

Dear Dr. Puska,

The Confederation of the food and drink industries of the European Union (CIAA) representing the EU food and drink industry welcomes the opportunity to comment on the draft Report of the Joint WHO/FAO Expert Consultation on 'Diet, nutrition and prevention of chronic diseases'.

Please find attached our comments to both clusters of recommendations:

- Recommendations on population nutrient goals
- Recommended action and integrated strategies for action

The CIAA would like to thank you for the attention you will give to our comments and hopes that they will be taken in due account.

We remain at your disposal to provide any additional information.

Best regards,

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(See attached file: _Letter to Dr Puska - CIAA comments on WHO.doc)(See attached file: _policy aspects.doc)(See attached file: _scientific aspects.doc)

Brussels, 14th June 2002

Dr Pekka Puska
Director, Noncommunicable Disease
Prevention and Health Promotion
World Health Organisation
CH – 1211 Genève 27-Suisse

Dear Dr Puska,

Subject: CIAA comments on the WHO/FAO expert consultation on ‘Diet, nutrition and prevention of chronic diseases’

The Confederation of the food and drink industries of the European Union (CIAA) represents the EU food and drink industry and contributes to the development of a European and international regulatory and economic framework addressing industry’s competitiveness, food quality and safety, consumer protection and respect for the environment.

The food and drink industry is the first industrial sector and a major employer in the European Union, employing 2.6 million people, with an annual turnover of more than 557 billion euros.

The CIAA welcomes the opportunity to comment on the WHO/FAO Expert Consultation on ‘Diet, nutrition and prevention of chronic diseases’.

The enclosed comments were necessarily prepared to a tight timescale and do not purport to be comprehensive. Therefore we reserve the right to add to them subsequently.

The European food and drink industry takes the issue of nutrition and chronic diseases (NCD) very seriously and recognises the problem of chronic diseases in the European Union (e.g. obesity, coronary heart diseases, cancer). However, it is generally recognised that these NCD have multi-factorial causes. CIAA believes that it is oversimplified to consider nutrition as the main cause and that more emphasis should be put on other lifestyle factors, as physical activity.

The CIAA would also like to stress the need to have science-based evidence when addressing the nutrient recommendations. This is also relevant for the policy recommendations. However, this principle is not consistently applied throughout the whole report and in particular with regard to the policy recommendations which are not evidenced based and are inconsistent with the background papers provided.

The CIAA is willing to establish a co-operation with your organisation and contribute with the know-how and expertise of its members in a joint effort to further the health and well-being of consumers.

The CIAA would like to thank you for the attention you will give to our comments and hopes that they will be taken in due account.

We would kindly ask you to advise us on the steps you envisage to finalise the expert report and whether the result of the public consultation will be made available on your web site.

We remain at your disposal to provide any additional information.

Yours sincerely,

R. DESTIN,
Director General

D. TAEYMANS
Director Scientific &
Regulatory Affairs

J. MARTINEZ SANCHEZ
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National Federations :

Fédérations des Industries agro-alimentaires du Luxembourg (FIAL),
 Fachverband Lebensmittelindustrie (FIAA),
 Nederlandse Voedingsmiddelen Industrie (VAI),
 Espanola de Industria de la Alimentacion y Bedidas (FIAB),
 Finnish Food & Drink Industries Federation (ETL),
 Bundesvereinigung der Deutschen Ernährungsindustries (BLL/BE),
 Danish Food and Drink Federation (FI),
 Ireland Food and Drink Federation (IFDF),
 Association Nationale des Industries Alimentaires (ANIA),
 Fédération de l'Industrie Alimentaire (FEVIA),
 Federation of the Hellenic Food Industries (SEVT),
 Food and Drink Federation (FDF),
 Swedish Food Federation (LI),
 Federazione Italiana dell'Industria Alimentare (FEDERALIMENTARE),
 Federacão Industrias Portugueses Agro-Alimentares (FIPA)

European sectors :

European Cereal Starch Association (AAC) / Association Producers of Isoglucose (API),
 Comité Européen des Fabricants de Sucre (CEFS),
 Union of the EU Soft Drinks Association (UNESDA),
 European Natural Sausage Casings Association (ENSCA),
 Association des Industries des Aliments Diététiques (IDACE),
 European Snacks Association (ESA),
 Fabricants Produits Alimentaires Surgelés (FAFPAS), Sauces – Condiments (FIC Europe)
 EU Seed Crushers' & Oil Processors' Association (FEDIOL),
 Union Européenne Sources d'Eaux Minérales (UNESEM),
 The Brewers of Europe (CBMC),
 European Association of Potato Processing Industries (UEITP),
 Liaison Centre for the Meat Processing (CLITRAVI),
 Association of soluble coffee makers of the EU (AFCASOLE) – Ice-cream Association of
 Food Industries of the EU (EUROGLACES) European Tea Committee (ETC),
 European Breakfast Cereal Association (CEEREAL),
 Association Ind. Juices & Nectars Fruits & Vegetables of the EU (AIJN), Association Cider &
 Fruit Wine Industry of EU (AICV),
 Int. Margarine Association of the Countries of Europe (IMACE),
 European Association of fruit & vegetable process. Industries (OEITFL),
 Féd. Européenne des Industries des Aliments Animaux Familiers (FEDIAF),
 Comité des Fabricants Levure Panification UE (COFALEC),
 European Salt Producers' Association (ESPA),
 Fed. Ass. Ind. Bouillons & Potages UE (FAIBP),
 Union org. Manufact. Pasta Products EU (UNAFPA),
 Group des Associations Meunières UE (GAM),
 European Fed. Of Coffee Roasting Association (EUCA),
 European Dairy Association (EDA),
 Intermediate Prod. Ind. For Bakery & Confectionery (FEDIMA)
 Associazione Industriali Mugnai e Pastai d'Italia (ITALMOPA - SEMOULIERS),
 European Vegetal Protein Federation (EUVEPRO),
 Ass. Chocolates, Biscuits and Confectionery Ind. (CAOBISCO)

CIAA COMMENTS ON THE POPULATION NUTRIENT RECOMMENDATIONS

General comments

1. Living conditions, medicine and diet have improved enormously in the last decades. Thanks to these improvements people in the developed world have a longer life expectancy and improved quality of life compared with 50 years ago. Such improvements (for which the food industry played a role) now allow the expression of chronic disease in the longer lived population. Having provided solutions to the historical nutrient deficiencies it is now important to consider dietary recommendations - for such recommendations to be meaningful they must be based on good science and not political expediency.
2. There are serious deficiencies that should be rectified if the final report is to be used as a science base for policy recommendations. The method used to prepare this report, asking one or more scientific experts to review an area of nutrition as it relates to public health, has been used in the past for defining recommendations and more recently by the World Cancer Research Fund¹ and Eurodiet². With the current call within all the health sciences for critical appraisal and systematic review methodology, such reviews or 'consensus reports', which are not systematic, can no longer be deemed acceptable for determining effective public health recommendations³. An example of a review, which did take a systematic approach, thereby ensuring that all evidence was judged in the same way, is that of the UK COMA Working Group on Diet and Cancer⁴.
3. The draft report proposes the setting of target nutrient intakes for the prevention of a range of chronic, non-communicable diseases:
 - Although the limitations in methods available for studying diet-disease relationships are emphasised, including: the inability to address temporal relationships in cross sectional studies; and the problems of confounding and bias in observational studies and limitations of small sample size in experimental interventions; it is not always clear to what extent these limitations have informed the conclusions, and particularly the recommendations, within the draft report.
 - The hierarchy of evidence used to categorise evidence as 'convincing' or 'probable' is not explicitly stated and this results in statements or conclusions that appear disproportionate in relation to the available evidence.
 - Moreover, the scientific case put forward for limits on the intake of many nutrients, is incomplete and cannot be considered an adequate basis for global reductions. It appears that the authors do not seek to justify the setting of population nutrient targets on public health grounds, but rather that the desirability of such targets is taken as axiomatic.

¹ WCRF (1997). Food, nutrition and the prevention of cancer: a global perspective. Am In Can Res. Wash. USA.

² Kafatos A and Codrington C eds (2001) Eurodiet reports and proceedings (special issue). Pub Hth Nut: 4 (2A), 265-436.

³ Brunner et al, 2001. 'Making Public Health Nutrition relevant to evidence-based action'. Pub Hh Nut 4(6), 1297-9

⁴ Department of Health (1998). Report on Health and Social Subjects no. 48. Nutritional Aspects of the Development of Diet and Cancer.

