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SUBMISSION BY THE INTERNATIONAL FOOD & BEVERAGE ALLIANCE ON THE SECOND WORLD HEALTH ORGANIZATION 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

The International Food & Beverage Alliance (IFBA) commends WHO for their significant work over the last year in developing a proposed set of global targets and monitoring framework for the prevention and control of NCDs. We also commend WHO for reaching out to stakeholders, including the private sector, to obtain views on the development of a global monitoring framework. It underlines the value of a whole of society approach and is recognition of the importance of multistakeholder action in the prevention and control of NCDs.

The Second WHO Discussion Paper, "A Comprehensive Global Monitoring Framework including Indicators and A Set of Voluntary Global Targets for the Prevention and Control of Noncommunicable Diseases," (version dated 22 March 2012) identifies five indicators with targets for the global monitoring framework for NCDs –

- mortality between ages 30 and 70 due to CVD, cancer, diabetes and chronic respiratory disease – 25% reduction
- hypertension – 25% reduction
- tobacco – 30% reduction
- salt – 30% reduction
- physical inactivity – 10% reduction.

In addition to the indicators with targets, the discussion paper also identifies a series of additional WHO core indicators for NCD surveillance, for which there are no recommended targets, but for which the WHO has proposed a national health systems response.

The members of IFBA wish to provide both general comments and more specific comments on the Second WHO Discussion Paper and in particular, in respect of two of the proposed targets - dietary salt intake and physical inactivity - as well as our views on certain of the additional WHO core indicators. 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, Kraft Foods, Mars, 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 the WHO in support of the WHO 2004 *Global Strategy on Diet, Physical Activity and Health* (the 2004 *Global Strategy),* including commitments to reformulate and develop products that support the goals of improving diets, and to promote physical activity.

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GENERAL COMMENTS

Support for a whole of society approach and global, voluntary actions to address NCDs. We are pleased to see the *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases* (A/RES/66/2) *(*the *Political Declaration)* recognizes that an effective approach to the global challenge of NCDs requires a whole of society effort and the contribution the private sector can make. We agree with many of the proposed actions included in paragraph 44 of the *Political Declaration* for the private sector. These are, in fact, the very actions that IFBA members have been undertaking voluntarily since 2004 and form the core of the five commitments made to WHO in May 2008. [1] We support the approach taken in the *Political Declaration* and in the Second WHO 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.

Focus on the main NCDs and the related risk factors. The Second WHO Discussion Paper appears to place less emphasis and prioritization on the four main NCDs - cardiovascular diseases, diabetes, cancers and chronic respiratory diseases and their modifiable behavioural risk factors, such as tobacco use, the harmful use of alcohol, unhealthy diet and lack of physical activity. See Table 1: "Examples of a framework for national NCD surveillance" (pg. 5) which lists eight risk factors and several social determinants. In our view, an emphasis on the priorities included in the *Political Declaration,* as endorsed by Member States, is critical to ensure strategies and resources are concentrated in these areas.

Inclusion of a target for physical inactivity. We are pleased to see the inclusion of a target for the reduction of physical inactivity. This target supports the need to help people address overweight and obesity issues through energy balance – calories in and calories out. For many years, IFBA members have engaged in successful initiatives on a global, regional, national and local level to promote and encourage physical activity. We would like to propose that we engage with WHO in discussions on how we might build on our efforts to date and form a collaborative effort with WHO in this area.

Evidence-based policy development. It is in the best interests of all stakeholders that public health policies and interventions be evidence-based and measureable. Further emphasis should be placed on thorough and comprehensive evidence-based science, peer-reviewed by subject-matter experts, to: i) support all policies and interventions; and ii) design, define and monitor the achievement of the global, voluntary targets.

Leadership of Member States. One of the roles of WHO Secretariat is to convene and encourage government, private sector and civil society to work together to combat NCDs. Accountability should be shared by all parties in a partnership, but at the very least it should be led by governments to ensure the adoption of policies and initiatives that reflect unique national circumstances and priorities and a collaborative effort among all stakeholders.

[1] IFBA 2009-2010 Progress Report. https://www.ifballiance.org/sites/default/files/IFBA_Progress_Report_2009-2010.pdf

Coherence and consistency with other WHO policies. In the adoption of policies and interventions to address NCDs, there should be alignment and consistency with the strategies outlined in the WHO 2004 *Global Strategy on Diet, Physical Activity and Health,* in the 2008-2013 WHO *Global Action Plan for the Strategy on the Prevention and Control of Noncommunicable Diseases,* and the WHO 2010 *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* in referring to a reduction in the marketing of foods high in fat, sugar and salt.

