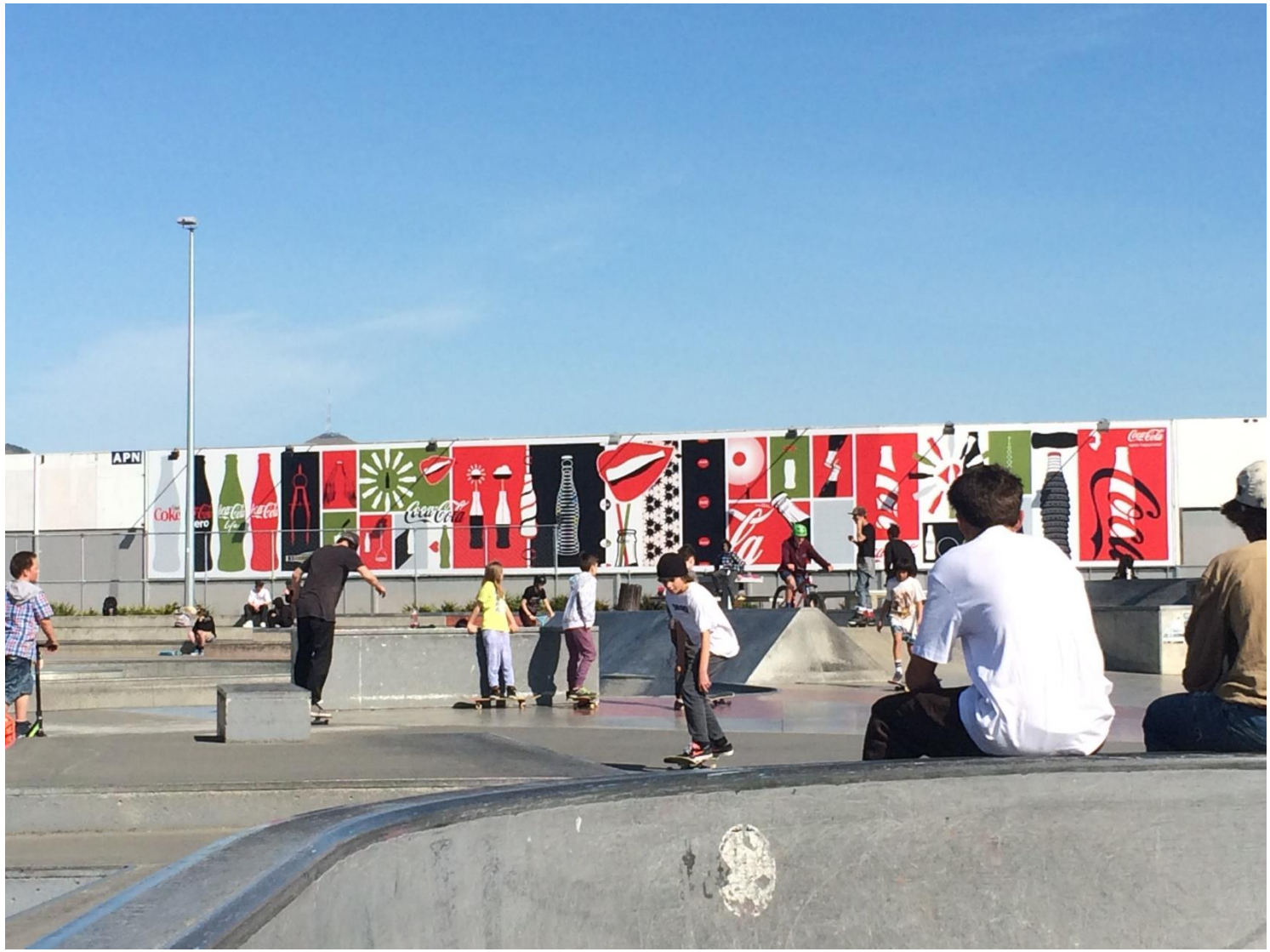


Figure 5: Christchurch skate park

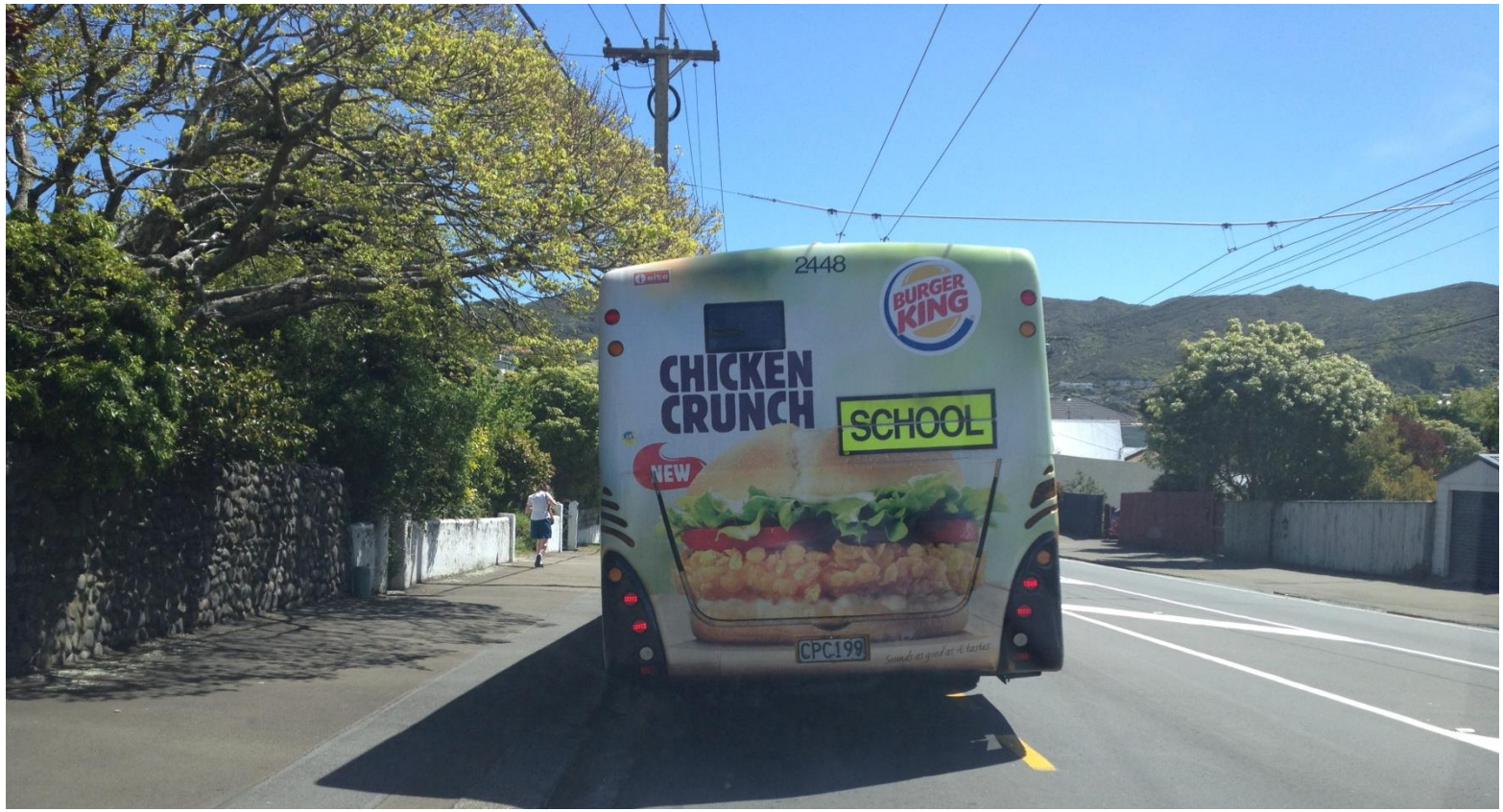


Figure 6: School bus

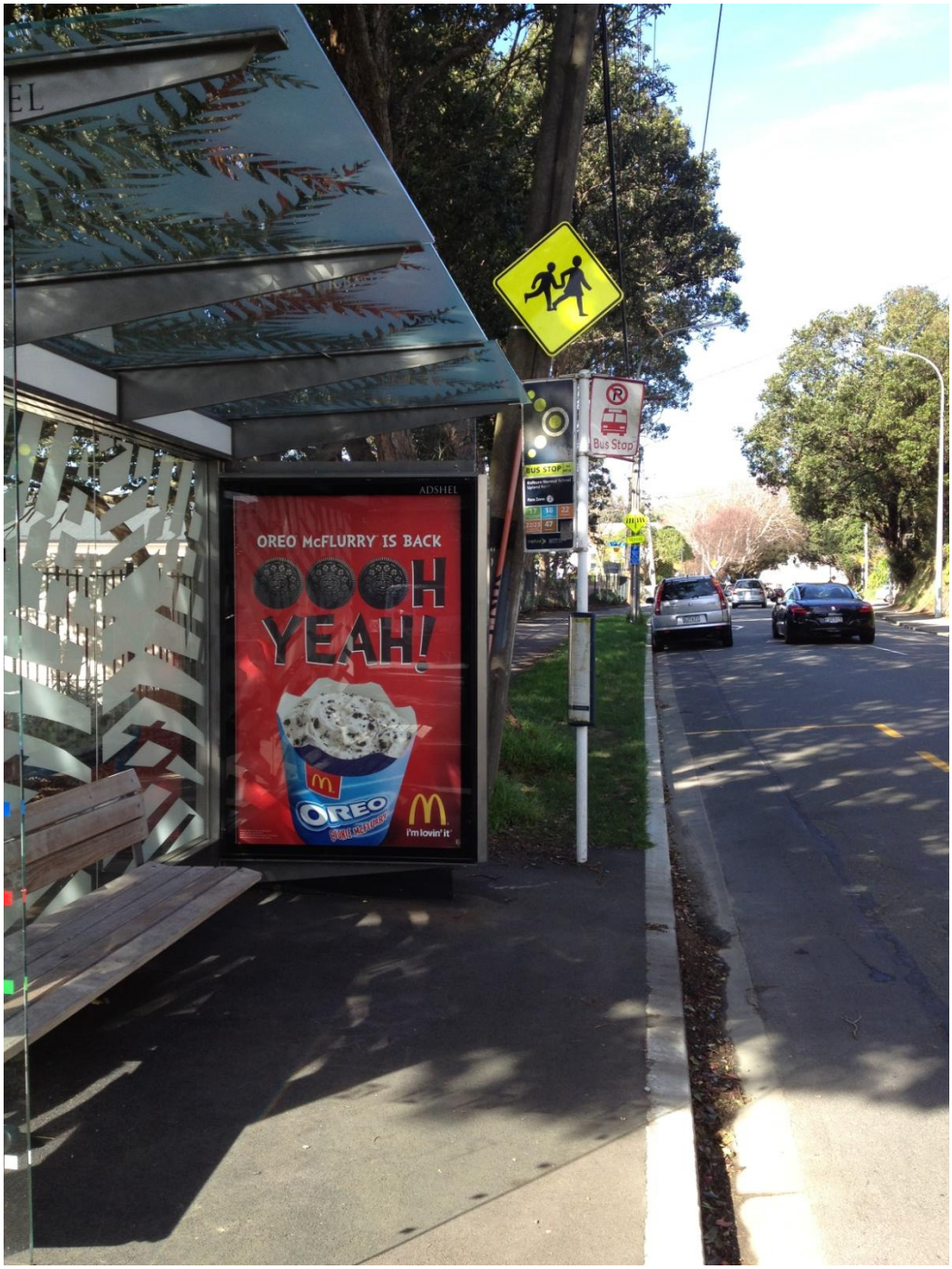


