



JOINT FAO/WHO FOOD STANDARDS PROGRAMME
CODEX COMMITTEE ON NUTRITION AND FOODS FOR SPECIAL DIETARY USES

37th Session
Bad Soden a.T. - Germany
23 – 27 November 2015

PROPOSED DRAFT ADDITIONAL OR REVISED NUTRIENT REFERENCE VALUES FOR LABELLING PURPOSES IN THE GUIDELINES ON NUTRITION LABELLING (VITAMIN A, D, E, MAGNESIUM, PHOSPHOROUS, CHROMIUM, COPPER, CHLORIDE AND IRON)

Comments of Brazil, Canada, Chile, Costa Rica, Ghana, New Zealand, United States of America, African Union, ELC, IADSA and ISDI

BRAZIL

SPECIFIC COMMENTS

Recommendation 1 – NRV-R for Vitamin A

Brazil prefers DIRV from EFSA as it is based on a more recent review of the literature and considering that the averaging value of the four DIRVs is 704µg, which is close to the EFSA DIRV (700µg).

Recommendation 2 – NRV-R for Vitamin D

Brazil prefers option “a” as the most suitable basis for the NRV-R for vitamin D. We suggest using the DIRV from Nordic countries (10 µg) as it is an INL98 based on a more recent review of the literature.

Recommendation 3 – Footnote to NRV-R for Vitamin D

Brazil agrees to establish a footnote to the NRV-R. In line with decision on Recommendation 2, we propose to refer to minimal sunlight exposure in winter:

“The NRV-R is based on minimal sunlight exposure [~~throughout the year~~] [in winter]. Competent national and/or regional authorities should determine an appropriate NRV-R that best accounts for population sunlight exposure and other relevant factors”.

Recommendation 4 – NRV-R for Vitamin E

Brazil agrees to establish a NRV-R of 9 mg.

Recommendation 5 – NRV-R for Iron

Brazil agrees to revise the NRV-R from 14 mg to 14 mg (15% dietary absorption) and 22 mg (10% dietary absorption) and based on WHO/FAO.

Recommendation 6 – Dietary Description for Iron

Brazil agrees to the dietary descriptions adapted from WHO/FAO (2006) that correspond to the selected NRVs-R.

Recommendation 7 – Footnote to NRV-R for Iron

Brazil agrees to also attach to iron the **footnote indicator currently attached to zinc.

Recommendation 8 – NRV-R for Magnesium

Brazil prefers the current NRV-R (300mg) because it is close to averaging of IOM, NIH and WHO/FAO DIRVs as they are based on balance studies.

Recommendation 9 – NRV-R for Phosphorus

Brazil agrees to establish a NRV-R of 700 mg and based on IOM.

Recommendation 10 – NRV-R for Copper

Brazil agrees to establish a NRV-R of 900 µg and based on IOM.

Recommendation 11 – NRV-R for Chromium

Brazil agrees to establish a NRV-R of 30 µg and based on IOM.

Recommendation 12 – NRV-R for Chloride

Brazil agrees to establish a NRV-R of 3000mg for chloride. We also support an equimolar value with sodium expressed in mg.

Recommendation 13 – Vitamin A Dietary Equivalents and Conversion Factors

Brazil agrees with recommendations A, B and C.

Recommendation 14 – Vitamin E Dietary Equivalents and Conversion Factors

Brazil agrees with recommendations A, B and C.

Recommendation 15 – Second Table Heading and Footnote

Brazil agrees to the proposed revisions in section 4.5 above.

Recommendation 16 – RASB Definition in Guidelines on Nutrition Labelling

Brazil agrees to insert the definition of RASB in the Annex to Guidelines on Nutrition Labelling at new paragraph 2.5.

Recommendation 17 – RECORD of NRV-R DECISIONS

Brazil agrees with recommendations A and B.

Recommendation 18 – Draft General Principles for NRVs-R for Older Infants and Young Children

That CCNFSDU agrees to the draft General Principles presented in section 8.

However, Brazil requests clarification for choosing the age range for DIRVs for older infants of 6-<13 months, and for young children within the range of 1-<4 years, because the age ranges defined in the Codex texts do not always align with the age ranges of DIRVs from RASBs accepted. We think it's more consistent to use the proposed age range for NRVs-R (item x.1).

Brazil agrees to the draft General Principles presented in section 8.

Recommendation 19 – Consequential amendments to age of general population in Nutrition Labelling Guidelines

Brazil agrees to revise 'older than 36 months' to '36 months and older' in paragraph 3.4.4, the Annex Preamble and GP 3.2.1.2.in the Guidelines on Nutrition Labelling.

CANADA**GENERAL COMMENTS**

For three nutrients (vitamin A, phosphorous, copper), the eWG is recommending that the DIRVs of one RASB (the IOM) serve as the basis for the NRV-Rs. During the 2015 electronic consultation, where there was more than one suitable DIRV established using the same (or similar) methodology, it was Canada's preference to base the NRV-R on an average of the DIRVs. Canada considered that an NRV-R based on an average of suitable DIRVs from different RASBs would be more acceptable to a broad range of national authorities than an NRV-R based on one RASB alone. Canada continues to prefer the approach of averaging suitable DIRVs established using the same (or similar) methodology; however, in order to reach consensus at the CCNFSDU meeting, Canada will not oppose majority support for using the IOM DIRVs as the basis for the NRV-Rs.

SPECIFIC COMMENTS**Recommendations for NRVs-R (TOR 1)****Recommendation 1 – NRV-R for Vitamin A**

During the 2015 electronic consultation, Canada supported using the average of the IOM, NIH, and EFSA INL98s as the basis for the NRV-R (755 µg rounded to 750 µg or 800 µg, depending on the rounding increments of the original DIRVs). In order to reach consensus, Canada will not oppose majority support for using the IOM DIRV as the basis for the vitamin A NRV-R.

RECOMMENDATION 2 – NRV-R for Vitamin D

That CCNFSDU agrees to:

- (A) revise upward the NRV-R from 5 µg
- (B) select either 10 µg or 15 µg and based on relevant RASB

(A) Canada supports revising the NRV-R upward from 5 µg.

(B) The Nordic Council INL98 considers a contribution of sunlight in the summer, whereas the IOM INL98 assumes minimal exposure to sunlight. Canada notes that in some populations, exposure to sunlight is minimal even in the summer. To help ensure that the NRV-R is appropriate for use in such populations, Canada supports selecting the IOM INL98 of 15 µg as the basis for the vitamin D NRV-R.

RECOMMENDATION 3 – Footnote to NRV-R for Vitamin D

That CCNFSDU agrees to:

- (A) establish a footnote to the NRV-R
- (B) adopt footnote wording including selection of text in square brackets in line with decision on Recommendation #2.

(A) Canada supports establishing a footnote to the vitamin D NRV-R.

(B) Canada supports adopting the proposed footnote wording: “The NRV-R is based on minimal sunlight exposure [throughout the year] [in winter]. Competent national and/or regional authorities should determine an appropriate NRV-R that best accounts for population sunlight exposure and other relevant factors.”

Canada supports the option [throughout the year] to help clarify the meaning of “minimal sun exposure” because the IOM INL98 assumes minimal sun exposure all year.

Recommendation 4 – NRV-R for Vitamin E

Canada supports establishing a vitamin E NRV-R of 9 mg.

During the 2015 electronic consultation, Canada supported using the average of WHO/FAO, EFSA, NHMRC and NIH N AIs (9 mg) as the basis for the NRV-R. Canada would also support using the recently-derived Nordic Council INL98 (9 mg) as the basis for the NRV-R. This approach is consistent with Guiding Principle 3.2.1.1 which states that NRVs-R should be based on INL98. Canada does not support basing the NRV-R equally on the Nordic Council INL98 and the average of the WHO/FAO, EFSA, NHMRC and NIH N AIs, since the methodology for establishing AIs and INL98s is very different.

