The challenge of childhood obesity:
The advertising industry’s perspective
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Childhood obesity is a serious problem impacting the health, well-being and life outcomes of the nation's children. It is a complex social issue, with child obesity levels strongly affected by lifestyle and geography. To be effective, solutions need to be evidence-based, maintain a sharp focus on the end objective of reducing childhood obesity, address multiple causal factors, and be targeted at where the problem is.

For more than a decade, advertising restrictions have been the centrepiece of measures to address childhood obesity. Indeed, the UK already has amongst the strictest and most effective restrictions on the exposure of children to the advertising of foods high in fat, salt and sugar anywhere in the world. But large reductions in children’s advertising exposure resulting from existing restrictions, and children’s changing media consumption habits, have had no measurable impact on childhood obesity, with broader evidence from around the world of any causal relationship between advertising and obesity also very weak.

A continuing focus on the failed strategy of further advertising restriction is founded on the misplaced belief that ‘children are bombarded by HFSS advertising’, and that increased exposure to advertising has driven an increase in food consumption. To the contrary, the rise in obesity has occurred during a decade of declining exposure to HFSS advertising and declining food consumption (overall calorie intake is down). Any effective solution must focus first and foremost on countering the dramatic declines in physical activity, and so calories expended. It is the many hours that children spend on sedentary behaviours daily – not the seconds during which children are exposed to food advertising – that deserve our primary focus.

As with many other public health issues, levels of social deprivation and to a lesser extent culture and ethnicity are major predictors of obesity levels. A fairly flat national picture masks two quite distinct, indeed opposite, outcomes – an improving trend in more advantaged communities, but a continuing increase in areas of high social deprivation. Child obesity is a problem heavily skewed to particular groups, demanding community-level solutions targeted at where the problem is to maximise effectiveness.

The key factors associated with childhood obesity are neither caused by advertising, nor can be remedied by its absence. Advertising in its nature is broad and relatively untargeted, while effective action demands localised interventions, targeted at where the problem is.

Success models for such approaches are emerging, including recent evidence from community-level initiatives discussed in this report – in Amsterdam, in Wakefield, and The Daily Mile.

These point to the fact that the most effective obesity reduction strategy will be focused at the local level on exercise, healthy living, and early intervention. This is about constructive measures from the bottom up, not prescriptive measures from the top down. Nationwide bans and restrictions seemingly remove the issue from sight but do little to encourage the healthy ways of living, eating and drinking required to deliver real reductions in childhood obesity.

Further work needs to be done to see how the programmes identified here can be scaled up nationwide, perhaps with the support of industry as well as other stakeholders, to magnify the programme and engage difficult-to-reach communities. The industry stands ready for further discussions and we welcome the opportunity to engage with Government on this issue of huge importance both to our country’s present and its healthier and happier future.
Childhood Obesity: Prevalence and Trends

Child obesity levels in the UK are unacceptably high and action needs to be taken to address this. However, they have stabilised and are relatively positive in terms of international comparisons.

This masks a very different picture across different local communities, with high – and still growing – levels of child obesity in more deprived areas cancelling out declines in more advantaged areas with already relatively low obesity levels.

National public health interventions are making a difference in more advantaged communities, which are easier to reach and influence, but have been insufficiently targeted to have a sustained, positive impact across all communities.
**Childhood Obesity: Prevalence**

Childhood obesity prevalence in 2016/17 was 10% in reception year, and 20% in year 6. Over time, obesity prevalence has fallen slightly in reception year compared to 2006/7, but it is higher for year 6 compared to 2009/10.

If exposure to food advertisements is a credible factor in obesity prevalence, it would be expected that a dramatic reduction in exposure to HFSS advertising over the past 10 years would have had a more significant impact on child obesity levels. Ofcom’s analysis in 2010 was that HFSS exposure by children on TV had fallen by 37% since the introduction of the rules in 2008. Since then, BARB data shows there has been a 41% fall in all food advertising exposure by children.

Digital targeting, including interest-based targeting, enables advertisers to direct their online advertisements away from certain groups, such as children. This - coupled with the recently strengthened non-broadcast rules - means exposure in the digital space is also low.

**Children’s exposure to HFSS advertising (approximate)**

Ofcom (2005, 2009) and BARB TV data analysis (2010, 2017). This graph is illustrative of the downward trajectory of HFSS exposure, however different methodologies make a direct comparison difficult.

Within this is exposure to HFSS product adverts of no appeal to children, such as butter and olive oil.
According to the National Child Measurement programme, (England and Wales, 2017), obesity prevalence among reception-aged children from a deprived background is 6.9% higher than among higher socio-economic area counterparts. This rises to 14.9% by year 6.

In 2016/17 Reception year obesity prevalence ranged from just 5% in Kingston upon Thames to 14% in Wolverhampton; and for year 6, from 11% in Rutland to 29% in Barking & Dagenham.
Obesity rates are highest in the most deprived 10 per cent of the population - approximately twice that of the least deprived 10 per cent.
The causes of childhood obesity in the UK

Childhood obesity poses a significant challenge to future public health across the globe. The UK is not unique in attempting to turn back the clock on this public health matter. Most countries have put in place some form of programme aimed at encouraging healthy lifestyles. And yet such programmes have had mixed success, with some programmes proving ineffective and potentially even counter-productive, and others showing signs of remarkable success in a relatively short space of time.

So, what is it that is driving the success of some obesity prevention models, but not others?

The causes of child obesity are multi-faceted and complex. Solutions will only be effective if they are targeted at where the problem is.

