Entitlements and Rights

Children's rights, childhood obesity and health inequalities

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ABSTRACT

This article focuses on the relationship between unhealthy food marketing, obesity, health inequalities and children's rights. In particular, it reflects on the extent to which a children's rights-based approach to the regulation of unhealthy food marketing can promote more effective obesity- and non-communicable disease-prevention strategies and thus help reduce health inequalities. After establishing that food marketing increases health inequalities, it calls for the recognition that food marketing has become a major children's rights concern that requires States to effectively implement the World Health Organization's (WHO) Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children (WHO 2010a).

INTRODUCTION

Childhood obesity and related non-communicable diseases (NCDs) have grown rapidly over the past 20 years and their prevention has become one of the most pressing public-health concerns globally. The number of obese children and adolescents (aged 5-19 years) worldwide has risen tenfold in the past four decades, from 11 million in 1975 to 124 million in 2016 (NCD Risk Factor Collaboration 2017).[1]

Once considered a problem for high-income countries (HICs), overweight and obesity rates are rising quickly in low- and middle-income countries (LMICs), where the rate of increase has been more than 30% higher than that of developed countries (WHO 2014). This is particularly worrying, as obesity is a major risk factor for a broad range of NCDs, including cardiovascular diseases, diabetes, musculoskeletal disorders and some cancers (WHO 2016a). Childhood obesity, more specifically, is associated with a higher chance of obesity, premature death and preventable disability in adulthood. It also affects a child's immediate health, education attainment and quality of life – not least because obese children are more likely to be subjected to stigma, prejudice and discrimination as a result of their obesity[2] (Puhl and Heuer 2010; Janssen et al 2004).

Obesity's potential to reverse many of the health benefits contributing to increased life expectancy make it an urgent concern (WHO 2016a). Beyond the individual harms it causes, obesity is increasingly associated with significant socio-economic consequences (Second International Conference on Nutrition 2014). Thus, the Sustainable Development Goals (SDGs)[3] urge "all countries and all stakeholders" to "end hunger, achieve food security and improved nutrition and promote sustainable agriculture" (SDG 2) and to "ensure healthy lives and promote well-being for all at all ages" (SDG 3) (UN 2015).

1 In 2016, an additional 213 million were overweight.

2 Stigmatization is sometimes even an intentional component of public health campaigns (Hartlev 2014).

3 https://www.un.org/sustainabledevelopment/sustainable-development-goals/.

Obesity is also associated with health inequalities, both within and between countries (Commission on the Social Determinants of Health (CSDH) 2008; Marmot 2005; Bleich et al 2012). Not only are obesity rates increasing much faster in LMICs – over-nutrition appears to be increasing without an accompanying decrease in rates of under-nutrition (Ulijaszek et al 2017) – but health inequalities in childhood obesity are also strongly associated with belonging to a socio-economic position group consuming more energy-dense diets (Wang and Lim 2012).

In HICs, there is an inverse association between the socio-economic position of a child and their obesity status (Zarnowiecki et al 2014). This is amplified in some groups, especially in relation to ethnicity, sex and other family circumstances (Brug et al 2012; Gupta et al 2012; Robinson et al 2012; Garasky at al 2009). In LMICs, there are links between childhood obesity and factors of both higher socio-economic position, such as wealth, and lower socio-economic position, such as lower levels of education and maternal malnutrition during gestation (Popkin and Slining 2013; Ulijaszek et al 2017). These obesity-related inequalities are likely to continue over the course of a child's life and thus also have a harmful impact on health and longevity in their adult lives (Case et al 2005; Connell et al 2014).

The NCDs and inequalities associated with childhood obesity raise the question of what is required from States to ensure that individuals and their families are supported in making healthier decisions, so that the prevalence and burden of NCDs and health inequalities can be durably reduced (WHO 2016b).