RECOMMENDATION 5 – NRV-R for Iron

That CCNFSDU agrees to:

- (A) modify the NRV-R to refer to % dietary absorption
- (B) revise the NRV-R from 14 mg to 14 mg (15% dietary absorption) and 22 mg (10% dietary absorption) and based on WHO/FAO.

(A) Canada supports modifying the NRV-R to refer to % dietary absorption.

(B) Canada supports revising the NRV-R from 14 mg to 14 mg (15% dietary absorption) and 22 mg (10% dietary absorption) and based on WHO/FAO.

Recommendation 6 – Dietary Description for Iron

Canada supports the proposed dietary descriptions adapted from WHO/FAO, including re-insertion of “diversified” at the beginning of the dietary description corresponding to 15%:

Iron**	14 (15% dietary absorption; Diversified diets, rich in meat fish, poultry, and/or rich in fruit and vegetables)
	22 (10% dietary absorption; Diets rich in cereals, roots or tubers, with some meat, fish, poultry and/or containing some fruit and vegetables)

Recommendation 7 – Footnote to NRV-R for Iron

Canada supports attaching to “Iron” the **footnote indicator currently attached to zinc.

Recommendation 8 – NRV-R for Magnesium

Canada supports revising the NRV-R from 300 mg to 310 mg. Canada supports using the average of the IOM, NIH/N, WHO/FAO and Nordic Council INL98s as the basis for the NRV-R.

Recommendation 9 – NRV-R for Phosphorus

During the 2015 eWG consultation, Canada supported selecting 750 mg as the phosphorous NRV-R, based on the rounded average of the IOM, NIH/N, and Nordic Council INL98s. In order to reach consensus, Canada will not oppose majority support for an NRV-R of 700 mg based on the IOM INL98.

Recommendation 10– NRV-R for Copper

Canada supports establishing a NRV-R of 900 µg. During the 2015 eWG consultation, Canada supported using the rounded average of the IOM and NIH/N INL98s as the basis for the NRV-R. To help reach consensus, Canada will not oppose majority support for an NRV-R of 900 µg based on the IOM INL98.

Recommendation 11 – NRV-R for Chromium

Canada supports the recommendation to establish an NRV-R of 30 µg and based on the IOM AI.

RECOMMENDATION 12 – NRV-R for Chloride

That CCNFSDU agrees to:

- (A) establish a NRV-R for chloride
- (B) select 2300 mg or 3000 mg and based on relevant rationale or RASB.

(A) Canada supports the recommendation to establish a NRV-R for chloride.

(B) Canada supports selecting an NRV-R of 2300 mg for chloride based on the molar equivalent to the IOM sodium AI because the AI reflects estimated requirements. Canada does not support establishing an NRV-R of 3000 mg based on the molar equivalent to the Codex NRV-NCD for sodium.

Vitamin Dietary Equivalents (TOR2)**RECOMMENDATION 13 – Vitamin A Dietary Equivalents and Conversion Factors**

That CCNFSDU agrees to:

- (A) insert an entry for vitamin A in the second table to paragraph 3.4.4.1 of the Guidelines on Nutrition Labelling
- (B) include both RAE and RE and their conventional conversion factors as alternative dietary equivalents for Vitamin A occurring naturally in food as discussed in section 4.1
- (C) include two principal forms of retinol that are added to food as shown in section 4.2
- (D) delete the * currently attached to vitamin A NRV-R and related footnote relating to declaration of β-carotene.

(A) Canada supports inserting an entry for vitamin A in the second table to paragraph 3.4.4.1.

(B) In the 2015 eWG consultation, Canada supported the name Retinol Activity Equivalents (RAE) for the more conservative factors (1:12:24) and Retinol Equivalents (RE) for the less conservative factors (1:6:12) in line with the general convention. Canada (and a large majority of eWG members) supported including the more conservative factors in the Guidelines on Nutrition Labelling. Given the diverse international, regional and national positions, in order to reach consensus, Canada would not oppose including both RAE and RE and their conventional conversion factors as alternative dietary equivalents for vitamin A occurring naturally in food.

(C) Canada supports including retinyl acetate and retinyl palmitate, the two principal forms of retinol added to food, in the Guidelines.

(D) Canada supports deleting the “*” currently attached to “vitamin A NRV-R and the related footnote related to the declaration of β-carotene.

RECOMMENDATION 14 – Vitamin E Dietary Equivalents and Conversion Factors

That CCNFSDU agrees to:

- (A) insert an entry for vitamin E in the second table to paragraph 3.4.4.1 of the Guidelines on Nutrition Labelling
- (B) include α -tocopherol as the active form of vitamin E occurring naturally in food as shown in section 4.3
- (C) include three common forms of vitamin E that are added

(A) Canada supports inserting an entry for vitamin E in the second table to paragraph 3.4.4.1 of the Guidelines.

(B) Canada supports including α -tocopherol as the active form of vitamin E occurring naturally in food rather than applying dietary equivalents.

(C) Canada supports limiting the information to key examples by only showing three common forms of vitamin E that are added.

Inclusion of Definition of RASB in Nutrition Labelling Guidelines**Recommendation 15 – Second Table Heading and Footnote**

Canada supports the second table heading revision: “Conversion factors for ~~niacin and folate~~ **vitamin** equivalents”.

Canada supports the footnote revision: “The conversion factors for vitamin equivalents in the Table provide supporting information for ~~national authorities~~ to enable **competent regional or** national authorities to determine ~~the appropriate~~ application of NRVs-R ~~at national level.~~”

Recommendation 16 – RASB Definition in Guidelines on Nutrition Labelling

Canada supports the recommendation to insert the definition of RASB in the Annex at new paragraph 2.5.

Record of Derivation of NRVs-R**Recommendation 17 – RECORD of NRV-R DECISIONS**

(A) Canada supports recording the details of all NRVs-R from this revision in the Annex to the Guidelines.

(B) Canada supports inserting the table in section 6 of the Annex at new section 4, updated to include decisions from this session of CCNFSDU.

Approach to Establish NRVs-R for Older Infants and Young Children (TOR3)**Recommendation 18 – Draft General Principles for NRVs-R for Older Infants and Young Children**

Canada supports the proposed Draft General Principles with one exception – the age range for young children.

During the 2015 eWG consultation, Canada supported establishing NRVs-R for young children using 13-< 48 months as the age range, rather than 13-<36 months. The IOM used 48 months as the cutpoint because toddlers less than 48 months experience greater velocity of growth in height compared to older children. WHO/FAO and NHMRC/MOH also used the 36-month span for young children. The rationale for the 24 month age range used in the Guidelines on Formulated Complementary Foods is not provided. Canada suggested that if the eWG agreed that the age range for older infants should be 13-<48 months, the age ranges in other Codex texts could be amended for consistency. Canada continues to support this position.

Recommendation 19 – Consequential amendments to age of general population in Nutrition Labelling Guidelines

Canada supports changing the wording from “older than” to “months and older”. However, as noted above, Canada prefers ‘48 months and older’.

