

Health professional associations and industry funding

The UK Royal College of Paediatrics and Child Health (RCPCH) announced in October, 2016, its decision to continue to accept funding from manufacturers of breast milk substitutes (BMS).¹ This decision raises serious concerns about the college's impartiality and sets a harmful precedent for other health professional organisations. In order to protect the credibility and the authority of professional organisations that contribute to the formulation of public policy, they need to adopt codes of conduct and practices that protect their independence from vested interests.

The RCPCH decision contravenes the spirit and aim of the International Code of Marketing of Breast-milk Substitutes (also known as the International Code), adopted by the World Health Assembly (WHA) in resolution WHA34.22, and subsequent relevant WHA resolutions. Other resolutions include WHA69.9,² adopted in May, 2016, in which WHO's Member States welcomed the new WHO Guidance on Ending Inappropriate Promotion of Foods for Infants and Young Children (also known as the Guidance).

The RCPCH decision creates clear competing interests. The International Code (article 7.3) and associated resolutions (WHA49.15 and WHA58.32) prohibit the acceptance by health workers of financial or material inducements (including contributions to fellowships and research grants for health workers, as well as contributions toward their participation in study tours or attendance at professional conferences) and call for avoidance of conflicts of interests. Additionally, recommendation 6 of the Guidance unequivocally states "...health professional associations should not...accept equipment or services from companies that market foods

for infants and young children, accept gifts or incentives from such companies" or "allow such companies to sponsor meetings of health professionals and scientific meetings".³ The prohibition on acceptance of any funding or other services, gifts, and incentives is unconditional. As such, the RCPCH's decision is in direct violation of the Guidance.

The RCPCH states that it has safeguards in place and will conduct an internal due diligence process regarding potential donors.¹ Factors to be considered in assessing the acceptability of funding include the reputation and credibility of the donor, its product impact and reputation, as well as the extent to which the donor's corporate policies and practices are aligned with the goals, visions, and values of the RCPCH. The RCPCH also states that it supports the International Code. The due diligence process would therefore need to ensure compliance of potential donors with the International Code. However, we firmly believe that health professional associations are not in a position, nor are they qualified, to assess and determine which companies comply with international policy and guidance documents related to the International Code.

Acceptance of funding or other incentives, however conditional, creates a sense of obligation and loyalty to the company in question. This is exactly what health professional associations, including the RCPCH, should avoid. They have a moral obligation to protect themselves and their members from inappropriate promotion of BMS in all forms, however indirect, and from resulting competing interests in health-care settings. Furthermore, health professional associations have a moral obligation to respect and protect women's and children's rights to be free from all forms of inappropriate marketing practices.

Notably, the RCPCH sets an unfortunate precedent for other

national paediatric associations. WHO strongly encourages its Member States to support and abide by the International Code and WHA resolutions. We are acutely aware of and deeply concerned about the continued inappropriate promotion of BMS in health facilities, and the effect this has on breastfeeding practices and infant deaths. The 2016 *Lancet* Series on breastfeeding highlights that the BMS industry is likely to be worth upward of US\$70 billion by 2019.⁴ By contrast, improving breastfeeding practices would annually save the lives of 820 000 children under the age of five, prevent thousands of women dying of breast and ovarian cancer, cut rates of obesity and type 2 diabetes, and improve performance on intelligence tests in people who were breastfed.⁵ The role and responsibilities of health professional associations, both globally and nationally, are pivotal to worldwide efforts to stop health systems from being conduits for marketing of BMS, even inadvertently.

The RCPCH has forfeited an opportunity to be a standard bearer and champion for children and young people globally and to exemplify implementation of the WHO International Code and Guidance. Instead, RCPCH is sending a strong message to its members and others worldwide that benefitting from funding from BMS manufacturers is acceptable. Unless this decision is reversed, the statement by its president that the RCPCH supports "WHO Guidance...on the marketing of breast milk substitutes"⁶ and considers the promotion of BMS over breastfeeding unacceptable, is clearly misleading and contradictory.

The authors alone are responsible for the views expressed in this letter and they do not necessarily represent the views, decisions, or policies of WHO. We declare no competing interests.

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Dietary guidelines are not beyond criticism

Mann and colleagues (Aug 27, p 851)¹ claim that criticisms of the dietary guidelines are not evidence-based. However, even by their own account, the promotion of reduced-fat dairy products in existing guidelines is not evidence-based, in view of the lack of association of dairy fat with cardiovascular risk, and the strong protective associations that exist between ruminant fatty acids and type 2 diabetes.² This evidence contradicts the theory that the effect of dietary saturated fat on serum cholesterol is the cause of the association between serum cholesterol and cardiovascular disease.

Carbohydrate intolerance is increasing in developed and developing countries, as indicated by growing rates of diabetes, obesity, and metabolic syndrome, with the consequent expansion of

health costs. Evidence is emerging that a major nutritional cause of modern chronic disease is the glycaemic environment created by the interaction between insulin resistance and foods with a high glycaemic load (GL), increased consumption of which has been a natural consequence of advice to limit dietary fat.³

Mann and colleagues cited two meta-analyses,^{4,5} excluding weight loss trials, in which low-fat diets were only compared with low quality, high GL control diets. However, in view of the disappointing results in most trials in which a low-fat diet has been compared with alternative dietary interventions, the evidence is unclear on whether a fat-restricted bias in dietary advice is justified.⁶ Population dietary guidelines should be adapted to include advice on carbohydrate restriction, which is likely to be beneficial or protective for a large, but growing, proportion of people.

GH reports part-time wages from the Real Food Publishing Company, which distributes the What The Fat? series of diet and science books, providing evidence for the health benefits of an appropriately carbohydrate-restricted real food diet with recipes and lifestyle advice for following said diet. CZ and GS are co-authors of What The Fat? and What The Fat? Sports Performance, and receive royalties from these works.

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- 1 Mann J, Te Morenga L, Maclean R, et al. Dietary guidelines on trial: the charges are not evidence based. *Lancet* 2016; **388**: 851–53.
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Authors' reply

Henderson and colleagues have misinterpreted our Comment¹ and the totality of evidence on which it is based. The issue is not whether or not dietary guidelines are beyond criticism but rather whether the criticisms are justified. A substantial body of observational, clinical trial, and experimental evidence summarised in our Comment support the recommendation to reduce total saturated fatty acids and that they might be replaced with unsaturated vegetable oils. Suggestions that some sources of saturated fatty acids might not be associated with adverse health outcomes and that some trans unsaturated fatty acids could be associated with reduced diabetes risk should be a stimulus for further research to enable dietary guidelines to be refined in the future. At present these data do not negate advice to reduce total saturated fat.

Diabetes has been increasing in close parallel with increasing obesity rates and declining diet quality.² Agreement is widespread with regards to the need to limit free sugars and rapidly digested starches, which account for the increase in total carbohydrate intake in the USA. However, we are unaware of any deleterious effects of minimally processed wholegrains or fibre-rich intact vegetables (notably legumes and pulses) and fruits—which are protective against diabetes, useful in its management, and with additional benefits in terms of cardiovascular and gastrointestinal disease.³ We find the link proposed by Henderson and colleagues between “carbohydrate intolerance” and “diabetes, obesity, and metabolic syndrome” puzzling. Carbohydrate intolerance is characterised by abnormal carbohydrate digestion as in lactose intolerance, and