Further on in this report, we will look at three initiatives aimed at reducing the prevalence of child obesity and encouraging healthy lifestyles. These programmes range in scale and are at different stages of development, from the relatively under-developed and small, but promising, initiative in Wakefield; to the large-scale and comprehensive Amsterdam Healthy Weight Programme.

Like these programmes, any effective solution to childhood obesity will combine evidence-based approaches that deliver increases in physical activity and healthy lifestyles while targeting resources at local areas and communities where the problem is biggest. This is a whole-society challenge and industry is committed to working together with Government and other stakeholders to deliver effective solutions which combine these elements.
Cost-effectiveness and impact of obesity levers, United Kingdom from the McKinsey Global Institute ‘Overcoming Obesity’ report, 2014

<table>
<thead>
<tr>
<th>Intervention Group</th>
<th>Estimated impact across full population</th>
<th>Estimated average cost per DALY</th>
<th>Strength of evidence rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portion Control</td>
<td>2,126</td>
<td>400</td>
<td>•••</td>
</tr>
<tr>
<td>Reformulation</td>
<td>1,709</td>
<td>2,600</td>
<td>••</td>
</tr>
<tr>
<td>High calorie food/beverage availability</td>
<td>1,137</td>
<td>200</td>
<td>•</td>
</tr>
<tr>
<td>Weight-management programs</td>
<td>967</td>
<td>1,300</td>
<td>••</td>
</tr>
<tr>
<td>Parental education</td>
<td>962</td>
<td>2,000</td>
<td>••</td>
</tr>
<tr>
<td>School curriculum</td>
<td>888</td>
<td>600</td>
<td>•</td>
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<tr>
<td>Healthy meals</td>
<td>868</td>
<td>14,000</td>
<td>•</td>
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<tr>
<td>Surgery</td>
<td>615</td>
<td>10,000</td>
<td>••</td>
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<td>Labelling</td>
<td>575</td>
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<td>Price promotions</td>
<td>561</td>
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<td>••</td>
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<tr>
<td>Pharmaceuticals</td>
<td>430</td>
<td>5,600</td>
<td>•••</td>
</tr>
<tr>
<td>Media restrictions</td>
<td>401</td>
<td>50</td>
<td>•••</td>
</tr>
<tr>
<td>10% tax on high-sugar/high-fat products</td>
<td>203</td>
<td>1,800</td>
<td>•</td>
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<tr>
<td>Workplace wellness</td>
<td>139</td>
<td>2,700</td>
<td>••</td>
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<tr>
<td>Active transport</td>
<td>67</td>
<td>31,000</td>
<td>•</td>
</tr>
<tr>
<td>Public-health campaigns</td>
<td>49</td>
<td>200</td>
<td>•</td>
</tr>
</tbody>
</table>

- ••• Sufficient evidence for weight change
- •• Limited evidence for weight change
- • Sufficient evidence for behaviour change
- •• Limited evidence for behaviour change
- • Logic based on parallel evidence
We explore here why further restrictions on food advertising would not be a meaningful component of a successful anti-obesity strategy, and indeed why they would actually be counter-productive.

The short answer to this comes from the real-world evidence about the ineffectiveness of advertising restrictions in reducing childhood obesity levels. The UK is a case in point. We already have amongst the strictest and most effective rules in the world to restrict the exposure of children to HFSS advertising. But the large reductions since the rules were introduced in 2008 have had no measurable impact on childhood obesity.

Advertising is already subject to significant restrictions to limit children’s exposure to HFSS advertising, with a highly precautionary approach taken by the CAP and BCAP Codes in line with current evidence. As part of this precautionary approach, the rules were tightened in 2017 to bring the rules applying to online advertising and other media to the same standards as for TV, protecting under 16s across all media. The current evidence is that the rules are already working effectively to protect children.

Quebec provides another example. There, advertising to children was banned in 1980 but it was not banned in the rest of Canada. Despite this, childhood obesity rates in Quebec remain similar to those in other provinces. The prevalence of overweight and obesity among children in Quebec grew by 140% during the first 15 full years of the advertising ban - a faster increase than elsewhere in Canada.3

These examples point to the fact that childhood obesity is a serious problem that demands effective interventions, not ‘doubling down’ on a strategy that has demonstrably failed.

Yet a misplaced belief in the effectiveness of incremental advertising restrictions persists, founded on the false assumption that “children are bombarded by HFSS advertising”.

Our analysis of children’s HFSS advertising exposure gives a lie to this. The analysis includes all pre-9pm TV viewing, as well as advertising in digital media, every day of the week, during 2017.

Far from being “bombarded” with these advertisements, the average child in the UK sees only around 11.5 seconds of HFSS advertising per day on television and digital media. And many of these advertisements are for products like butter and mayonnaise, which are likely to be of little interest to a child.

Leaving aside the substantial cost of the proposed restrictions (affecting large swathes of economic activity in the media and advertising industry) and the failure to focus the impact of the restrictions toward children (the impact on adult advertising exposure would dwarf the impact on child exposure by a ratio of 16 to 1 across TV and digital), no one can credibly assert that addressing around 11.5 seconds of HFSS food advertising per day per child is a rational solution to the problem. That amounts to about one hundredth of one percent of each child’s day.
The fact that already strong restrictions have had no impact on childhood obesity is unsurprising for the simple reason that the food advertisements were not causing childhood obesity in the first instance. Indeed, there is no credible scientific support for the notion that advertising caused the dramatic rise in childhood obesity that countries across the globe have experienced in recent decades. In what was arguably the most comprehensive review of the subject ever commissioned, the U.S. Institute of Medicine report, the authors concluded that “current evidence is not sufficient to arrive at any finding about a causal relationship from television advertising to adiposity among children and youth.”