CHILE

R. No.	RECOMMENDATION	Comments
1	NRV-R for Vitamin A	We support this recommendation.
2	NRV-R for Vitamin D	We support 15 ug (IOM)
3	Footnote to NRV-R for Vitamin D	We think that this footnote is not necessary, because it could confuse regarding the essentiality of vitamin D needs, in accordance to the solar exposure of population.
4	NRV-R for Vitamin E	Although the last time Chile recommended 15 mg, with this new proposal we do agree with 12 mg (Average of INL 98 values).
5	NRV-R for Iron	We support this recommendation.
6	Dietary Description for Iron	We support this recommendation.
7	Footnote to NRV-R for Iron	We support this recommendation.
8	NRV-R for Magnesium	Although the last time Chile recommended 365 mg, with this new proposal we do agree with 310 mg (Average of INL 98 values).
9	NRV-R for Phosphorus	We support this recommendation
10	NRV-R for Copper	We support this recommendation
11	NRV-R for Chromium	According this support, we do agree with 30 ug.
12	NRV-R for Chloride	We support the Chair proposal, with 3000 mg.
13	<p>Vitamin A Dietary Equivalents and Conversion Factors</p> <p>That CCFSDU agrees to:</p> <p>A insert an entry for vitamin A in the second table to paragraph 3.4.4.1 of the <i>Guidelines on Nutrition Labelling</i></p> <p>B include both RAE and RE and their conventional conversion factors as alternative dietary equivalents for Vitamin A occurring naturally in food as discussed in section 4.1</p> <p>C include two principal forms of retinol that are added to food as shown in section 4.2</p> <p>D delete the * currently attached to vitamin A NRV-R and related footnote relating to declaration of β-carotene.</p>	<p>A. Yes, we agree to include it.</p> <p>B. We support RAE conversion values.</p> <p>C. Yes, we agree to include them.</p> <p>D. Yes, we agree to delete it.</p>

R. No.	RECOMMENDATION	Comments
14	<p>Vitamin E Dietary Equivalents and Conversion Factors</p> <p>That CCNFSDU agrees to:</p> <p>A insert an entry for vitamin E in the second table to paragraph 3.4.4.1 of the <i>Guidelines on Nutrition Labelling</i></p> <p>B include α-tocopherol as the active form of vitamin E occurring naturally in food as shown in section 4.3</p> <p>C include three common forms of vitamin E that are added to food as shown in section 4.4.</p>	<p>A. Yes, we agree to include it.</p> <p>B. Yes, we agree to include it.</p> <p>C. No, because "<i>all-rac-α-tocopherol (dl- α-tocopherol)</i>****" is principally used as antioxidant instead of a source of vitamin E. For this purpose "<i>all-rac-α-tocopheryl acetate</i>" and "<i>all-rac-α-tocopheryl succinate</i>", should be included.</p>
15	<p>Second Table Heading and Footnote</p>	<p>Yes, we agree with this proposal.</p>
16	<p>RASB Definition in <i>Guidelines on Nutrition Labelling</i></p>	<p>Yes, we agree.</p>
17	<p>RECORD of NRV-R DECISIONS</p> <p>That CCNFSDU agrees to:</p> <p>A record the details of all NRVs-R from this revision in the Annex to the <i>Guidelines on Nutrition Labelling</i></p> <p>B insert the table in section 6 into the Annex at new section 4 updated to include decisions from this session of CCNFSDU.</p>	<p>A. Yes, we agree with this proposal, considering updating the values according the respective CCNFSDU meeting.</p> <p>B. Yes, we agree with this proposal, considering updating the values according the respective CCNFSDU meeting.</p>
18	<p>Draft General Principles for NRVs-R for Older Infants and Young Children</p> <p>That CCNFSDU agrees to the draft General Principles presented in section 8.</p>	<p>No, we are not agree.</p> <p>We propose following:</p> <p>1: Delete it, because it is already included in the before text.</p> <p><i>“Higher priority should be given to values in which the evidence has been evaluated through a systematic review.”</i></p> <p>2: Replace by 6-12 months, instead of “6-<13”, in order to maintain same range age, than X.1.</p> <p>3: Replace by 12-36 months, instead of “1-<4”, in order to maintain same range age than X.1.</p> <p>4: Delete it, because it included in X.3.1.1.</p> <p><i>“X.3.1.2 The older infant NRVs-R should be determined by selecting the most appropriate DIRV or an average of highly similar DIRVs for older infants.</i></p> <p><i>X.3.1.3 The young children NRVs-R should be determined by selecting one or more appropriate DIRVs, combined or weighted where necessary, to reflect the age range for young children in X.1.</i></p> <p><i>X3.1.4 DIRVs may be selected from any of the suitable data sources in X.2 to derive NRVs-R for older infants, and to derive NRVs-R for young children.”</i></p>

R. No.	RECOMMENDATION	Comments
19	<p>Consequential amendments to age of general population in Nutrition Labelling Guidelines</p> <p>Subject to agreement to Recommendation #18, that CCNFSDU agrees to revise 'older than 36 months' to '36 months and older' in paragraph 3.4.4, the Annex Preamble and GP 3.2.1.2.in the <i>Guidelines on Nutrition Labelling</i>.</p>	We support "36 months and older".

COSTA RICA

Recommendation 1: NRV-R for vitamin A

Costa Rica supports the most recent EFSA value (700 µg) first and foremost, as expressed in the second eWG consultation. However, it could support Recommendation 1 if a consensus is reached on this point.

Recommendation 2: NRV-R for vitamin D

Costa Rica supports amending the current value to 10 µg. This value represents most recent opinion, it is even appropriate for countries with low sunlight exposure (Nordic) and presents less risk to countries with high sunlight exposure.

Recommendation 3: Footnote to NRV-R for vitamin D

Costa Rica supports the inclusion of a footnote for vitamin D according to the value selected by the Committee.

Recommendation 4: NRV-R for vitamin E

In the eWG Costa Rica supported an NRV-R for vitamin E of 15 mg, as per the IOM, and subsequently 12 mg based on the EFSA value. However, we will support a value of 9 mg if a consensus is reached on this point.

Recommendation 5: NRV-R for iron

Costa Rica supports Recommendation 5.

Recommendation 6: Nutritional description of iron

Costa Rica supports Recommendation 6.

Recommendation 7: Footnote to NRV-R for Iron

Costa Rica supports Recommendation 7.

Recommendation 8: NRV-R for magnesium

Costa Rica supports Recommendation 8.

Recommendation 9: NRV-R for Phosphorus

Costa Rica supports Recommendation 9.

Recommendation 10: NRV-R for copper

Costa Rica supports Recommendation 10.

Recommendation 11: NRV-R for chromium

Costa Rica initially supported a value of 35 µg in accordance with the NIH. However, 30 µg is also close to the value estimated by FAO/WHO (33 µg), and so Costa Rica supports the recommendation.

Recommendation 12: NRV-R for chloride

Costa Rica believes it is necessary to await the opinion of EFSA before defining a value for chloride. However, if a relevant rationale or the relevant RASB documentation is submitted, it would preferably support the value of 2,300 mg or the value reached by consensus.

Recommendation 13: Vitamin A dietary equivalents and conversion factors

Vitamin		Dietary equivalents
Niacin, etc.
Vitamin A occurring naturally in food	1 µg of Retinol Activity Equivalents (RAE) = OR	1 µg of retinol 12 µg of β-carotene 24 µg of other provitamin A carotenoids
	1 µg of Retinol Equivalents (RE) =	1 µg of retinol 6 µg of β-carotene 12 µg of other provitamin A carotenoids
Vitamin A added to food	1 µg of retinol =	1.15 of µg retinyl acetate* 1.83 of µg retinyl palmitate*

* Stoichiometrically calculated from retinol.

Costa Rica supports all points in Recommendation 13.

Recommendation 14: Vitamin E dietary equivalents and conversion factors

The CCNFSDU should agree to:

- A. Insert an entry for vitamin E in the second table of paragraph 3.4.4.1 of the Guidelines on Nutrition Labelling.
- B. Include α-tocopherol as the active form of vitamin E occurring naturally in food, as indicated in section 4.3.
- C. Include the three common forms of vitamin E that are added to food, as shown in section 4.4.