SPECIFIC COMMENTS

Global monitoring

Key elements of a sustainable global monitoring framework

Pg. 7, 1st paragraph. We believe that a "one size fits all" approach to monitoring and evaluation will not work. We, therefore, support the WHO position that governments may 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. *(See IFBA comments under Dietary salt intake: baseline data availability, measurement issues and requirements).*

Governance, Secretariat and tools

Pg. 8, 3rd paragraph. The *Political Declaration* recognizes the role of WHO as the primary specialized agency for health. The *Political Declaration* also requests WHO in collaboration with the UN Secretary-General and other UN agencies and Member States to present to the UN General Assembly progress reports from time to time. This paragraph states that WHO will provide support for the development of the global monitoring framework and the establishment of an interagency group, advised by an independent technical advisory group, who "will play a key role in assessing progress." To the extent possible, while maintaining the appropriate balance between transparency and confidentiality, and in the event we may lend some assistance to these groups, we seek clarity on the composition, role and responsibilities of both of these groups.

Recommendations for a set of voluntary global targets and indicators

Pg. 11, 1st paragraph. The Second WHO Discussion Paper proposes 2010 as the baseline for all targets. As WHO acknowledges, reaching consensus on a global monitoring framework and targets is challenging and local adaptations of targets may be needed based on the specific country situation. We agree with this and also believe flexibility may be needed on the same basis in respect of the proposed baseline to reflect historical performance and what can reasonably be expected going forward. For example, IFBA members have been voluntarily making incremental reductions in salt levels in food products over many years. 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.

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ANNEX 1: Detailed description of targets to be achieved by 2010

4. Dietary salt intake

Target: Annex 1 calls for a target of 30% relative reduction in mean population intake of salt, with the aim of achieving a target of less than 5g of salt per day by the end of 2025. (pg. 19, 3rd paragraph). We share the objectives which underpin the mandate of the WHO to develop a population-based salt reduction strategy and support this goal. The target is a pragmatic approach and acknowledges the challenges in reducing sodium.

Reducing sodium levels is complex and challenging, both technically and in terms of consumer acceptance. Salt plays a crucial role in taste, preservation and texture, and our goal is to make meaningful and measurable changes without sacrificing functionality, quality, food safety or taste. This process takes time. Consumer acceptance is a critical factor that guides our reformulation work. Today, there is no widely available suitable substitute for sodium that provides similar functionality. As every product has a unique food matrix, each food product requires a different approach to sodium reduction. Salt reductions have been achieved through recipe reformulations; the introduction of salt replacers, such as lower-sodium sea salt; and salt enhancements such as aromas, herbs and spices. However, each product requires its own combination of sodium reduction technologies. Experience has shown that consumers need to re-educate their taste buds to appreciate foods with a reduced sodium level, and major changes must be made slowly in order to ensure acceptance. For such reasons, a realistic solution to these challenges is to gradually reduce sodium levels. Accordingly, we continue to invest in research and development resources and consumer insights to explore innovative approaches to reduce the salt in our products and raise awareness and create a demand for lower sodium products.

Indicator and public health relevance: The WHO states that the reduction target of 30% is "to be achieved by implementation of salt reduction interventions including mass media campaigns to inform and empower consumers to make informed choices and reduced salt content in processed foods through product reformulation." (pg. 19, 4th paragraph). We both agree, and disagree, with this indicator.

First, we support the WHO recommendation on implementation through mass media campaigns to inform and empower consumers to make informed choices and reduce sodium consumption. We believe fact-based consumer education is a key component of any salt reduction intervention and are committed to working with others to help raise consumer awareness on this issue.

We recommend governments also encourage all local stakeholders, including health care professionals and non-governmental organizations, to support sodium reduction initiatives, raise awareness and consumer demand for low-sodium diets. Interventions on sodium reduction should also employ the core capabilities our industry has to offer, including insights into consumer behaviour – from motivating consumers to adopt more active, healthier lifestyles and balanced diets to understanding taste preferences and evolving needs, and build on the continuing efforts to bring consumers along through a gradual, incremental and inclusive approach.