Figure 7: Bus shelter outside primary school, Wellington

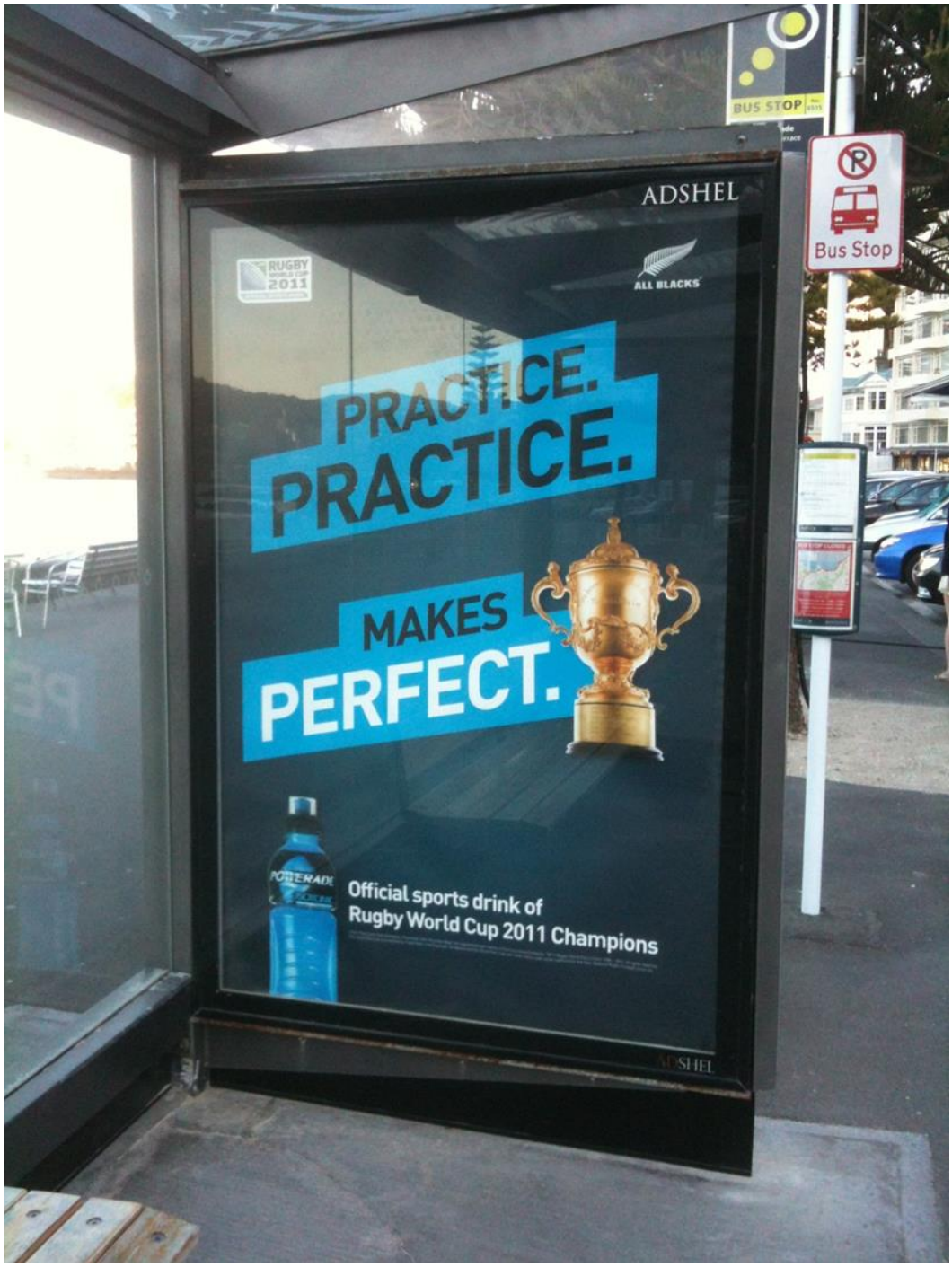


Figure 8: Bus shelter, connection with sport and implication that drinking Powerade improves sports performance

