INTERNATIONAL FOOD & BEVERAGE ALLIANCE

SUBMISSION BY THE INTERNATIONAL FOOD & BEVERAGE ALLIANCE ON THE REVISED WORLD HEALTH ORGANIZATION DISCUSSION PAPER (VERSION DATED 25 JULY 2012) ON A COMPREHENSIVE GLOBAL MONITORING FRAMEWORK, INCLUDING INDICATORS, AND A SET OF VOLUNTARY GLOBAL TARGETS FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES

The *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases* (the *Political Declaration*) unanimously adopted by Member States in September 2011 called for a "whole of society" effort and a collaborative approach to address the global challenge of NCDs.[1] The *Political Declaration* charged WHO with the responsibility of developing a global monitoring framework, including a set of indicators, to monitor trends and assess progress made in the implementation of national strategies and plans on NCDs, and recommendations for a set of voluntary global targets for the prevention and control of NCDs.

We commend the WHO on the work they have done over the last year in developing this monitoring framework and voluntary global targets, and for involving all stakeholders, including the private sector, in the process.

The members of the International Food & Beverage Alliance (IFBA) wish to provide both general and more specific comments on the Revised WHO Discussion Paper (version dated 25 July 2012) on a "Comprehensive Global Monitoring Framework, including Indicators and a Set of Voluntary Global Targets for the Prevention and Control of Noncommunicable Diseases" (the Revised Discussion Paper). Our comments are supplementary to, and should be viewed in conjunction with, those we submitted on the Second WHO Discussion Paper (dated 22 March 2012) "On a Comprehensive Global Monitoring Framework including Indicators and a Set of Voluntary Global Targets for the Prevention and Control of Noncommunicable Diseases".[2]

The comments that follow reiterate some of the concerns we expressed in our earlier submission and also provide our views on the new elements contained in this Revised Discussion Paper.

IFBA is a group of ten of the world's leading food and non-alcoholic beverage companies – The Coca-Cola Company, Ferrero, General Mills, Grupo Bimbo, Kellogg's, Mars, Mondelēz International, Nestlé, PepsiCo and Unilever – who share a common goal of helping consumers around the world achieve balanced diets and healthy, active lifestyles. In May 2008, we made five global commitments to WHO in support of the WHO 2004 *Global Strategy on Diet, Physical Activity and Health* (the WHO 2004 *Global Strategy),* including commitments to reformulate and develop products that support the goals of improving diets, to provide fact-based nutrition information, to restrict the marketing of foods high in

[1] A/RES/66/2

[2] To view IFBA's submission on the Second WHO Discussion Paper, click here

fat, sugar and salt to children, to promote balanced diets and active, healthy lifestyles, and to work in partnership with others to address global public health challenges.

GENERAL COMMENTS

Support for evidence-based, cost-effective, population-wide interventions.
We support the approach taken in the *Political Declaration* and in the Revised Discussion Paper on the proposed global, voluntary actions and monitoring for evidence-based, cost-effective, population-wide interventions. Meeting these targets will be challenging, but once the global, voluntary targets are ultimately defined, we will do our part to help achieve them.

Coherence and consistency with the *Political Declaration* and official UN and WHO policies.
As a basic principle, the adoption of consensus indicators, voluntary global targets and a global monitoring framework should be aligned and consistent with the NCD risk factors and interventions set out in the *Political Declaration*, and the WHO 2004 *Global Strategy* and the WHO 2010 *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* (the WHO 2010 *Set of Recommendations on Marketing to Children)*[3] incorporated by reference in the *Political Declaration.*

Flexibility on 2010 as a baseline for all voluntary global targets.
The Revised Discussion Paper and Second Discussion Paper propose 2010 as the baseline for all targets. As indicated in our previous submission, as WHO proposed, local adaptations of targets may be needed. We also believe, that in order to reflect historical performance and what can reasonably be expected going forward, flexibility may be needed in respect of the proposed baseline for each of these targets. For some targets, a proposed baseline of 2012 may be more appropriate. For others, like sodium reduction, tracking the specific elements – including consumer education, awareness initiatives and voluntary industry reduction efforts - to capture reduction efforts that were well underway *prior* to the proposed 2010 baseline year may be necessary. For example, IFBA members have been voluntarily making incremental reductions in salt levels in food products for decades. If a 2010 baseline is adopted, a number of these changes will be missed. Furthermore, given these historical reductions, in some countries the proposed 30% target to reduce population salt intake may not be achievable without acknowledging the reductions already achieved.

Baseline data availability, measurement issues and requirements.
As we indicated in our previous submission, we need to acknowledge that a "one size fits all" approach for data collection processes, monitoring and evaluation may not work. Currently there is a lack of

[3] Resolution WHA63.14

measureable data, robust data collection processes and uniform tracking systems across countries. A stepwise approach employing different models for different regions will be necessary.