Second, we disagree that salt reduction interventions should be limited to simply reducing the salt content in processed foods. Each country is unique and has distinctive dietary patterns, and the source of sodium in consumers' diets will vary accordingly. 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, last paragraph). To be effective, 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, for example: i) home cooking, restaurants, take-away outlets, bakeries and food service; ii) foods that are significant contributors to sodium intake, including foods that do not contain significant amounts of sodium but may be significant contributors due to consumption levels; iii) other contributors of sodium, including functional ingredients; and iv) special consideration should be given to foods that have inherent sources of sodium, such as dairy foods.

Although IFBA member companies are present all over the world, in most countries our presence is limited compared to local packaged food companies and foodservice sales, including artisanal products (i.e. products sold on the site of production), cafes, restaurants and street stalls. An effective intervention must be implemented across the spectrum of the food industry and involve local producers – often the primary source of food sold, particularly in developing markets – to ensure a level playing field and overall consumer acceptance of lower sodium products.

IFBA has committed to reformulate products and develop new products with improved nutritional profiles that support the goal of helping people improve their diets and achieve healthier lifestyles. Our reformulation work is based on a comprehensive approach – taking into consideration the complete product profile (rather than the elimination of a single nutrient) and balancing the ingredients needed to deliver the overall desired nutritional profile, as well as taste expectations. Each reformulation leads to a relevant change in the nutritional composition of the product specific to the nutrient needs of local diets.

Globally, our members have reformulated or innovated tens of thousands of products since 2004 to provide better-for-you options, including several thousand products with lower or reduced sodium levels. For example: Kellogg's has had an active salt reduction programme in place in the EU since 1999 which to date has led to the removal of 50% salt in major cereal brands; since 2009 Kraft Foods has reduced sodium in its *Dairylea* cheeses by 25%, and also reduced sodium levels over the years in *Vegemite* by 20%. Unilever has achieved a 10-25% reduction in salt in powdered soups in Europe and South America since 2005. Grupo Bimbo has achieved a 20-30% reduction in salt levels in its bread portfolio in Mexico and the U.S. since 2008 and in 2009. General Mills has reduced salt levels in its *Old El Paso Dinner Kits* distributed in the EU by 23%, and in 2011, 54 products were reformulated in the U.S. achieving a reduction of at least 10% and five new lower-sodium products were introduced. Mars reduced sodium in its *Dolmio Taste of Italy* pasta sauces in Europe by 44%, and by the end of 2011, more than 50% of pasta sauces in the U.K. had met the U.K. Food Standard Agency's 2012 targets. Starting in 2004, in the U.K. PepsiCo's *Walkers* reduced the salt in many of its crisps and snacks between 25% and 55%. Nestlé's *Maggi* new soups and bouillon range in Chile contain 50% less salt and the salt level in its' *Maggi* noodles in India has been reduced by 34%.

Notwithstanding the reductions made to date, IFBA members have publicly committed to continue their efforts to reformulate products and develop new products with lower or reduced sodium levels. The following table illustrates these commitments.

Table 1: IFBA Members' Sodium Reduction Targets		
Company	**Territory**	**Target**
General Mills	U.S.	-20% across top 10 product categories (2015)
Grupo Bimbo	U.S./ Mexico	-30% across leading bread brands and salty snack brands (2015)
Kellogg's	Global	Continue reducing salt in breakfast cereals leading brands
Kraft Foods	Global Latin America North America	Continue sodium reduction efforts , in addition to region-specific goals -10% across cheese and biscuit portfolio (by end 2013) -10% across product portfolio (by end 2012)
Mars	Global	-15% across entire global food portfolio (2015)
Nestlé	Global	-25% in products with a sodium content greater than 100mg/100kcal (2005-2010) - Continue reducing sodium levels by an average of 10% in products which can best contribute to reducing sodium intake (soups, recipe mixes and pizza portfolio) (2012-2015)
PepsiCo	Global	-25% in key global brands in key countries (2015)
Unilever	Global	-25% across product portfolio to meet an interim target of 6g of salt per day, with ambition to go further with 15%-20% gradual reductions to 5g per day (2010-2015)

