



Response from First Steps Nutrition Trust to the follow-up questions from the European Commission's Working Group meeting on health claims held 20th June 2016

July 26th 2016

Q1. What are your views on the use of health claims on foods for infants and young children? Should health claims not be authorised for such foods at all? Please bear in mind that any rejection decisions need to be justified. If you are supporting such rejection provide a justification that would be compatible with the rules of Regulation (EC) No 1924/2006.

We believe there should be no health claims allowed on foods marketed for infants and young children 0-3 years. Evidence shows that the use of health and nutrition claims is particularly widely used in the baby food category. In a recent study (Hieke *et al*, 2016) the use of health claims on packaged foods across 5 European countries was examined. Foods marketed for infants and young children had the highest number of health claims. We believe this can mislead consumers and is potentially detrimental to the health of infants and young children.

Regulation EC 1924/2006 paragraph (18) states '*Given the positive image conferred on foods bearing nutrition and health claims and the potential impact these foods may have on dietary habits and overall nutrient intakes the consumer should be able to evaluate their global nutritional quality, therefore nutrition labelling should be complementary and should be extensive on all foods bearing health claims*'.

In a recent review of wet/processed baby food meals in jars and pouches on the UK market by the four main manufacturers (report in press, First Steps Nutrition Steps) no extensive nutrition labelling is given on any of the products (479 products were reviewed marketed from 4months+ to 9months+). However health claims are made for some nutrients and for some food components, without any explanation of the relevance of these in the diet or the fact that other nutrients that might be expected to be there are in very low amounts or even missing.

The composition of commercially prepared baby foods marketed in the UK have been examined by several authors. The existing evidence identifies key issues and concerns with manufactured baby foods, including the predominance of sweet, smooth foods, low energy density, and some evidence suggesting that commercial foods are lower in key nutrients such as protein, iron and B vitamins than homemade equivalents.

One of the key issues is the predominance of sweet baby foods and the impact this may have on infant and young child diets. Garcia *et al* (2013), collected nutritional information from infant foods available on the UK market from Cow & Gate, Heinz, Hipp, Ella's Kitchen, Boots and Organix. Of the

479 foods collected they found that 364 (79%) were ready-made (wet) spoonable foods. Just under a half (223) of foods in the study were sweet foods, with 80% including fruit in the name, around a third of these products were a fruit only sweet food, however, for the rest of the sweet fruit products the amount of fruit included was not clearly stated. Around a half (44%) were aimed at infants from 4 months of age and almost two thirds (65%) of foods aimed at this age group were sweet foods. Table 1 shows the contribution of commercial baby foods to energy and macronutrients intakes in the latest Diet and Nutrition Survey of Children aged 6-18 months. Whilst commercial baby food contributed about 15% of energy in the first year of life, these foods provided between 25-44% of free sugars. These foods are therefore disproportionately high in sugar and health claims allowed for other ingredients may mask this. We believe allowing a health claims for another nutrient on a sweet baby food would not allow consumers to 'evaluate the global nutritional quality' of a food

Table 1: The reported contribution of commercial baby foods to energy and macronutrient intakes by age group in the Diet and Nutrition Survey of Children aged 6-18 months¹

% of total energy or nutrients provided by commercial baby foods	4-6 months	7-9 months	10-11months	12-18 months
Energy	16	17	14	6
Protein	19	20	15	5
Fat	8	10	8	4
CHO	20	21	17	8
Total sugars	13	15	12	6
Free sugars (non-milk extrinsic sugars)	44	34	25	11

As well as health claims potentially masking higher sugar foods, they may also mask foods of poorer nutritional quality. Zand et al (2012) looked into the amounts of riboflavin and pyridoxine in commercial infant meals. The authors analysed 8 different jars of meat and vegetable based baby foods from leading UK supermarkets and riboflavin was not found at a detectable level in any of the products. In addition to leaching and degradation via the heating process, this lack of riboflavin could be explained by its sensitivity to light while stored in glass jars. The amount of pyridoxine (vitamin B6) detected in the meat and vegetable baby foods was 0.052 and 0.056mg/100g respectively, which can be compared with an RNI for infants for pyridoxine of 0.2-0.4mg/day. Zand et al (2011, 2012a, 2012c) carried out a series of investigations on eight popular manufactured baby foods. Once the foods were analysed, the authors constructed the foods (along with formula milk) into a representative daily diet for an infant. They found that the daily intake of a number of micronutrients including, iron, zinc, calcium magnesium, selenium and B vitamins riboflavin and

¹ <https://www.gov.uk/government/publications/diet-and-nutrition-survey-of-infants-and-young-children-2011>

pyridoxine, fell below daily recommended intakes when compared to the requirement of a 6 – 9 month old infant.