4. The authors contend that this draft aligns with previous work (p 21) "*the present recommendations, therefore, complement the existing series of FAO/WHO reports on energy and nutrient requirements*". Some examples of inconsistencies include:
 - With regard to sugars (obesity and dental caries), it is at odds with the FAO/ WHO Expert consultation 'Carbohydrates in Human Nutrition' (FAO, 1998) as well as with the "D-A-CH reference values for the nutrient intake for Germany, Austria and Switzerland" (DGE 2000) and "The dietary reference intakes for energy, proteins, fats and digestible carbohydrates" of the Health Council of the Netherlands (2001), as all these authoritative reports did not set a target or even withdrew a target for sugar, in line with the scientific evidence.
 - On sodium, consideration relies to a great extent on several meta-analyses (Minerals: blood pressure and CVD chapter, references 2, 3, 8 and 10) that are not considered valid by other experts in this area. Several other valid meta-analyses were not included.
 - In Europe trans fatty acids (TFA) are not a major risk factor for cardiovascular diseases.
 - The Draft Report contains many inconsistencies especially between the evidence tables in the chapters 4.1 to 4.6 and the table 1 of Annex 1. Furthermore the evidence tables 6 and 7 of the Draft Report are selective in quoting only dietary factors and ignoring other lifestyle factors like e.g. the impact of smoking (with respect to obesity, coronary heart diseases and cancer) or virus infections (with respect to some forms of cancer).
5. The draft report makes many broad policy recommendations which are not based on sound science, are inconsistent with the background papers provided, recent international expert consultations by WHO/FAO and other specialist bodies, and which are not applicable to a large proportion of the world's population who are suffering from under nutrition.
6. It would seem important to differentiate between the needs of developing countries and developed countries, and to focus on the main shared goals, i.e. to improve the availability of a wide variety of foods to support balanced eating and adequate intakes of energy and nutrients across all WHO/FAO member nations.
7. Finally, the draft report makes sweeping recommendations for fundamental changes to global agricultural production, food production and distribution, with scant evidence of benefit, or consideration of practicality, impact or unintended consequences. There is a need for greater input from experts in these areas.
8. While the recommendation to increase exercise is supported, we would question whether the figure of one hour a day can be supported from both the science or from a motivational point of view for consumers. In fact recommending such a high level may actually discourage consumers from taking any exercise. For instance the recent Diabetes Prevention Programme showed that consumers managed to reduce their calorie intake by 450 calories a day and increase their exercise by 150 minutes per week for at least 18 months. This resulted in an improvement in weight loss, diabetes risk and a number of other risk factors.
The WHO press release dated 4 April 2002: <http://www.who.int/inf/en/pr-2002-23.htm> recommends 30 minutes a day of moderated physical activity. We would presume that this recommendation should be consistent with previous WHO reports.

Therefore it may be prudent to propose either that consumers take at least 150 minutes exercise per week or a range of exercise say 150 - 240 minutes per week.

Detailed comments on the population nutrient recommendations

General comments on Chapter 4: “Population nutrient recommendations for preventing chronic diseases” and Annex 1 (Summary of the strength of evidence)

The Draft Report on “Diet Nutrition and the Prevention of Chronic Disease” presents nutrition recommendations in the format of dietary nutrient goals for the population world-wide. Some of these targets, notably those relating to sugar, salt and fat, cannot be adequately supported by the available scientific evidence and the Summary of the strength of evidence (Annex 1) has to be corrected accordingly.

Sugar (obesity and dental caries):

- Carbohydrates, including sugar, are a required constituent of a balanced diet, and there is a lack of scientific justification for setting population sugar targets on public health grounds. Even if enforced, such targets would not deliver the health gains predicted by the Draft Report.
- The Draft Report discriminates between “free sugars”^{* 1} and “other sugars”¹, proposing a limitation of “free sugars” intake to less than 10% food energy. The available scientific evidence does not support this categorisation of sugars. All sugars, whether naturally present or added, are carbohydrates. There is no nutritional difference between carbohydrates that is attributable to their chain length or disposition within foods. The definition proposed in this Draft Report is identical to an earlier terminology that was specifically rejected by a recent FAO/WHO expert consultation on carbohydrates (FAO 1998). The proposal for a population target for “free sugars” is consequently unacceptable.
- The scientific case put forward for a “free sugars” target in respect of obesity is vague and speculative. Sugar (or “free sugars”) is a natural carbohydrate contributing 4kcal/g, in common with all other carbohydrates. High carbohydrate diets (including sugar) are useful in weight management and the prevention of excess weight and obesity. The report does not provide any scientific data to justify a separate nutrient goal for “free sugars” within the total carbohydrate goal of 55–75% energy for weight management.
- The scientific case put forward for a limit in “free sugars” consumption as a means of reducing the prevalence of dental caries is demonstrably erroneous and misleading. All fermentable carbohydrates can contribute to dental caries if oral hygiene is inadequate (FDI 2001). In these circumstances it is not the amount of carbohydrate consumed but its frequency which is the risk.

¹ **Note: “Free sugars” defined in the report as “All mono- and disaccharides added to foods by manufacturer, cook and consumer, plus sugars naturally present in honey, syrups and fruit juices.” “Other sugars” defined as “sugars naturally present in whole grain foods, whole fruit and vegetables, milk and milk products.**

- The targets have been rejected by several FAO/WHO consultations (1998), at the EURODIET conference (2000) and by many authoritative reports of the Netherlands (2001), Austria, Switzerland and Germany (2000).

Salt intake:

- From a practical perspective, if sodium is the nutrient of concern then it should be made clear and it should not be given as salt only, given the multiple sources of sodium in the diet.
- The statement issued 10th December 1999 by 11 leading clinical experts, 6 of whom are ex Presidents of the British Hypertension Society, and one a current vice President, cannot be ignored. Nor can the recommendations of the Canadian Hypertension Society as summarised in the CMAJ, May 4, 1999 by Fodor et al. Their conclusion that '*Restriction of salt intake for the normotensive population, is not recommended at present because of insufficient evidence that this would lead to a reduced incidence of hypertension...*' must be reflected in the draft report.
- Other recommendations in relation to prevention of hypertension, include promotion of low fat dairy products, fruit and vegetables, which they thought would do more to reduce blood pressure.

The European Salt Producers' Association has submitted comments on the salt recommendations. CIAA endorses these comments from ESPA.

Dietary fat:

We welcome the clear recognition that it is the quality of the fat consumed that will have an influence on health and not solely the total quantity of fat. There is much innovation in the food industry to provide products that deliver the appropriate amounts of both essential and non-essential fatty acids to satisfy the nutritional needs of consumers.

There is much international discussion on dietary guidelines for fat intake where some countries (e.g. The Netherlands) have made recommendations that differ from those made in the WHO/FAO draft report.

The recommendations should be simple to understand and therefore, with regard to saturated fatty acids, it may cause confusion to begin to distinguish between the effects of specific saturated fatty acids. With regard to trans-fatty acids (TFA), it is not correct to refer to hydrogenated fats as an indication of the presence of TFA because they may be formed during partial hydrogenation but not in the case of full hydrogenation. The margarine industry has successfully implemented innovative production processes to dramatically reduce the amount of TFA in their products.

Literature:

- DGE: Deutsche Gesellschaft fuer Ernaehrung, Oesterreichische Gesellschaft fuer Ernaehrung, Schweizerische Gesellschaft fuer Ernaehrungsforschung und Schweizerische Vereinigung fuer Ernaehrung (2000) "Referenzwerte fuer die Naehrstoffzufuhr". Umschau/Braus, Frankfurt am Main.
- FAO. Carbohydrates in Human Nutrition. Report of a Joint FAO/WHO Expert Consultation. Rome. 14 – 18 April 1997 FAO Food and Nutrition Paper 66. Food and Agriculture Organisation, Rome 1998.
- FAO: Fats and oils in human consumption. Report of a joint expert consultation organised by FAO and WHOI, Rome, 1993: FAO Food and Nutrition Paper 57 (1994).
- FDI (Fédération Dentaire Internationale): The FDI's Second World Conference on Oral health promotion: Core Messages in Oral Health Education. August 1999; London. International Dental Journal 2000, 50: 115 – 174.

- Health Council of the Netherlands (2001). “Dietary Reference Intakes: energy, protein, fats and carbohydrates”. Health Council of the Netherlands, The Hague.
- Joint FAO/WHO Consultation on Preparation and use of Food-Based Dietary Guidelines (1995: Nicosia, Cyprus). Preparation and use of food based dietary guidelines: a report of a joint FAO/WHO Consultation. WHO Technical Report Series 880. World Health Organisation, Geneva 1998.
- WHO (1998) Obesity: Preventing and managing a global epidemic. Geneva. World Health Organisation.
- CMAJ: Canadian Hypertension Society, May 4, 1999 by Foder et al.

Comments on Chapter 4.1: „Nutrient recommendation for the prevention of excess weight gain and obesity“ and the related background paper (Annex 2).