IFBA members also take part in sodium reduction initiatives, working with governments at the national and local level to voluntarily reduce the sodium in their products. For example, in a voluntary initiative on salt reduction between industry and the UK Food Standards Agency, between 2003 and 2008, salt consumption was reduced by approximately 10% across the board and in some foods, the presence of salt was reduced by up to 70%. In March, 2011, IFBA members, Ferrero, General Mills, Kellogg's, Kraft Foods, Mars, Nestlé, PepsiCo and Unilever committed to new salt reduction targets for the end of 2012 as part of their support of the UK government's new "The Public Responsibility Deal." In Canada, the Ministry of Health, industry and IFBA members have collaborated on a voluntary sodium reduction strategy which seeks to reduce sodium consumption to 2,300 mg per day by 2016. In the U.S., IFBA members are working with the New York City Health Department and Centres for Disease Control are coordinating a national effort, launched in 2010, to reduce the amount of salt in packaged and

restaurant food by 20% over five years. IFBA members are also part of a working group of public, private and NGO sector participants with PAHO to address issues of healthy lifestyles and diet, including efforts to reduce sodium consumption through consumer education and research, as well as reformulation. [2]

Baseline data availability, measurement issues and requirements: In terms of data collection processes, monitoring and evaluation, we all face a number of challenges. Currently, there is a lack of robust data collection and tracking systems, and differing views among countries on how sodium intake data should be collected and monitored. There is also a lack of effective and measureable data and accurate dietary surveys at the local level. Effective monitoring and evaluation systems need to be based on dietary intake surveys that look at all nutrients.

We also need to acknowledge that a "one size fits all" approach may not work. There is no single baseline - acceptable sodium intakes vary country by country and are based on local tastes and cultural habits. As such, we believe that a comprehensive monitoring and evaluation framework must identify and track, based on local data, national sodium consumption habits as well as:

- Track, by country, the overall impact on public health of the entire sodium reduction initiative; and
- Track the impact of specific elements- - including consumer education, awareness initiatives and voluntary industry reduction efforts - ensuring to capture reduction efforts that were well underway prior to the proposed baseline year, and changes over time of population consumption patterns.

5. Physical inactivity

Target: Annex 1 calls for a 10% relative reduction in prevalence of insufficiently physically active adults.

Indicator: We fully support the recommendation to include a target for the reduction of physical inactivity by 10%. However, the target and indicator proposed is for adults aged 18+ years. Interventions for the prevention and treatment of overweight and obesity, including childhood overweight and obesity, typically target increases in physical activity and reductions in physical inactivity and sedentary behaviour, together with science-based nutrition education and balanced diets. If we are to prevent and control NCDs, then we must begin by inspiring and encouraging positive, active healthy behaviour and habits early in life. We recommend the target and indicator be amended to ensure a continued focus on physical activity for all ages.

Target Setting: Raising awareness of the importance of balanced diets and increased levels of physical activity is one of the five commitments IFBA members made to WHO in May 2008. For many years, IFBA members have supported hundreds of initiatives around the world, at the global, regional, national and

[2] For more information on these and other initiatives on product reformulation, please visit the IFBA website at: https://www.ifballiance.org/commitment-1-product-composition-and-availability.html.

local level to promote balanced diets and physical activity in the marketplace, in the workplace and in communities. Examples of our efforts may be found on our website and in our public, annual progress reports, also available on our website. [3] We can also share our experiences and data we have that illustrate the impact of such programmes on increasing physical activity.

WHO recommended core indicators for NCD surveillance in the global monitoring framework

Table 2: "Core indicators for NCD surveillance" (pg. 10) presents the full set of indicators recommended by WHO for global monitoring of progress towards reducing NCDs, (summarized in Figure 1: "Indicators and for the for the global monitoring framework for NCDs." In addition to those selected for global target setting - mortality from NCDs, blood pressure/hypertension, tobacco smoking, dietary salt intake and physical inactivity, WHO has also recommended the consideration of policies: i) to eliminate partially hydrogenated vegetable oils (PHVO) in the food supply; and ii) to reduce the impact on children of marketing of foods high in saturated fats, trans-fatty acids, free sugars or salt.

Following is our perspective on each of these additional core indicators and a summary of the progress IFBA has made to date in these areas.

Re: Elimination of industrially produced trans-fat/partially hydrogenated vegetable oil from the food supply

As part of IFBA's 2008 commitment to reduce key ingredients of public health concern from our products, trans-fat has been virtually eliminated or significantly reduced in most products of IFBA members. Manufacturing processes have been designed which severely restrict the use of partially hydrogenated fats.

Re: Reduce impact on children of marketing of foods high in saturated and trans fats, sugar and salt

We agree with the recommendations outlined in the in the 2010 WHO *Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children* (WHO *Recommendations on Marketing)* which provides a flexible policy framework, including self-regulation.