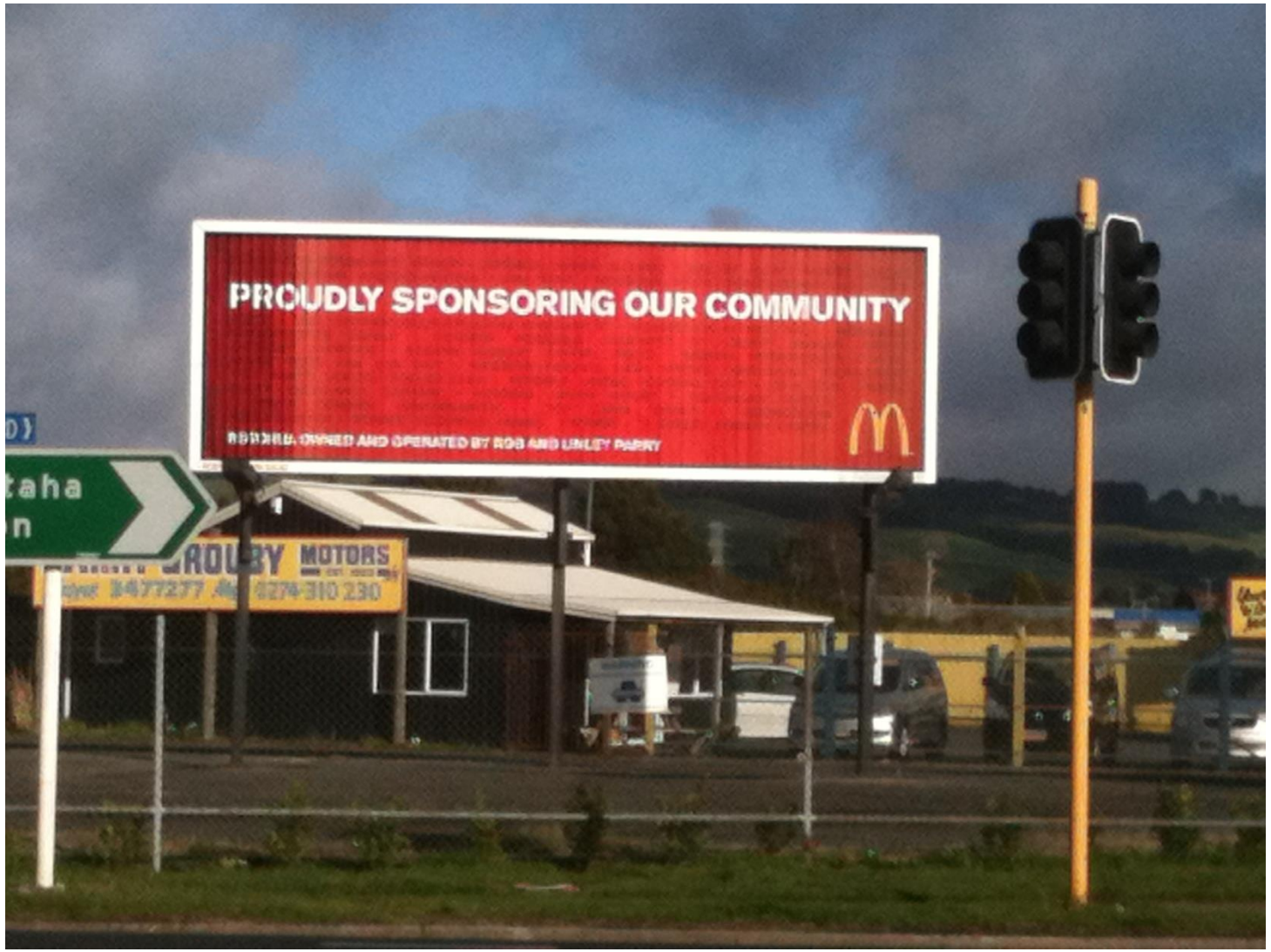


Figure 9: Intersection, Rotorua