Vitamin		Dietary equivalents
Niacin, etc.
Vitamin E occurring naturally in food	1 mg of α-tocopherol =	1 mg of RRR-α-tocopherol (d-α-tocopherol) =
Vitamin E added to food	1 mg of RRR-α-tocopherol =	1.10 mg of RRR-α-tocopheryl acetate** 1.23 mg of RRR-α-tocopheryl succinate** 2.00 mg of all-rac-α-tocopherol (dl-α-tocopherol)***

** Stoichiometrically calculated from RRR-α-tocopherol

*** Conversion factor for all the all-rac-α-tocopherol based on half the activity of RRR-α-tocopherol.

Costa Rica supports all points in Recommendation 14.

Recommendation 15: Second table heading and footnote

The CCNFSDU should agree to the revisions proposed in section 4.5.

Heading

Conversion factors for ~~niacin and folate~~ vitamins equivalents

Footnote

The conversion factors for vitamin equivalents given in the table provide supporting information for ~~national authorities~~ that enables **competent national or regional authorities** to determine how to apply the NRVs-R correctly at a national level.

Costa Rica supports Recommendation 15.

Recommendation 16: RASB definition in Guidelines on Nutrition Labelling

Costa Rica supports Recommendation 16.

Recommendation 17: Record of NRV-R decisions

Costa Rica supports Recommendation 17.

Recommendation 18: Draft General Principles to establish NRVs-R for older infants and young children

Costa Rica supports Recommendation 18.

Recommendation 19:

Costa Rica supports Recommendation 19.

GHANA**Recommendation 1: NRV – R for Vitamin A**

Ghana supports the recommendations to retain the NRV-R for Vitamin A at 800µg.

Rationale: We consider the level proposed by IOM to be safe and will contribute greatly in the management of Vitamin A deficiency, which is a public health issue in Ghana.

Recommendation 2: NRV-R for Vitamin D

We do not support the upward revision of the NRV-R from 5µg. We propose the level is maintained at 5µg but allow competent national and/or regional authorities to review NRV-R based on country or regional needs up to 15µg.

Recommendation 3:

We support the establishment of a footnote to the NRV-R and footnote to read:

The NRV-R is based on minimal sunlight exposure throughout the year. Competent national and/or regional authorities should determine an appropriate NRV-R that best accounts for population sunlight exposure and other relevant factors.

Rationale: In line with recommendation 2

Recommendation 4: NRV-R for Vitamin E

We support the establishment of NRV-R for Vitamin E at 9mg.

Rationale: The proposed levels are physiologically adequate for its function.

Recommendation 5: NRV-R for Iron

We support the modification of the NRV-R of iron to refer to % dietary absorption and revision from 14mg to 14mg (15% dietary absorption) and 22mg (10% dietary absorption)

Rationale: The level of absorption of iron is dependent on the dietary source.

Dietary Description for Iron

Recommendation 6: We support the dietary descriptions adapted from WHO/FAO with the introduction of “less diversified” in the second text as follows:

Iron**	<p>14 (15% dietary absorption; Diversified diets, rich in meat fish, poultry, and/or rich in fruit and vegetables</p> <p>22 (10% dietary absorption; Less Diversified Diets rich in cereals, roots or tubers, with some meat, fish, poultry and/or containing some fruit and vegetables</p>
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Recommendation 7: Footnote to NRV-R for iron

We support the introduction of a footnote to iron as proposed.

Recommendation 8: NRV-R for Magnesium

Ghana supports the revision of NRV-R from 300mg to 310mg based on average of IOM,NIHN, WHO/FAO ± Nordic Council (INL98 ± RI).

Rationale: Magnesium is an important mineral in the normal functioning of body muscles including the heart and therefore the proposed level will support this function especially with the increased cardiovascular complications.

Recommendation 9: NRV-R for Phosphorus

Ghana supports establishment of NRV-R for Phosphorus at 700mg based on IOM.

Rationale: At 700mg, there can be an optimum absorption taking into consideration the Calcium to Phosphorus ratio of 2:1.

Recommendation 10: NRV-R for Copper

We support the establishment of a NRV-R of 900µg.

Rationale: Copper is an essential trace mineral which helps to increase the absorption of iron amongst others and the recommended level is safe.

Recommendation 11: NRV-R for Chromium

We support the establishment of a NRV-R of 30µg. In the absence of sufficient data on the element, we would recommend that other RASBs should carry out further review of the element.

Recommendation 12: NRV-R for Chloride

Ghana supports the establishment of a NRV-R for Chloride and at 3000mg.

Rationale: Given that CCNFSDU has adopted a NRV-R of 2000mg for Sodium (Na) and the primary source of chloride in the body is from salt, it is appropriate to set the NRV-R for Chloride at 3000mg based on the molar ratio of Sodium to Chloride and the WHO recommendation of 5g (5000mg) of salt per day.

Recommendation 13: Dietary Equivalents and Conversion Factors for Vitamin A

Ghana supports adoption of the recommendations

Rationale: This will provide common basis for comparison of various forms of Vitamin A and interpretation of results and ensure consistent use of conversions factors of Vitamin A.

Recommendation 14: Dietary Equivalents and Conversion Factors for Vitamin E

Ghana supports adoption of all recommendations made in this section.

Rationale: This will allow comparison of various forms of Vitamin E and common basis for interpretation of results as well as ensure consistency in the Guidelines.

Recommendation 15: Format of Second Table to Paragraph 3.4.4.1, Heading and Footnote

We support the proposed revision to the heading and footnote of section 4.5

Rationale: The revision of the heading and footnote will enhance clarity and ensure consistency in the guidelines.

Recommendation 16: Inclusion of Definition of RASB in Nutrition Labelling Guidelines

Ghana supports the insertion of the definition of RASB in the Annex to Guidelines on Nutrition Labelling.

Rationale: This is useful information for users of the Guidelines.

Recommendation 17: Record of derivation of NRVs-R

Ghana supports the recommendation by the eWG to record the details of all NRVS and insert the table in section 6 into the Annex

Rationale: This will make referencing of NRVs-R in the Guidelines simpler.

Recommendation 18 and 19: Approach to establish NRVs-R for older Infants and Young Children (TOR3)

Ghana supports recommendations to draft general Principles for NRVs-R for older infants and young children.

Rationale: Older Infants and young children have peculiar nutritional needs and susceptibilities. Developing separate nutrient requirement for this sub-population will be a good way of addressing these needs.

NEW ZEALAND**Recommendation 1: Vitamin A**

The recommendation to retain the current NRV-R as 800 µg is based on a narrow majority eWG view. As noted in previous consultations, New Zealand's preference is to base the NRV-R on the dietary intake reference value (DIRV) established by EFSA at 700 µg¹.

Both the IOM² and EFSA¹ have derived DIRVs using the factorial approach and the same physiological endpoint (maintenance of 20 µg retinol/g liver) based on the work of Olson and colleagues in 1987³. The main difference in the derivation of DIRVs by each of the two RASBs is the reference body weight used. The IOM used a reference body weight of 68.5 kg, which is much higher than that used by EFSA 63.3 kg and the WHO/FAO 60 kg. As the reference body weight used by WHO/FAO is closer to that used by EFSA, it would be preferable to base values on the EFSA derived INL₉₈ as these would be most internationally relevant to global reference body weights. Furthermore, use of the EFSA DIRV would not result in exceeding the UL for retinol for young children.

Based on use of the factorial approach and reference body weights which more closely resemble internationally applicable reference body weights, New Zealand supports the use of the EFSA vitamin A value of 700 µg.

