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1 Draft general scientific guidance for stakeholders on 2 health claim applications

3 EFSA Panel on Dietetic Products, Nutrition and Allergies (NDA)

4 Abstract

5 The European Food Safety Authority asked the Panel on Dietetic Products Nutrition and Allergies to
6 update the General guidance for stakeholders on the evaluation of Article 13.1, 13.5 and 14 health
7 claims published in March 2011. Since then, the NDA Panel has completed the evaluation of Article
8 13.1 claims except for claims put on hold by the European Commission, and has evaluated additional
9 health claim applications submitted pursuant to Articles 13.5, 14 and also 19. In addition, comments
10 received from stakeholders indicate that general issues that are common to all health claims need to
11 be further clarified and addressed. This guidance document aims to explain the general scientific
12 principles applied by the NDA Panel for the evaluation of all health claims and outlines a series of
13 steps for the compilation of applications. The general guidance document represents the views of the
14 NDA Panel based on the experience gained to date with the evaluation of health claims, and it may be
15 further updated, as appropriate, when additional issues are addressed.

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18 **Keywords:** guidance, health claims, general principles, scientific aspects, applications

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41

42 **Summary**

43 The European Food Safety Authority (EFSA) asked the Panel on Dietetic Products Nutrition and
44 Allergies (NDA) to update the General guidance for stakeholders on the evaluation of Article 13.1,
45 13.5 and 14 health claims published in March 2011.

46 Since then, the NDA Panel has completed the evaluation of Article 13.1 claims (except for claims put
47 on hold by the European Commission), and has evaluated additional health claim applications
48 submitted pursuant to Articles 13.5, 14 and also 19. In addition, comments received from
49 stakeholders indicate that general issues that are common to all health claims need to be further
50 clarified and addressed.

51 This guidance document aims to explain the general scientific principles applied by the NDA Panel for
52 the evaluation of all health claims and outlines a series of steps for the compilation of applications.

53 Once it is adopted, it will supersede the General guidance for stakeholders on the evaluation of Article
54 13.1, 13.5 and 14 health claims and the pre-submission guidance on administrative and procedural
55 questions for applicants intending to submit applications for authorisation of health claims made on
56 foods.

57 The guidance document was subject to public consultation (17 July to 11 September 2015). The
58 general guidance document represents the views of the NDA Panel based on the experience gained to
59 date with the evaluation of health claims, and it may be further updated, as appropriate, when
60 additional issues are addressed.

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111

112 **Background and Terms of Reference as provided by EFSA**

113 **Background**

114 Regulation (EC) No 1924/2006¹ harmonises the provisions related to nutrition and health claims and
115 establishes rules governing the Community authorisation of health claims made on foods. According to
116 the Regulation, health claims should be only authorised for use in the Community after a scientific
117 assessment of the highest possible standard to be carried out by EFSA.

118 Owing to the scientific and technical complexity of health claims, the EFSA Panel on Dietetic products,
119 Nutrition and Allergies (NDA Panel) has placed considerable focus on developing scientific criteria for
120 substantiation of health claims and has published guidance documents on the scientific substantiation
121 of health claims since 2007².

122 Based on experience gained with the evaluation of health claims and taking into account outcomes of
123 public consultation³, it is noted that general issues that are common to all health claims (e.g. general
124 principles, administrative and procedural aspects related to the health claim evaluation process) need
125 to be further clarified and addressed in the general guidance document for stakeholders to assist
126 applicants in preparing and submitting their applications for the scientific evaluation of health claims.

127 To this end, the NDA Panel is asked to update the General guidance for stakeholders on the
128 evaluation of Article 13.1, 13.5 and 14 health claims⁴.

129 **Terms of reference**

130 The NDA Panel is requested by EFSA to update the General guidance for stakeholders on the
131 evaluation of Article 13.1, 13.5 and 14 health claims.

132 The guidance document shall clarify and address general issues that are common to all health claims
133 (i.e. pursuant to Articles 13.1, 13.5, 14 and 19 of Regulation (EC) No 1924/2006), taking into account
134 the experience gained with the evaluation of health claims by the NDA Panel including outcomes of
135 public consultation.

136 The draft guidance shall be released for public consultation prior to finalisation.

137 Before the adoption of the guidance document by the NDA Panel, the draft guidance needs to be
138 revised taking into account the comments received during the public consultation.

139 A technical report on the outcome of the public consultation on the guidance document shall be
140 published.

¹ Regulation (EC) No 1924/2006 of the European Parliament and of the Council of 20 December 2006 on nutrition and health claims made on foods. OJ L 404, 30.12.2006, p. 9–25.

² <http://www.efsa.europa.eu/en/nda/ndaclaims.htm>

³ <http://www.efsa.europa.eu/en/supporting/pub/758e.htm>

⁴ <http://www.efsa.europa.eu/en/efsajournal/pub/2135.htm>

141 **Assessment**

142 **1. Introduction**

143 The general guidance for stakeholders on the evaluation of Article 13.1, 13.5 and 14 health claims,
 144 published in March 2011⁵, laid down the general principles applied by the EFSA Panel on Dietetic
 145 products, Nutrition and Allergies (NDA Panel) for the evaluation of health claims and was based on the
 146 experience gained by the NDA Panel from earlier evaluations.

