Response from Dr João Breda, Programme Manager Nutrition, Physical Activity and Obesity, WHO Regional Office for Europe to Keith Taylor, MEP regarding proposed EU Delegated Acts.

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Comments on the potential health impact arising from key elements of the delegated acts on infant and baby foods

There are concerns regarding the potential negative health effects of commercially available foods for infants and young children < 2 years of age (WHO STAG, 2013), notably through:

- The undermining of exclusive breastfeeding for the first six months of life and the replacement of, rather than complementing, intake of breast milk in children beyond six months
- An increased risk of childhood obesity or risk factors relating to cardiovascular diseases, diabetes and cancer due to excess intake of energy, free sugars, salt and/or fat
- The reinforcement of sweet or salty taste preferences leading to the development of undesirable and unhealthy preferences and dietary habits in early childhood.

Depending on their nutritional composition, commercially available foods and follow-on formulas for infants and young children may be nutritionally less adequate when compared to the optimal nutrition provided through continued breastfeeding and the timely introduction of home-prepared complementary foods:

- The vast majority of commercially available foods for infants and young children have excess calories, with too much sugar and salt.
- While the types of commercially available foods on the market may be highly heterogeneous in terms of nutritional composition, evidence does suggest that when comparing the composition of many of these foods to a standard – such as the WHO guidelines on sugar intake for adults and children – a high percentage of foods are found to be too high in added sugar (and salt) (Cogswell, 2015; Garcia, 2013).
- A large proportion of commercial "baby dinners" and the majority of cereal bars/breakfast pastries, fruit, and infant/toddler snacks, desserts, and juices contain added sugar and are often more energy dense than comparable home-prepared family foods and are no healthier than their counterpart products aimed at adults (Cogswell, 2015; Garcia, 2013; Elliot 2015; Elliot 2011).
- WHO has issued guidelines recommending a reduction in intake of free sugars throughout the lifecourse. In both adults and children, WHO recommends that intake of free sugars should not exceed 10% of total energy intake (strong recommendation). WHO also suggests that a further reduction of the intake of free sugars to below 5% of total energy intake would have additional health benefits.
- The current threshold in the delegated act, setting a limit of 30% of total energy content in baby foods from sugars, is thus tremendously high and tighter limits on permissible levels of sugar are needed. Indeed, WHO has stated that sugar and salt should not be added to complementary foods (WHO, 2015).

- Sensory experiences, beginning early in life, can shape preferences. Infants and children learn to prefer unique taste profiles of foods to which they are exposed. Promoting breastfeeding and providing appropriate complementary foods for infants and young children that are low in sugars and salt is important to protect the developing child from excess intake later in life, thus preventing obesity and diabetes (Mennella et al, 2014; Birch et al, 1999).
- WHO also maintains that breast milk remains the most appropriate liquid part of a progressively diversified diet for the vast majority of children between 6 and 24 months of age, once complementary feeding has begun. The practice being introduced in some countries of providing infants with specially formulated milks (or 'follow-up milks') is not necessary (WHO, 1986). For those children who, for various reasons, are not breastfed, or for whom breastfeeding will stop before the recommended duration, acceptable milk sources exist.

Commercial foods for infants and young children may also be marketed inappropriately in a way has (i) direct effects on the nutritional status of infants and young children aged 6-23 months, and (ii) indirect spillover effects on infants under the age of 6 months:

- Studies strongly suggest a direct correlation between marketing strategies for follow-up formulae, and perception and subsequent use of these products as breast-milk substitutes (Cattaneo et al, 2014).
- Where advertising baby formula is prohibited, there is intensive marketing of follow-on formulas as "weaning milks", a distinction many mothers do not understand. In many instances, the packaging, branding and labelling of follow-up formula closely resembles that of infant formula often making it difficult to distinguish between products. A shift away from marketing of breastmilk substitutes may be observed but there is a simultaneous increase in marketing for follow-on formula with a greater emphasis on the brand and common logos, which is often interpreted by mothers as marketing for breast milk substitutes (Dickinson et al, 2013).
- One of the consistent findings of review exercises looking at the effects of marketing is that it operates at the brand level, in addition to product and category level. Much marketing is carried out with the aim of building brand awareness/recognition and brand loyalty (Cairns et al, 2013; Hastings et al, 2006). In sum, when marketing follow-on formula, companies may also effectively promote breast milk substitutes.
- Techniques used to build the brand-consumer relationship include the use of brand marketing alone (e.g. use of common logos and messages, which may cut across products and product categories). It has been shown that brand preference often precedes purchase or purchase requests, and that brand marketing has the ability to influence purchase and preference for products not necessarily featured in the marketing.
- This may result in its early introduction, thereby undermining exclusive breastfeeding up to six months of age and sustained breastfeeding up to two years or beyond.

- If follow-up formula is marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement for breast milk, it is covered by the International Code on the Marketing of Breast Milk Substitutes (WHO, 2013).
- In addition, where follow-up formula is otherwise represented in a manner which results in such product being perceived or used as a partial or total replacement for breast milk, such product also falls within the scope of the International Code (WHO, 2013).
- Similarly, according to guidance from WHO and the Food and Agriculture Organization, via Codex Alimentarius, there is no exemption regarding the use of claims on follow-on formula (Codex Alimentarius,1997).

Breastfeeding is the best option for infant feeding. It ensures the best trajectory for growth and development, while preventing noncommunicable diseases later in life; it should be exclusive during the first six months of life. It is therefore considered one of the most critical elements health promotion and protection – the best start in life.

Breastfeeding practices within the WHO European Region, especially exclusive breastfeeding rates, are far from complying with the WHO recommendations. The Region has the lowest breastfeeding rates of all the WHO regions. In 2006–2012, only an estimated 25 % of infants were exclusively breastfed for the first six months in the WHO European Region as compared with 43 % in the WHO South-East Asia Region.

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