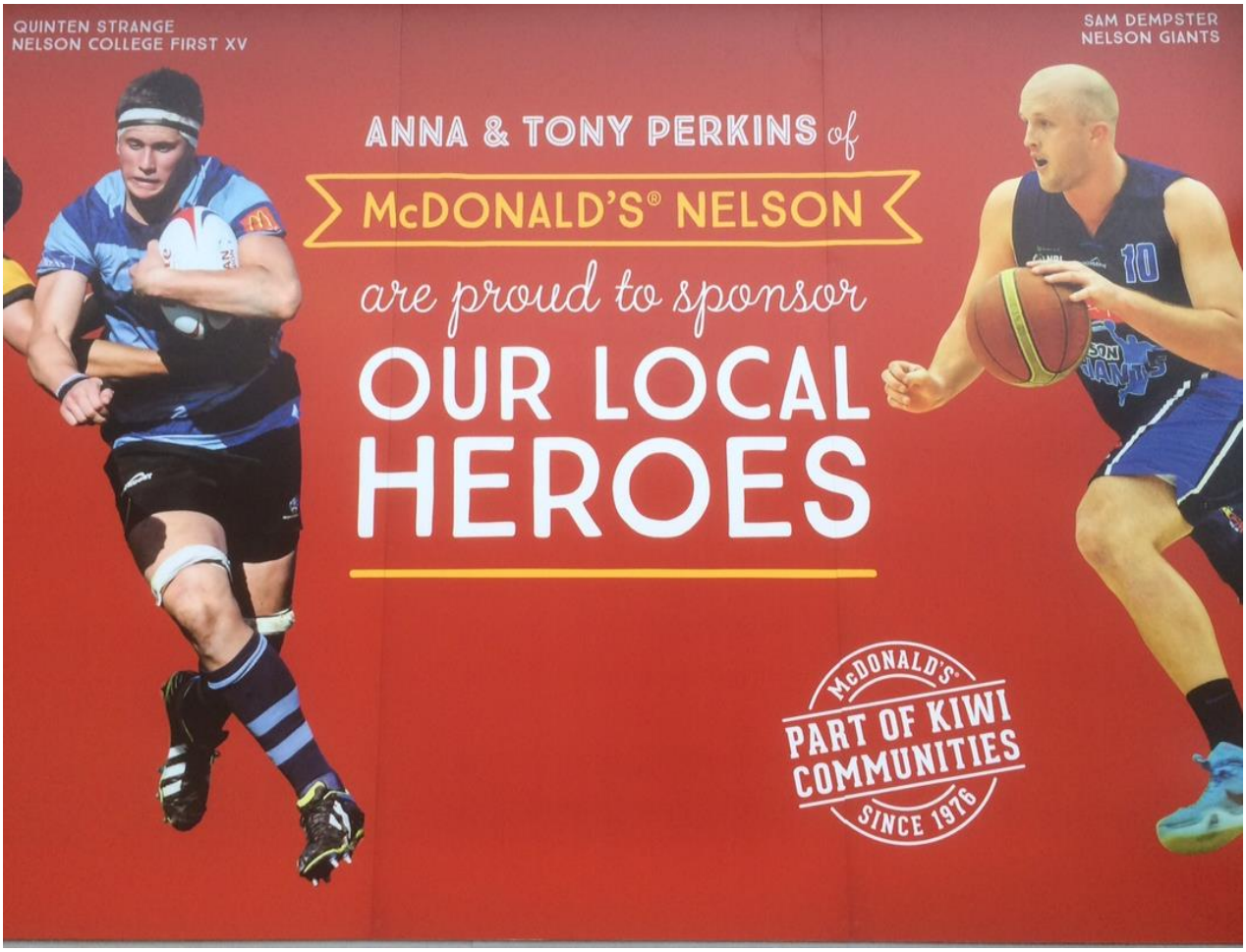


Figure 10: Billboard, Nelson

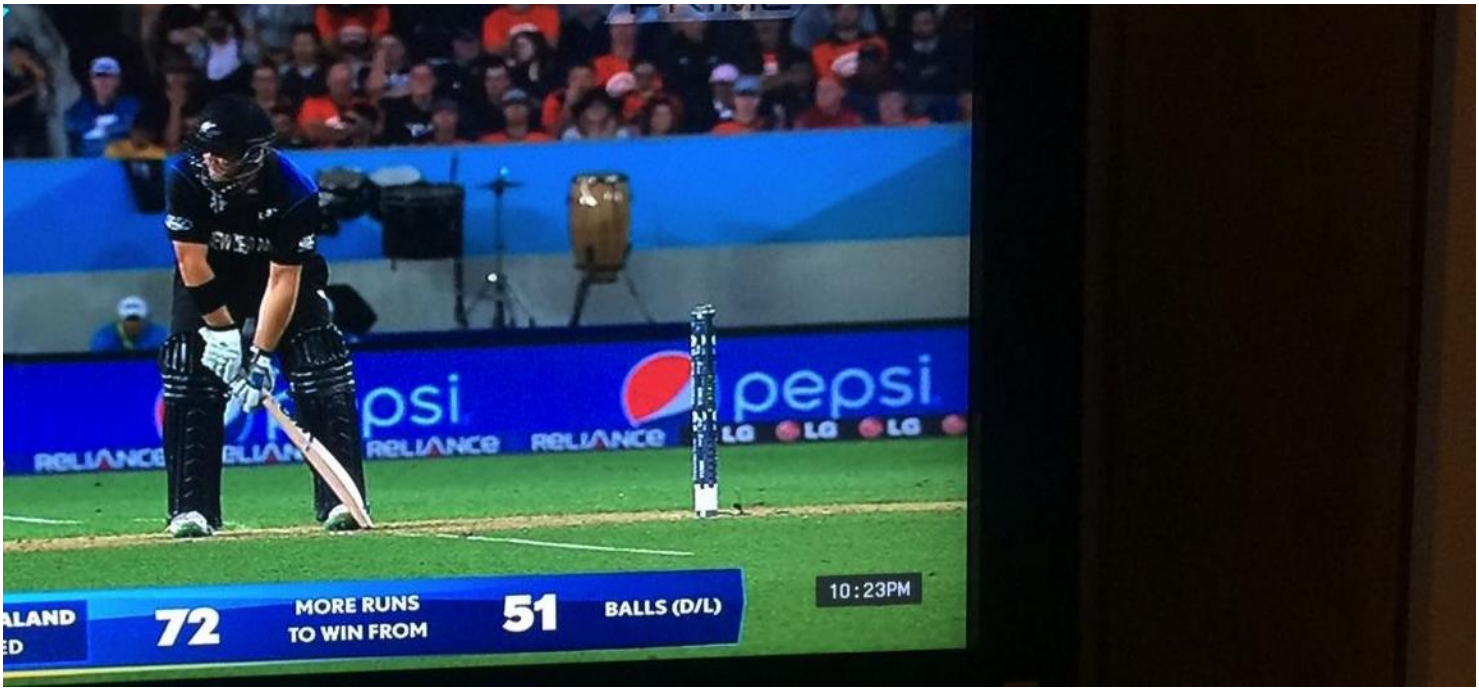
