International Association of Consumer Food Organizations (IACFO)
Association Internationale des Organisations de Consommateurs De Produits Alimentaires
Asociación Internacional de Organizaciones de Alimentos para el Consumidor
Internationaler Verband der Nahrungsmittel Organisationen fuer Verbraucher
Associazione Internazionale delle Organizzazioni degli Alimentari per il Consumatore
食品国際消費者機構

June 15, 2011

His Excellency Dr. Joseph Deiss, President of the UN General Assembly,
Ambassador Sylvie Lucas, Permanent Representative of Luxembourg, and
Ambassador Raymond Wolfe, Permanent Representative of Jamaica
United Nations
New York, N.Y. 10017

Re: Considerations for the "Outcomes Document" for the September 19-20, 2011 UN High Level Summit on the Prevention and Control of Non-Communicable Diseases (NCDs), and the NGO Hearing on NCDs on June 16, 2011

Dear Dr. Deiss, Mme. Lucas, and Mr. Wolfe:

I am writing on behalf of the International Association of Consumer Food Organizations (IACFO)[1] to urge you to lead the development of an Outcomes Document that promotes and enables national governments to take effective measures to curb the enormous burden of nutrition-related cancers, cardiovascular diseases. IACFO's nearly 2 million members help the members of our growing association of non-profit, non-commercial organizations to press for improved food- and nutrition-related public laws and company practices on five continents. One of our members, the Centre for Science in the Public Interest (CSPI), publishes the world's largest-circulation health newsletter—*Nutrition Action Healthletter*—with nearly 1 million subscribers globally, mainly in North America.

IACFO's international nutrition policy reform advocacy

Since 1997, IACFO and its member organizations have participated in food standard-setting committees of the Codex Alimentarius Commission as an officially recognized observer. In 2005, we urged the World Health Organization to persuade the United Nations to convene a high level summit to encourage implementation of reforms to promote better diet and physical activity.[2] Some of our members use WHO scientific reports to inform our advice to national governments and to advocate the implementation of sensible, effective nutrition law reforms.

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Members: Center for Science in the Public Interest (CSPI), Washington, DC USA and Ottawa, Canada ■ The Japan Offspring Fund, Tokyo, Japan ■
■ The Food Commission, London, UK ■ Center for Social Responsibility, Singapore ■ Union for the Protection of Consumers' Rights, Armenia ■
■ Lingue pour la Defénse du Consmmateru, Benin ■ Pro Teste, Brazil ■ Voluntary Organization in Interest of Consumer Education (VOICE), New Delhi, India ■
■ Consumers Association of Penang, Penang, Malaysia ■ Consumer Education Trust (CONSENT), Kampala, Uganda ■
■ International Baby Food Action Network (IBFAN), Cambridge, UK ■ Zambia Consumers Association, Kitwe, Zambia ■

The food supply and burden of nutrition-related illnesses are enormous

It is now understood that the number of cancer, cardiovascular disease, and diabetes deaths attributable to poor nutrition rivals the number of deaths caused by tobacco consumption. According to health experts, cardiovascular disease, diabetes, and certain cancers caused by excess sodium intake, poor blood cholesterol and glucose levels, inadequate fruit and vegetable intake, and excess abdominal body fat are responsible for approximately one-fifth of all deaths globally,[3] or 14 million deaths annually.[4] Ten of the 19 leading causes of death are nutrition-related risk factors (see figure 1).[5] The human and economic costs of doing nothing to prevent nutrition-related diseases are enormous and born by everyone and all industry sectors, not just food companies.

While the total financial value of the food and beverage supply exceeds the value of the tobacco industry more than 8-fold—$3 trillion for food plus $1 trillion for beverages compared to nearly $500 billion for tobacco[6]—the food industry is uniquely complex, often with tens of thousands of nutritionally varying products available for sale in a single country distributed through channels that are increasingly national and international. Indeed, the sheer size of the food supply can make some impressive-sounding voluntary "achievements" seem more impressive than they truly are, such as the boast of removing 822 tons of salt from the food supply noted in the European Platform in 2008, a reduction of approximately 1/100th of one percent of current salt intake, at a time when 30%-50% multi-year reductions (i.e., more than 3,000-fold larger reductions) are needed.[7]

Nearly everyone depends on the nutritional quality the food supply, so it should attract at least as much authoritative policy guidance in public international law to mitigate the NCD disease risk as harm caused by tobacco and breast milk substitutes. The policy recommendations in a 2009 World Cancer Research Fund report are based on the review of more than 7,000 scientific studies concerning the relationship between cancer and diet, alcohol, and physical activity. [8] Likewise, the WHO's G*lobal Strategy on Diet, Physical Activity and Health,*[9] adopted by the World health Assembly in 2004, though encouraging, lacks the specificity and legal stature of a WHO convention.