Comments:

- Proper emphasis has not been given in the current draft report to the role of physical activity in of obesity and development of the various related chronic diseases.
- The scientific case put forward for a “free sugars” target in respect of obesity is vague and speculative. Sugar (or “free sugars”) is a natural carbohydrate contributing 4kcal/g, in common with all other carbohydrates. High carbohydrate diets (including sugar) are useful in weight management and the prevention of excess weight and obesity. The report does not provide any scientific data to justify a separate nutrient goal for “free sugars” within the total carbohydrate goal of 55–75 % energy for weight management
- The report speculates that obesity has occurred because of a higher carbohydrate consumption resulting from public health messages to decrease fat intake. Lower levels of physical activity are a more plausible explanation of the “American paradox” (i.e. lower fat intakes concomitant with increasing obesity), as supported *inter alia* by evidence of falling total energy intakes, concurrent with increasing prevalence of obesity (Gregory *et al.* 1990, Gregory *et al.*, 2000, Prynne *et al* 1999). Such speculation is out of place in a scientific review of this nature, and an inappropriate basis for public health policy.
- A considerable body of scientific evidence from many different countries supporting an inverse relationship between dietary fat and sugar. This demonstrates that high sugar consumers are also low fat consumers and have lower BMIs and vice versa. (Stam-Moraga *et al* 1999, Gibson 1996, Gibney 1995, Bolton Smith and Woodward 1994). The difficulty of reducing both fat and sugar intake together in the diet has been discussed in many publications and this has been demonstrated even in trained dieticians (Cole Hamilton *et al.* 1986).
- It is stated that some low fat foods, “such as snack bars and breakfast cereals”, have the same energy density as the full fat versions due to the “addition of large amounts of sugar”. Fat reduced breakfast cereals are not produced, being already inherently low in fat. Even so, the single reference given (Seidell JC, 1999) does not support the opinion given. Increasing the sugar level of a cereal food does not increase its energy density, as the energy content of sugar is identical to that of the carbohydrates and protein it replaces.
- A significant body of evidence demonstrates that increased intakes of low fat, high carbohydrate foods, do not lead to a passive over-consumption of total energy, and hence increased body weight (Gibson and O’Sullivan 1995, Bertrais 2000, Cho S *et al.* 2001, Wyatt HR *et al.* 2002). On the contrary, studies in free living subjects, show a stoichiometric decrease in energy from fat (i.e. a reduced energy density) and no increase in total energy intakes, following the consumption of low fat, high carbohydrate food, (Kirk *et al*, Kleemola *et al.*)

- An inappropriate level of attention is directed towards soft drinks in the report and conclusions are made that are speculative. The evidence on sugar and sugar-containing drinks is not adequately considered and conclusions cannot be reached on their role in the development of obesity. Only 3 studies are quoted, including only one intervention study, which all have obvious and key methodological flaws. Evidence of efficacy is not provided for the restriction of energy-dense foods or soft drinks in the development of obesity. The importance of hydration for individuals in both developed and developing country settings is ignored.
- The much published inverse relationship that exists between fat and sugar in the diets is not considered under the sugar in drinks section. In an analysis of the contribution of sugars to the energy density of the diets of pre-school children (Gibson (2000)) examined the contribution of soft drinks and found that the lower energy dense diets contained more energy from soft drinks.

Final recommendations:

- The conclusions regarding the role of sugar are very different to those in other recent WHO Reports, which conclude that no relationship exists between the consumption of sugar and the prevalence of obesity. No good quality evidence has been presented to suggest that these earlier conclusions should be changed.
- Despite the lack of convincing evidence presented, sugar is given an equal status to fat in the conclusions and recommendations. However it is interesting to note that in the overall summary of the strength of evidence (Annex 1 p.1 of the draft report) no mention is made of free sugars as a causative factor for obesity.
- No evidence is presented to suggest that the measures recommended to restrict energy dense foods and soft drinks would bring about the changes in nutrient consumption or indeed have the intended influence on obesity and related diseases.

Literature:

- Bellisle F., Rolland-Cachera, M-F., Deheeger M., Guilloud-Bataille M.; Obesity and Food Intake in Children: Evidence for a Role of Metabolic and/or Behavioural Daily Rhythms. *Appetite*, 1988, 11, 111-118.
- Gibson SA and O'Sullivan KR. Breakfast cereal consumption patterns and nutrient intakes of British schoolchildren: *J Roy Soc Health*; December 92: 366-370
- Bertrais S et al. Contribution Of Ready-To-Eat Cereals To Nutritional Intakes in French Adults; Relations With Corpulence. *Annals of Nutrition and Metabolism*. 2000, 44: 249-255
- Cho S, Johnson G and Block G. The Effect of Breakfast Type on Macronutrient Intakes and Body Mass Index (BMI) of Americans. Presented at Experimental Biology 2001, March 31-April 4, 2001 (in press)
- Wyatt HR et al. Long-term weight loss and breakfast in subjects in the National Weight Control Registry. *Obes Res* 2002 Feb;10(2):78-82
- Gregory et al. National Diet and Nutrition Survey: young people aged 4 to 18 years. HMSO 2000
- Gregory et al. The dietary and Nutritional Survey of British Adults. HMSO 1990.
- Prynne CJ et al. Food and nutrient intake of a national sample of 4-year-old children in 1950: comparison with the 1990s. *Public Health Nutr* 1999 Dec;2(4):537-47
- Kirk TR, et al. Dietary fat reduction achieved by increasing consumption of a starchy food--an intervention study. *Eur J Clin Nutr* 1997 Jul;51(7):455-61
- Kleemola P, Puska P, Vartiainen E, Roos E, Luoto R, Ehnholm C. The effect of breakfast cereal on diet and serum cholesterol: a randomised trial in North Karelia, Finland. *Eur J Clin Nutr* 1999 Sep;53(9):716-21

- The Report of the Joint FAO/WHO Expert Consultation on Carbohydrates in Human Nutrition (1998)
- Technical Report 894 "Obesity: Preventing and Managing the Global Epidemic" (2000)

Comment on Chapter 4.2: „Nutrient recommendations for the prevention of type 2 diabetes“ and the related background paper (Annex 3).

The para on diet and disease makes recommendations (p.29) how to reverse the abnormalities of impaired glucose-tolerance and diabetes: „ *replace an appreciable proportion of dietary saturated fats with unsaturated fats and increase the intake of non-starch polysaccharides and increase the proportion of low glycemic index carbohydrates.*“ The subsequent disease-specific recommendations address specifically the prevention of weight gain / early treatment of overweight and obesity, particularly in high risk groups, physical activity, the fat intake (total fat less than 30% energy) and fat quality (saturated fat less than 7% energy) and the intake of non-starch polysaccharides.

Comments:

Basically, some discrepancies were identified, e.g. between the Draft Report and the background paper and between some statements in the background paper and consensus opinion of leading Diabetes Organisations.

Recommendations for fat consumption and fat quality

The text in the background paper does not specify a restriction of SAFA to less than 7% energy. The text recommends a SAFA fat consumption of less than 10% energy (see p.15 in 4.2.3: Dietary fats). Surprisingly table 2 of the chapter (p.27) introduces the 7% figure for SAFA and recommends that total fat intake should not exceed 35% energy. The latter figure seems to be in some contrast to the population target for fat (15-30% energy). In summary, there are some discrepancies with respect to fat recommendations made in the Draft Report versus the supporting background paper.

Carbohydrates

The chapter 4.2.4.2. „Dietary fibre and glycemic index“ make some statements which are not supported by scientific evidence and are even in contrast to most recent evidence based statements for the treatment and prevention of Diabetes from the American Diabetes Association (Franz et al. 2002). On p.8 of the background paper it is stated that „*the actual quantity of carbohydrate in the diet seems to be of little importance in relation to its quality* (p.8).“ However, the Technical Review Committee of the ADA (Franz et al. 2002) concluded: „*There is strong evidence for the statement: With regards to glycemic effect of carbohydrates, the total amount of carbohydrate in meals and snacks is more important than the source or type.*“ And: „*there is some evidence for the statement: although the use of low-glycemic index food may reduce postprandial hyperglycemia, there is not sufficient evidence of long-term benefit to recommend general use of low-glycemic index diets in type 2 diabetes patients.*“

Furthermore the ADA focusses in the recommendations for the prevention of type 2 diabetes on weight loss and exercise. They concluded „*that structured programs for the prevention of diabetes should emphasize lifestyle changes including education, reduced fat and energy intake, regular physical activity and regular participant contact can produce long-term weight loss of 5-7 % of starting weight and reduce the risk for developing diabetes.*“

In summary:

The background paper (Annex 3 of the WHO Draft Report) supports only some targets for fat intake (total fat and SAFA) with a slightly different view than Table 2 of the Draft Report.