Recommendation 2: Vitamin D

New Zealand supports recommendation 2A and 2B to revise the NRV-R for vitamin D upward of 5 µg. Our preference would be to establish an NRV-R of 10 µg based on the Nordic recommendations.

Recommendation 3: Vitamin D Footnote

New Zealand supports adoption of a footnote. It is considered that a simplified version of the proposal could be considered that would be relevant for either the IOM or Nordic DIRV. Further to this, the current footnote also specifies that the value may not be applicable where local conditions can provide sufficient allowance for vitamin D. The following is suggested:

The NRV-R is based on minimal sunlight exposure and may not be applicable for all countries. Competent national and/or regional authorities should determine an appropriate NRV-R that best accounts for population sunlight exposure and other relevant factors.

Recommendation 4: Vitamin E

New Zealand supports the recommendation to establish an NRV-R of 9 mg.

As evidenced in the documentation of physiological endpoints provided by the Chair of the eWG there is considerable uncertainty in the establishment of a DIRV for vitamin E from almost all RASBs. Due to the level of uncertainty in establishing a DIRV for vitamin E, New Zealand is supportive of maintaining the WHO/FAO as a primary source to establish an NRV-R for vitamin E in line with the General Principles. The WHO/FAO value is based on the average dietary intakes of population median intakes in countries where vitamin E deficiency is not apparent and could be rounded to 9 mg α-tocopherol for labelling purposes⁴.

It is also recognised that averaging the DIRVs based on dietary intakes WHO/FAO⁴, EFSA⁵, NHMRC/MOH⁶, NIH⁷ would result in a NRV-R of 9 mg. New Zealand notes as there is no new evidence to deviate from the WHO/FAO⁴ value this should be referred to in the Source of NRVs table in line with GP 3.1.1

Recommendation 5: Iron

Support recommendations 5A and 5B to include reference to percentage dietary absorption in the NRV-R for iron at two levels:

15% dietary absorption: NRV-R 14 mg

10% dietary absorption: NRV-R 22 mg

The Committee has expressed continued support for the derivation of two NRV-R values for iron. This enables national authorities to decide to use of one of these two values based on considerations of dietary absorption in the national diet but still provides guidance and harmonisation as to how best to select an NRV-R for iron.

Recommendation 6: Dietary Descriptor for Iron

New Zealand supports the recommendation to adopt a modified version of the WHO/FAO (2006) text to simplify the descriptors as presented in the Agenda paper. It is useful to highlight the importance of a diversified diet for those diets which are able to attain higher dietary absorption of iron.

Iron**	<p>14 (15% dietary absorption; diversified diets, rich in meat, fish, poultry, and/or rich in fruit and vegetables)</p> <p>22 (10% dietary absorption; diets rich in cereals, roots or tubers, with some meat, fish, poultry and/or containing some fruit and vegetables)</p>
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Recommendation 7: Footnote for Iron

New Zealand supports this recommendation.

Recommendation 8: Magnesium

New Zealand is supportive of retaining the current NRV-R of 300 mg for magnesium. However if there is strong support the recommendation in the Agenda paper to establish an NRV-R of 310 mg based on the average of RASBs we would not oppose this. Of the RASBs, all have referred to the use of balance studies which are considered an appropriate method to base magnesium requirements there is no strong rationale to select one RASB over another.

Recommendation 9: Phosphorous

New Zealand supports the recommendation to establish an NRV-R for phosphorous of 700 mg based on the IOM and EFSA reports that this is sufficient to maintain serum P in the normal range and equimolar ratio of calcium to phosphorous.

Recommendation 10: Copper

New Zealand supports the recommendation to establish an NRV-R for copper of 900 µg based on the IOM.

Recommendation 11: Chromium

New Zealand does not support the recommendation to establish an NRV-R for chromium.

There are limitations in the availability of experimental data to establish a nutrient requirement level for chromium as evidenced by all RASBs, two of which did not determine a DIRV for this reason. In addition the scientific opinion published by EFSA most recently reviewed the scientific evidence related to chromium and found insufficient evidence to substantiate its essentiality in the human diet. EFSA stated that the mechanism for the roles of essential function of chromium in metabolism have not been substantiated, that no dose response curve existed, or information on the reversibility of possible deficiency, and that there is no evidence of essentiality in animal nutrition.

Furthermore, no WHO/FAO requirement level has been established nor Codex NRV-R for chromium. As such New Zealand does not consider it necessary to establish an NRV-R for chromium at this time. In addition to this the Codex Guidelines for Vitamin and Mineral Supplements under Section 3.1 Selection of Vitamins and Minerals:

3.1.1 Vitamin and mineral food supplements should contain vitamins/provitamins and minerals whose nutritional value for human beings has been proven by scientific data and **whose status as vitamins and minerals is recognised by FAO and WHO**.

If the Committee wish to proceed to establish an NRV-R for chromium for the purposes of the applicability of these guidelines, then it will be necessary to also establish that FAO and or WHO has recognised the nutritional value of chromium for human beings. This should be considered for all vitamins and minerals for which the WHO/FAO have not established an INL98.

Recommendation 12: Chloride

New Zealand does not support recommendation 12 A or 12 B.

It is not considered necessary to establish an NRV-R for chloride which is not an essential nutrient. Only one RASB (the Institute of Medicine) has established a dietary intake reference value for chloride. The establishment of an NRV-R for the purposes of achieving molar equivalence to sodium is not sufficient scientific justification for either an NRV-R or NRV-NCD as the purpose does not contribute to a nutritional requirement, or reduction of non-communicable disease.

The Agenda paper highlights several issues regarding the establishment of an NRV for chloride. Firstly in establishing an NRV based on equimolar equivalence to sodium this would result in an intake of salt which exceeds the WHO recommendations. The addition of a footnote to explain this would only further complicate this issue. In addition to this it would also result in an NRV-R which exceeds the UL for young children.

Recommendation 13: Vitamin A Dietary Equivalents and Conversion Factors

The approach recommended in the Agenda paper to the vitamin A dietary equivalents and conversion factors is quite complicated and could be seen as confusing. It is preferable that a decision is made as to whether retinol equivalents (RE) or retinol activity equivalents (RAE) are used. In light of the recent EFSA Scientific Opinion, and lack of clear WHO/FAO stance on appropriate conversion factors, New Zealand prefers the use of retinol equivalents at this time.

New Zealand does not support recommendation 13C. Inclusion of molar weight conversion factors of individual fortificants is not considered necessary and is inconsistent with the listing of other nutrients. The amended table does not provide a comprehensive list of all forms of vitamin A which can be added to foods and we question what its purpose is. Although this information is useful for calculation purposes it does not provide a comprehensive list, or advice as to how to apply this principle to other nutrient fortificants.

New Zealand suggests the following for inclusion in the second table to paragraph 3.4.4.1:

Vitamin A	1 µg retinol equivalents (RE) =	1 µg retinol 6 µg β-carotene 12 µg other provitamin A carotenoids
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Regarding recommendation 13 D, NZ supports this recommendation.

Recommendation 14: Vitamin E Dietary Equivalents and Conversion Factors

New Zealand supports this recommendations 14 A and B – to include an entry for vitamin E in the second table to paragraph 3.4.4.1 and to list this as α-tocopherol.

As stated in the previous response, it is not considered necessary to provide the calculation of vitamin E fortificants by molar weighting.

Recommendation 15: Second table heading and footnote

Support recommendation 15 to amend the table heading and footnote.

Recommendation 16: RASB Definition

New Zealand supports recommendation 16 to insert the definition of RASB in the Annex to Guidelines on Nutrition Labelling at new paragraph 2.5. It is important to include this definition for future work related to the establishment of NRV-R or NRV-NCD.