If food advertising were fuelling obesity rates, the only possible way it could do that would be on the “calories in” side of the intake/expenditure balance, because food advertising has no impact on physical activity and “calories out”. If advertising were the culprit, one would expect to see two things accompanying the rise in obesity rates: (1) data indicating an increase in food marketing to children, (2) an increase in caloric intake by children as a result.

Overall intake of calories, fat and saturated fat has decreased since the 1970s. This trend is accompanied by a decrease in sugar and salt intake, and an increase in fibre and fruit and vegetable intake.

British Heart Foundation (October 2012), ‘Coronary heart disease statistics’

Neither of these is happening. Instead, child food advertising exposure has actually been declining, and caloric intake has declined as well. In targeting where the problem is to deliver effective action to address the root causes of child obesity, we need to look at the other side of the “calories in” versus “calories out” equation. It should therefore come as no surprise that, given technological and other societal shifts in recent decades, caloric expenditure through physical activity has indeed dropped considerably among British children.

The Journal of the Royal Society of Medicine in 2004 said that:

[The decisive contribution to today’s obesity epidemic has been a reduction in physical activity. Today, children expend about 600 kcal/day less than their counterparts 50 years ago, and contemporary British children, even in the pre-school years, spend much of their time seated. Television-watching and computer games contribute, and there has been a large increase in car journeys on behalf of children.]

That reduction in physical activity continues to occur. In developing effective interventions, it is the many hours that children spend on sedentary behaviours daily – not the seconds during which children are exposed to food advertising – that deserve our primary focus.

We acknowledge that advertising is a small part of a much broader and more complex picture and in terms of the drivers of obesity, its impact on children’s food preferences has been described as “modest” by Ofcom, with a direct impact of around 2%. However, various analyses, most recently the McKinsey report, have all shown that advertising or “media” restrictions are not a “silver bullet” or a significant driver of effectiveness in tackling childhood obesity.
Researchers at the Institute for Fiscal Studies have observed that the greatest reduction in calorie consumption, between 27% and 30%, has occurred in couples with children. Concurrently, while calories purchased outside the home for consumption have increased among all groups over the past 20 years, the increase has been smaller among families with children than other groups. This research suggests that among all groups consuming fewer calories, the greatest reduction has occurred among young families and children.
The average person is now consuming over 20g less sugar than 20 years ago

**Free sugar consumption: average per person per day (g)**

Approx. **90g**

2001/2

Approx. **85g**

2009

Approx. **70g**

2016/7

WHO recommend free sugars should be less than 10% of total energy intake, suggesting 5% would be beneficial. For a person consuming 2000 calories, this would equal 50 grams of sugar. (World Health Organisation, 2015: Guideline: sugars intake for adults and children)

Evidence suggests that a lack of exercise, both in adults and children, is what is driving the continued prevalence of obesity among certain groups in the UK, rather than the food itself.

A 2017 NHS review of obesity in England found 26% of adults were classified as inactive (undertaking fewer than 30 minutes of physical activity a week). Data from 2016 classifies 26% of English adults as obese, suggesting a direct correlation between inactivity and obesity prevalence.

Regular exercise contributes to a healthy lifestyle, leading to a healthy digestive system, and increased metabolism among children.

And yet, a 2015 NHS study demonstrates the limited number of children meeting the recommended daily physical activity guidelines. Only 28% of 5-7 year olds met the recommended daily amount of physical activity, and as children get older, their already low activity levels decline further. By the time children reach the ages of 13-15, only 12% meet the recommended amount of daily activity. Children’s activity levels clearly decrease as they get older, correlating with the rise in obesity prevalence as children reach their teenage years.
These statistics suggest that a significant proportion of UK children are not getting enough exercise.

Awareness of this problem seems to be rising among schools and teachers across the UK, as indicated by support for exercise programmes such as the *Daily Mile*. This kind of initiative is invaluable in the fight against childhood obesity – it is easy to implement, costs nothing to sustain, and over time it can embed in children’s minds the need for daily exercise. This is a healthy lifestyle message they can carry with them throughout their adult lives.

Indeed, the success of the *Daily Mile* programme suggests that it is not only children who stand to benefit from the scheme. Adults across the country could also benefit from a *Daily Mile* style exercise initiative and this should be explored in a potential scaling-up of the programme.

Studies also suggest that a lack of sleep can also be a contributing factor to obesity levels. A 2011 research project, led by a team of medical professionals in Birmingham, conducted research on the impact of sleep on obesity prevalence. Their study suggests that adolescents who do not get enough sleep are at risk of becoming obese.

The widespread roll out of a simple exercise initiative, such as the *Daily Mile*, has the potential to significantly reduce child obesity levels.

A three-month pilot scheme at Coppermill school in London resulted in substantial improvements to children’s fitness and mental well-being. The pilot demonstrates how a ‘simple low-cost physical activity initiative can significantly improve the physical health and well-being of primary school pupils’.

Strategies such as this would reduce the inequalities in access to sporting facilities and equipment, giving all children equal access to a simple and cheap form of daily exercise. This in turn would help to reduce the health inequalities between the most and least well-off in society.