The role of clinical services in preventing nutrition-related disease

Much health care usage is both a symptom of the failure of disease prevention, and a potentially important mechanism for identifying the manifestation of nutrition-related and other NCD health risks, which often do not have physical manifestations that are apparent to the patient (e.g., blood cholesterol levels, sodium-related hypertension, etc.). While universal and regular access to qualified medical services is essential, many health, labour productivity, and public finance benefits can be achieved by preventing disease onset in the first place using policies that are generally developed and implemented outside of traditional government health departments, especially in departments responsible for sales taxes, food labelling, education, government procurement, occupational health, and economic development. The OECD and others have verified that such "upstream" interventions are often substantially more cost-effective than downstream interventions.[10]

The need for authoritative health promoting nutrition law guidance in a World Trade Organization regime dominated by a harmonization-oriented Codex Alimentarius Commission

The need for international guidance in establishing national food statutes and regulations led to the formation of the Codex Alimentarius Commission in the early 1960s. The legal importance of Codex standards was reinforced in the 1990s by the creation of the World Trade Organization and its subsequent trade dispute resolution decisions. However, Codex standards have had the practical effect of putting an upper limit on the amount of consumer protection measures that may be adopted by national authorities[11] (by, for example, long remaining silent on the validity of mandatory back-of-pack (or front-of-pack) nutrition labelling. Codex standards have also long authorized national laws that may promote poor health by, for example, authorizing national laws allowing low saturated fat claims on high-sodium foods.

The United Nations Summit "outcomes document" should support national governments' efforts to initiate nutrition-related law reform measures to curb NCDs that are based on the best available evidence, the best laws, and sensible innovative approaches. Imperfections in the evidence base or the lack of identical policy precedents should not stymie or stall innovation in prevention policies. Currently, government worries about enacting strong health protection measures that exceed Codex standards and food companies' persistence in using any lawful food marketing practices regardless of the net effect on public health have created a food marketing environment that favours product sales at the expense of nutrition status and population health.

Codex standards have become, for national law-makers, a safe harbour against trade dispute challenges. Codex standards can become an important vehicle for consolidating widely accepted nutrition policies. However, the custom has been for Codex to defer developing global standards until a critical mass of national standards have been enacted. The Codex methodology is well-suited to codifying the main elements of national laws that dominate globally, years, sometimes decades after those laws emerge. For example, the Codex Food Labelling Committee's decision earlier this year to *begin* the multi-year process of establishing a global standard for mandatory back-of-pack nutrition labelling was made 21 years after the U.S. Congress passed the *Nutrition Labelling and Education Act.* It seems unlikely that the much more visible and useful mandatory *front*-of-pack labelling will be promoted by that Codex standard, at least without binding guidance to Codex from the U.N.

National governments seeking to employ legal and fiscal measures to curb diet-related diseases lack the detailed and authoritative guidance that is now available to support government efforts to promote breastfeeding and to discourage tobacco use, namely, the World Health Organization's *International Code of Marketing of Breast-Milk Substitutes* and the *Framework Convention on Tobacco Control*. Policy guidance from the United Nations is needed to help encourage national authorities to take effective measures to minimize the adverse health, economic, and development burdens of dietary and food related non-communicable diseases and promote good health generally.

National governments' policy-makers should take proactive measures to conserve human lives. The costs of doing nothing are large and borne by all of society and all industry sectors—not just (some parts of) the food sector—and inaction chiefly favours shorter lives and the profit aspirations of tobacco companies, alcohol companies, and some quarters of the food industry, whose products drive higher rates of disease. As the World

Bank recently noted, "the cost-effective interventions that address CVD, tobacco use, alcohol abuse, consumption of unhealthy fats, and excessive salt intake are now comparatively well understood."[12] Obesity-related policy interventions have been reviewed by the Organization for Economic Cooperation and Development (OECD),[13] and the World Economic Forum has recognized the importance of addressing the threat of NCDs.[14]

Without decisive action by the United Nations in September to establish new authoritative health-focused international technical guidance for national nutrition standards, the Codex/WTO process may continue to hobble or stall national regulatory efforts to improve nutrition status and public health.

Conflicts of interest

Food companies are designed and, in most cases, legally obliged to pursue profits using all lawful means. Concern about commercial motives undermining health is the chief justification for WHO-originated public international law governing breast milk substitutes and tobacco products. Objective dietary advice calls for a measured balance of fruits, vegetables, whole grains, and sources of protein (and minimizing added salt, unhealthful fats, and sugars), the balance of which generally differs sharply from the quarters of the food industry that have the highest motivation and resources to influence public policies.