Recommendation 17: Record of NRV-R Decisions

New Zealand supports recommendations 17 A and 17 B to insert a table documenting the details of the basis of the NRVs-R in the Guidelines on Nutrition Labelling. This enables transparency and allows future work in this area to easily review decisions made.

NRVs-R for Older Infants and Young Children

New Zealand agrees in principle to establishing NRVs-R for older infants and young children and acknowledges the thorough process that has been undertaken to draft general principles for the establishment of NRVs-R for this age group. We recommend that the prioritisation of this work should be considered within the Committee given the amount of work that is required to establish NRVs and the current full agenda of the Committee. This prioritisation and timing for this work should also consider the current status of nutrient content and health claims for this age group within the relevant Codex Standards and Guidelines.

As indicated in the in the Agenda Paper, Section 7.1; the *Codex Guidelines for Use of Nutrition and Health Claims* (CAC/GL 23-1997) state that nutrient content and health claims are not permitted on foods for infants and young children except where specifically provided for in the relevant Codex standards or national legislation (paragraph 1.4). Currently, there are no specific provisions for nutrient content or health claims in any Codex standard targeted to this age range. As claims are only able to be made when permitted in national legislation it is unclear if the derivation of Codex NRVs-R for this age group would result in harmonisation. Many national authorities have their own NRVs for labelling purposes and it would be useful to know if there are countries that permit claims for infants and young children but have no NRVs to underpin them. Without this information New Zealand still questions the usefulness of establishing a set of NRVs for this age group at this point in time. If the current provision in Codex texts were to change we would consider this of higher priority. There could be an opportunity to target the development of NRVs-R for older infants and young children for priority nutrients rather than the full list of nutrients which have been derived for the general population.

We look forward to further discussions at the Committee as to the timing of development of NRVs for this age group.

Recommendation 18: Draft General Principles for NRVs-R for Older Infants and Young Children

In principle, New Zealand agrees to the draft General principles with amendments. New Zealand supports the findings of the eWG that two age groups should be considered, and that where possible pragmatic approaches to establishing NRVs-R should be taken.

Regarding **GP X.2.3** it is considered more appropriate to use consistent definitions and approaches to define the applicable age ranges as used in other relevant Codex Standards as referred to in Section 7.3. The wording could either be included as illustrated below, or provided as a definition either in the footnote or definitions section of the Guideline.

x.2.3 The DIRVs should reflect intake recommendations for older infants (**from the 6th month of age and not more than 12 months**); and young **children more the age of 12 months up to the age of three years (36 months)**.

GP X.3.1.1: This GP refers to the preference to select INL98 values. In the case of DIRVs for this age group, particularly older infants, these values are rarely established and often do not provide a more scientifically robust nutrient requirement value. Consequently this GP may not be as important to include.

Recommendation 19 – Consequential amendments to age of general population in Nutrition Labelling Guidelines

New Zealand supports this recommendation.

References

1. EFSA (European Food Safety Authority). Scientific opinion on dietary reference values for vitamin A. *EFSA Journal*. 2015;13(3):4028.
2. IOM (Institute of Medicine). *Dietary reference intakes for vitamin A, vitamin K, arsenic, boron, chromium, copper, iodine, iron, manganese, molybdenum, nickel, silicon, vanadium, and zinc*. Washington DC, USA: National Academies Press; 2001.
3. Olson JA. Recommended dietary intakes (RDI) of vitamin A in humans. *Am J Clin Nutr*. 1987;45(4):704-716.
4. WHO/FAO. Vitamin and mineral requirements in human nutrition: Report of a joint FAO/WHO expert consultation, Bangkok, Thailand, 21-30 September 1998. . 2004;World Health Organisation and Food and Agriculture Organization of the United Nations.
5. EFSA (European Food Safety Authority). Scientific opinion on dietary reference values for vitamin E as α -tocopherol. *EFSA Journal*. 2015;13(7):4149.
6. National Health and Medical Research Council (AU). Nutrient reference values for Australia and New Zealand including recommended dietary intakes. 2006. <http://www.nhmrc.gov.au/publications/synopses/n35syn.htm>.

UNITED STATES OF AMERICA

General Comments

The United States agrees with the proposed NRV-R values (vitamin A, vitamin E, iron, magnesium, phosphorus, copper, chromium) and the dietary description and accompanying footnotes for iron.

The United States suggests considering a consistent approach for deriving NRVs. For some nutrients, (vitamin E (based on AIs) and Magnesium (INL98s based on balance studies)), we note that the proposed NRV uses the average of values from RASBs using the endpoint, while for other nutrients, (vitamin A, phosphorus, copper), the proposed NRV is based on a single RASB, even though other RASBs provide DIRVs that are based on the same endpoint. The United States suggests that a consistent approach for deriving NRV's be followed.

Proposed NRV-R for Vitamin D and Footnote

The United States supports using the IOM DIRV of 15 μ g based on the physiological endpoint of serum 25(OH)D associated with bone health and limited exposure to sunlight and suggests including a footnote to reflect the IOM's assumption of limited exposure to sunlight for clarity.

Proposed NRV-R for Chloride

The United States supports establishing a NRV-R for chloride based on the IOM AI of 2300 mg. The IOM AI is based on requirements equimolar to the IOM AI for sodium. However, we do not support using 3000 mg, a value equimolar with the NRV-NCD for sodium, because the criteria for establishing a NRV-NCD for chloride are not met as an NCD endpoint specific to chloride intake is lacking.

Vitamin A Dietary Equivalents and Conversion Factors

The United States supports using "RAE" as the only unit of measure for vitamin A and using one set of vitamin A dietary equivalents: 1 µg retinol of 12 for beta-carotene and 24 for the other provitamin A carotenoids. Providing two units of measure (RAE and RE and their proposed respective conversion factors) would be unclear and may create confusion for countries in determining which unit of measure to use.

AFRICAN UNION

Recommendation 1: NRV-R for Vitamin A

Position: AU supports the adoption of the recommendation.

Rationale: The AU considers the proposed level safe to the population and that such level will complement the effort in Vitamin A deficiency management in the region. Vitamin A is physiologically important especially in relation to body immunity and in vision. Vitamin A contributes to reduction of mortality in children under five years of age.

Recommendation 2 and 3: NRV-R for Vitamin D

Position: AU proposes maintaining 5 µg. In addition, a footnote should be introduced to allow national authorities to adjust the levels up to 15 µg.

Rationale: Vitamin D deficiency is mainly related to the exposure to sunlight. Countries within the tropics ideally have a reliable exposure that would enable the people in those region syntheses enough Vitamin D. However, other countries which do not have such exposure may need to have vitamin D supplied through diet and hence the need to allow national authorities the latitude to make a decision on the same.

Recommendation 4: NRV-R for Vitamin E

Position: AU supports adoption of the recommendation

Rationale: Vitamin E is an important antioxidant in the body and the proposed levels are physiologically adequate for its function.

Recommendation 5: NRV-R for Iron

Position: Support adoption of the recommendation

Recommendation 6: Dietary Description for Iron

Position: AU supports its adoption

Recommendation 7: Footnote to NRV-R for Iron

Position: AU supports the adoption of the recommendation

Rationale for iron related recommendations: Quality of absorption of iron and zinc depends on the source (Animal sources are better absorbed as compared to plant sources e.g. the heme and non heme iron.)

Recommendation 8: NRV-R for Magnesium

Position: AU supports the adoption

Rationale: Magnesium is important mineral in the normal functioning of body muscles including the heart and therefore the proposed level will support this function especially with the increased cardiovascular complications

Recommendation 9: NRV-R for Phosphorus

Position: AU recommends the adoption of 550 mg as opposed to 700 mg

Rationale: For proper absorption of phosphorus, a Ca:P ration of 2:1 is optimal and will ensure that both calcium and Phosphorus is well absorbed in the body. 550 mg will ensure a ratio of 1.8 which is quite within the range of optimal absorption.