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*Percentage of children meeting the daily physical activity recommendations*  
NHS Health Survey England 2015: physical activity in children

5-7 year olds: 28%

8-10 year olds: 26%

11-12 year olds: 18%

13-15 year olds: 12%

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*Declining activity levels amongst children*

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While there is debate about the effectiveness of different measures to combat child obesity, there is an acceptance that its causes are multi-faceted and complex. It is also a fact that, as with many other public health issues, incidence of child obesity is much higher in areas of social deprivation and among certain cultural and ethnic groups. Indeed, fairly stable levels of child obesity at the national level mask two quite distinct, indeed opposite, pictures within local communities – an improving trend in more advantaged communities, but a declining picture in areas of high social deprivation.

Solutions to the issue of obesity, as well as being targeted, need to recognise that over-consumption of HFSS foods is not the only obesity factor to address.

With overall UK calorie consumption trending down (helped by public education initiatives such as Change for Life), ‘excess calories’ are driven as much by modern life and from a decline in physical activity, as changes in eating patterns among some groups.

Any effective solution to childhood obesity will combine evidence-based approaches that:

1. Deliver increases in physical activity and healthy lifestyles
2. Target and activate resources at the local community level, where the problem is greatest

This is not simply theory. Success models are emerging that combine these elements to deliver real reductions in child obesity. We share three best practice examples here:

1. The Amsterdam Healthy Weight Programme – a joined-up, whole system approach delivered with high intensity at the community level.
2. Wakefield – like in Amsterdam, this consists of a series of sustained and practical exercise and healthy lifestyle programmes that have started to make a difference in a community with a high incidence of obesity.
3. The Daily Mile – a simple but powerful initiative that can easily and effectively deployed at the local level to complement healthy eating education and intervention.
The Amsterdam Healthy Weight Programme (AAGG) was established in 2013 by the Amsterdam Municipality to give every child a healthy childhood and future, regardless of their start in life. The overall objective is to achieve a healthy weight for all children in Amsterdam by 2033.

In Amsterdam in 2013, around 21% of under 18s were overweight or obese, (compared to 13% of 10-year olds in the Netherlands who were overweight or obese).

Amsterdam and its child obesity challenges have much in common with many urban areas in the UK, and there is also much to learn from its success. Commencing in 2012, the programme is still running and evolving based on what works and finding new approaches to areas where it has worked less well (for instance amongst older children).

The programme is focused on communities where the need is greatest, choosing 11 areas of low socio-economic status (and high child obesity levels). Its success can be attributed to the package of measures focused on both school and neighbourhood initiatives. The main risk factors for childhood obesity were identified to be: 1: families with little money, 2: non-western ethnicity, 3: parents with limited education, 4: growing up in a major city. The programme was designed, implemented and amended with these risk factors providing the foundation.

### The result

Compared to the low impact of nation-level measures, the results are impressive\(^1\):

<table>
<thead>
<tr>
<th>Percentage Decrease</th>
<th>Description</th>
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<tbody>
<tr>
<td>12%</td>
<td>9/11 of the areas with the highest proportion of overweight children are now lighter</td>
</tr>
<tr>
<td>16%</td>
<td>16% decrease amongst 5 year olds</td>
</tr>
</tbody>
</table>

Overweight and obesity amongst children in Amsterdam by socio-economic status from the start of the Healthy Weight Programme in 2012 up until 2015.

![Bar chart showing the percentage decrease in overweight and obesity among children in Amsterdam by socio-economic status from 2012 to 2015.](https://www.amsterdam.nl/bestuur-organisatie/organisatie/onderwijs-jeugd-zorg/zo-blijven-wij/amsterdam-healthy/)

\(^1\) ‘Amsterdam will be the healthiest city for children!’, Review 2012-2017; [https://www.amsterdam.nl/bestuur-organisatie/organisatie/onderwijs-jeugd-zorg/zo-blijven-wij/amsterdam-healthy/](https://www.amsterdam.nl/bestuur-organisatie/organisatie/onderwijs-jeugd-zorg/zo-blijven-wij/amsterdam-healthy/)
The 1000 day approach

The 1,000 days between a woman’s pregnancy and her child’s 2nd birthday offer a unique window of opportunity to build healthier and more prosperous futures. The approach has been adopted in Amsterdam in a number of actions and interventions, including information sharing, counselling and health care screening and extra support for at risk families, pre-natal home visits, engagement with midwives and ongoing support for pregnant and new mothers up to two years if from a more deprived background.

Jump-in – Healthy schools

Schools where children’s average BMI is higher than the average for The Netherlands are supported through the ‘Jump-in’ programme.

This helps the target schools put health on the agenda and provides them with personal support, an online toolkit with practical tips and advice, and parental education.

A controlled trial in 19 primary schools of 2,848 children (50% boys) with two-year measurements showed significant benefits on organised sports participation, particularly in girls of Moroccan and Turkish descent. The outcome shows that a school-based strategy combining environmental and personal interventions can be successful in improving sports participation among children.

Why has the Amsterdam programme been successful?

Three simple lifestyle rules form the basis of the successful Amsterdam model: healthy food and drink, exercise and sleep. Low income families are given subsidised sports centre membership and physical activities. A comprehensive package of measures embeds these lifestyle rules in children’s everyday lives.\(^\text{12}\)
**School Garden Programme**

The school garden programme existed before the Healthy Weight programme and has been incorporated. It could be described as a field-to-plate initiative teaching pupils how to plant, tend and grow crops, harvest them and cook them.

**Community focus**

Each focus neighbourhood has its own community manager, and unique specificity of actions and interventions suited to the locality.