In 2008, IFBA member companies voluntarily committed to change how and what they advertise to children under 12 years of age. 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. This is in line with the aims of the 2010 WHO *Recommendations on Marketing.* [4]

[3] IFBA website: https://www.ifballiance.org/. Please visit the Resources page for our annual progress reports and other information and publications at: https://www.ifballiance.org/resources.html
[4] IFBA's Global Policy on Advertising and Marketing Communications to Children is available at : https://www.ifballiance.org/commitment-3-responsible-marketing-advertising-children.html

The voluntary actions by IFBA companies help drive change in the marketplace. For the third year running, compliance monitoring data shows a very high rate of compliance with the global policy. In 2011, third-party monitor, Accenture Media Management (Accenture) reported a 97.6% compliance

rate for television advertising and 100 % for print and internet advertising in child-directed media. Accenture examined more than one million television advertisements on more than 1,200 channels over a three-month period in ten countries – Australia, Brazil, China (Guangzhou region), India, Mexico, New Zealand, Russia, South Africa, Thailand and the Ukraine. They also examined print and internet advertisements in seven of these countries – Australia, Brazil, China, India, New Zealand, Russia and South Africa. [5]

Impact monitoring data from Canada, the EU and the U.S.A demonstrate a major reduction in the exposure of children under 12 years of age to marketing communications for products high in fat, sugar and salt. For example, monitoring of television food advertising in the EU by companies participating in the EU Pledge, including IFBA members, over the past three years, confirms a downward trend in children's exposure to television food advertising since 2009. Monitoring by Accenture PriceWaterhouse Coopers and BDRC Continental reports:

- -79% in 2011 in children's exposure to advertising for products that do not fulfil better-for-you criteria (through children's programmes defined as more than 50% of the audience being under the age of 12 years). Over all markets monitored in the past three years, the average is -85%.
- -29% in 2011 in children's exposure to advertising for products that do not fulfil companies' better-for-you criteria in all programmes. Over all markets monitored in the past three years, the average is -48%.
- -21% overall reduction in children's exposure to advertising for all EU Pledge member companies' products (regardless of nutritional criteria). Over all markets monitored in the past three years, the average is -29%. [6]

In Canada, Advertising Standards Canada (ASC) in 2009 undertook a comparative study of children's advertising pre-introduction of the Canadian Children's Food and Beverage Advertising Initiative (CAI) and post its inception to better understand how the landscape of advertising to children under 12 has changed. In 2004, only 63% of food and beverage products advertised were better-for-you products. By contrast, in 2008, more than 95% of food and beverage products advertising to children under 12 were for better-for-you products. [7] In 2010, ASC conducted a spot check of television advertising, monitoring 12 days of child-directed television advertising over four Canadian channels that broadcast programming specifically directed to the under 12 years of age audience. Of the television advertising for food and beverage products, almost 80% was for products covered under the CAI, and almost 80% of

[5] Accenture. *2011 Compliance Monitoring Report for the International Food & Beverage Alliance on Global Advertising on Television, Print and Internet* (March 2012) is available at: https://www.ifballiance.org/sites/default/files/IFBA%20Accenture%20Monitoring%20Report%202011%20FINAL%20010312.pdf
[6] http://eu-pledge.eoincolley.com/sites/eu-pledge.eu/files/reports/EU_Pledge_2011_Monitoring_Report.pdf, 15-16
[7] http://www.adstandards.com/en/childrensinitiative/2010ComplianceReport.pdf, 27-28

these products were either a source of a nutrient or part of a food group that has been identified by Health Canada as one to be encouraged in Canadian children's diets, such as fibre, whole grains or dairy products. [8]

In the U.S., according to the December 2010 report issued by the Council of Better Business Bureaus on the Children's Food and Beverage Advertising Initiative for 2009, the nutrition profile of products shown in child-directed advertising continued to improve through product reformulation and innovation. A review of children's programming in 2010 found that advertised products contribute important nutrient shortfalls (potassium, fibre, calcium, magnesium and vitamin E) or food groups to encourage in children's diets. For example, more than 75% of child-directed food advertising was for products providing at least 10% of the Daily Value (DV) of one shortfall nutrient, or a half-serving of a food group to encourage. [9]

19 April 2012

[8] http://www.adstandards.com/en/childrensinitiative/2010ComplianceReport.pdf, i-ii
[9] http://www.bbb.org/us/storage/16/documents/cfbai/cfbai-2010-progress-report.pdf, 9-10