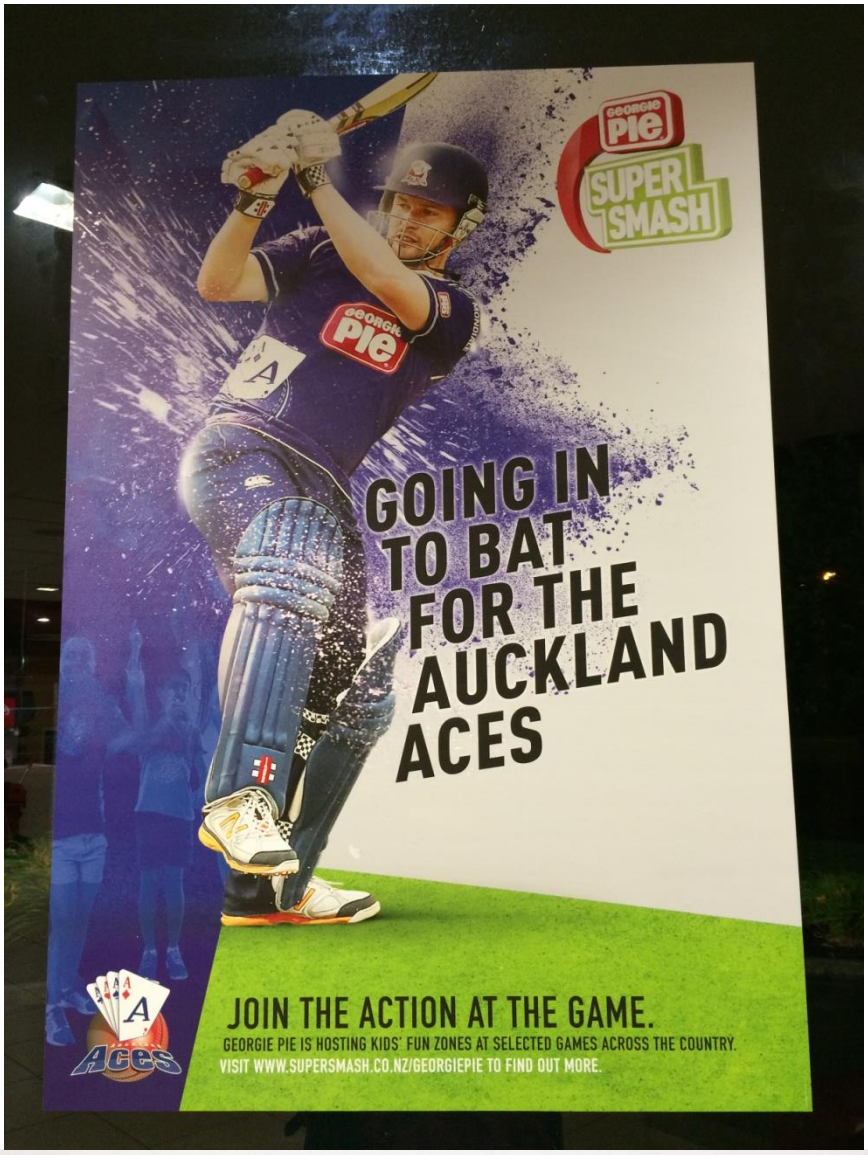
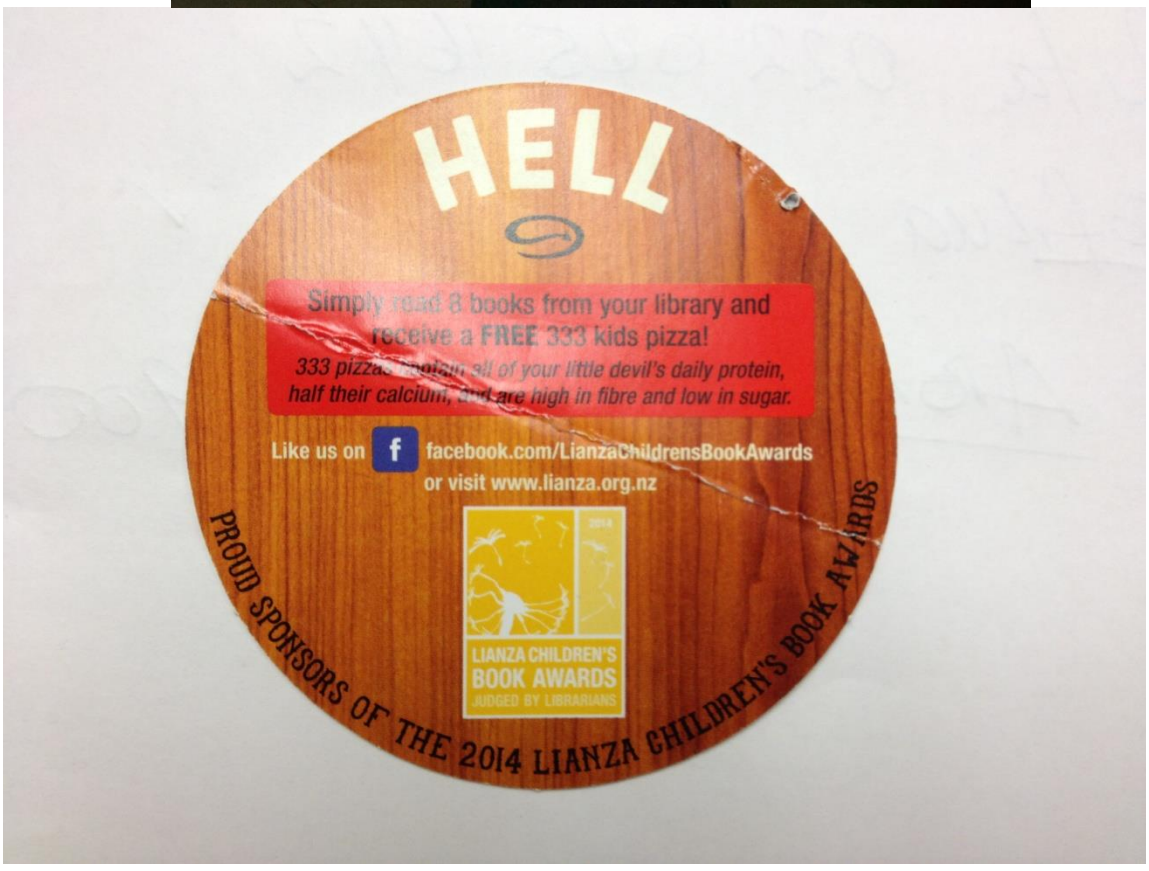