With respect to carbohydrate intake, the background paper (Annex 3 of the WHO Draft Report) states *„that there is no specific carbohydrate guideline which is aimed at the prevention of type 2 diabetes (p. 17): this may be due to large differences in carbohydrate consumption in relation to energy intake between different populations and countries. These make it difficult to advocate guidelines as they may be contrary to general food practices.“* and *„ the optimal fibre intake for the prevention of diabetes still needs to be determined.“* The background paper (Annex 3) thus does not justify a target for „free sugars“.

Literature:

- Franz MJ et al.: Evidence-based nutrition principles and recommendations for the treatment and prevention of Diabetes and related complications. Technical Review. Diabetes Care 2002; **25**, 148 – 198

Comments on Chapter 4.3: “Nutrient recommendations for the prevention of cardiovascular diseases” and the related background paper (Annex 4).

Comments:

- This chapter proposes that there is convincing evidence for increase consumption of fruit, berries and vegetables. We believe the evidence would be ‘**probable**’ as the science in this area is largely based on epidemiological associations and a few intervention studies, which have demonstrated favourable effects on blood pressure and homocysteine.
- Recommendations to increase fish consumption should be fully investigated to avoid unintended consequences on aquatic environments worldwide.
- It seems unclear why 7% energy from saturated fat (SAFA) is recommended when the recent nutrition guidelines in Holland, Austria, Switzerland and Germany have recommended a different figure. We felt the scientific evidence which states that myristic and palmitic acid increase the risk of heart disease compared to lauric acid is limited. It may also not be possible from a practical point of view as all these fatty acids are widely used in the diet.
- Trans fatty acids are formed by natural biohydrogenation of fats in the rumen of cattle and sheep and they are formed during an industrial process, called partial hydrogenation. Trans fatty acids have always been part of the human diet and are found in a wide range of foods such as meat, milk, butter, some margarines and many bakery and processed foods.
- The proposed link between trans fatty acid (TFA) intake and risk of cardiovascular disease is primarily based on epidemiological evidence taken from a number of large-scale studies. Correlations have been drawn between the increased use of hydrogenation and the increase in coronary heart disease and other health problems. However, saturated fatty acids are present in far greater amounts in our diet they are a more significant factor in the risk of heart disease.
- Evidence cited to support a “probable” ranking for beta carotene supplements is largely based on data from smokers. These individuals do not represent the general population. The recent Heart Protection Study (n= 20,536) found no adverse effects on vascular or non-vascular morbidity or mortality from supplementation with beta carotene, vitamin E and vitamin C (Collins et al. The Heart Protection Study. *Circulation* 2002;105:e37-e41).
- This paper omits large parts of the scientific data from epidemiological, mechanistic and intervention studies available on the relationship between intake of vitamin E as well as other antioxidant vitamins (vitamin C and beta carotene) with the risk reduction of cardiovascular disease. Therefore the scientific basis for the rating of the evidence is insufficient and the subsequent recommendations are inadequate. The overall scientific evidence strongly suggests a decrease in risk with dietary antioxidants and a possible decreased risk with vitamin E supplements.

- The section on sodium relies to some degree on several meta-analyses that are not considered valid by the experts in this area (ref. 2, 3, 8 and 10). Several other valid meta-analyses were not included (ref. Graudal NA, Galloe AM, Garred P. Effects of Sodium Restriction on Blood Pressure, Renin, Aldosterone, Catecholamines, Cholesterols, and Triglycerides. *J Am Med Assoc* 1998; 279:1383-1391; Midgley JP, Matthew AG, Greenwood CMT, Logan AG. Effect of Reduced Dietary Sodium on Blood Pressure: A Meta-analysis of Randomized Controlled Trials. *J Am Med Assoc* 1996; 275:1590-1597; Swales JD. "Dietary Sodium Restriction in Hypertension" in Hypertension Pathophysiology, Diagnosis and Management. Ed. Laragh JH, Brenner BM. Raven Press, New York, 1995. pp 283-298).
- With regard to the Dietary Approaches to Stop Hypertension (DASH) studies it is important to note that the investigators failed to conclude that the DASH diet (fruits, vegetable and low fat dairy products) was the nutritional priority to lowering blood pressure, and not sodium restriction.
As a practical matter, the lowest sodium diet is not one that free-living individuals self-selected. All of the foods used were specially prepared. The data presented support the benefit of diets high in fruits, vegetables and whole grains being possibly a more effective approach.

Literature:

- Hulshof KFAM, van Erp-Baart MA, Anttolainen M et al. Intake of fatty acids in Western Europe with emphasis on trans fatty acids: The Trans Fair Study. *Eur J Clin Nutr.* 1999; 53: 143-57
- Pryor WA. Vitamin E and Heart Disease: Basic Science to Clinical Intervention Trials. *Free Radical Biol Med* 2000;28:141-164.
- Kaul, Devaraj, Jialal. Alpha-Tocopherol and Atherosclerosis. *Proc Soc Exp Biol Med* 2001;226:5-12.
- Witztum JL, Steinberg D. The Oxidative Modification Hypothesis of Atherosclerosis: Does It Hold for Humans? *Trends Cardiovasc Med* 2001;11:93-102.

General comments on Chapter 4.4: “Nutrient recommendation for the prevention of cancer” and the related background paper (Annex 5)

Comments

- Diet is now generally regarded to be of equal importance to tobacco consumption, as a risk factor for human cancer. However, this relationship is not straightforward. Some cancers are associated with dietary excess (e.g. colon, breast endometrium), whilst others are linked to poor nutrition (e.g. stomach, liver, oesophagus). Further more, some cancers appear to have an inverse relationship with each other, such as colon and stomach. Because of this complexity, care needs to be taken that recommendations intended to decrease the risk of cancer at one site, should not inadvertently increase the risk of cancer at another. In addition, other health related consequences need to be properly considered.
- The digestive tract is obviously the most likely site to be affected by dietary factors. Colorectal cancer is the second most common in Europe. Although it's relationship to diet is complex, there is strong evidence that diets rich in whole-grain cereal are protective. For oropharyngeal and oesophageal cancers, the major risk factors are alcohol intake and smoking. Stomach cancer, which is the third most common in Europe (but declining), may be linked to early and chronic *H.pylori* infection. Adequate intakes of fruits and vegetables appear to have a protective effect for oropharyngeal, oesophageal and stomach cancers.
- Overwhelmingly, the main influence on risk of lung and respiratory tract cancers is smoking. This is seriously exacerbated by exposure to asbestos dust. Epidemiological studies indicate that, people with the highest tertile intakes of fruits and vegetables have one third of the risk, compared to people in the lowest tertile.
- The strongest diet related, adverse influences on the hormone-related (breast, endometrial and prostate) cancers are total energy and overweight. Fruit and vegetables have little protective effect. However, whole-grain cereals are protective for breast and endometrial, and adequate physical activity may reduce risk in the case of breast and prostate cancers.
- In terms of dietary patterns which reduce total cancer risk, the only adverse factor with which we can speak with confidence is total energy intake. There is little consistent evidence on the claimed “causal” factors, which have included meat, fat (total and saturated) and salt.
- Protective diet related factors which are supported consistently by the totality of the evidence are fruit, vegetables, whole grain cereals and a healthy body weight (which also has food energy and physical activity components).

Conclusions

The only sensible conclusions to be drawn from the evidence available at present, concern the protective factors. We can say with confidence that to minimise our risk of cancer, in addition to giving up smoking, we should:

- a) maintain a healthy body weight with a BMI of 20 to 25,
- b) eat a wide variety and large amount of vegetables,
- c) eat a wide variety of fresh fruits, and plenty of them,
- d) eat plenty of whole-grain cereal,

e) eat a varied diet with a wide variety of food types and sources (including meat, fish and dairy products)

Comments on Chapter 4.5: “Nutrient recommendations for the prevention of dental diseases” and Annex 1 (Summary of strength of evidence for dental caries) and Annex 6 (The scientific basis for the prevention of dental diseases)

General comment:

The scientific background paper (Annex 6) which provides the basis for the recommendations suggested in chapter 4.5 as well as for the classification of the strength of evidence in Annex 1 is in contrast to the consensus views of the dental profession, e.g. “NIH Consensus Statement on diagnosis and management of dental caries throughout life” (2001). It also conflicts with other expert consultations of FAO/WHO. Furthermore, the background paper is in itself contradictory in the judgement and acceptance of the established modern methods to assess the cariogenicity of foods and drinks (Rugg-Gunn, 2001). The background paper does not accept this worldwide acknowledged methodology (Scientific Consensus Conference in San Antonio, 1985; and in London 1999 (Rugg-Gunn, 2001; Curzon and Hefferren, 2001)) in that it questions the validity of the results obtained with fruits, starchy staple foods, lactose, dried fruits, bread and wholegrain foods but surprisingly recognizes the results of plaque pH studies which tested novel carbohydrates for their dental risks. The background paper (Annex 6) therefore comes to several conclusions which are not supported by the dental community worldwide (FDI, 2001). The WHO Draft report thus even provides information which is misleading, e.g. with several statements in the evidence tables which claim that a food is dentally safe when it is not the case (details see below).