Interventions have included: a healthier shopping area with local businesses offering healthier choices, outreach programmes to parents and guardians, after school activities, sport and other opportunities for physical activity, training religious leaders in healthy lifestyles, working with ethnic minority organisations to promote a healthy weight, and supporting advice to food bank clients.

**Health care**

Beyond the involvement of health care in terms of midwifery and support to expectant and new mothers and young parents, the programme has an explicit focus on identifying and treating children who are already obese, and particularly those children who are morbidly obese.

**Strengthening the excellence of professionals**

The programme explicitly decided not to invest in new 'street level' professionals, but to train the existing professionals in the city in what their role in the AHWP is and how they, in their work, can contribute to creating a healthier lifestyle of children and a healthier environment. More than 500 professionals, both working for the municipality, and commissioned with partner organisations, have already been trained.

**Poverty focus**

Poverty limits choice when it comes to the maintenance of a healthy lifestyle. Food banks provide nutrition information and link service users to city farms and vegetable gardens. Financial advice and language support is offered as well as financial support for youth sports.

**Planning initiatives**

The city is also trying to increase cycle paths and walkways, and sports and play areas particularly in priority neighbourhoods. Active transport to school and activity in school are supported and encouraged.
Responding to the Challenge of Obesity in Wakefield

Since 2010, Wakefield has implemented several initiatives to tackle the challenge of obesity within its borders. The Three Area Project (TAP) was launched in 2010 as a three-year project, which saw £2.5m invested by the council and the NHS in three communities to help encourage healthier lifestyles and reduce obesity rates.

The three-year TAP programme came to an end in 2013 and was deemed a success as the proportion of people in the areas doing moderate levels of activity had risen by more than a fifth to 34%, while the numbers describing themselves as eating very healthily rose by more than half to 16%.

The initial focus on these three areas has since been followed by a district-wide push. The number of activators has been increased to six and the team is now working with 48 primary schools. They train lunchtime supervisors so they can encourage active play, host cookery courses for parents and put on alternative sports clubs including everything from skipping to dance.

Measures undertaken in Wakefield

One of Wakefield’s local primary schools, Greenhill Primary School, has created an outdoor adventure park with a fitness trail and climbing ropes, and a ‘mini-forest’ in which children are actively encouraged to run around, to achieve the recommended levels of physical activity. The school also has an orchard where children can grow their own fresh produce which is then used by the chefs for healthy meals, as well as a beehive, from which the school makes its own honey. Three of Wakefield’s biggest parks have had trails installed to encourage families to get into the outdoors.

Other activities have also been aimed specifically at adults: One of the local rugby league clubs has started running a health programme inviting overweight men in for games of rugby and fitness training each week, and there are more than 40 organised walking events every week providing all-body workouts. Following the end of the TAP programme, the proportion of people in the areas doing moderate levels of activity had risen by more than a fifth to 34%, while the numbers describing themselves as eating very healthily rose by more than half to 16%.

The head of Greenhill Primary School, Martin Fenton, said that the children are more likely to eat vegetables that they have grown, and the school has now become truly healthy. Before the project started, a third of 4 and 5-year-olds were obese and overweight, but as it was rolled out district-wide it dipped to under a quarter, bringing it in line with the national average. Public Health England has noticed the progress and is carrying out research into how Wakefield achieved this.
The Daily Mile

“I started The Daily Mile 6 years ago whilst the headteacher of a small Primary School in Stirling. It is incredible to think that since then it has been endorsed by the Mayor of London and the Prime Minister and 750,000 children across 39 countries are now signed up.

Thousands of young lives have already been transformed by this simple, free, effective activity and we are thrilled that The Daily Mile is now halving childhood obesity. It is a noble but achievable goal especially when daily exercise becomes a way of life and then maintained into adulthood.

I am delighted by the commitment and look forward to working with the government to get British primary pupils running a mile every day. Simply put this is a win for children.”

- The Daily Mile Founder, Elaine Wylie

The Daily Mile is a simple, powerful, hugely successful initiative that can be easily and effectively deployed at local level to complement healthy eating education and intervention. While focused on overall child well-being through activity, research indicates that it is a highly effective means of reducing child obesity levels.

Almost 4,500 schools are taking part (as of October 2018). The Government has recently placed The Daily Mile at the heart of its childhood obesity strategy, endorsing the idea that 15 minutes of daily activity improves physical fitness, health and well-being, and can transform the lives of young people across Britain.

Initiatives like The Daily Mile are important in encouraging children to exercise in their early stages of development, encouraging them to become involved in what could be a lifetime habit. Children who exercise more regularly at a younger age tend to grow up to lead healthier lifestyles.

Scientific research indicates that this short but regular physical exercise can also have a more long-term impact on children’s health.

How it works

Delivered by school staff, students engage in a walk/jog/run for 20 minutes or 1 mile every day during school time, being able to self-select their pace and allowed to socialise with classmates and teachers during the walk/run.

Unlike many past initiatives, The Daily Mile is straightforward and free.