Furthermore, even companies (and industry associations) that promote "disease protective" foods (like fruits, whole grain bread, and seafood) as well as "disease causative" foods (like sugary jams, salty white bread, and fatty ground beef) making their interests incongruous with public health nutrition. We urge you to recognize the importance of ensuring that no companies or industry associations acquire privileged opportunities to advance their member's commercial interests in policy advising roles. Transparency is an inadequate tool for correcting such conflicts of interest, especially when it is possible for conflicted advisors to obstruct consensus in advisory or standard-setting functions.

Even the World Trade Organization requires that standard setting bodies demonstrate "transparency, openness, impartiality and consensus, effectiveness and relevance, and coherence."[15]

Key elements of a successful nutrition-related chronic disease prevention strategy

We urge that Summit "outcomes document" reflect the following food- and nutrition-related priorities to ensure that:

- Government policies respecting the formulation of processed foods for products like bread, cheese, fruit preserves, and pickles (so-called "identity" or "commodity" standards) and other commercial food production practices allow and promote (or mandate):
    - Reductions in added sugar and salt,
    - Reduction in sugar in soft drinks;

    - Replacement of refined flours with whole grains,
    - Replacement of trans-fat-laden partially hydrogenated oils and animal fats with poly- and mono-unsaturated vegetable oils,
    - Minimization of the use of nitrite additives and synthetic dyes, and
    - Increase in the use of non-starchy fruits and vegetables (the absence of which is sometimes masked by food claims and added colourings);
- Consumption taxes, pricing controls, and agri-food subsidies that sometimes promote consumption of what the WHO calls "disease causative" foods and discourage "disease protective" foods are realigned to promote healthy eating;
- Help develop further strategies to prevent and mitigate harmful effects of commodity price shocks, especially for nutritious foods;
- Government food procurement policies include sound nutrition standards to promote healthy eating (especially in schools, workplaces, and government sponsored sporting events);
- Food labelling, advertising, and school curriculum polices are reinforced to ensure that objective information predominates and that marketers do not take unfair advantage of the impressionability of children; and
- Medical education and clinical treatment that often stresses prevention counselling and other remedial measures until, e.g., *after* a heart attack, or the onset of Type II diabetes, where such treatment is available at all.

Conclusion

We applaud the leadership of the WHO and the United Nations for holding this summit and encourage their continued work to support the adoption by all countries of nutrition-enhancing public health policies and to ensure that those efforts are not undermined by commercial conflicts of interest. Indeed, WHO's efforts to prevent commercial conflicts of interest are central features of its *Framework Convention on Tobacco Control*, and *International Code of Marketing of Breast-milk Substitutes,* as they should be for international food standards concerning the prevention of nutrition-related NCDs.

We very much look forward to supporting the important work of the United Nations High Level Summit in September and, to the extent that resources permit, to championing nutrition-related policy reforms in our members' countries with the support of United Nations institutions.

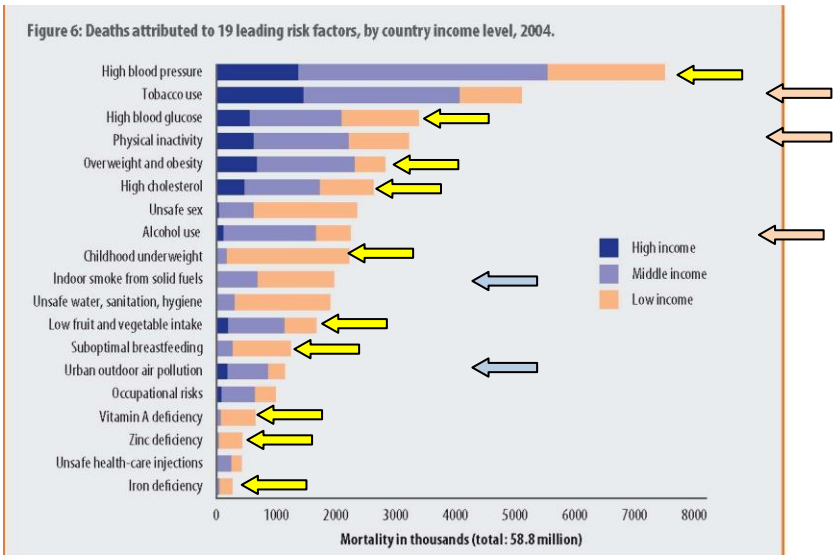
Respectfully submitted,

Bill Jeffery, LLB
International Association of Consumer Food Organizations (IACFO)
c/o Canadian Regional Office
Centre for Science in the Public Interest, Ottawa, Canada