Comments on Chapter 4.5

1. The para “background” (p 38) states that “preventive strategies are clearly more affordable and sustainable”, but neither this chapter nor the related background paper (Annex 6) nor Annex 1 provided detailed information on the most effective caries preventive strategies, namely regular oral hygiene practice with the use of fluoride in its various forms and the promotion of oral selfcare among the population. The recent NIH consensus conference on “diagnosis and management of dental caries throughout life” (March 2001, Bethesda) summarized the expert consensus of the best methods available for the primary prevention of dental caries initiation throughout life as well as for reversing and arresting the progression of early caries, which is oral hygiene and the use to fluoride. These aspects have not been considered appropriately in the Draft Report.

2. In the para “trends” (p 38) it is stated that “dental caries is a progressive disease and increases with age”. However, in the last 30 years caries has declined in children, adolescents and young adults. This demonstrates that the progression of caries lesions can be delayed substantially. Even reversal of early caries lesions can be achieved by of regular oral hygiene with fluoride. This should be mentioned in the report.

The statement that *“in developing countries that are exposed to increased intakes of sugars, the prevalence and severity of dental decay is increasing”* is not supported neither by data in the background paper nor by data of the Global Oral Health Data Bank.

Also the statement that *“diet and nutrition may play a serious role in the aetiology of periodontal disease in more transitional societies”* is not corroborated by scientific evidence either, on the contrary, periodontal disease is related to dental and gingival plaques. Consequently it relates to oral hygiene and not to diet.

3. In the para on “diet and disease” the description of dental caries should make clear that dental caries is regarded as a bacterially based disease and that all fermentable carbohydrates can be involved in tooth decay (see review by König , 2001).

The statement that “*undernutrition coupled with high intake of sugars results in levels of caries greater than expected than for the level of sugars intake*” (p.38 and p.39 footnote to Table 8) is speculative and not supported by scientific evidence either, the literature quoted in Annex 6 does not provide any proof.

The statement that “*dental caries is preventable by limiting the amount of free sugars*” is not supported by scientific evidence. The term “free sugars “ was rejected (FAO 1998). The strategy to improve dental health by reducing the consumption of free sugars on a population wide basis is not supported, as all carbohydrate foods including e.g. fruits, wholegrain bread can contribute to dental caries. Therefore, if poor oral hygiene habits prevail, it is a matter of frequency not amount.

Research into the risk factors for erosion has shown that the development of dental erosion seems to be part of a cumulative process influenced by frequency and time of acid exposure, oral hygiene practices and individual susceptibility. It is not the increased consumption of dietary acids from soft drinks and juices but an unusually longer contact time of the acidic fluids in the mouth. Furthermore erosive lesions have also been observed in vegetarians, who have higher fruit and vegetable intakes but not necessarily a high consumption of soft drinks.

4. Strength of evidence: The statement that “*there is good evidence for no relationship with intake of starch-rich foods (such as bread, potatoes and cereals) and probably for fruits and vegetables*” is not corroborated neither by experimental caries research nor by intra-oral plaque-pH-telemetry data. Bread is not regarded as dentally safe. Therefore the statement, that “*there is no relationship with intake of starch-rich foods*” on p. 38 of the WHO Draft Report as well as on Table 8 on p. 39 is incorrect and misleading, as it confers the impression to the consumer that these foods are dentally safe, when in fact they are not. The same criticism applies to Table 8, to whole fresh fruits and dried fruits, as well as milk as they all can contribute to dental caries (König, 2001; van Loveren 2000).

As all carbohydrate foods can contribute to dental caries, the disease specific recommendation (p. 40) to limit “free sugars” intake to 6 – 10 % or to less than 15-20 kg/per person per year is unrealistic from several aspects, as this recommendation has not been shown to be effective nor practicable nor acceptable. Dr. Barmes (formerly WHO Department of Non-Communicable Diseases) already stated in 1986 that the area of dietary control has consistently been the least successful in the areas of preventive dentistry (Barmes, 1986).

Comment on Annex 1: Summary of strength of evidence for dental disease

1. In Annex 1 the statement that “free sugars, frequency and amount” are “convincingly increasing” the risk for dental caries has to be corrected according to the International Consensus. The terminology has to be changed from “free sugars” into “fermentable carbohydrates to cover all carbohydrates, which can contribute to caries. The “amount” has to be deleted, as frequency is the risk not the amount.

2. In Annex 1 the statement that starch has convincingly no relationship to dental disease is incorrect, as dental research has shown, that starch can contribute to caries as well. Therefore that line has to be deleted.

3. The statement that “whole fresh fruits” have probably no relationship to dental disease is in contrast to dental research and the statement has to be deleted.

4. Good oral hygiene/absence of plaque contributes convincingly to the prevention of periodontal disease. The footnote no. 12 should also comprise dental caries, as good oral

hygiene/absence of plaque, e. g. plaque removal and the use of fluoride are the established caries preventive measures. Therefore the footnote no. 12 should also mention dental caries.

Literature

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General comments on Chapter 4.6: “Nutrient recommendation for the prevention of osteoporosis” and the related background paper (Annex 7)

Comments:

- The chapter is focussed on diagnosis and it underestimates the importance of diet. Other factors such as hormonal influences and physical activity are also not fully investigated.
- The risk of osteoporosis might be minimized by ensuring optimal peak bone mass by appropriate calcium intakes in early life as well as by reducing losses later.
- A sedentary lifestyle, smoking, low body weight, alcohol consumption and low calcium intakes have all been implicated as risk factors. Adequate physical activity as well as appropriate calcium intake influences bone strength.
- The role of vitamin K in the prevention of osteoporosis is underestimated in this report. Human intervention studies and epidemiological data clearly demonstrate that vitamin K can improve bone health.
- The evidence that sodium is important in the aetiology of osteoporosis or that sodium restriction may be a beneficial strategy for fracture prevention is inconclusive.
- There is no sound evidence that the consumption of salt at the present average level of 9 g/day constitutes a risk factor for osteoporosis.

Literature:

- Cohen and Roe. Review of risk factors in osteoporosis with particular reference to a possible aetiological role of dietary salt. *Food Chem Toxicology* 2000; 38:237-253
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CIAA COMMENTS ON RECOMMENDED ACTION

General comments

1. CIAA agrees, in principle, to a responsibility regarding access to a safe, nutritious and affordable food supply. CIAA members anticipating changes in consumers' needs and based on sound science already provide a wide choice of high quality, safe, wholesome food, at affordable prices produced in accordance with the principles of good husbandry and manufacturing, sound economics and sustainable environmental standards.
2. The EU food and drink manufacturing industry believes that sound science-based, environmental and social standards should underpin international trade. CIAA welcomes the WTO Doha Declaration and the commitment to world trade liberalization, by means of a new round of world trade negotiations. This liberalisation of trade must be equitable.
3. Although CIAA wholly supports appropriate efforts to facilitate greater levels of daily moderate physical activity where needed, this recommendation may not be appropriate in some communities of developing countries where energy expenditure from physical activity may already exceed total energy consumed.
4. We question the use of terms such as '*healthier food and drink choices*' and '*questionable nutritional value*', and the context in which they are used which appears to denigrate individual foods. Many foods that are high in fats and/or sugars make valuable essential contributions to the nutritional intakes of individuals within civil societies. From a nutrition perspective, the composition of individual foods is relatively unimportant, what matters, is the nutrient content and overall balance of the total diet as a whole over time. The report should make clear that all foods have a function in a balanced diet.
5. No evidence is presented to substantiate the use of proposed fiscal policies or need for more stringent codes of advertising practice in reducing chronic diseases. The proposal to advocate fiscal policies forgets that industry is characterised by an inelastic supply and demand. The average demand price elasticity for developed countries is 0,0. Hence price increases (or fiscal policies) would have no effect on consumption, let alone on health. Only for developing countries is the demand price elasticity calculated to be $-0,1$ (hence a 1% price increase causes a 0,1% consumption decrease), due mainly to income effects. It can hardly have been the intention to advocate fiscal policies in developing countries, where indeed they would have serious adverse effects on the economies (agricultural exports) of those countries.
6. In the majority of EU Member States, the existing self-regulatory advertising codes, including comprehensive Codes that apply to the advertising of foods to children, serve to protect consumers of all ages and to prevent them being misled. CIAA would like to stress that there is no evidence to suggest that advertising is the principal influence on

children's behavior. The most important influence on children's eating habits are parents and family environment.