Initially focused on primary school children, with the launch of ‘Fit for Life’ the principles behind The Daily Mile have now been extended to anyone aged 11+. 
Benefits

- Simple and free to implement
- Proven to be sustainable – happens all year round, every year
- Sociable and inclusive
- It’s not a race or competition – no sense of failure
- Beneficial for children with additional support needs
- Applicable to all age groups
- Doesn’t interfere with teachers’ timetabling as only lasts 15 minutes
- Can be done in school uniform
- Increases focus, concentration and behaviour in class
- Leads to generally higher levels of fitness, which, in turn leads to higher levels of confidence and greater participation in PE and sports class

Impressive results

As a decentralised programme, there is no single database of results for The Daily Mile. However, a pilot study by the Universities of Stirling and Edinburgh indicates a strong impact on reducing child obesity through increased physical activity.13

An evaluation of its introduction in Abbey Park Middle School, Pershore, based on pre- and post-introduction (12 weeks in) measures, showed broad impact on children’s wellbeing:

- 95% of students responded that the Daily Mile helped them with their social development
- 95% responded that it helped with their health and body development
- 91% responded that it increased engagement in physical activity with their family
- 73% responded that it improved relationships with teachers
- 55% responded that it enhanced concentration
- 12% responded that it improved sleep patterns

References

Industry has come together over the last decade with several initiatives to offer support and partnership with Government to help communicate its healthy and active lifestyle message to wider audiences.
The Joy of Moving (JOM) programme is a key Ferrero CSR project – we are passionate about getting children active, in line with our nutritional principles. We believe in a balanced and varied diet, together with eating in moderation and a physically active lifestyle. Globally the programme is known as Kinder + Sport. In the UK, there is no branding and we call it Joy of Moving.

The JOM programme uses a new methodology, developed by Ferrero and leading experts, which uses play through movement to help children to develop skills in four major areas:

- Physical fitness
- Motor coordination
- Cognitive functions and creativity
- Life skills

With physical movement that feels like play and not exertion, children’s enjoyment increases and this encourages them to learn more complex skills. Inspiring this joyfully active approach will help develop lifelong habits and attitudes towards physical movement.

The main part of the programme is the Move & Learn project which is delivered by partner organisations the EFL Trust, SPFLT, and FAI as well as local community club organisations. This high quality programme ensures that each child individually receives 9 hours of the teaching over 6 weeks. This consists of a combination of physical activity and classroom lessons on nutrition. In the five years of the programme so far, we have moved more than 240,000 children in the UK and Ireland, delivering over 1,200,000 hours of learning, in hundreds of schools.

All content delivered in schools has been developed independently by nutrition, education and sporting experts in line with the National Curriculum and official Government guidance contained within the Eatwell Guide. The programme is well received by teachers, students and stakeholders.

In addition to the Move and Learn project, we also have introduced the Joy of Moving Festivals. The JOM festivals are a summer term activity where children of all ages and abilities can get involved in play and movement through a day or half day at their school.

Case study: The Joy of Moving

Case study: Magic Breakfast

Over half a million British children go to school without breakfast. Magic Breakfast provides a nutritious breakfast to over 30,000 children across nearly 500 primary secondary and Special Educational Needs schools, plus Pupil Referral Units - where 35% or more of the children are eligible for Free School Meals and therefore targeting those most in need.

PepsiCo is proud to donate porridge and orange juice every day to Magic Breakfast.

Since they partnered with Magic Breakfast in 2009, they’ve donated almost a million servings of Quaker porridge oats and over a million litres of 100% fruit juice respectively.
Case study: Support for The Daily Mile

ITV believes that television can make a real difference in encouraging the British public to live more healthily and in early 2018 they launched ITV Feel Good. It’s a behaviour change initiative that aims to inspire the nation to eat better and move more. It’s an initiative that runs across editorial, marketing, online and commercial teams.

ITV Feel Good is made up of programming across ITV schedule - from features and discussion in big daytime and news shows to prime time factual entertainment and current affairs. With its own area on ITV.com plus a huge marketing campaign, ITV Feel Good has outlined tips and tricks to make the message of healthy living easy to swallow with no need for lycra. You won’t find any complicated diets or expensive exercise plans on ITV Feel Good; just simple easy ways to make healthy living more fun, sociable and totally everyday.

Case study: Cinema support for The Daily Mile

The cinema advertising industry is currently arranging to donate screen time to The Daily Mile campaign as part of its commitment to encouraging healthy lifestyles amongst its audiences. The Cinema Advertising Association (the trade association for cinema contractors) is working with the UK Cinema Association (the umbrella body of cinema exhibitors) to see if they can create a template of community involvement between local cinemas and schools to stimulate further participation.

As part of this initiative ITV have also made two large, ground breaking interventions.

1. Since April ITV has partnered with The Daily Mile which encourages kids to run/jog for 15 minutes every day. Having put the on-air promotional weight of ITV behind the Daily Mile campaign the number of schools taking part in the last 9 months has more than doubled and the number of children at schools now organising their own Daily Miles is almost one million.

Veg Power

2. In October, ITV announced a major new advertising campaign to encourage the nation to eat more vegetables. 95% of teenagers and 80% of adults do not have enough veg in their diet and this has an impact on health and well-being. ITV are partnering with the UK’s leading advertising agency, a group of supermarkets and a not for profit group called “Veg Power” to run a very different sort of advertising campaign for vegetables, something far removed from a traditional public health campaign. ITV will be showing the vegetable advertising in the middle of our most popular entertainment programmes from January 2019. ITV are contributing £2m of airtime for this campaign with a plan is to create a bold, engaging and creative initiative that will change people’s attitudes and inspire families across the UK to eat more greens.
In 2014-15, again in the context of the Government’s discussions about tackling obesity, the food, soft drink and advertising sectors including broadcasters came together in a “Coalition of the Willing”, coordinated by the Advertising Association, ISBA (the Voice of British Advertisers), the Food and Drink Federation (FDF) and the British Soft Drinks Association (BSDA).