A food may make a claim for 'iron' or 'omega-3 fats' or 'portions of fruit or vegetable' but often these additions may be relatively small and other nutrients which would be present in a home-made equivalent may be totally missing. We believe therefore that as per para (17), in contradiction of EC regulation 1924/2006, that this may '*encourage or condone excessive consumption of a food or disparage good dietary practice*'.

Claims are made for products containing omega-3 fats, but the amounts are often negligible as this simply comes from the rapeseed oil used in manufacture. Suggesting a health benefit through a claim on what might be a nutritionally inferior product cannot be seen as being in line with the principles of regulation (EC) 1924/2006.

In the UK some baby food makes a claim based on their own recommended amount of a nutrient, even though this is not a recommendation made by public health authorities and may refer to a version of a nutrient for which health benefits are not usually made. e.g.

'There is x% of Cow & Gate's recommended daily Omega-3 intake (6-8 months) per jar (0.12g/100g).'

A product may make a claim '*contains 60% of reference value vitamin C*' but contain 50% of energy from sugar or '*contains 28% reference value for thiamin*' and contain 1/3 energy from sugar and potentially little riboflavin for example.

The legislation para (10) suggested that '*the application of nutrient profiles as a criterion would aim to avoid a situation where nutrition or health claims mask the overall nutritional status of a food product which could mislead consumers when trying to make health choices in the context of a balanced diet.*' This however has not happened. Companies often make statements such as

"Nutritionally tailored for every age and stage, our milks and foods are made to support your little one's development"

"Perfectly balanced for growing babies"

But these have no meaning as we have no nutritional profiles for products to explain what this might mean. In fact when menus suggested by baby food companies including their products are analysed, we have found that they do not meet the energy and nutrient needs of the group and could lead to excessive amounts of energy and sugars, and too few of some other nutrients.

Companies often make statements on products which are misleading – for example that a baby food contains '5 vegetables' – when asked what this meant, one company responded:

"We acknowledge that only small amounts of some vegetables may be used and we are not making the claim that each vegetable variety constitutes a portion. This statement indicates the total number of vegetables included within the product, irrespective of the amount used."

Q2. What are your views concerning the possibility of not authorising at all health claims on nutrients whose presence is required by legislation (i.e. minimum amount)? Please explain the rationale for your answer.

We do not believe there should be any health claims on foods for infants and young children, but where there is a mandatory addition this should never be used as a health claim since it will be in all products.

Q3. Alternatively what do you think of the possibility of authorising the claims on such substances with a wording that clarifies that “all [category of foods] contain X. X contributes to Y”? Evidently conditions of use for the claim would refer back to the compositional requirements laid down in the respective pieces of legislation.

We do not need health claims on foods for infants and young children and where an ingredient is mandatory then no health claim should be made.

Q4. Should health claims be authorised on nutrients whose presence is not required by legislation, how would you then set conditions of use?

Paragraph (17) of EC 1924/2006 states that ‘A nutrition or health claim should not be made if it is inconsistent with generally accepted nutrition and health principles or if it encourages or condones excessive consumption of any food or disparages good dietary practice.’ There should therefore be no health claims allowed for nutrients whose presence is not required by legislation, as, as detailed in the response to Q1 this can lead to consumers being misled.

Q5. What are your views on the use of health claims on non-regulated products for infants and young children (i.e. food supplements, young child formulae)? Should health claims not be authorised for such foods at all? Please bear in mind that rejection decisions need to be justified. If you are supporting such rejection please provide a justification that would be compatible with the rules of regulation (EC) No 1924/2006.

Young child formula should not carry health claims as this undermines current UK public health. In recent years there has been a proliferation in the production and marketing of fortified milks for children over the age of 1 year. Despite recommendations that children from 12 months onwards should have the majority of their nutrients from a diverse local diet, alongside continued breastfeeding or the consumption of whole (full-fat) animal milk, these products have created a new market. The marketing of these milks frequently exploit parental concerns about child

nutrition, and the marketing of fortified milks by the same companies that produce infant formula allows cross-promotion and brand extension. The recent WHA resolution 69.9² makes clear that these products should be covered by marketing restrictions as they are breastmilk substitutes.

The Scientific Advisory Committee on Nutrition in the UK have also recommended that average population intakes of 'free sugars' should not exceed 5% of energy for age groups from 2 years upwards (SACN, 2015). High sugar intakes are discouraged in the diets of all toddlers who require nutrient dense diets and it is recommended that added sugars are kept to a minimum (NHS Choices, 2016).