cc. Dr. Margaret Chan, Director General of World Health Organization

Hi Excellency, Mr. Ban Ki-moon, Secretary-General, United Nations

Figure 1



Prevention and Control Mechanisms

Driver / Environment	**Breastfeeding and the *International Code on Marketing of Breast Milk Substitutes*** [16]	**Food & Non-Alcoholic Beverages**	**Tobacco consumption and the *Framework Convention on Tobacco Control***
Economic: Value added tax, other excise taxes, subsidies	• ICMBS Article 5: No free samples, discount coupons, loss leaders, gifts of utensils. • Subsidize and remove taxes from medically necessary breast milk substitutes only.	• Shift taxes from "disease risk protective" foods and beverages to "disease risk causative" ones; [17] • Shift subsidies toward nutritious fare	• FCTC Article 6 encourages tax and price controls on tobacco products (and terminating duty-free policies). • FCTC Article 14(2d) supports access to affordable treatment of tobacco dependence including pharmaceutical products pursuant to Article 22 (in developing economies). • FCTC Article 15 supports mandating products marking to help track illicit products, monitor cross-border trade and share information with taxation and customs authorities to facilitate law enforcement.
Economic: Government Procurement	• Ensure adequate public subsidies to improve maternal nutrition for vulnerable populations.	• Establish binding science-based nutrition standards for foods purchased with public funds or distributed in government facilities for government purposes (e.g., schools, workplace, community, recreation and sporting events). • Provide public funds to subsidize nutritious foods for low income people, children, and high risk populations.	• Free or subsidized tobacco should not be provided by governments to workers or others under any circumstances.
Information: Disclosure on Consumer Product Labelling and to Government Databases	• ICMBS Article 9: Labels should inform about product use, risks, composition, superiority of breastfeeding, that the substitute should only be used on the advice of a health worker.	• Mandate disclosure of amounts of nutrients/ ingredients of highest public health importance on the Front-of-Pack of foods and detailed Nutrition Facts elsewhere following prescribed format. • Mandate calorie, sodium or other important nutrients on menus of large restaurant chains.[18]	• FCTC Article 10: Supports requiring manufacturers and importers to disclose to governmental authorities information about the contents and emissions of tobacco products. • FCTC Article 11: Supports mandating (by 2008) graphic, rotating warning labels re harmful effects on 50%+ of label, preventing misleading

			claims (including "light" and "mild"), and disclosure of constituents and emissions
Information: Advertising and other appeals to emotions	• ICMBS Article 4: governments must ensure that information about child feeding is accurate and promotes exclusive breastfeeding as superior for child nutrition, infection control, expense. • ICMBS Article 5: marketing personnel may not directly contact pregnant women, or mothers of infants or young children.	• Prohibit advertising to children (as Quebec, Sweden and Norway have done …*per se* manipulative. Such advertising aims to promote products by convincing those who will always believe.[19] or ads for foods (and restaurants) falling short of specific nutrition standards as the United Kingdom had done.[20] • Strengthen limits on misleading advertising.	• FCTC Article 13: Ban all domestic and cross-border tobacco ads, promotions, and sponsorships in TV, print, radio by 2008 and Internet and other media by 2010 and at a minimum, restrict ads or o require warnings in ads, o limits on misleading statements, a ban on financial incentives, o disclosure of expenditures on such promotions, and o cooperate in efforts to ban cross-border transmission of such advertising, promotion and promotion of international events.
Education, Community: Advice that is based on the best available evidence, w/o conflicts of interest by regulated industries	• ICMBS Article 8: Manufacturers may not "educate" pregnant women, or mothers of infants or young children. • Publicly fund lactation consultants as needed	• Establish food-based dietary guidance in a manner that is insulated from commercial conflicts of interest and promoted widely.	• FCTC Article 10: Mandate disclosure to the public of composition and emissions of tobacco products. • FTC Article 12: Launch public awareness program about addictiveness, health, environmental and economic impact of tobacco production and consumption.
Education: Health professionals	• Include evidence-based independent information in curriculum in family or sex education.	• Include independent food preparation, and nutrition education in curriculum, especially in secondary school	FCTC Article 12: Sensitization and awareness on tobacco control for health, community, social workers, and policy makers
Education: Children		• Include independent science-based nutrition and food preparation through-out K-12 curriculum, esp. in secondary school. • Establish school nourishment programs with strong nutrition standards,[21] substantial subsidies,[22] and integrated with healthy school policies (including nutrition and food preparation in the curriculum) contemplated by the WHO *School Policy Framework*[23]	FCTC Article 14 aims to ensure that Member States develop and implement effective programs for cessation at schools, and sporting events.
Child Protection			FCTC Article 16: No sales to minors, require retailers to post signs requiring age ID; prohibit tobacco theme candy or toys, limit access (or ban) to vending machines; ban on sales of small