Childhood obesity results from a combination of the child's exposure to an unhealthy environment, and the behavioural and biological responses of the child to that environment, with the individual child's response to the environment deeply influenced by developmental and life course factors. The combination of changes in the environment, including food consumption – unhealthy food[4] being cheaper, more readily available and ubiquitously marketed – and a decline in physical activity, results in an obesogenic environment, leading to energy imbalance (WHO 2016b).

These upstream causal factors are not controlled by children, so childhood obesity is not the result of voluntary choices, especially when it comes to younger children (WHO 2016b). As obesity is not exclusively a matter of personal responsibility (Brownell et al 2010; Pearl and Lebowitz 2014; Brownell 1991; Minkler 1999), creating an environment conducive to healthy behaviour is recognized by the international community as a matter of societal responsibility (UN General Assembly 2012; WHO 2004; WHO 2010a; WHO 2013).

One avenue worth exploring is the added value of a children's rights approach to obesity and NCD prevention. In September 2011, the UN General Assembly, in its Political Declaration on NCDs, reaffirmed "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and recognized "the urgent need for greater measures at the global, regional and national levels […] in order to contribute to the full realization of the right of everyone to the highest attainable standard of physical and mental health" (UN General Assembly 2012, p.2).

Two years later, the WHO Global Action Plan on the Prevention and Control of NCDs 2013-2020 highlighted the imperative to place a human-rights, equity-based principle at its core.[5] More recently, the WHO Commission on Ending Childhood Obesity reaffirmed the fundamental importance of the child's right to the highest attainable standard of health in guiding States' efforts to address this major public-health challenge:

> *"Government and society have a moral responsibility to act on behalf of the child to reduce the risk of obesity. Tackling childhood obesity resonates with the universal acceptance of the rights of the child to a healthy life as well as the obligations assumed by State Parties to the Convention of the Rights of the Child."* (WHO 2016a, p.8)

A children's rights-based approach works towards strengthening the capacities of right-holders (children) to understand and realize their rights and those of duty-bearers (States) to meet their legal obligations under the UN Convention on the Rights of the Child (CRC)[6] and other legally binding international human-rights instruments. By imposing legal obligations on States, a children's rights-based approach guarantees a degree of State accountability, making

4 The term 'unhealthy food' is used to refer to energy-dense, nutritiously poor foods and non-alcoholic beverages that are high in fats, added sugar or salt.

5 Similarly, the WHO's Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013–2020 places a human-rights, equity-based principle at its core (WHO 2013).

6 https://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx.

effective remedies more likely where rights are violated. A children's rights approach supports the monitoring of State commitments and has the potential to translate the commitments and obligations enshrined in the CRC into operable, durable and realizable entitlements. Furthermore, as children's rights are inalienable and universal, the language of human rights can ensure that a given issue is afforded special consideration in public policy (for more, please see UNICEF 2018; Garde et al 2017b).

This short article focuses on the relationship between unhealthy food marketing, obesity, health inequalities and children's rights. In particular, it reflects on the extent to which a children's rights-based approach to the regulation of unhealthy food marketing can promote more effective obesity and NCD prevention strategies and thus help reduce health inequalities. After (1) establishing that food marketing increases health inequalities, (2) it calls for the recognition that food marketing has become a major children's rights concern, which (3) requires that States effectively implement the WHO's Set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children (WHO 2010a).

1. Unhealthy food marketing as a contributor to childhood obesity and health inequalities

There is unequivocal evidence that the marketing of unhealthy food is linked to preferences for unhealthy food, consumption of unhealthy diets and, therefore, to childhood obesity (WHO 2016b). This is particularly problematic from the perspective of health inequalities in at least two respects.