SPECIFIC COMMENTS

PART 1: Global monitoring framework for NCDs, including a set of indicators

Table 1 (pg. 3) presents a set of indicators for global monitoring of progress towards reducing the impact of NCDs. The indicators cover the three components of the global monitoring framework: outcomes, exposures and health system response.

Following are comments from IFBA on:

(i) two of the health system response indicators –
   a. the elimination of industrially produced trans fat;
   b. the reduction of the marketing of foods high in fats, sugar and salt to children; and

(ii) two of the new exposure indicators –
   a. fat intake; and
   b. low fruit and vegetable intake.

1. Health system response indicators

The proposed health system response indicators include the adoption of:

- "national policies that virtually eliminate partially hydrogenated vegetable oils (PHVO) in the food supply and replace with polyunsaturated fatty acids (PUFA)" (pg. 4); and
- "policies to reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars, or salt." (pg. 4)

As indicated in our previous submission, in principle, we support both of these proposed health system response indicators. However, to ensure consistency with the flexible policy framework (including self-regulation), approved by Member States in the WHO *Set of Recommendations on Marketing to Children,* both indicators should be revised to provide for the inclusion of a "set of policy options."

a) Elimination of industrially-produced trans fat

IFBA members have been working to eliminate trans fats in their products for a number of years. Today, we have virtually eliminated industrially produced trans fats from our product portfolios; saturated fats have been reduced and levels of essential fats and "good" or healthy fats, such as PUFAs have been increased. IFBA members also collaborate with governments in efforts to eliminate industrially produced trans fats from the food supply. For example, IFBA members are participating in the "Trans

Fat Free Americas" agreement established by PAHO in 2008 and in the UK government's "The Public Responsibility Deal," a collaborative approach, established in March 2011 that aims to create an environment that can empower and support people to make informed, balanced choices that will help them lead healthier lives. Participating IFBA members each committed to the elimination of artificial trans fats by the end of 2011, and at the end of the year, each member had met its target.

The Revised Discussion Paper recommends the replacement of trans fatty acids with PUFAs as a "best buy" for the prevention of NCDs. (pg. 17). We believe that this proposed indicator is not an appropriate measure and should be revised as follows: "Replacement of industrially produced trans fatty acids with unsaturated fats, where possible. Manufacturers should try not to increase the original sum of saturates and trans fatty acids."

The food industry needs the flexibility to use a variety of oils, including PUFAs, monounsaturated fatty acids (MUFAs) and saturated fats to help reduce and eliminate trans fats from products. Our goal, when reformulating or developing new products, is to eliminate or reduce trans fat without increasing the level of saturated fats – while still maintaining the same texture, taste, shelf-stability and freshness consumers have come to expect. We achieve this by using alternative oils and oil blends, but finding alternative oils and oil blends that can still provide the same characteristics offered by trans fats but with a better nutrition profile is challenging. In most products, industrially produced trans fatty acids cannot be replaced with PUFAs. We need to use fats and oils that can remain semi-solid at room temperature and maintain product freshness, while being trans fat free. While we continue to look for mono- and poly-unsaturated oil blends (such as soybean oil blend) for some products, tropical oils have also proven to be an effective substitute for trans fat.

b) Reducing the marketing of foods high in fats, sugar and salt to children

The Revised Discussion Paper recommends Member States adopt policies to reduce the marketing of foods high in saturated fats, trans-fatty acids, sugars or salt to children based on the May 2010 *Set of Recommendations on Marketing to Children.* We support this recommendation and would further recommend that Member States be encouraged to consider the adoption of a "set of policy options" consistent with the approach approved by Member States in the 2010 WHO *Set of Recommendations on Marketing to Children,* which provided a non-prescriptive set of policy options, including self-regulation.

In 2008, our members voluntarily committed to change how and what they advertise to children under 12 years of age on a global basis. This approach *reduces* the impact on children of the marketing of foods high in saturated fats, trans-fatty acids, sugars or salt and *increases* exposure to foods and beverages compatible with a balanced diet and healthy, active lifestyle. The policy IFBA members adopted - which is in line with the aims of the 2010 WHO *Recommendations on Marketing to Children* –

has been working, with third-party studies showing a major reduction in the exposure of children under 12 years of age to marketing communications for products high in fat, sugar and salt.[4]

2. Exposure indicators

The Revised Discussion Paper includes a set of new proposed exposure indicators including fat intake and low fruit and vegetable indicators.

a) *Fat intake and low fruit and vegetable intake*

IFBA members are committed to helping people around the world improve their diets and achieve healthier and more active lifestyles.