7. We support an emphasis on sound information about dental health, in particular to encourage good oral hygiene and to facilitate regular daily use of fluoride toothpaste.

8. Product information must be readily available to enable the consumer to have freedom of choice and at the same time, understand and use nutrition information in conjunction with other sources. This information needs to be scientifically sound and easy to understand so that the consumer can quickly assess the role of a specific food product in the context of a balanced diet.
9. Consumer education is of key importance in order to facilitate informed choice. We do not support the implication that education materials produced by the private sector are biased.
CIAA would like to highlight that it is critical with respect to effectiveness of nutrition education to develop nutrition communication/education programmes involving all stakeholders.

Detailed comments on the proposed recommended action.

(The texts that are framed come from the WHO/FAO draft report)

Recommendations to civil society

- Support community-wide expansion on information on how to prevent chronic diseases :

CIAA fully supports the above mentioned recommendation always on the condition such information is scientifically sound.

- Pressure local politicians to facilitate a local environment that supports health (e.g. bike paths, exercise facilities in public paths, etc.)

Education about the detrimental effects of obesity and lack of fitness is essential to increase awareness of the importance of daily moderate physical activity in the prevention of obesity and associated ill-health.

There is a need for better understanding of the aetiology of obesity and the means to address the problem, through appropriate, targeted, community lifestyle practices. We note the following in particular:

- The low levels of physical activity, and sedentary behaviour now prevalent in many countries, play an important role in the development of obesity, by greatly reducing energy needs⁵. It is important to identify effective means to reverse this trend.
- There is also a need to put the role of adequate physical activity into context with the role of a healthy balanced diet in reducing risk. The diet and nutrition literature indicates that achievement of energy balance remains a major issue and is exacerbated by a high fat diet.
- Furthermore, there are a number of effective programmes available for the maintenance of appropriate body weight and avoidance of obesity. For example reduced energy diets, low fat diets, slimming clubs, and commercial formula diets are all possible options. It is important to consider all options and to match individuals to specific treatments.

- Consciously make healthier food and drink choices and thus reduce demand for high sugar and high fat foods and insist on healthy alternatives.

We question the use of the terms '*healthier food and drink choices*'. Many foods that are high in fats and/or sugars make valuable contributions to the nutritional intakes of individuals within civil societies. In terms of balanced eating, the nutritional composition of any individual food is relatively unimportant, what matters, is the nutrient content and overall balance of the total diet, over time. All foods have a function in a balanced diet.

All foods have nutritional value and can therefore contribute to a balanced diet: there is no such thing as a 'good' or 'bad' food, there are only good or bad diets. As a varied diet is an essential condition for balanced nutrition, it is important to assess a person's diet in terms of its total nutritional content.

⁵ Prentice, A. M & Jebb, S.A. (1995). Obesity in Britain: gluttony or sloth? British Medical Journal 311, 437-9.

There is no strong evidence of an effect of energy density (or energy dense foods), other than the contribution made by the higher fat content of the diet in increasing energy intake. There is also a universally found inverse relationship between sugars intake and obesity: although this relationship is recognised in the obesity chapter, it appears ignored in the policy proposals.

The food and drink industry aims to satisfy consumers' needs and expectations by supplying a wide variety of safe, tasty and nutritious foods.

- Pressure schools and other public facilities not to have vending machines, or to at least have healthy choices in them as well and to monitor the validity and bias of competitions, teaching aids and advertising.

CIAA agrees that it is important to have a variety of products on offer in vending machines, particularly if these are not provided elsewhere in the school and/or other public facility. However, CIAA strongly questions the necessity for, and aims of, proposed advice against the usage of vending machines. Vending machines can vend a wide choice of products that can meet the different needs of the purchaser. In schools these needs can vary from supplementing a meal of the day (breakfast/lunch), maintaining fluid and energy levels of pupils and staff to fulfilling a requirement to replenish energy or fluids following physical activity and sport. Maintaining hydration status by consuming liquids and energy levels during the course of the day is important and this has not been considered in the WHO Consultation Report.

There is no evidence to suggest that the vending of soft drinks and snacks is related either to overall nutrient consumption nor indeed the development of chronic diseases. Hence recommendations in this context on the presence of vending machines in schools or other establishments does not have any scientific basis at all.

There are strict guidelines that have been set out for the use of vending machines. For example, in Great Britain the Automatic Vending Association of Britain's (AVAB) has a Code of Practice for Vending in Schools, which was drawn up with the assistance of the Schools Nutrition Action Group (1994).

- Teach children to recognise the inherent pressure and persuasion of advertising, especially on television.

A world-wide literature review commissioned by the former UK Ministry of Agriculture Fisheries & Food (MAFF) through the Universities of Exeter and Dundee of the studies that had been undertaken to provide information on how television commercials affect the food choice of children concluded that *"there is no evidence to suggest that advertising is the principal influence on children's eating behaviour. Indeed the opposite is likely to be true, in that advertising is just one influence amongst many factors"*. Dr. Brian Young of Exeter University, one of the report's authors has since commented :-

"There are several issues that emerged from the MAFF report. One was that many food choices and preferences were already in place well before children have any idea of what advertising is about or why it's there. There's a lot of evidence that these food-related habits originate in infancy and during the very early years. After a

rigorous examination of the research literature we concluded that there is no serious and methodologically sound evidence that shows that food advertising leads to an increase in the consumption by children of whole categories of foods.”

A recent analysis in Germany demonstrated that children did not consume more of the most frequently advertised food products. The study concluded that other factors, including the eating behaviour of family and friends are more influential. (Report of the German Nutrition Society published 2000).

This observation is supported by another recent publication which looked into the “relationships between use of television during meals and children’s food consumption pattern” (Coon et al. Paediatrics 107, No. 1, January 2001). The results of this research suggest that the association between television advertising and the foods children eat extends to foods other than those normally advertised.

In looking at advertising its total context is important for understanding its relative influence. One of the most important aspects of this total context is the family environment. Research conducted in 1994 examined the family’s perception of the relative contribution of all potential influences on children’s food preferences and their actual consumption and identified other values which operated to position food choices. Thus, television advertising is recognised by families as having only a marginal influence on their food choices, similar to several other factors. Its impact is absorbed within the wider and stronger pattern of family life. Influence from family members accounts for more than three-quarters of what families describe as the important factors in shaping their children’s diets. Therefore, the authors conclude that there is no evidence to support the idea that television is the major influence on children’s diets. Rather than families seeing advertising as distorting the pattern of their children’s eating it was, in fact, perceived as potentially positive in that it might encourage children to try new foods.

In summary, advertising as a relative influence is unlikely to compromise a healthy diet because it simply does not command enough influence when seen in the context of other family processes.

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|---|
| <ul style="list-style-type: none"> • Use public transport, walking and cycling more often. |
|---|

CIAA wholly supports the intention of encouraging daily physical activity.

- | |
|--|
| <ul style="list-style-type: none"> • Parents should insist that dental education should be included in nutrition education at schools and at antenatal classes where available and should be based on sound non-biased information. |
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The CIAA agrees with an emphasis on sound information about dental health, in particular to encourage good oral hygiene and to facilitate regular daily use of fluoride toothpaste

Recommendations to national governments

Governments have a responsibility to protect and promote the health of their populations and communities by ensuring access to a safe, nutritious and affordable food supply. Governments should also ensure the poorest and most disadvantaged sectors of the society have access to “adequate” and nutritious food, that is a basic human right. A further responsibility is to make freely available facilities for performing regular physical activity. The increasing levels of modernisation and competing demands of economic development and health have sometimes created a situation where actions by governments have contributed to a decrease in physical activity and an increase in the intake of an energy-dense diet contrary to their own health guidelines. Governments have a responsibility to ensure advertising is accurate, informative and unlikely to contribute to ill-health, especially in young children.

The food and drink industry aims to satisfy consumer needs and expectations by supplying a wide variety of safe, tasty and nutritious foods at affordable prices throughout the year.

Advertising should be accurate, informative and unlikely to contribute to habits leading to ill-health. In the EU, the existing misleading advertising legislation, Council Directive 84/450/EEC, serves to protect consumers of all ages and to prevent them being misled.

Food and nutrition policies

- Encourage a food production policy based on small regional food producers as such policy often prevents the movement of people from a rural to urban setting, resulting in a loss of diversity of food production of traditional foodstuffs in favour of wide-scale production of cash crops demanded by export markets;

Since consumers associate positive attributes to regional production and marketing, CIAA understands the inclination to promote regional products.

However, in real life, regional production and marketing by itself is not an indication of quality as such. It is not because a product comes from a local farm that it is per se better in terms of quality or safety compared to a product that comes from further away.