I. **Exposure to advertising.** Not only do children tend to be exposed to marketing more than adults (Lodolce et al 2013), but children from lower socio-economic positions tend to be exposed to a greater degree of marketing than children from higher socio-economic positions (see, for example, Grier and Kumanyika 2010) through a broad range of media, including television (Adams et al 2011b and 2012), magazines (Adams and White 2009), outdoor advertising (Adams et al 2011a) and the placement of fast-food outlets (Smoyer-Tomic et al 2008; Hobbs et al 2017). Moreover, such marketing is often targeted specifically at these groups (Grier and Kumanyika 2011), thereby amplifying their pre-existing vulnerabilities. Digital marketing methods are even more of a concern, as they can target children with precision (Montgomery 2015; WHO 2016).

II. **The impact of advertising.** Children's particular susceptibility to unhealthy food marketing is heightened for those from a lower socio-economic group, including children from LMICs (Cairns et al 2013). It has been found, for example, that these children tend to change their food preferences after only brief exposure to marketing (Kumanyika and Grier 2006). Furthermore, overweight and obese children – who may already have been negatively impacted by unhealthy food marketing – are more susceptible to such marketing than non-overweight children (Halford 2007).

States, however, have done very little overall to restrict the marketing of unhealthy food to children. They have opted to focus their efforts on conveying nutritional information to consumers in an attempt to foster awareness of the quality of the food available to them, rather than adopt measures intended to change food environments by reducing the accessibility and affordability of unhealthy food and promoting those of healthier food.

Increasing consumer information is helpful in better fulfilling the right of consumers to information, as well as empowering individuals to make healthier choices for themselves and their families. Still, if information-disclosure requirements are not part of a broader strategy, their contribution to obesity prevention will inevitably be very limited. Furthermore, for information to work most effectively, consumers need to be exposed to and perceive relevant, sufficient and reliable (i.e. not misleading) information, which they can understand and which allows them to draw correct inference on the healthiness of food.

However, we know that consumers do not always perceive and understand the information provided and, even when they do, they are subject to biases and information heuristics. For example, we tend to give preference to short-term pleasures of taste over longer-term health goals (Grunert et al 2010; Grunert and Wills 2007; Grunert 2002). These cognitive limitations are magnified in members of lower socio-economic position groups. For instance, poverty has psychological consequences, including stress and negative affective states, which lead to short-sighted and risk-averse decision-making, which reinforce habitual behaviours (Haushofer and Fehr 2014).

Similarly, poorer members of society will more often have to make decisions that require volition, which draws on finite psychological resources, so that earlier acts to maintain willpower for healthy decisions will have detrimental impacts on later attempts to do the same. This decision fatigue is more common in members of lower socio-economic groups. Moreover, rationality is not always a reliable determinant of

consumer decisions, as consumer behaviour is multifaceted (Gokani 2018). This is particularly the case among members of lower socio-economic groups, for whom access to affordable, healthy food may be more difficult (Drewnowski 2004).

Restricting the marketing of unhealthy food, particularly to children, provides a much more promising way to promote healthier food environments and protect children's rights – all the more so as marketing restrictions are likely to have a greater positive impact on disadvantaged children, thereby contributing to greater equalities in health (Friant-Perrot and Garde 2014).

2. Unhealthy food marketing to children as a major children's rights concern

Unhealthy food marketing negatively affects a broad range of children's rights, which are protected under the CRC, not least, the right to the enjoyment of the highest attainable standard of health and related rights. This short article draws on the report that the United Nations Children's Fund (UNICEF) commissioned from the Law & Non-Communicable Diseases Unit of the University of Liverpool, published in April 2018 (UNICEF 2018). Readers are referred to this report for a fuller analysis of the relationship between food marketing and children's rights (see also Ó Cathaoir 2017).

The right to enjoy the highest attainable standard of health (often referred to as the right to health) is a universal human right. Specifically, it is protected by Article 24 of the CRC, which requires that "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" (Article 24(1)) and specifically "combat disease and malnutrition […] through, inter alia, the provision of adequate nutritious foods" (Article 24(2)(c)).