			quantities of cigarettes. FCTC Article 16: Ban on free samples to children.
Physical: Reformulation and physical environment	• ICMBS Article 10: product quality is essential to protect the health of infants.	• Mandate/encourage reduction/elimination of: ○ sodium/salt to help mitigate the world's leading risk factor for death,[24] responsible for 4 million to 8.5 million deaths annually, [25] by a combination of mandatory sodium reduction measures[26] and/or structured voluntary reductions coupled with other regulatory measures;[27] ○ partially hydrogenated oils (trans fats) and reduction of saturated fats;[28] ○ added (free) sugars. • Promote construction of free drinking foundations in work places, schools and other public places. • Proximity of nutrient-poor choices to small children in food stores and proximity of junk food restaurants in relation to schools. • Increase access to supermarkets.	• FCTC Article 9 mandates testing, regulation, and disclosure of tobacco composition and emissions and protects public from environmental tobacco smoke in public places/transit, and workplaces. FCTC Article 17: promote economically viable alternatives for tobacco workers, growers and sellers. FTCT Article 18: Have due regard to the protection of the environment.
Limits on Retail Sales	• ICMBS Article 8: sales-volume based wages and commissions are prohibited.		
Settings: Workplace (Public and Private)			• FCTC Article 8 aims to prohibit exposure to second hand smoke in workplaces, public transit and indoor public places • FCTC Article 14 aims to ensure that Member States develop and implement effective programs for cessation at workplaces. • Include smoke cessation counselling and

			medication in workplace wellness programs and occupational health and safety laws
International Standards	• **Ratify, implement and report successes and failures of WHO *International Code of Marketing of Breast-milk Substitutes.***	• **<u>Codex Must be Re-tasked or Accompanied By An Authoritative Standard Setting Process that facilitates and promotes disease preventing policies</u>. Codex Alimentarius Commission food labelling, nutrition, and compositional standards should promote health as a chief priority and should lead and stimulate, not follow, national efforts.** • **<u>Framework Convention on Nutrition and Food for Health</u>: If existing International Institutions (e.g., Codex) are unable to lead prompt change, UN and WHO should lead negotiation of an international treaty on food marketing, akin to *International Code of Marketing of Breast milk Substitutes* and the *Framework Convention on Tobacco Control*.**	• **Ratify, implement and report successes of the *Framework Convention on Tobacco Control.***
Monitoring, Reporting. Enforcement and, Development Technical Assistance	• WHO Constitution Article 62 calls for implementation efforts to be reported to WHO annually by Member States. • ICMBS Article 11: manufacturers must report marketing practices and NGOs report violations to governments and manufacturers. • ICMBS Article 11: WHO Director General must report to the World Health Assembly biennially on implementation of the Code. • WHO provides technical assistance on request.	•Expand economic and health statistics collected and reported in WHO World Mortality Statistics to include NCD diseases and at least four drivers. • Urge national authorities to collect and report similar statistics. • Collect and report national information about progress on implementing public policy and industry practice measures; NGOs could create an on-line registry to crowd-source in the absence of reporting by governments and companies: (i.e., limits on advertising to children and prevalence of such ads; rules and amounts of food taxes for various nutrition profiles; food labelling rules) •Collect and report intervening variables: smoking rates, blood pressure, serum cholesterol levels, blood sugar levels,	• FCTC Article 19 promotes legal reforms to fixing tobacco-related civil and criminal liability on tobacco companies and provide for compensation and information sharing among Convention parties re laws and jurisprudence and the health effects from exposure to tobacco • FCTC Article 20 promotes research on the determinants and consequences of tobacco consumption and exposure, locating substitute crops, evaluation of tobacco control, and a database of laws and regulations. • FCTC Article 21: Parties to file biennial reports on tobacco taxes, consumption rates, legal controls taken, including bans on ads and promos, barriers encountered and technical assistance provided. • FCTC Article 22: Share information, legal and scientific technical assistance, promote viable

			alternative livelihoods for farm workers and crops for farmers, and help make treatment and control of nicotine addiction affordable to all. • FCTC Article 23-26: Establish the Conference of the Parties to facilitate the exchange of information, mobilize financial resources, implementation and evaluation of strategies
Healthcare	• ICMBS Article 6: prohibits health care facilities from being used to advertising, promote or distribute free samples of substitutes, except where medically necessary • ICMBS Article 7 — supports prohibiting financial inducements or free samples, to promote substitute by health workers —supports prohibiting free samples to mothers, pregnant women or their families —calls on health workers to promote breast feeding, —supports restricting marketing personnel to providing factual and scientific information to health workers	• Ensure professional healthcare services assist and encourage use of food labelling	• FCTC Article 14 aims to ensure that national health systems include the diagnosis, treatment, and counselling of tobacco dependency (which may include medicines)
Healthcare And Prevention Services	• Include NCD/health impact analysis into national budget planning cycle analysis • Support Universal High Quality Health Care • *Earmark revenue collected from tax on tobacco, alcohol, risk "causative foods" and inactivity-promoting products are earmarked for* o *Subsidizing disease protective foods (e.g., fruits, vegetables, whole grains), and activity promoting products and services* o *Preventative clinical services (lactation consultants, dietitians, smoke cessation counselors, and* o *Public education programs* o *Universal health care* • Ensure healthcare services include media literacy training		
Common international issues.	• Cross-Border Advertising: National authorities should collaborate to ensure that national restrictions on advertising to protect children, or to limit the promotion of unhealthful foods, products that promote physical inactivity, alcoholic beverages, or tobacco are not undermined by signals coming in from unregulated foreign jurisdictions.		