IFBA members have introduced new products and reformulated tens of thousands of products globally since 2004 with improved nutritional profiles, removing or reducing key ingredients of public health concern – sodium, saturated fats and trans fats and sugar – and adding ingredients considered beneficial for good health, such as whole grains, vitamins and minerals, fruits and vegetables.[5] And our work continues.

IFBA members are also committed to providing consumers with clear, fact- and science-based nutrition information to help them make informed and healthy food choices. The product label and the nutrition facts panel or table is a primary source of information for consumers and in November 2010, IFBA members adopted a set of "Principles for a global approach to fact-based nutrition labeling." Nutrition information is provided on-pack on the key nutrients of public health concern – calories, total fats/saturated fats, sodium/salt and sugars per 100g/ml and/or per serving. Beyond the package, IFBA members provide consumers with practical health and nutrition information through a variety of media, including company websites, social media apps, help lines, email alerts, brochures and newsletters. IFBA members also promote healthy eating awareness through community events, and multi-media consumer education campaigns.

PART 2: Voluntary global targets

Table 2 (pg. 20) is a list of examples of voluntary global targets. This list has increased to 11 targets from the five included in the Second Discussion Paper. The original five targets are now designated either as "adopted" – 25% reduction in premature mortality from NCDs – or as "targets with wide support" - raised blood pressure, tobacco use, salt/sodium intake and physical inactivity. The remaining six targets are identified as "targets with support for further development" and relate to obesity, fat intake,

[4] For examples, please see Second Discussion Paper at 9-10
[5] Examples of these product innovations may be found in IFBA's 2011 Progress Report, at 7-13.

alcohol, and cholesterol and health system responses such as the availability of drug therapy to prevent heart attack and strokes and essential medicines for NCDs.

Following are comments from IFBA on:

(i) the target adopted – premature mortality from NCDs;
(ii) targets with wide support -
    a. salt/sodium intake;
    b. physical inactivity; and
(iii) targets with support for further development –
    a. obesity; and
    b. fat intake.

1. Support for the voluntary global target adopted on premature mortality from NCDs

We support the global outcome target, adopted by Member States at the World Health Assembly in May, of a 25% reduction in premature mortality from NCDs by 2025. [6]

2. Support for voluntary global targets on reductions on population intake of salt and physical inactivity.

As indicated in our previous submission, we also support the voluntary global targets, now designated as "targets with wide support":

- a 30% reduction in population intake of salt, with the aim of achieving a target of less than 5g of salt per day by the end of 2025; and
- a 10% reduction in physical inactivity, as indicated in our previous submission on the Second WHO discussion paper on this topic.

However, while we support both of these targets in principle, we wish to reiterate our concerns on how these targets are proposed to be achieved.

a) Salt/sodium intake

Reducing sodium intake requires a multistakeholder solution. Governments, health authorities and health care professionals, NGOs, the private sector, the food industry, retailers, restaurants, nutritionists, scientists and consumers all have a role to play. As a member of the private sector, we fully acknowledge the part we play as part of the solution.

The Revised Discussion Paper and the Second Discussion Paper recommends implementation of salt reduction interventions through two primary means: mass media campaigns to inform and empower consumers to make informed choices, and reduced salt content in processed foods through product reformulation.

[6] Decision WHA 65.8

We fully support the mass media campaigns as an intervention. We believe that fact-based consumer education is a key component of any salt reduction intervention and experience has shown this works. IFBA members have been, and continue to be, involved in various multistakeholder initiatives with governments and NGOs in a number of countries to help raise consumer awareness on this issue.

As indicated in our previous submission, while we believe that reducing the salt content in processed foods – a process our members have been involved in for decades – is a necessary intervention, it cannot be the only intervention. To be effective, salt reduction interventions should be based on research and scientific evidence to identify and address *all* sources of sodium, not just the salt content in processed foods. As the Second WHO Discussion Paper states, "In many high income countries, approximately 75% of salt in the diet comes from processed foods and meals prepared outside the home. In many low- and middle-income countries, most sodium consumption comes from salt added at home in cooking and at the table or through condiments such as fish sauce and soy sauce." (pg. 19).

Although IFBA member companies are present all over the world, in many cases our products represent a small portion of a population's diet. An effective intervention must take into account the entire diet of the population base to ensure overall consumer acceptance of lower sodium products.