Recommendation 10: NRV-R for Copper

Position: AU supports the adoption

Rationale: Cu is important element in the body coenzymes and this level is both safe and efficacious.

Recommendation 11: NRV-R for Chromium

Position: AU supports the adoption and further studies

Rationale: There is little information in regard to Cr though generally accepted that it plays an important role of body metabolism. The other RASBs should be encouraged to carry out further review on this element either to confirm the above level or form basis of its revision in future.

Recommendation 12: NRV-R for Chloride

Position: AU supports adoption of part A of the recommendation and a 3000 mg for the NRV

Rationale: 3 000 mg is based on the molar ratio of sodium to chloride which is the primary source of chloride in the body. Since the committee had already adopted a NRV of 2 000 mg for Na and that WHO recommends a consumption of 5 g (5000 mg) of salt (mainly in the form of NaCl), therefore 3, 000 mg will be appropriate NRV for Cl.

Recommendation 13: Vitamin A Dietary Equivalents and Conversion Factors

Position: AU supports adoption of the recommendation

Rationale: This will allow comparison of various forms of Vitamin A and same interpretation of results.

Recommendation 14: Vitamin E Dietary Equivalents and Conversion Factors

Position: AU supports the adoption

Rationale: This will allow comparison of various forms of Vitamin E and same interpretation of results.

Recommendation 15: Second Table Heading and Footnote

Position: AU supports the adoption

Rationale: The footnote as amended will add clarity to the table and ensure consistency in the guidelines

Recommendation 16: RASB Definition in *Guidelines on Nutrition Labelling*

Position: AU supports the adoption

Rationale: Enhances common understanding for the terminology.

Recommendation 17: RECORD of NRV-R DECISIONS

Position: AU supports the adoption of the recommendation

Recommendation 18 and 19 Approach to establish NRVS-R for older infants and young children

Position: AU supports the adoption of the 2 recommendations.

ELC – Federation of European Specialty Food Ingredients Industries

We have comments on recommendations 1 on vitamin A, 2 and 3 on vitamin D, 4 on vitamin E, 13 on conversion factors for vitamin A, 14 on conversion factors for vitamin E.

Recommendation 1 – NRV-R for Vitamin A

We support the proposal to retain the NRV-R for vitamin A at 800 µg which is consistent with many values around the globe.

Recommendation 2 – NRV-R for Vitamin D

We fully support the increase of the NRV-R for vitamin D. Recent scientific evidence demonstrate that the key role of vitamin D is a number of metabolic pathways and its positive impact on health. Recent data shows that a vitamin D intake of 20 µg/day reduces the risk of osteoporosis and decrease the risk of falling in relation to its role in muscle strength. EFSA gave a positive EFSA opinion on the role of vitamin D in reducing the risk of falling. This opinion has been translated into an EU authorized claim.

We believe a value of 15 µg should be used. 75 nmol is recognized as the serum level necessary for beneficial effects. To achieve the circulating level, at least 20 µg of vitamin D is needed. Therefore a value of 10 µg would be too low. The question of sun exposure is valid only to a certain extent. It's well known that people leaving countries enjoying sunny weather usually have low serum level of vitamin D. This is due to diverse reasons: staying inside, limited exposure to sun, sunscreens...

Recommendation 3 – Footnote to NRV-R for Vitamin D

We agree with the inclusion of a footnote but believe there is an inversion in the text above the footnote.

The text reads as follows:

“Given the previous application of a footnote to the vitamin D NRV-R and the wide range of global sunlight exposure and other relevant factors, a footnote similarly expressed to the current zinc footnote is

recommended. The footnote text refers to 'minimal' instead of 'limited' and has two options subject to the CCNFSDU decision on Recommendation #2: [throughout the year] if 15 µg is preferred, or [in winter] if 10 µg is preferred. *The NRV-R is based on minimal sunlight exposure [throughout the year] [in winter]. Competent national and/or regional authorities should determine an appropriate NRV-R that best accounts for population sunlight exposure and other relevant factors.*"

Sunlight is more important during summer time therefore if the reference taken is "throughout the year" then the corresponding NRV-R value should be the lowest one.

On the opposite, in winter time, the sunlight is short and less strong and therefore when the reference taken is "winter" only, then the corresponding NRV-R value should be the highest one.

Therefore if 15 µg is chosen, the footnote should read

*"The NRV-R is based on minimal sunlight exposure **in winter**. Competent national and/or regional authorities should determine an appropriate NRV-R that best accounts for population sunlight exposure and other relevant factors."*

If the final choice is 10 µg, then the footnote should read:

*"The NRV-R is based on minimal sunlight exposure **throughout the year**. Competent national and/or regional authorities should determine an appropriate NRV-R that best accounts for population sunlight exposure and other relevant factors."*

Recommendation 4 – NRV-R for Vitamin E

We disagree with the recommendation to establish a value for vitamin E at 9 mg. **We strongly believe that a value of 15 mg** allows for correct protection of long-chain PUFAs. This value is in line with the DACH recommendations (levels between 12 and 15 mg for men and 11 to 13 mg for women and taking into account the PUFA intakes). In a recent publication (see Annex), a vitamin E requirement of 12 to 20 mg RRR-alpha-tocopherol was calculated to be necessary to protect consideration a typical intake of dietary PUFAs from being oxidized in the cell membrane. As lots of countries currently recommend to increase the consumption of PUFAs, we believe this is a strong argument to go for a higher NRV-R for vitamin E. We would also like to comment on the fact that IOM value is not overestimated. IOM took a different approach when setting the value at 15 mg. However, values from DACH and IOM are convergent.

Recommendation 13 – Vitamin A Dietary Equivalents and Conversion Factors

We agree with recommendation 13 and keeping the 2 different conversion RAE and RE due to various usages around the world.

IADSA – International Alliance of Dietary/ Food Supplement Associations

Recommendation 1 — NRV-R for Vitamin A

IADSA agrees to an NRV-R of 800 µg based on the IOM INL₉₈. IADSA notes that in its response in May 2015 it was pointed out that the average values of 750 µg/day from EFSA for males, 765/day from NIH and 800 µg/day from IOM is 772 µg/day, when rounded up is 800 µg/day. The NRV-R of 800 µg/day is justified by the approaches developed by the eWG.

Recommendation 2 — NRV-R for Vitamin D

A IADSA supports the recommendation to revise upwards the NRV-R from 5 µg.

B IADSA confirms that the emphasis should be on the most recent review and based on INL₉₈ values. In this case, both Nordic and IOM values could be acceptable. The IOM value of 15 µg is preferred. To date, the EFSA scientific opinion is not available. The UK Scientific Advisory Committee on Nutrition (SACN) consultation is continuing on its July 2015 draft report on vitamin D and health. An RNI for vitamin D of 10 µg/day is proposed. However, concerns have been expressed that, for the growing number of elderly people, a higher amount of vitamin D (15 µg/day) should be provided on a daily basis to ensure that stable circulating concentrations in the blood plasma and levels in other tissues are maintained over time.

Recommendation 3 — Footnote to NRV-R for Vitamin D

A IADSA agrees to the establishment of a suitable footnote.

B IADSA proposes the wording as follows:

~~"The NRV-R is based on minimal exposure [throughout the year] [in winter]. Competent national and/or regional authorities should determine an appropriate NRV-R that best accounts for population sunlight exposure and other relevant factors."~~

The current eWG proposed footnote could be misleading to national / regional authorities when determining the NRV-R for the population. Factors including modern behaviors such as the use of sunscreen, limited outdoor activities, etc. shall also be taken into consideration, since these factors have made sunlight an unreliable source of vitamin D.