	• International Sporting Events: International sporting events including the Olympic Games and single-sport international tournaments (especially those involving competition among children and UN institutions) should not be used to advertise and promote, tobacco, breast milk substitutes, nutrient-poor foods, alcoholic beverages, or sedentary leisure, all of which promote consumption and leisure that undermines the pursuit of athletic excellence, public health, and child protection.

References

[1] The International Association of Consumer Food Organizations (IACFO) is an association of non-governmental organizations (NGOs) that represent consumer interests in the areas of nutrition, food safety, and related food policy matters. IACFO was formed in 1997 to increase consumer representation in the debate over the global food trade and to work with international agencies responsible for harmonizing standards related to the production, distribution, and sale of foods. IACFO has participated in meetings of the World Health Organization, the World Trade Organization, the UN Food and Agriculture Organization, the Organisation for Economic Co-operation and Development, and, most of all, food labelling and nutrition committees of the WHO/FAO Codex Alimentarius Commission. IACFO and its members also represent consumer interests before government regulatory agencies on five continents and release reports examining current nutrition policy and food safety issues.

[2] Comments of the International Association of Consumer Food Organizations (IACFO) to the Round-Table Discussion on the WHO *Global Strategy on Diet, Physical Activity and Health.* Geneva. Switzerland. March 23, 2005. Available at: http://www.cspinet.org/canada/pdf/final_WHO2005.pdf See the general guidance set out in the Resolution 57.17 of the 57th session of the World Health Assembly passed May 22, 2004 adopting the "Global Strategy on Diet, Physical Activity and Health" at: http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf) and series of subsequent WHA resolutions and WHO technical reports.

[3] World Health Organization. *Global Health Risks: Mortality and burden of disease attributable to selected major risks*. 2009. WHO. Geneva. See, esp. p. 17. Available at http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf

[4] WHO. Risk factor estimates for 2004. www.who.int/healthinfo/global_burden_disease/risk_factors/en/index.html Beaglehole, Bonita, et al. Priority actions for the non-communicable disease crisis. 2011. *The Lancet.* Available at: www.thelancet.com

[5] WHO. *World Health Risks.* 2009 at p. 10. Available at: http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf

[6] See: Statistics reported by the World Lung Federation at: http://www.tobaccoatlas.org/females.html and http://www.tobaccoatlas.org/males.html and Datamonitor. *Global Food, Beverage & Tobacco, Industry Profile* Reference Code: 0199-2059. April 2006 Available at: http://www.marketlineinfo.com/mline_pdf/industry_example.pdf

[7] *EU Platform on Diet, Physical Activity and Health*. April 2008. States at page 30: "Figures provided to the Platform suggest that Members have removed at least 822 tonnes of salt from food products since 2004." However, 500 million Europeans consuming only the WHO-recommended 5 g of salt daily would have consumed approximately 3.65 million tons of salt during the 4-year period (5 grams/person-day * 365 days/year * 4 years * 500 million people 1 ton/1,000,000 grams). Considering that many Europeans consume nearly double WHO recommended intake, this constitutes of as little as 1/100th of 1% of current intake, an undetectable rounding error. Furthermore, some of the pledges were for world-wide operations (not just Europe), so the contribution to public health is even more diffuse to the point of being imperceptible, far from boast-worthy. The report is available at: http://ec.europa.eu/health/ph_determinants/life_style/nutrition/platform/docs/eu_platform_2008frep_en.pdf

[8] See: WCRF. *Policy and Action for Cancer Prevention— Food, Nutrition and Physical Activity: A Global Perspective*. Washington, D.C. 2009. Available at: http://www.dietandcancerreport.org/

[9] Resolution 57.17 of the 57th session of the World Health Assembly passed on May 22, 2004 adopting the "Global Strategy on Diet, Physical Activity and Health."
Available at: http://www.who.int/gb/ebwha/pdf_files/WHA57/A57_R17-en.pdf and the *Strategy at* http://www.who.int/dietphysicalactivity/SPF-En.pdf