Significant sodium reduction in processed foods is complicated as salt plays an important role in taste, preservation and processing. Our goal is to make meaningful and measureable changes without sacrificing taste, functionality, quality or food safety. There is no single technical solution – approaches will differ across food categories. IFBA members have invested millions in research and development resources and consumer insights over the years to develop a variety of approaches to provide consumers with a broad range of lower salt food products:

i) the gradual stepwise reduction of salt in foods over an extended period of time so as not to be noticed by the consumer – for example, the salt in Kellogg's *All-Bran* cereal was reduced by three-fourths over 20 years; in the UK, PepsiCo's *Walkers* brand reduced the salt in many of its crisps and snacks between 25% and 55% over an eight-year period. While results are positive, the amount of salt that can be reduced is limited before the product becomes unpalatable;
ii) the use of salt substitutes and replacers, such as potassium chloride, to enhance the salty flavor, or to replicate the function of salt without affecting the sodium content of the foods;
iii) the use of flavor enhancers, such as herbs and spices, which have the ability to increase the perceived salty taste, without the high sodium content; and
iv) the deployment of new processes and production methods – for example, to reduce the sodium from its *Hint of Salt* saltines, Mondelēz International developed an entirely different cracker leavening system to replace the sodium bicarbonate.

Notwithstanding the significant reductions made to date, IFBA members continue to explore new technologies and approaches that offer the potential for the further reduction of salt levels in foods**.** For example, Unilever scientists recently discovered they could enhance people's perception of the saltiness of their food by giving it a smell which they associated with salt (although salt itself does not have an odour), paving the way for the company to help people improve their health by making tasty products with a lower salt content. Nestlé has partnered with a U.S.-based life sciences firm to identify and develop ingredients for reduced-salt foods that correspond with consumer taste expectations.

b) Physical inactivity

We fully support the 10% reduction in physical inactivity, however as we stated in our previous submission, we believe the proposed indicator which is set for adults aged 18+ years should be amended to ensure a focus on physical activity for all ages. If we are to prevent and control NCDS, then we must begin by inspiring and encouraging positive, active, healthy behavior and habits early in life. Raising awareness of the importance of physical activity is one of the five commitments IFBA members made to WHO in May 2008. Over the years, IFBA members have supported hundreds of successful initiatives around the world, at the global, regional, national and local level to promote balanced diets and physical activity in the very settings the discussion paper recommends – in schools, in the workplace and in communities.[7]

3. Targets with support for further development: obesity, fat intake, cholesterol and raised blood pressure.

Several of the proposed targets - obesity, cholesterol, and raised blood pressure - are proposed to be achieved by the promotion of healthy diets including increased consumption of fruits and vegetables and reduced intake of saturated fats and the promotion of increased physical activity. In principal, we support the further development of these targets and look forward to providing comments on them more fully as they are drafted. In the meantime, we offer the following preliminary comments.

a) Obesity

We support the proposed target of "no increase in obesity prevalence," and agree with the WHO that "the proposed target is ambitious" and will require "a comprehensive portfolio of actions to ensure optimal energy balance by stimulating healthier diet and physical activity since early stages of life." (pg. 24). Obesity is a serious public health issue. Its causes are multi-faceted and far-reaching and solving this problem requires a "whole of society" approach, and we are committed to being part of the solution. IFBA members are involved in a number of different initiatives around the world designed to support active, healthy living and have taken decisive actions in restricting marketing and advertising to children, improving the nutrition value of our products and introducing new ones through innovation, in supporting and developing nutrition education and physical activity programs which reach millions, and

[7] Examples of our efforts may be found on our website and in IFBA's 2011 Progress Report at 20-35

participating in national and regional efforts with governments, NGOs and professional organizations to help improve the diets and health of people globally.

b) Fat intake

We support the proposal for a voluntary target on fat intake. However, we believe that the proposed voluntary target of a 15% reduction in total energy intake from saturated fatty acids in adults aged 18+ is too high and should be re-considered to provide a voluntary reduction in the range of 5% to 10%. For example, the EU High Level Group on Nutrition and Physical Activity recently met to consider a proposal for a common EU structure on the reduction of saturated fat and agreed to recommend a 5% reduction of saturated fats in four years from 2012.[8]

The EU High Level Group on Nutrition and Physical Activity also recommended that the proposal be a base for a flexible structure on which Member States can build their national strategies. We note that Paragraph 63 of the *Political Declaration* referred to in the WHO in the Revised Discussion Paper also recommends, "Member States to consider the development of national targets based on national situations, building on the guidance provided by WHO…" (pg.19). We support the position that governments need the flexibility to establish national targets which reflect their unique circumstances, and are consistent with, but not necessarily the same, as the proposed global targets, and recommend that this be reiterated in the final document.

Finally, we also recommend that Member States be given the flexibility to establish health system response indicators aimed at meeting the proposed target that go beyond product reformation and include the consideration and adoption of various policy options, including self-regulation, to reduce portion sizes and raise public awareness of an overall healthy eating pattern and behavior that focuses on suggested portion sizes and consumption frequency of certain food categories, as recommended by the EU Framework for National Initiatives on Selected Nutrients.

18 October 2012

[8] Conclusions of the Chair, Flash Report, High Level Group on Nutrition and Physical Activity, 14 June 2012. http://ec.europa.eu/health/nutrition_physical_activity/docs/ev20120614_ccl_en.pdf