Consumers also want products coming from all over the world and not only regional products. Moreover limiting the food supply to regional production would result in insufficient food supply. The limitation of the provision of foodstuffs to regional products does not respond to the consumer requirements and expectations. Regional products and products from all over the world have equally a place in the consumer’s shopping basket.

- Develop and implement intersectoral food, nutrition and agriculture policies, which will enable adequate production and domestic supply of fruits, vegetables and whole grain cereals, at affordable prices to all segments of the population;

The industry believes that sound science-based, environmental and social standards should underpin international trade. CIAA considers that there is no evidence within Europe that inadequacies of supply of fruit, vegetables or grains are the reason for poor consumption of these foods. Before implementing increased production in other parts of the world there needs to be an assessment of need and demand. Otherwise resources will be wasted producing food that will not be eaten.

- Develop and implement policies, which will enable an adequate and sustainable supply of fish in domestic markets.

CIAA agrees that the (sustainable) supply of fish should be encouraged and that the current downward trend in sustainable supply must be reversed. For CIAA, “adequate and sustainable” supplies of fish in “domestic markets” cannot be provided by domestic policies alone: these must be in tune with international policies for the provision of such supply to be made freely available through international trade.

National dietary guidelines

- Facilitate the development and adaptation of dietary recommendations and food-based dietary guidelines that keep pace with societal changes, with advances in nutrition science and which reflect the specific nutritional problems of communities as countries move through nutrition transition.

CIAA recognises the need for the development of local dietary guidelines and dietary advice. The food-based dietary guidelines should take into account the cultural context of the population for which they are developed. Patterns of food consumption vary considerably from one country to another, even from one region to another.

Nutritional needs differ from person to person. These needs, both physiological and psychological, are influenced by a variety of factors: genetic characteristics, age, sex, race, size, activity level, heredity, sensorial preferences, etc. Depending on the individual, these needs – which will vary over time – can be met by an infinite number of different combinations.

There are many parameters that guide and affect food choice. Although the nutritional dimension is a critical one, cognitive, symbolic, cultural and social variables also

have an impact on eating behaviour. Such aspects should be taken into account when developing nutrition policies, nutrition information, education programmes and specifically dietary recommendations.

A change in the nutrient content of the diet cannot be made on the basis of scientific guidelines alone. Although it is clear that each country should develop scientific guidelines suitable for its population, it must also develop effective food-based dietary guidelines to achieve the goal of effectively solving health problems. This is best done by integrating health considerations and dietary goals when forming such scientific guidelines and by developing effective partnerships among the many sectors that influence food supply and food selection.

Guidelines need to promote a healthy balanced diet for all rather than the attainment of specific numerical goals by populations as a whole.

Regulation of food quality, advertising and labelling

- Ensure and monitor the guidelines for the quality and composition of food served in schools, hospitals, day-care centres and government organisations;

CIAA supports the objective of developing factual guidance for caterers preparing food served in schools, hospitals, day-care centres and governmental organizations. However, CIAA questions the necessity for such guidelines to cover the 'quality' and 'composition' of food served, unless in respect of food safety issues (e.g. bacterial contamination).

In this respect, CIAA supports the European Commission initiative to consolidate and simplify EU food hygiene legislation, in particular by emphasising a whole chain approach to reinforce, integrate and enhance food safety standards throughout the food supply chain. CIAA would welcome an emphasis on implementation of HACCP (Hazard Analysis and Critical Control Points) principles based on those developed by Codex. This would enable the application and enforcement of legislative requirements proportionate to the food safety risk posed by the operation. CIAA considers that all food businesses regardless of scale, geographical location or point in the chain – from primary production to sale to the final consumer - must be included within the scope of Community food hygiene legislation and, in turn, be subject to the requirement to operate to HACCP principles.

- Employ regulatory measures to discourage the hydrogenation of oils and fats intended for dietary consumption or manufacture of food products;

Hydrogenation is a long established safe process that has been used all over the world by the food industry for over 75 years. It is a fully accepted technology that enables the food industry to bring a wide choice of products to the consumer. Therefore there is

no compelling evidence to regulate or discourage hydrogenation provided it does not produce high levels of trans fatty acids.

The important point is to encourage consumers to cut down on saturated and trans fatty acids. The presence of hydrogenated fat is not a useful guide since products containing hydrogenated fat can contain high, medium or low levels of saturated and/or trans levels.

Additionally it should be remembered that saturated fat intake is on average between 10% and 19 % energy in Europe whereas trans fat intake ranged from 0.5% and 2.1% energy. It should also be remembered that since this data on trans was collected the margarine and spreads industry has reduced the level of trans in their products and therefore the intake has been further reduced.

- Enact and enforce measures for labelling of food products, with respect to their sodium, fatty acid and sugar content, with clear codes, which will enable consumers to readily identify products with high sodium and/or fatty acid content;

CIAA recognises that nutrition information is a useful tool for consumers to make an informed choice. Already in 1990 the legislator in the European Union has therefore adopted the Nutrition Labelling Directive (90/496/EC) which provides the legal framework for nutrition labelling in the European Union. It requires compulsory nutrition labelling in the case of nutrition claims appearing on labelling, in presentation or in advertising. It also lays down the format and the nutrients which have to be declared. As a minimum beside the energy values, the amounts of protein, carbohydrate and fat have to be labelled. Where claims are made for sugars, saturates, fibre or sodium the information has to include energy value and the amounts of protein, carbohydrate, sugars, fat, saturates, fibre and sodium.

Beside this mandatory nutrition labelling many companies provide nutrition information on their products on a voluntary basis which are given in same format. Many food groups already use various color codes to indicate nutrient content (e.g. fat content in milk is indicated by different color of packaging, unsalted biscottes have a specific color packaging). These experiences must be taken into account before any new recommendation.

Therefore most of the manufactured products in the market of the European Union bear nutrition information which comply with the recommendations given by WHO/FAO and enable consumers to readily identify products with high sodium and/or fatty acid content as well as the content of other nutrients as mentioned above.

When the WHO/FAO recommendations on nutrition labelling were presented to the Codex Committee on Food Labelling in May 2002 in Halifax, to be taken into consideration in the discussion of the Codex Committee, it was acknowledged that nutrition labelling would be an important instrument for implementing recommendations of the consultation and should be considered in the broader context of public health strategies and policies concerning diet and health. In CIAA's view, the WHO/FAO recommendation was already put into practice for many years in the European Union on a mandatory as well as on a voluntary basis. Therefore there is no need for additional action of the European legislator nor the food industry. In addition to the information given on the packaging, many companies offer nutritional information via other means to consumers such as the internet, leaflets, free telephone lines etc. This allows tailor-made information, which fulfils the individual requirements.

In addition it should be stated that labels cannot be used as a substitute for consumer education. Labels can only be used to highlight some aspects of nutritional properties in a brief manner (e.g. nutritional amount, short messages in form of claims). It gives not enough space for longer explanations on nutritional quality which may also be difficult to define, as

different individual constellations need a different nutritional composition. Therefore nutrition education needs to use other tools than labelling.

See more detailed comments under section on 'Recommendations to the private sector and industry' – labelling of food products.

- Take action to respond to the changing food supply by developing or adjusting food regulations that control food quality and safety, the labelling of foods and the advertising of food.

CIAA would like to point that the development of food law at EU level is continuous and dynamic, e.g. the recent agreement on the General Food Law Directive and the establishment of the European Food Safety Authority.

Moreover, legislation in labelling and advertising is in place at EU level ensuring a high level of consumer protection in terms of information and allowing consumers to choose foods that are safe, nutritious and that can make an important contribution to their diets.

- Set more stringent codes of practice on advertising (including advertising and information on the www) of sugar-rich items, especially to children, and consider introducing fiscal pricing policies on such items. Income generated through such schemes could be used to fund health promotion and or health research.

Advertising to children, in particular, is extensively regulated by national and European legislation. In addition to extensive regulation, advertising is also governed by extensive industry self-regulatory systems. Recent research demonstrates that these systems work to the satisfaction of consumers, industry and regulators.

Advertising stimulates brand competition and awareness, and has a relatively small influence on food choice, diet or consumption patterns.

See also comments addressed under section 'Recommendations to civil society' on Advertising, and under section 'Recommendation to international agencies' on Fiscal pricing policies.

The proposal to advocate fiscal policies mainly for sugar-rich items forgets that that industry is characterised by an inelastic supply and demand. The average demand price elasticity for developed countries is 0,0. Hence price increases (or fiscal policies) would have no effect on consumption, let alone on health. Only for developing countries is the demand price elasticity calculated to be $-0,1$ (hence a 1% price increase causes a 0,1% consumption decrease), due mainly to income effects. It can hardly have been the intention to advocate fiscal policies in developing countries, where indeed they would have serious adverse effects on the economies (agricultural exports) of those countries.