[10] Franco Sassi. *Obesity and the Economics of Prevention*. Organization for Economic Cooperation and Development. 2010. Paris. Available at: www.sourceoecd.org/socialissues9789264063679

[11] World health Organization and World Trade Organization Secretariat. *WTO Agreements and Public Health: A Joint Study by the WHO and the WTO Secretariat* at pp. 32-37 and 65. Available at: http://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf

[12] World Bank. *Capitalizing on the Demographic Transition: Tackling Noncommunicable Diseases in South Asia. 2011*. Available at: http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/223546-1296680097256/7707437-1296680114157/NCDs_South_Asia_February_2011.pdf

[13] Franco Sassi. *Obesity and the Economics of Prevention*. Organization for Economic Cooperation and Development. 2010. Paris. Available at: www.sourceoecd.org/socialissues9789264063679

[14] World Economic Forum. *Global Risk 2010: A Global Risk Network Report. 2010.* WEF. Zurich, Switzerland. Available at: http://www.weforum.org/pdf/globalrisk/globalrisks2010.pdf

[15] World health Organization and World Trade Organization Secretariat. *WTO Agreements and Public Health: A Joint Study by the WHO and the WTO Secretariat* at p. 34. Available at: http://www.wto.org/english/res_e/booksp_e/who_wto_e.pdf

[16] See: *International Code of Marketing of Breast-milk Substitutes.* 1981. World Health Organization. Geneva. Available at: http://www.who.int/nutrition/publications/code_english.pdf

[17] Most OECD countries apply lower or zero rates of tax to broad categories of food, but many inconsistently use nutrition factors in making the distinction. See: Organisation for Economic Cooperation and Development. *Consumption Tax Trends 2008: VAT/GST and Excise Rates, Trends and Administration Issues*. 2008. Available at: http://www.oecd.org/document/20/0,3746,en_2649_33739_41751636_1_1_1_1,00.html

[18] Section 4205 of House of Representatives *Bill 3590, The Patient Protection and Affordable Care Act*, which was signed into law by President Obama on March 23, 2010. Available on-line at: http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590ENR/pdf/BILLS-111hr3590ENR.pdf

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[19] *Attorney General of Québec* v. *Irwin Toy, Ltd*., [1989] 1 *Supreme Court Reports* 927 at 988-9. See also: Bill Jeffery, "The Supreme Court of Canada's Appraisal of the 1980 Ban of Advertising to Children in Quebec: Implications for "Misleading" Advertising Elsewhere." 39 *Loyola of Los Angeles Law Review* 237-276 (2006).

[20] Office of Communications (OfCom). *High Fat Sugar Salt Advertising Restrictions. Final Review.* July 2010 at 6 and 32.
Available at: http://stakeholders.ofcom.org.uk/binaries/research/tv-research/hfss-review-final.pdf

[21] The US Government's new nutrition standards represent a significant improvement over the old program. Federal Register. Vol. 76, No. 9. pp. 2494-2570. January 13, 2011. Proposed Rules. Doc No: 2011-485. *Nutrition Standards in the National School Lunch and School Breakfast Programs.* Available at: http://federalregister.gov/a/2011-485 See also: Nutrition Standards for Ontario Schools: http://www.edu.gov.on.ca/extra/eng/ppm/150.html and http://www.edu.gov.on.ca/extra/eng/ppm/Appendix150.pdf

[22] For example, in the United States, the federal government subsidizes school means at the rate of $1.27/student/school-day, the quotient of US$14 billion spent on school meals divided by 58 million students in kindergarten, elementary and high schools, assuming a 190-day school year. See: "Table 1: Enrollment Status of the Population 3 Years Old and Over, by Sex, Age, Race, Hispanic Origin, Foreign Born, and Foreign-Born Parentage: October 2008." Available at: http://www.census.gov/population/www/socdemo/school/cps2008.html And see: United States Department of Agriculture. Federal Costs of School Food Programs,

http://www.fns.usda.gov/pd/cncosts.htm Assuming a 190-day school year. Based on the most recent statistics available, Canadian provincial governments collectively fund student meal programs less than $0.04/student/school-day. CSPI. Prepared with files from Breakfast for Learning and the US Department of Agriculture. Current Public Investment in School Foods (as of January 2009). Available at: http://cspinet.org/canada/pdf/child-nutritionbackgrounder-jan2009-budget.pdf

See also: J Larry Brown, William H. Beardslee, Deborah Prothrow, *Impact of School Breakfast on Children's Health and Learning: An Analysis of the Scientific Research* (Nov. 2008) Unpublished Manuscript. Harvard School of Public Health. Available at: http://www.sodexofoundation.org/hunger_us/Images/Impact%20of%20School%20Breakfast%20Study_tcm150-212606.pdf which states:

> *…more than 100 published research articles, provides the scientific basis for concluding that the [US] federal School Breakfast Program is highly effective in terms of providing children with a stronger basis to learn in school, eat more nutritious diets, and lead more healthy lives both emotionally and physically…significantly improves their cognitive or mental abilities, enabling them to be more alert, pay better attention, and to do better in terms of reading, math and other standardized test scores. Children getting breakfast at school also are sick less often, have fewer problems associated with hunger, such as dizziness, lethargy, stomach aches and ear aches, and do significantly better than their peers who do not get a school breakfast in terms of cooperation, discipline and inter-personal behaviors.*

[23] Available at: http://www.who.int/dietphysicalactivity/SPF-En.pdf Mary L. McKenna. Policy Options to Support Healthy Eating in Schools. *Canadian Journal of Public Health.* 2010. 101 Supp.:S14-S17. Available at: http://journal.cpha.ca/index.php/cjph/article/view/1910/2213

[24] World Health Organization. *World Health Report 2002: Reducing Risks, Promoting Healthy Life*. WHO: Geneva. Available at http://www.who.int/whr/2002/en/whr02_en.pdf at Table 4.9, page 86. According to the WHO, hypertension is second only to underweight in children as the leading cause of disease,[24] the major cause of cardiovascular disease,[24] and, according to one meta-analysis of research, accounts for 62% of strokes and 49% of ischemic heart disease.[24] See: Lopez AD, Mathers CD, Ezzati M, et al. Global and regional burden of disease and risk factors, 2001: Systematic analysis of population health data. *Lancet.* 2006; 367:1747-1757 at 1755.

[25] See, e.g., Asaria P, Chisholm D, et al. Chronic disease prevention: Health effects and financial costs of strategies to reduce salt intake and control tobacco use. *Lancet.* 2007; 370: 2044-2053 at 2044. Available at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61698-5/fulltext and Strazzullo P, D'Elia L, Kandala N-B, Cappuccio FP. Salt intake, stroke, and cardiovascular disease: meta-analysis of prospective studies. *Br Med J.* 2009;339:b4567.

[26] U.S. Institute of Medicine. *Strategies to Reduce Sodium Intake in the United States. Report Panel Chair,* Dr. Jane E. Henney (former Commissioner of the Food and Drug Administration). IOM. Washington. 2010. Available at: http://www.iom.edu/Reports/2010/Strategies-to-Reduce-Sodium-Intake-in-the-United-States.aspx and

[27] Hasan Hutchinson, Chair, and Mary L'Abbe, Chair, then Vice-Chair, Sodium Working Group (a multistakeholder expert advisory group to the Minister of Health). *Sodium Reduction Strategy for Canada.* Ottawa. Health Canada. 2010. Available at: http://www.hc-sc.gc.ca/fn-an/alt_formats/pdf/nutrition/sodium/strateg/indexeng.pdf

[28] WHO Scientific Update on trans fatty acids: summary and conclusions. *European Journal of Clinical Nutrition*. 2009;63:S68-S75 at S74. Available at: http://www.nature.com/ejcn/journal/v63/n2s/pdf/ejcn200915a.pdf which concluded that:

> *The evidence…strongly supports the need to remove PHVO from the human food supply… [and] revising this recommendation so that it encompasses the great majority of the population, and not just the population mean, to protect large subgroups from having high intakes.*

Public Health Impediments Regulation [banning trans fat in restaurants in British Columbia, Canada]. B.C. Reg. 50/2009 enacted under the authority of *Public Health Act,* Statutes of British Columbia, Canada. 2008, c. 28. Available at: http://www.canlii.org/en/bc/laws/regu/bc-reg-50-2009/latest/ ; R Uauy, A Aro, R Clarke, R Ghafoorunissa, M L'Abbe, D Mozaffarian, M Skeaff, S Stender and M Tavella; and Order on the content of trans fatty acids in oils and fats etc. Order No. 160 of 11 March 2003. The following is laid down pursuant to Section 13,

Section 55, subsection 2 and Section 78 subsection 3 of *Act No 471* of 1 July 1998 on foodstuffs etc. (Foodstuffs Act); English Translation available at: M R L'Abbé, S Stender, C M Skeaff, Ghafoorunissa and M Tavella. "Approaches to removing *trans* fats from the food supply in industrialized and developing countries." Eur J Clin Nutr 63: S50-S67 at S54. Available at: http://www.nature.com/ejcn/journal/v63/n2s/pdf/ejcn200914a.pdf ; and Federal Trans Fat Task Force. *TRANSforming the Food Supply*. Health Canada. Ottawa. 2006. Available at http://www.hc-sc.gc.ca/fn-an/alt_formats/hpfb-dgpsa/pdf/nutrition/tf-gt_rep-rap-eng.pdf