Figure 11: Inappropriate sponsorship, televised sports


georgie pie
SUPER SMASH
GOING IN TO BAT FOR THE AUCKLAND ACES
JOIN THE ACTION AT THE GAME.
GEORGIE PIE IS HOSTING KIDS' FUN ZONES AT SELECTED GAMES ACROSS THE COUNTRY.
VISIT WWW.SUPERSMASH.CO.NZ/GEORGIEPIE TO FIND OUT MORE.
Aces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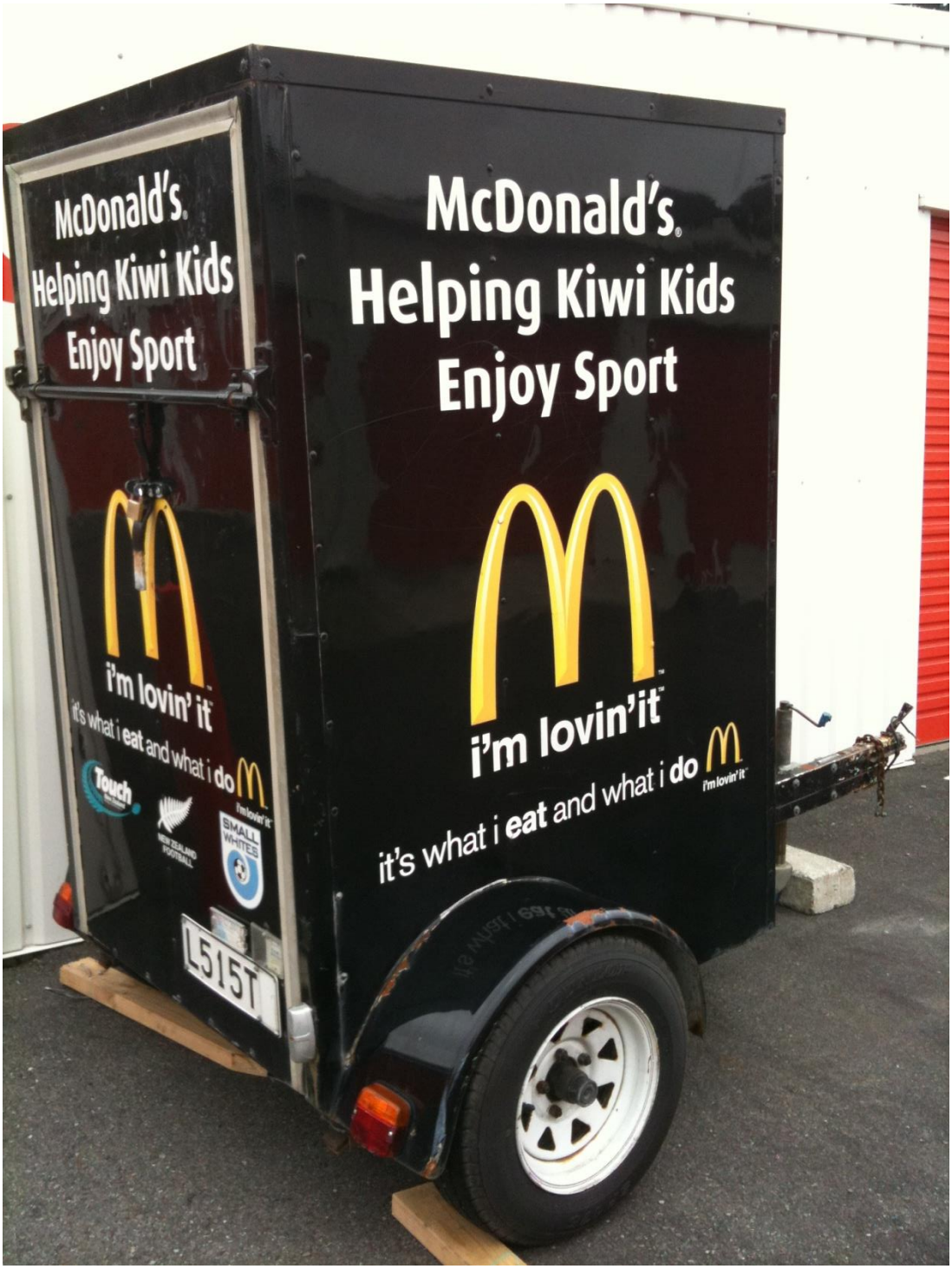