The Committee on the Rights of the Child has issued a General Comment on Article 24[7] and interprets the child's right to health broadly as "an inclusive right, extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also to a right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinant of health"[8] (Committee on the Rights of the Child 2013, p.3).

As such, the right to health has an important role to play in disease prevention, including childhood obesity and related diseases (WHO 2016b). States must fulfil children's right to health to the maximum extent of their available resources and, where needed, within the framework of international cooperation.[9] The notion of the "highest attainable standard of health" takes into account both the child's biological, social, cultural and economic conditions and the resources available to the State, supplemented by other resources made available by others, including NGOs and the international community. States must, therefore, provide equality of opportunity for every child to enjoy the highest attainable standard of health (as opposed to any standard of health) (UNICEF 2018).

The lack of explicit reference to childhood obesity in the text of the CRC itself does not exempt States from their obligation to adopt effective obesity prevention strategies. "Children's health is affected by a variety of factors, many of which have changed during the past 20 years and are likely to continue to evolve in the future".[10] States must, therefore, interpret the Convention in a dynamic manner and address the concerns affecting children at the present time, not as they were when the Convention was adopted, when obesity was not seen as a major global health issue.

An increasing number of statements by various UN Agencies and Special Rapporteurs confirm that the marketing of unhealthy food to children has become a children's rights concern. In particular, the Committee on the Rights of the Child has noted that the food industry spends billions of dollars on persistent and pervasive marketing strategies that promote unhealthy food to children. It has called for children's exposure to fast foods to be limited and for the marketing of them, "especially when [it] is focused on children", to be regulated. It further believes that their availability in schools and other places should be controlled.[11]

In a number of recent State Reports, the Committee has also called on countries with high obesity rates to regulate unhealthy food marketing to ensure that they comply with their obligations under the CRC, thus emphasizing that childhood obesity is increasingly viewed as a major children's rights issue. As Anand Grover, then UN Special Rapporteur on the Right to Health, put it in 2014:

7 Committee on the Rights of the Child, General Comment 15: http://www.refworld.org/docid/51ef9e134.html.

8 Ibid, paragraph 1.

9 Convention on the Rights of the Child, Article 4: https://www.ohchr.org/en/professionalinterest/pages/crc.aspx.

10 Committee on the Rights of the Child, General Comment 15(5)

11 Ibid, paragraph 47

"Owing to the inherent problems associated with self-regulation and public–private partnerships, there is a need for States to adopt laws that prevent companies from using insidious marketing strategies. The responsibility to protect the enjoyment of the right to health warrants State intervention in situations when third parties, such as food companies, use their position to influence dietary habits by directly or indirectly encouraging unhealthy diets, which negatively affect people's health. Therefore, States have a positive duty to regulate unhealthy food advertising and the promotion strategies of food companies. Under the right to health, States are especially required to protect vulnerable groups such as children from violations of their right to health." (Grover 2014, p.11)

3. The effective implementation of the WHO Recommendations as the cornerstone of a children's rights-based approach to obesity prevention

In light of the unequivocal evidence linking unhealthy food marketing to childhood obesity (Boyland and Tatlow-Golden 2017), we argue that States, as part of their duty to respect, protect and fulfil the right to health, the right to food and other related rights, should implement the WHO Recommendations and restrict such marketing with a view to reducing its negative impact on children and the enjoyment of their rights.

The WHO's set of Recommendations on the Marketing of Foods and Non-Alcoholic Beverages to Children fleshes out the provisions that States should adopt to comply with their obligations under the CRC to respect, protect and fulfil children's right to health, their right to food and all the other rights that are negatively affected by unhealthy food marketing. These Recommendations are evidence based and were unanimously adopted by the World Health Assembly (WHA) in May 2010[12] (for the genesis of and an introduction to the Recommendations, see Garde and Xuereb 2017).