IADSA believes that a single, harmonised NRV-R should be established globally rather than having the amount left to individual competent authorities to set.

Recommendation 4 — NRV-R for vitamin E

IADSA accepts that the appropriate candidate DIRVs are in the range 9–15 mg. However, IADSA continues to support a value of 12 mg based on the rationale of EFSA AIs of 13 mg/day for males and 11 mg/day for females, the average values of IOM, Nordic Council of Ministers and EFSA values, and the average values of IOM and WHO/FAO values.

Recommendation 5 — NRV-R for Iron

IADSA accepts that regional phytate intakes vary considerably around the world, and that there is a body of opinion within the eWG which concludes that two levels of dietary absorption are appropriate, along with corresponding dietary descriptions. IADSA still prefers a single value for nutrition labelling purposes of 14 mg and an average absorption of 16 or 17%. IADSA is doubtful of the underlying science supporting vastly different DIRV amounts of 14 mg and 22 mg based on absorption levels of 15% and 10%, respectively.

Recommendations 6 and 7 — Dietary description for iron/footnote for iron

IADSA supports the use of appropriate dietary descriptions consistent with similar statements for zinc. However, IADSA reiterates the point of view that for nutrition labelling purposes, a single, harmonised value for the NRV-R for iron and an absorption value of 16 or 17% would be preferred.

Recommendation 8 — NRV-R for Magnesium

IADSA agrees to the revision of the NRV-R from 300 mg to 310 mg.

Recommendation 9 — NRV-R for Phosphorus

IADSA agrees to the establishment of an NRV-R for phosphorus of 700 mg.

Recommendation 10 — NRV-R for Copper

IADSA has considered the points identified in CX/NFSDU 15/37/4 and supports a value in the range 850–900 µg based on depletion/repletion studies. IADSA noted in the previous consultation that the IOM value of 900 µg was in fact a rounded-up value from 850 µg, and that the average of IOM and NIH based on INL₉₈ values was also 850 µg. IADSA has no strong preference in the choice of 850 or 900 µg.

Recommendation 11 — NRV-R for Chromium

IADSA agrees to the proposal to establish an NRV-R of 30 µg.

Recommendation 12 — NRV-R for Chloride

IADSA strongly supports a single value for the establishment of an NRV-R for chloride. The technical rationale proposed by the eWG to relate the values for sodium and chloride to the WHO recommendation for salt (5 g salt/day) provides an interesting and pragmatic solution to having an NRV-R for chloride of 3000 mg for nutrition labelling purposes.

Recommendation 13 — Vitamin A Dietary Equivalents and Conversion Factors

IADSA agrees with the proposals A, B, C and D suggested by the eWG Chair. IADSA continues to support separate label declarations of the amount of a particular carotenoid in a product, wherever possible.

Recommendation 14 — Vitamin E Dietary Equivalents and Conversion Factors

IADSA agrees with proposals A, B and C.

IADSA would however recommend that the inclusion of the three forms should be accompanied by a footnote that would emphasise that these forms are examples of common forms of vitamin E added to foods. This footnote would avoid that the three key examples should be regarded as the only forms permitted for use in foods.

Recommendation 15 — Second Table Heading and Footnote

IADSA agrees to the proposed revisions in section 4.5.

Recommendation 16 — RASB definition in Guidelines on Nutrition Labelling

IADSA agrees that the inclusion of the definition of RASB is vitally important, not only for the establishment of NRVs-R but also for NRVs-NCD.

Recommendation 17 — Record of NRV-R decisions

IADSA supports the recommendation to:

A Record the details of all NRVs-R from this revision in the Annex to the Guidelines on Nutrition Labelling.

B Insert a table in Section 6 into the Annex at new Section 4 updated to include decisions from this session of CCNFSDU.

Recommendation 18 — Draft General Principles for NRVs-R for older infants and young children

IADSA supports the Draft General Principles in Section 8.

Recommendation 19 — Consequential amendments to age of general population in the Guidelines on Nutrition Labelling

IADSA agrees to the change to “36 months and older”.

ISDI – International Special Dietary Foods Industries

GENERAL COMMENTS

SECTION 7 - APPROACH TO ESTABLISH NRVs-R FOR OLDER INFANTS AND YOUNG CHILDREN (TOR3)	ISDI COMMENTS
<p>In accordance with eWG’s 3rd term of reference, an approach was considered to establishing NRVs-R for labelling purposes for older infants and young children, aged 6–36 months for the same nutrients for which NRVs-R are established for the general population. The following sections consider the purpose of these NRVs-R, the population groups and their age ranges, calculation issues and the relative value of NRVs-R for older infants and young children compared with those for the general population.</p>	<p>ISDI agrees on the general approach to establish NRV-R for older infants and young children. However ISDI would like to seek clarification on the scope/target of the usage of these NRV-R for labeling and considers, at this stage, that they should be limited to foods specifically formulated for 6-36 month olds. These foods are covered by the following Codex standards and guidelines:</p> <ul style="list-style-type: none"> • Follow-up formula (STAN 156–1987) • Processed cereal-based foods (STAN 74–1981 Rev.1-2006) • Canned baby foods (STAN 73–1981) • Formulated complementary foods for Older Infants and Young Children (CAC/GL 8–1991 Rev 2013) <p>The application of NRVs-R for labelling purposes needs to be considered in the context of the [essential] composition and labelling requirements of these standards and guidelines.</p>
JUSTIFICATION	
<p>Products that are covered by one of these 4 Codex standards and guidelines are specifically formulated for this particular age group. These standards and guidelines impose specific requirements on improving safety and quality of the product aiming to protect the older infants and young children (such as additives and contaminants).</p>	

SECTION 8 - DRAFT GENERAL PRINCIPLES FOR ESTABLISHING NRVs-R FOR OLDER INFANTS AND YOUNG CHILDREN	ISDI COMMENTS
<p>X.2.3 The DIRVs should reflect intake recommendations for older infants within an age range of 6–<13 months, and for young children within an age range of 1–<4 years.</p>	<p>X.2.3 The DIRVs should reflect intake recommendations for older infants within an age range of 6 to 12 months, and for young children within an age range of 1 to 3 years (12 to 36 months).</p>
JUSTIFICATION	
<p>Alignment with the relevant Codex Standards</p>	

SPECIFIC COMMENTS

RECOMMENDATION 18: DRAFT GENERAL PRINCIPLES FOR NRVS-R FOR OLDER INFANTS AND YOUNG CHILDREN	ISDI COMMENTS
That CCNFSDU agrees to the draft General Principles presented in section 8.	ISDI supports the general principles of section 8 as proposed. <ul style="list-style-type: none"> • Different NRVs-R for older infant and young children • Older infants (6-12 months, 7 month span) and young children (13-35 months , 23 months span) in line with Codex for formulated complementary foods for older infant /young children and with FuF discussion DIRV from any acceptable RASBs on case to case basis for relevance ,as a basis.
JUSTIFICATION	
N.A.	

RECOMMENDATION 19: CONSEQUENTIAL AMENDMENTS TO AGE OF GENERAL POPULATION IN NUTRITION LABELLING GUIDELINES	ISDI COMMENTS
Subject to agreement to Recommendation #18, that CCNFSDU agrees to revise 'older than 36 months' to '36 months and older' in paragraph 3.4.4, the Annex Preamble and GP 3.2.1.2.in the Guidelines on Nutrition Labelling.	ISDI supports the revision of the NRVs by CCNFSDU for children above 3 years (3 years and older). The distinction should be made between Young Children (12-36 months) and Children (above 36 months).
JUSTIFICATION	
N.A.	