Fortified milks can undermine good nutrition in young children since they are almost universally higher in sugar than a plain animal milk or unsweetened milk alternative and many are flavoured. The use of the words 'growing-up' milk in the names of some products could be construed as a health claim, and as per paragraph (3) in EC regulation 1924/2006 if a claim is made in the name this should be accompanied by a related nutrition or health claim which complies with the regulation. The potential contribution of higher-calorie, energy-dense milk products to overweight and obesity in children has been suggested (Brand-Miller et al, 2013). Plain animal milk has a composition which may be protective against the development of insulin resistance and chronic disease (Pereira et al, 2002) and therefore if alternatives to this increase risk of chronic disease, this is of concern to public health. The consumption of easily absorbed sugars can stimulate excessive postprandial hypoglycaemia and insulinaemia, which may be linked to risks of obesity, type 2 diabetes and coronary heart disease (Brand-Miller et al, 2013). Measurement of metabolic responses to consumption of a range of fortified milks with added sugars has reported that some of the milks sampled had a glycaemic index that was similar to consuming a sugar-sweetened soft drink (Brand-Miller et al, 2013). (The glycaemic index indicates how quickly the body produces insulin in response to a sugar load.)

Although the evidence is not clear, it has also been suggested that repeated exposure to sweet, flavoured drinks in infancy and toddlerhood might contribute to the development of oral health problems and a preference for sweet drinks in later life. The health risks associated with regular consumption of fortified sweetened milk products by young children could therefore be significant.

The European Food Safety Agency (EFSA) state in their report in October 2013³:

"No unique role of young-child formulae with respect to the provision of critical nutrients in the diet of infants and young children living in Europe can be identified, so that they cannot be considered as a necessity to satisfy the nutritional requirements of young children"

² http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_ACONF7Rev1-en.pdf.

³ European Food Safety Authority (2013) Scientific Opinion on nutrient requirements and dietary intakes of infants and young children in the European Union. The *EFSA Journal* 11(10):3408 [103 pp.]. DOI: 10.2903/j.efsa.2013.3408 Accessed from: <http://www.efsa.europa.eu/en/efsajournal/pub/3408>

In 2016 the German Federal Institute for Risk Assessment (BfR) clearly stated that fortified milks for children over 1 year are superfluous in a balanced diet for young children, offer no nutritional advantage, and there may be potential risk from an 'uncontrolled increase' in the intake of some nutrients (BfR, 2016). This statement also points out that manufacturers' of fortified milks for toddlers frequently refer to high consumption levels on the product packaging which could lead to high intakes of both macro and micronutrients. This is in contravention of regulation EC 1924/2006 where paragraph (10) states that '*... (should) aim to avoid nutrition or health claims that mask the overall nutritional status of a food product*'

We have shown that fortified milks for young children have a poorer nutritional profile than whole animal milk in respect of some nutrients (data sent previously to Department of Health) and para (9) in regulation EC1924/2006 states that '*foods promoted with claims may be perceived by consumers as having a nutritional, physiological or other health advantage over similar or other products to which such nutrients and other substances are not added. This may encourage consumers to make choices which directly influence their total intake of individual nutrients or other substances in a way which would run counter to scientific advice.*'

Q6. Should you consider that such health claims should be authorised how would you then set conditions of use?.

Health claims on foods and drinks for infants and young children are likely to mislead and we do not believe that, as per regulation EC 1924/2006 para (17) that '*a nutrition or health claim should not be made if it is inconsistent with generally accepted nutrition and health principles or if it encourages or condones excessive consumption of any food or disparages good dietary practice.*' Much of the evidence on products marketed to infants and young children which carry health claims may in fact not encourage good dietary practice and goes against public health guidance. Without any nutrient profiling to consider energy and nutrient content and contributions holistically in light of national and global guidance, health claims will undermine this regulation.

Q7. Do you have specific comments you want to make on nutrition claims for foods for infants and young children (6m to 3y)?

Public health guidance on the introduction of foods to infants and young children does not just detail '*what*' food should be given but also '*how*' that food should be given. The importance of food in infant and young child development, and in encouraging good lifetime dietary habits, is well established, and therefore it is important to also consider issues such as food texture and how food might be served when baby foods are marketed.