In May 2012, the WHO published a framework implementation report to provide technical support to Member States in implementing the Recommendations and in monitoring and evaluating their implementation. The report is designed to draw their attention to key issues arising at the different stages of the policy cycle, from policy development to policy implementation, policy monitoring and policy evaluation (WHO 2012).[13] Repeated calls have been made on States to ensure that the Recommendations are properly implemented (WHO 2013; WHO 2016b). Nevertheless, they remain poorly implemented to date (Kraak et al 2016; Garde and Xuereb 2017).

The WHO Recommendations should be seen as a guide for actions that States should consider in order to end childhood obesity. As such, they have the potential to support a children's rights-based approach to obesity prevention, even though they do not specifically refer to children's rights.

The Recommendations call on States to reduce the impact of unhealthy food marketing to children and urge them to adopt policies to tackle the two main components of marketing: (1) the exposure, or reach and frequency of the marketing message and (2) the power, or creative content, design and execution of the message. They call on governments to set clear definitions, including:

- The age group for which restrictions shall apply (namely, defining who a 'child' is for the purposes of the Recommendations);
- The communication channels, settings and marketing techniques to be covered, bearing in mind the Recommendations' broad definition of the central notion of 'marketing';[14]
- What constitutes marketing to children, according to factors such as product, timing, viewing audience, placement and content of the marketing message; and
- What foods fall within the scope of marketing restrictions (what constitutes unhealthy food).

Member States are specifically requested to define settings where children gather and ensure that they are free from all forms of unhealthy food marketing. As Recommendation 5 states, these settings include, but are not limited to, nurseries, schools, school grounds and pre-school centres, playgrounds, family and child clinics and paediatric services (including immunization programmes), as well as during any sporting and cultural activities that are held on these premises.

12 World Health Assembly (WHA) Resolution 63/14.

13 Both the Recommendations and the framework implementation report are available at: http://www.who.int/dietphysicalactivity/marketing-food-to-children/en/index.html.

14 The Recommendations define the notion of 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".

However, there are many additional settings – which may vary significantly from one State to another – where children commonly gather, such as public playgrounds, swimming pools, summer schools and programmes, afterschool programmes and sporting events. The settings also include temporary displays or gathering points for children, such as activity areas created for children in airports, community centres, places of worship and shopping malls. Finally, and as the WHO framework implementation report points out, the areas surrounding "settings where children gather" are also worth considering, for example, where food-business actors use highly prominent billboards to promote their goods and services very near schools (WHO 2012 , p. 22).

The WHO Recommendations explicitly recognize the greater potential of a comprehensive approach that restricts all forms of unhealthy food marketing to children to achieve the desired result. By contrast, a stepwise approach is, by definition, more selective in nature and vulnerable to leaving gaps in the regulatory framework. A children's rights approach to food-marketing regulation requires that the outstanding challenges and loopholes are both recognized and addressed at the national, regional and global levels. In particular, States should be cognizant of the fact that if they regulate unhealthy food marketing too narrowly, marketing is likely to shift:

- From regulated to unregulated programmes (e.g. from children's programmes to general programmes with a high children's audience in absolute numbers);
- From regulated to unregulated media (e.g. from broadcast to digital media, packaging or sponsorship);
- From regulated to unregulated marketing techniques (e.g. from licensed to equity brand characters); and
- From regulated to unregulated settings (e.g. from schools to other settings where children gather).

The restrictions that the UK introduced a decade ago on unhealthy food marketing in and around children's television programmes demonstrate the limits inherent in a stepwise approach, allowing for a shift of marketing investment from children's to adult airtime. A high number of children watch mixed-audience programmes that fall outside the scope of the prohibition. As a result, the overall effectiveness of the rules introduced to protect children from the harmful impact of unhealthy food marketing is limited, as the UK broadcast regulator has recognized.