Inspired by the McKinsey Global Institute report: Overcoming Obesity: an initial economic analysis, the industry coalition proposed a package of measures in a programme designed to deliver measurable impact within three years.

Case study: business4life

The industry has come together in two initiatives over the last decade, with business4Life and with the Coalition of the Willing, to offer support and partnership with the Government, to help communicate its healthy and active lifestyle message to wider audiences.

In 2008, the Advertising Association launched business4Life to signify industry’s commitment and support for the Change4Life movement which was just being launched.

business4Life was a coalition of 37 companies and organisations from the food and beverage, retail, media, advertising, fitness and healthcare sectors, which committed to using the marketing and communications skills of its members as a force for good to help deliver the Department of Health’s 4Life messages and other Government messaging which encourages healthier lifestyles.

These companies pledged to make a £200 million in-kind contribution to the Change4Life movement by using their marketing, branding and advertising skills to encourage better diets and more exercise.

b4L was recognised as a formal partner of Change4Life and its main objective was to facilitate across-sector collaboration between companies to amplify DH’s 4Life messaging and help position Change4Life as a truly society-wide movement.

b4L members committed to integrate core campaign messages into branded communications and use broadcast media to amplify the 4Life central theme to millions of consumers, many of whom are the most difficult to influence through conventional marketing but are most in need of adopting healthier lifestyles. It is precisely because business4life members have such strong consumer brands that it was felt they would add real value to Change4Life.

b4L was a successful catalyst for industry partnerships for several years and the Change4Life brand has continued to flourish.

Case study: Coalition of the willing

In 2014-15, again in the context of the Government’s discussions about tackling obesity, the food, soft drink and advertising sectors including broadcasters came together in a “Coalition of the Willing”, coordinated by the Advertising Association, ISBA (the Voice of British Advertisers), the Food and Drink Federation (FDF) and the British Soft Drinks Association (BSDA).

Inspired by the McKinsey Global Institute report: Overcoming Obesity: an initial economic analysis, the industry coalition proposed a package of measures in a programme designed to deliver measurable impact within three years.

These included:

1. A tightening of CAP’s HFSS advertising restrictions (achieved in 2016)
2. Reformulation and pack size changes to remove tens of billions of calories from the market and a reduction of calories in soft drinks by 20% by 2020 (ongoing)

The first action was achieved last year, and CAP, as a transparent and rigorous self-regulatory body, is now reviewing the effectiveness of the rule changes.

The second is ongoing action by the food and soft drinks industry.

The action being taken by some parts of industry, including ITV and STV in sponsoring The Daily Mile, would suggest there is still an opportunity for Government and industry to cooperate in a wider programme of behaviour change, should the will be there.
We all share the widespread concern about the obesity trends in our society, especially amongst children. It is important that a way forward is found to tackling it effectively. However, as this report shows, the way to reduce levels of childhood obesity that will have the most impact is through promoting an active lifestyle, not through restrictions on advertising.

This report shows that, as with many other public health issues, levels of social deprivation and, to a lesser extent, cultural background is a major predictor of obesity levels.

A fairly flat national picture masks two quite distinct trends and outcomes in obesity levels– an improving trend in more advantaged communities, but a continuing increase in areas of high social deprivation.

Child obesity is a problem heavily skewed to particular groups, demanding solutions targeted at where the problem is most prevalent in order to maximise effectiveness. This suggests that effective action must be targeted at local level and that blanket nationwide restrictions across media are not the answer. Such advertising restrictions will not be effective solutions but will be damaging to commercial media and have an additional impact on the quality of media, content and jobs.

With overall UK calorie consumption trending down (helped by public education initiatives such as Change for Life), ‘excess calories’ are driven as much by modern life and from a decline in physical activity as by changes in eating patterns among certain groups.

Some practical solutions – Amsterdam, Wakefield, The Daily Mile - are underway and their success is already being demonstrated. The Government has highlighted the importance of The Daily Mile in its Chapter 2 of the Obesity Plan, which is good. But more needs to be done.

The Daily Mile is successful and the backing of ITV and STV is giving it a tremendous publicity boost. One option might be to develop Phase 2, involving parents and adults, and activity outside schools and at weekends. Getting people active outside the controlled school environment is harder to do and would need significant investment, coordination and even more publicity.

Wakefield and Amsterdam show what can be done in local communities, but more needs to be done to run similar pilots in other targeted areas where obesity and deprivation are at their worst.

We all have an interest in improving the health of the nation, industry as well as Government and other stakeholders.

Let’s look at ways to do this together.
Annex

Advertising Exposure by U16s in the UK

We explain below the data analysis supporting our finding that children under 16 in the UK see on average only 11.5 seconds of HFSS advertising on TV and online a day.

Data sources
This is based on an analysis of a full year of data from 1 January – 31 December 2017. The data sources are set out at the end of this annex.

The model used
To estimate the proportion of HFSS advertisements children were exposed to, we developed a 'top 100 food ads' proxy – the 100 food and drink advertisements with the highest child impacts in 2017.
This proxy provides a meaningful overview of children’s exposure to food advertisements, focusing specifically on the advertisements between 6am and 9pm that children see the most.

Looking at media impacts
Our analysis is based on the industry measurement of media “impacts”. A media impact (or impression) is each opportunity an individual has to view an advertisement – i.e. when an ad is displayed, and a person is present to view it.
For online advertising, measures of viewability are included to ensure we are measuring exposure of ads that are viewable, not just served.