Figures 12, 13 & 14: Inappropriate sports association

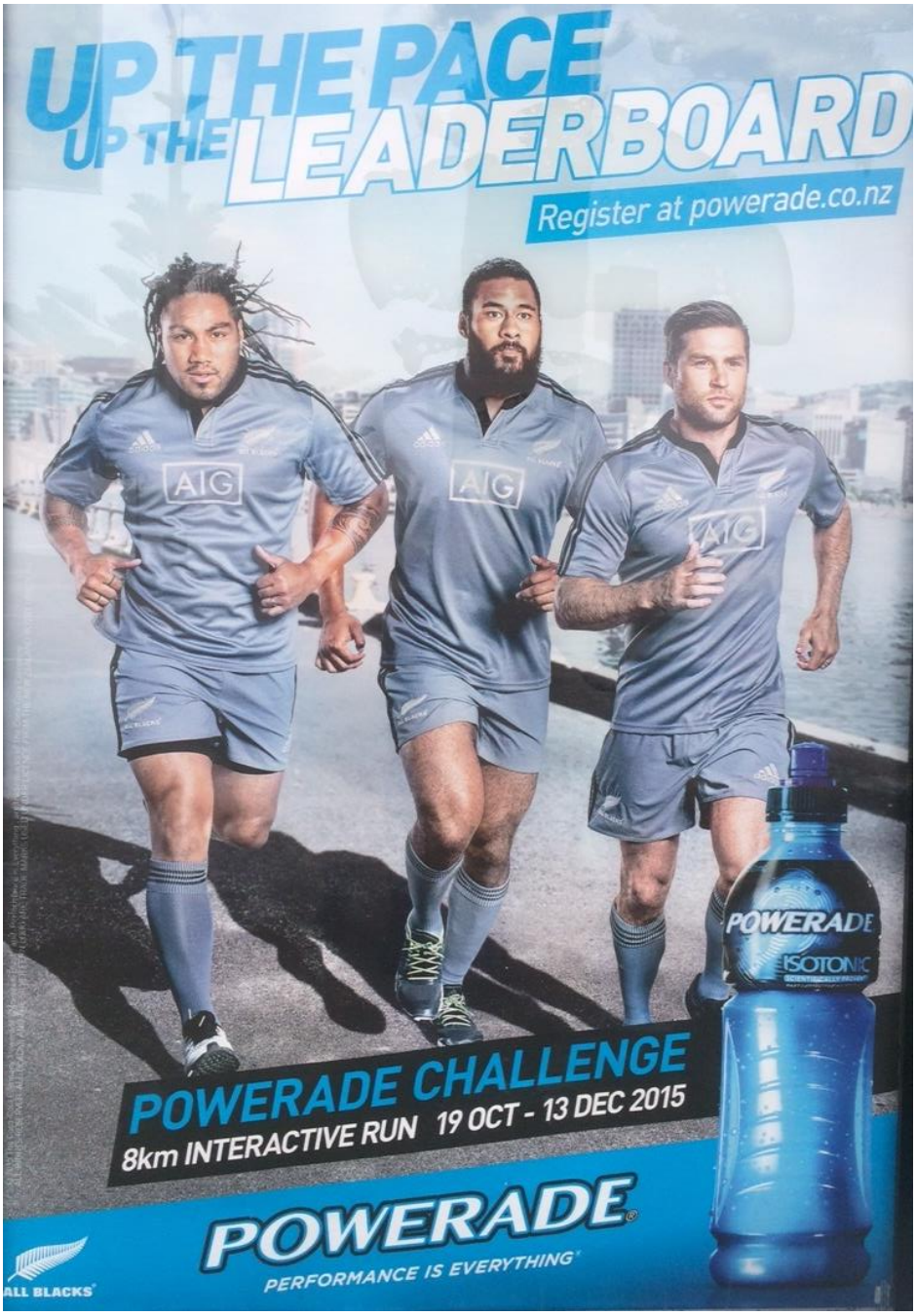

Figure 15: Inappropriate sports sponsorship