In its evaluation of July 2010, Ofcom highlighted the high compliance rate of broadcasters with both the letter and the spirit of the scheduling restrictions, noting that between 2005 and 2009, children saw at least 37% less unhealthy food advertising. Nevertheless, it also found that the volume of unhealthy food advertising aired throughout the day had increased and that children only saw 1% less unhealthy food advertising overall in adult airtime (Ofcom 2010; Adams et al 2011b and 2012).[15]

Researchers at the University of Liverpool went further and concluded that, despite regulation, children in the UK were exposed to more television advertising for unhealthy than healthy food items, even at peak children's viewing times (Boyland et al 2011). Mixed-audience programmes, such as family shows and sporting events, are frequently used to promote unhealthy food and are classic examples of the artificial separation of 'direct' and 'indirect' marketing: what should count is the actual exposure of children to unhealthy food marketing, not the classification of a programme.

A children's rights-based approach mandates States to protect all children, including adolescents. While the CRC does recognize that children's vulnerabilities may vary from one stage of childhood to another, it applies to all children[16] and does not exempt States from their obligations to protect them from harm, including the harm stemming from unhealthy food marketing. The research focusing on children's cognitive development assumes that at a certain age, their cognitive abilities will be sufficient to protect them from adverse advertising influences. However, one needs to be wary of assumptions about older children's media literacy in recognizing and resisting marketing (for more, see WHO Regional Office for Europe 2016).

An increasing number of studies have called for a paradigm shift, arguing that States should not only consider whether children have the cognitive capacity to identify the persuasive intent of advertising, but also whether teenagers (older children) possess the same resistance as adults to commercial advertising. Advertising can manipulate consumer behaviour through implicit persuasion, which may, in turn, explain why cognitive defence would not protect older children (Nairn and Fine 2008; Harris et al 2009).

This is compounded by the fact that during childhood and adolescence, children's brains are biased towards rewards and they are more likely to respond to cues in their environment, including marketing (Casey 2015). Unlike adults, however, children may not activate areas of the brain that are important for inhibitory control, as these areas are less developed (van Meer et al 2015).

15 Researchers from Newcastle University concluded that children were exposed to the same level of unhealthy food advertising as they were before the Ofcom rules came into force, confirming that children were still exposed to unhealthy food advertisements during programming that was not specifically aimed at them (Adams 2012).

16 Article 1 of the CRC defines a 'child' as every human being under 18 years of age.

As food selection is primarily a response of the human visual system, food marketing can promote over-consumption (van Meer et al 2016). Such responses may be augmented in overweight and obese children, encouraging additional over-consumption (Bruce et al 2010; Stice et al 2008; Yokum et al 2011; Davids et al 2010). This thinking is further supported by findings that obesogenic environments interfere with consumers' ability to act in their long-term interests by inducing a preference for unhealthy food (Wansink 2011; Oullier and Sauneron 2010; Just et al 2007; Wansink and Chandon 2006; Étilé 2013; Institut National de la Santé et de la Recherche Médicale (INSERM) 2017).

The approach proposed here would not lead to the marginalization of the role of parents, who are primarily responsible for the upbringing of their children. Rather, it would empower them by modifying the environments that encourage obesity, helping them to better care for their children and thus discharge their parental responsibilities, as recognized by the CRC.[17]

17 For a more detailed account of the implementation of the WHO Recommendations in the UK, see Garde et al 2017.

CONCLUSION

As Amartya Sen notes, reducing inequalities is about restoring the capability of individuals to access a nutritionally balanced diet (Sen 2009). Dietary choices should not be purely theoretical, but achievable by all. Equal access to food for all entails a rethink of 'freedom' as the substantive empowerment of individuals, regardless of their environment and resources, to access healthy food.

Effectively regulating unhealthy food marketing is part of what States must undertake to change food environments, end childhood obesity, promote children's rights and reduce health inequalities. It is only then that all children, including the most vulnerable, will be properly protected from the harmful impact that unhealthy food marketing and other commercial determinants have on them.

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