Moreover specific price elasticity calculations for sugar containing products also give price inelastic final demands per sector. Fiscal policies on these categories would therefore not lead to changes in the consumption of the category as a whole, albeit that the market shares of different producers within those categories may be affected.

Supply is also inelastic, e.g. the response of agricultural producers to changes in world prices is small to non-existent, especially due to long time-lags in for example cane-crops, and the large sunk costs needed to increase or decrease processing capacity.

Physical activity

- Develop and implement policies involving urban planning and transport to create facilities for supporting regular physical activity by all people of all ages;

CIAA supports the development and implementation of policies to contribute to increase physical activity.

- Ensure that regular physical activity is included in school curricula.

CIAA welcomes the inclusion of physical activity in school curricula.

Nutrition education

- Utilise mass communication channels to promote community nutrition education.

Nutrition education plays an important role in helping European consumers to meet their dietary requirements in a safe and responsible manner.

Member States should be encouraged to pursue and strengthen nutrition education in order to help consumers make informed choices regarding healthy diets and lifestyles.

CIAA looks forward to discussing how best the food industry can contribute to communicate nutrition messages.

- Provide guidelines for the use / content of educational materials on diet and health to ensure they are sound, non-biased and not biased towards the interests of the food industry.

CIAA believes that guidelines, backed by a strategy for implementation including effective health promotion and education programmes for healthy eating and healthy lifestyles could make a significant contribution towards promoting better health for all citizens of Europe.

CIAA is willing to contribute the know-how and expertise of its members in a collaborative effort to improve further the health and well-being of Europe's consumers.

CIAA looks forward to discussing the best means to develop nutrition communication/education programmes which would involve all stakeholders.

Monitoring and surveillance

- Establish the means of monitoring the severity and prevalence of diet-related chronic diseases and the risk factors associated with them (e.g. intakes of sodium, fat and

sugars) and adopt global standard guidelines for methods of data collection where possible.

CIAA supports as a major pre-requisite, the need to establish appropriate means to monitor health indicators, efficient data collection and adequate surveillance of food intake, particularly by vulnerable groups of the population.

Recommendations to international agencies

- Facilitate the development of global trade policies which will ensure adequate supply of health promoting foods to all population groups of the world, through appropriate measures related to production subsidies, pricing and transnational movement (WTO, WHO, FAO).

CIAA considers that the recommendation is in contradiction with the declared ambition of the WTO negotiations in the area of agriculture. The precise aim is to reduce farm subsidisation, more particularly those subsidies that have distortive effects on production and trade. Current developments follow in general the tendency of more market oriented agricultural policies and less trade obstacles with a view to favour global economic growth and prosperity. To recommend subsidisation and pricing policies does not seem to be an appropriate global response, in particular as regards developing countries, since it would increase inequalities and distortion of competition.

CIAA supports the SPS agreement, Codex and other appropriate international food standards as the principal global basis for developing consumer health protection, minimising trade barriers and consequently facilitating global economic development. Codex is most effective and relevant when focused on the establishment of quantifiable, science-based standards aimed at enhancing food safety.

- Facilitate the development of national food-based dietary guidelines, in collaboration with national agencies (WHO, FAO)

See detailed comments under section on ‘National dietary guidelines’.

- Assist in developing and testing models of community empowerment, involving local production, nutrition education and enhanced consumer consciousness (WHO, UNDP).

CIAA would like to underline that partnership with international agencies (recommendations) and national authorities (Regulations) illustrates the social role played by the food industries. Initiated by health bodies, mass prevention is based on both industrial adherence to legal provisions (processing, labelling) and engagement in consumer education as shown by measures implemented with the contribution of various stakeholders (example: Arbeitskreis Jodmangel in Germany) or by reference to global programme (ICCIDD).

See more detailed comments under section on 'Food and Nutrition Policies'

- Highlight and disseminate the information on the detrimental impact of diet-related chronic diseases on peoples' quality of life throughout the life course.

The development of chronic diseases (obesity, coronary heart diseases and cancer) are generally recognised as having multi-factorial causes and, although diet certainly plays a role, it should not be considered in isolation.

For example, coronary heart diseases is related to such life-style factors as smoking, stress, levels of physical activity, genetic, socio-economic and environmental factors, and high blood pressure. Any dietary modification that is to be recommended for either individuals or whole communities must be based on an objective evaluation of the available evidence within the context of these lifestyle factors.

- Encourage the development of national monitoring and surveillance system on the prevalence and trends of diet-related chronic diseases in different age groups, as well as on national dietary intakes. Where necessary, guidance on standardised methods for these data collection should also be provided.

CIAA supports the development of efficient monitoring, data collection and surveillance of food intake, particularly by vulnerable groups of the population.

- Recommend fiscal pricing policies for items that are high in free sugars and fats and are otherwise of questionable nutritional value and encourage national governments to adopt more stringent codes of advertising practice, especially those aimed at children and to support countries in creatively interpreting WHO regulations to allow these policies.

CIAA is surprised and concerned that recommendations on fiscal policies, which are the prerogatives of national governments, were made even though there was no input into the Report from economic experts. There is no evidence to support the assumption that such discriminatory pricing measures would have the desired effect of changing dietary habits. Indeed they would have serious adverse effects on the economies (agricultural exports) of developing countries. Furthermore, they would have adverse effects on the nutrition of the populations in those countries since there is a much greater dependence on sugar and fats for energy and fat-soluble vitamins. In developed countries where attempts to change dietary habits have been attempted through discriminatory taxation policies, they have failed. One major problem for authorities in this respect is how do they decide which foods have 'questionable nutritional value'? Most governments are advocating balanced diets rather than labelling foods as 'good' or 'bad' since all foods contribute to overall nutrient intake.

Finally, advertising has been addressed earlier in our comments where the evidence again clearly shows that it has no impact on children's eating behaviour (UK government report) - it is about brand competition.

See more detailed comments under section on 'Regulation of food quality, advertising and labelling' – introduction fiscal pricing policies on sugar-rich items.

- Promote nutrition as an essential part of training for medical and dental health professionals and ensure that medical and dental health issues are an important component of the education of nutritionists and other health professionals.

CIAA supports the requirement that health and other professionals with an impact on nutrition education, should have some nutrition training as part of their professional training programmes. However, it is essential that such information is factual and based on an established objective evaluation of the science.

Recommendations to the private sector and industry

- Make low-sodium, low-fat and low-sugars/sugar-free foods and non-acidic drinks widely available in the market, through appropriate manufacturing practices, and lower the sodium content of regularly consumed foods like breads and cereals. Manufacturers should also look at means to reduce the erosive potential of soft drinks.

CIAA members already provide a very wide range of food and drink products to facilitate choice and meet individual taste preferences and specific dietary requirements including products with lower fat and lower sugar level, gluten-free and/or reduced saturated and trans levels. The industry remains committed to innovation as a means to meeting consumer demands on healthy eating where there is technological scope to do this and where food safety, taste and functionality is not compromised.

- In addition to the amount of fat in products, ensure that the quality of the fat used for food preparation is not high in saturated fat or transfatty acids.

The current world supply of oil already allows manufacturers to choose a wide variety of oils which they can blend to make products with different fatty acid compositions

CIAA would like to emphasise the fact that the margarine industry has reduced the level of saturated and trans fat over the last 8 years. However current technology for the manufacture of biscuits and pastry does not permit the direct replacement of saturated and trans fat with unsaturated fat.

- Implement effective and non-misleading food labelling practices that will help consumers exercise informed choice with respect to sodium, quality and quantity of fat and sugar content of purchased foods.

See detailed comments under section on 'Regulation of food quality, advertising and labelling'.

- Consider the labelling of foods with simple symbols of high nutritional quality, i.e. those that conform with all or nearly all the nutritional recommendations in this report.

The use of symbols for "high nutritional quality" also seems to be not an effective way to help consumers making an informed choice. Firstly it is in most cases an individual decision which products are of high nutritional quality for an individual person with special requirements. Furthermore there is no evidence that symbols would influence and change

consumer habits and choices better than words. This was shown by recent experiences in UK, Netherlands and Sweden. Moreover it is not possible to consistently identify individual goods as conforming to guidelines relating to the whole diet.

Finally such symbols would be unnecessarily and unjustified divide products into "good" and "bad" while knowing that there is nothing like good or bad food but only good or bad diets.

For more comments see section on 'Regulation of food quality, advertising and labelling'.

- By working closely with relevant government and consumer groups, develop creative ways if implementing many of the recommendations above, in ways that are acceptable to all parties, to the extent possible.

CIAA argues for an effective liaison between all stakeholders in order to identify and support sound action programmes designed to improve health and well being.