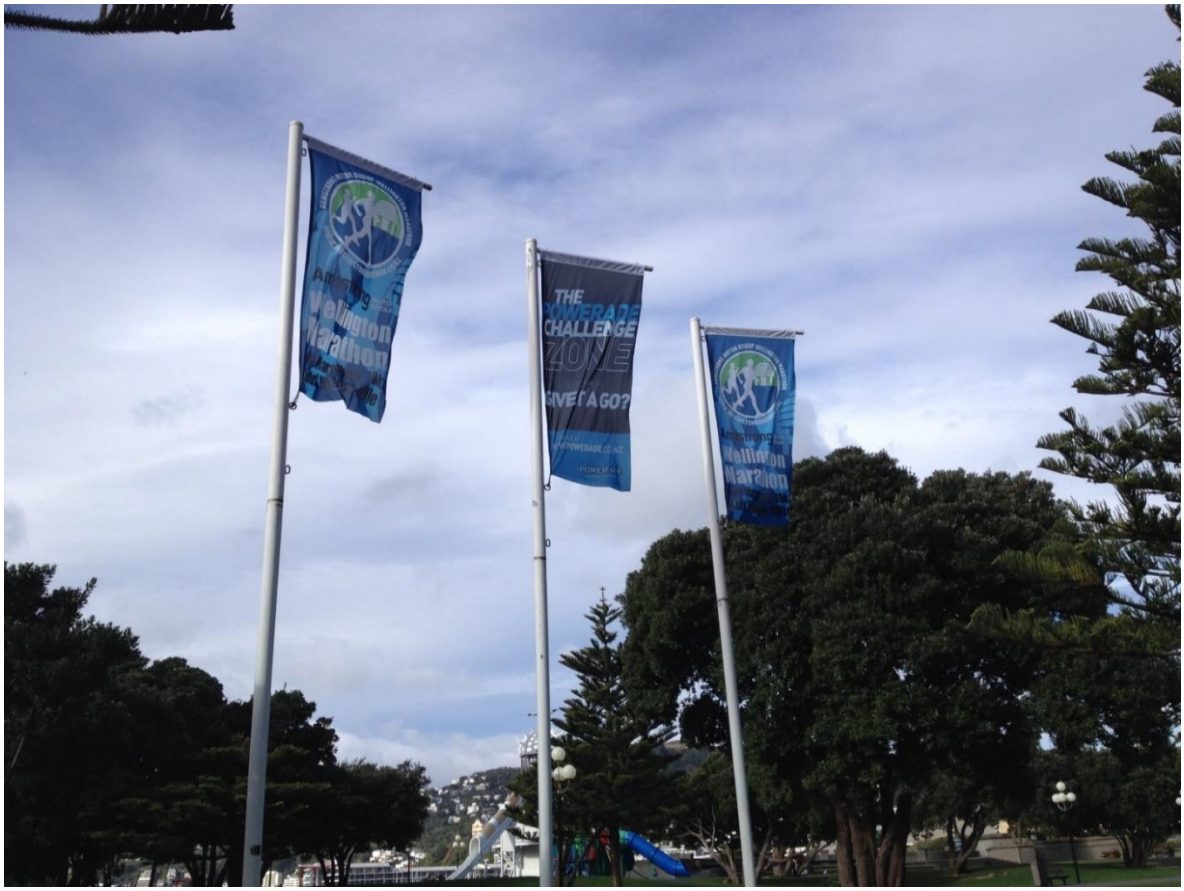

Figure 16: Inappropriate sports sponsorship

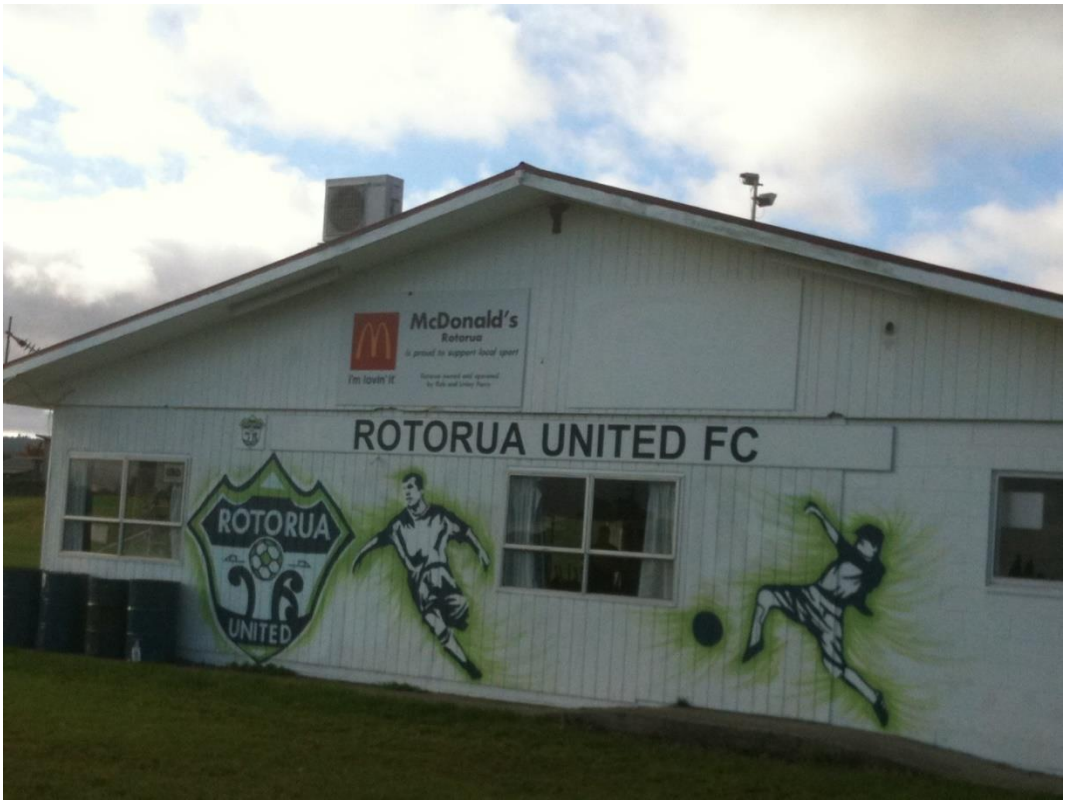

Figure 17: Inappropriate sports sponsorship