Converting impacts to seconds of exposure
To give a more reflective picture of exposure, we converted daily impacts into actual seconds of exposure.
Using 2017 BARB data we have established the average length of a UK TV food advert to be 21.9 seconds, doing so based on the following durations and respective share of impacts for each.

Assessing the child exposure
We looked at the child HFSS impacts in this list divided by the total number of impacts in the full set to give an approximation of HFSS exposure versus non-HFSS exposure.
23.9% of that set of impacts were for HFSS products (based on the current Nutrient Profiling Model).

How reliable is this model?
This is not an exact science and instead should be viewed as an indicative estimate. An analysis of the entirety of 2017 food ads could lead to a higher proportion of HFSS ads. However, if we were to double this and assume that 50% of all food ads were HFSS, in practice this would only increase the average exposure per day by a child in the UK to 20 seconds, instead of 11.
Using BARB data we have the total number of individual TV advertising impacts delivered in the UK, for all products and services and all audiences (aged 4+) for 2017.

**Annex**

**TV HFSS Exposure**

Using the HFSS proxy, we estimate that 23.9% of TV food advertising impacts received by children between 6am and 9pm are classified as HFSS under the Nutrient Profiling Model. This equates to approximately 11 seconds of child exposure to HFSS TV advertising per day.

**Child Exposure to all food advertisements**

This shows that the average UK child sees 2.69 TV ads per day of all food advertisements, equating to 59 seconds of exposure across the 24 hour day. 56% of all TV food impacts occur between 6am & 9pm. 6.63% of these are received by children. This equates to 2.00 television ads a day, or 44 seconds of TV exposure to all food advertising per day for the average child, between 6am and 9pm.

Of the 44 seconds:

- 21 seconds (48.7%) relates to HFSS advertising which is already restricted during and around programmes with a 120 index or above. (The 120 index is the tool used to determine which programmes have a higher than average share of U16s in the total viewing audience).
- 23 seconds relates to exposure to all other food advertising between 6am and 9pm.

**Children’s exposure to HFSS**

Given that 95% of all food advertising is seen by adults, this analysis shows that the impact of any watershed ban would fall disproportionately on adults – for every one child impact removed, 14 adult (16+) impacts would be lost.

**Adult’s exposure to HFSS**

95% of these food advertising impacts are received by children (aged 4-15).

17.4% of all TV advertising impacts relate to food, of any type.

Only 5% of all TV advertising impacts relate to food, of any type.

95% are seen by adults.

17.4% of all TV advertising impacts relate to food, of any type.

Only 5% of all TV advertising impacts relate to food, of any type.

95% are seen by adults.
Annex

**Digital HFSS Exposure**

Data looking at HFSS advertising is not easily available and so therefore we have used some conservative estimates, but the best estimate is that *current exposure of children under 16 to digital advertising for HFSS foods is less than 0.5 seconds per day.*

**This takes into account:**

- The number of food ads that are non-HFSS
- The percentage of ads that are served to under 16s
- Then those which are viewable
- Then those that are viewed and for how long (and even then we know there will be varied engagement – some will pay attention, some won’t)

By applying the format of average CPM’s to spend data from the IAB/PWC Digital Adspend Study 2017, we generated the total number of digital advertising impacts (or impressions) in the UK during 2017 (all categories, all audiences). CPMs relate to cost per thousand which is a term used to denote the price of a thousand impressions on a web-page.

**Total Exposure**

Of these, 4% of total digital impacts were for food advertisements (Nielsen AdDynamix).

**Child Exposure**

Just 3.4% of the total food impacts were viewed by children under 16 (comScore).

By applying UK population figures, this equates to 0.36 food ads per day viewed by the average child, which at an average 5 seconds per view, equates to an average child exposure to any food advertising of 1.8 seconds a day.

Using our earlier outlined HFSS proxy (that 23.9% of all food ads are HFSS), that gives a total of just under half a second of HFSS advertising per child per day seen online.
Annex

Data Sources

We have used the best available data to compile this analysis. Any assumptions made have been conservative and fully outlined.

BARB

(Broadcasters Audience Research Board) is responsible for delivering the UK's television audience measurement currency – and is the measurement standard for all UK advertisers and broadcasters (as well as regulators and government). It uses a long-established and robust methodology that has evolved to reflect different ways in which TV is now consumed. It is a continuous second by second measure of the viewing behaviour of the UK's 27 million TV households, across all channels and devices, covering programming as well as advertising. BARB has two sources of data: 1. People-based data: the BARB panel; 2. Device-based census data for online TV viewing. It links what is being shown (on screen) with who is watching. The research panel mirrors the UK population, aged 4 and above.

The IAB/ PwC Digital Adspend Study

has measured the size of the digital advertising market since 1997 (reporting twice a year). UK media owners submit digital advertising revenue figures confidentially to PwC who then analyse the submissions and produce aggregated data that shows the size of the UK digital advertising market. Any gaps in the data are filled by the work of the Digital Adspend Advisory Board, which includes the major agency groups, and provides estimated figures for any major media owners that do not submit figures directly to the study.

Nielsen AdDynamix

is the industry standard service by which UK advertisers and media agencies monitor advertising expenditure and creative across all media, including online. It monitors the total universe of individual advertisements and provides standardised analyses at the category level as well as tools for bespoke analyses.

Techedge Advantedge

is a market-leading analysis tool used to facilitate bespoke analyses of these very complex databases.

ComScore

measures online consumer behaviour and advertising exposure across all digital platforms and devices. It does this via a consumer panel who have monitoring software installed on their computers and other devices.
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