Many baby foods have a low energy density, and this is often the case when foods are sold in pouches. In our study (in press) on average, the foods aimed at infants aged 9, 10 and 12 months + had very low energy density at 0.69kcal -0.74kcal/g. The low energy density of commercial baby foods in pouches is primarily due to the water content of the products. In order to be squeezed through the opening of a pouch the food has to be smooth, hence water is often a main ingredient in these foods. Food packaged in jars also have a relatively high water content. Infants and young children are discouraged from sucking foods from pouches, yet manufacturers often show pictures of infants and young children doing this. This can damage oral health, dissociates the child from the food type and goes against our complementary feeding guidance. We also encourage the development of chewing and texture in infant foods, and soft foods marketed for older infants contradict this guidance. Allowing health claims on baby foods which are typically sweet and smooth for younger infants and excessively smooth for older infants and young children does not meet our general public health guidance for this age group contravenes the regulation principle (17) *'a nutrition or health claim should not be made if it is inconsistent with generally accepted nutrition and health principles or if it encourages or condones excessive consumption of any food or disparages good dietary practice.'*

Many of the foods marketed for older infants and young children as snack foods make nutrient or health claims, but may contain high amounts of sugar. For example, Heinz Biscotti make a nutrient claim *'Made with baby grade ingredients and with added Thiamin (vitamin B1)'* but this product also has 25% of its energy from sugar. With current concerns about childhood obesity, the use of nutrition and health claims on products which are not encouraged in the diets of young children should be avoided.

A study from the US showed how common front of pack nutrition related claims on children's cereals mislead consumers, with consumers inferring from the claims that the products presented were more nutritious than other products, even when they had lower overall nutritional quality. This study also showed that consumers interpreted the claims more broadly than their literal interpretation in terms of health benefits (Harris et al, 2011).

Q8. Delegated Regulation (EU) 2016/128 on foods for special medical purposes (FSMPs) shall enter into application in 2019/2020 and ban all nutrition and health claims on FSMPs. Do you agree that, taking this into account, no health claims should be authorised on FSMPs for infants and young children in the meantime to ensure consistency?

In the study by Hieke et al (2016) looking at health claims on foods in Europe, foods for special medical purposes was the group of foods with the highest proportion of nutrition, health and symbolic claims (78%, 71% and 24% respectively). The highest number of claims for a single product were also found on baby foods. We believe that the use of claims on these products misleads consumers and that no health claims should be authorised.

References

Bundesinstitut für Risikobewertung (BfR) (2016) *Toddler milk drinks are not better than cows' milk*.

Statement available at:

http://www.bfr.bund.de/en/press_information/2011/29/toddler_milk_drinks_are_not_better_than_cow_milk-126749.html

Brand-Miller J, Atkinson F, Rowan A (2013). Effect of added carbohydrates on glycemic and insulin responses to children's milk products. *Nutrients*, **5**, 2-31.

Garcia, A. L., Raza, S., Parrett, A., & Wright, C. M. (2013). Nutritional content of infant commercial weaning foods in the UK. *Archives of Disease in Childhood*, **98**, 793–797.

Garcia, A. L., McLean K, & Wright, C. M. (2015). Types of fruits and vegetables used in commercial infant foods and their contribution to sugar content. *Maternal and Child Nutrition*. Online: DOI: 10.1111/mcn.12208

Harris JL, Thompson JM, Schwartz MB, Brownell KD (2011). Nutrition related claims on childrens' cereals: what do they mean to parents and do they influence willingness to buy? *Public Health Nutrition*, **14**, 2207-2212.

HiekeS, Kuljanic N, Pravst I et al (2016) Prevalence of nutrition and health-related claims on pre-packaged foods: A five country study in Europe. *Nutrients*, **8**, 137-153.

Pereira MA, Jacobs D, van Horn L, et al (2002). Dairy consumption, obesity and the insulin resistance syndrome in young adults. *Journal of the American Medical Association*, **287**, 2081-2089.

Scientific Advisory Committee on Nutrition (2015) *Carbohydrates and Health*. [pdf] London: The Stationery Office. Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445503/SACN_Carbohydrates_and_Health.pdf

Zand, N., Chowdhry, B. Z., Zotor, F. B., Wray, D. S., Amuna, P. & Pullen, F. S. (2011). Essential and trace elements content of commercial infant foods in the UK. *Food Chemistry*, **128**, 1, 123-128.

Zand, N., Chowdhry, B. Z., Pollard, L. V., Pullen, F. S., Snowden, M. J., & Zotor, F. B. (2012a). Commercial 'ready-to-feed' infant foods in the UK: macro-nutrient content and composition. *Maternal & Child Nutrition*, **11**, 2, 202-214.

Zand, N., Chowdhry, B. Z., Wray, D. S., Pullen, F. S. & Snowden, M. J. (2012b). Elemental content of commercial "ready-to-feed" poultry and fish based infant foods in the UK. *Food Chemistry*, **135**, 4, 2796-2801.

Zand N, Chowdhry BZ, Pullen FS, Snowden MJ, Tetteh J (2012c). Simultaneous determination of riboflavin and pyridoxine by UHPLC/LC–MS in UK commercial infant meal food products. *Food Chemistry* **135** (2012) 2743 – 2749.