147 Since then, the NDA Panel has completed the evaluation of Article 13.1 claims (except for claims put
 148 on hold by the European Commission), and has evaluated additional health claim applications
 149 submitted pursuant to Articles 13.5, 14 and also 19. In addition, comments received from
 150 stakeholders during public consultations on guidance documents for health claims on specific areas⁶,
 151 during stakeholder meetings, and by e-mail through the EFSA's Application Desk, indicate that an
 152 update on general issues that are common to all health claims is needed.

153 This guidance document aims to explain the general scientific principles applied by the NDA Panel for
 154 the evaluation of all health claims and outlines a series of steps for the compilation of applications.

155 The draft guidance was discussed and endorsed at the NDA Plenary meeting on 30 June 2015 for
 156 release for public consultation. Once adopted, it will supersede the guidance published in 2011⁷, and
 157 the Pre-submission guidance for applicants published in 2007⁸.

158 **2. Objectives and scope**

159 This guidance is intended to assist applicants in preparing applications for the authorisation of health
 160 claims (pursuant to articles 13.5, 14 and 19 of Regulation (EC) No 1924/2006) through an
 161 understanding of:

- 162 a) the general principles which have been applied by the NDA Panel for the scientific evaluation
 of health claim applications;
- 163 b) the elements which should be considered by applicants for the compilation of applications.

165 Examples drawn from previous evaluations are used in this guidance to illustrate these aspects. This
 166 document does not intend to cover potential future health claims which have not been evaluated by
 167 the Panel, or provide detailed advice on specific applications.

168 This guidance should be read in conjunction with the Scientific and technical guidance for the
 169 preparation and presentation of an application for authorisation of a health claim⁹, Regulation on
 170 Nutrition and Health Claims made on foods¹⁰, Guidance on the implementation of Regulation (EC) N°
 171 1924/2006¹¹, Commission Regulation (EC) No 353/2008¹², Commission Implementing Decision of 24
 172 January 2013¹³, and future guidelines and regulations, as applicable.

173

⁵ <http://www.efsa.europa.eu/en/efsajournal/pub/2135.htm>

⁶ <http://www.efsa.europa.eu/en/supporting/pub/758e.htm>

⁷ <http://www.efsa.europa.eu/en/efsajournal/pub/2135.htm>

⁸ <http://www.efsa.europa.eu/en/ndaguidance/docs/ndapresubmissionguidance.pdf>

⁹ <http://www.efsa.europa.eu/en/efsajournal/pub/2170.htm>

¹⁰ Regulation (EC) No 1924/2006 of the European Parliament and of the Council of 20 December 2006 on nutrition and health claims made on foods. OJ L 404, 30.12.2006, p. 9–25. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:2006R1924:20100302:EN:PDF>

¹¹ Guidance on the implementation of Regulation (EC) No 1924/2006 on nutrition and health claims made on foods – Conclusions of the Standing Committee on the Food Chain and Animal Health, 14 December 2007. http://ec.europa.eu/food/food/labellingnutrition/claims/guidance_claim_14-12-07.pdf

¹² Commission Regulation (EC) No 353/2008 of 18 April 2008 establishing implementing rules for applications for authorisation of health claims as provided for in Article 15 of Regulation (EC) No 1924/2006 of the European Parliament and of the Council (Text with EEA relevance) (OJ L 109, 19.4.2008, p. 11): <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:2008R0353:20091221:EN:PDF>

¹³ Commission Implementing Decision of 24 January 2013 adopting guidelines for the implementation of specific conditions for health claims laid down in Article 10 of Regulation (EC) No 1924/2006 of the European Parliament and of the Council. OJ L 22, 25.1.2013, p. 25–28. <http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32013D0063>

174 3. Definition of terms

175 In the context of this guidance document:

- 176 - **Food/constituent** means a food category, a food or a food constituent (e.g. a nutrient or
177 other substance, or a fixed combination of nutrients/other substances).
- 178 - The term **essential nutrient** refers to a substance that must be obtained from the diet
179 because the body cannot make it, or cannot make it in sufficient quantities for normal
180 function(s).
- 181 - **Other substance** means any food/constituent which is **not** an essential nutrient.
- 182 - **Efficacy study** refers to an intervention study (in humans, in animals) which investigates the
183 relationship between the food/constituent and the claimed effect.
- 184 - **Pertinent study** means a human study from which scientific conclusions can be drawn for
185 the substantiation of a claim.
- 186 - The **totality of the evidence** describes all the studies (e.g. in humans, in animals, *in vitro*)
187 which are taken into consideration to conclude on the substantiation of a claim (including
188 studies in favour and not in favour of the claim).
- 189 - **Supportive evidence** refers to studies/data which, on their own, are not sufficient for the
190 scientific substantiation of a claim, but may become part of the totality of the evidence if
191 pertinent human (efficacy) studies are available.
- 192 - A **study group** is considered as **representative** of the target population for a claim (i.e. the
193 general healthy population or subgroups thereof) when the study subjects have been
194 randomly selected from the target population and not on the basis of a particular
195 characteristic which may limit the generalisation of the results obtained to the target
196 population for a claim.
- 197 - A **suitable study group** means a study group which is representative of the target
198 population for the claim or a study group from which extrapolation of the results to the target
199 population is biologically plausible.

200 4. What is the legal framework for the authorisation of health claims 201 in the EU? Who does what and when?

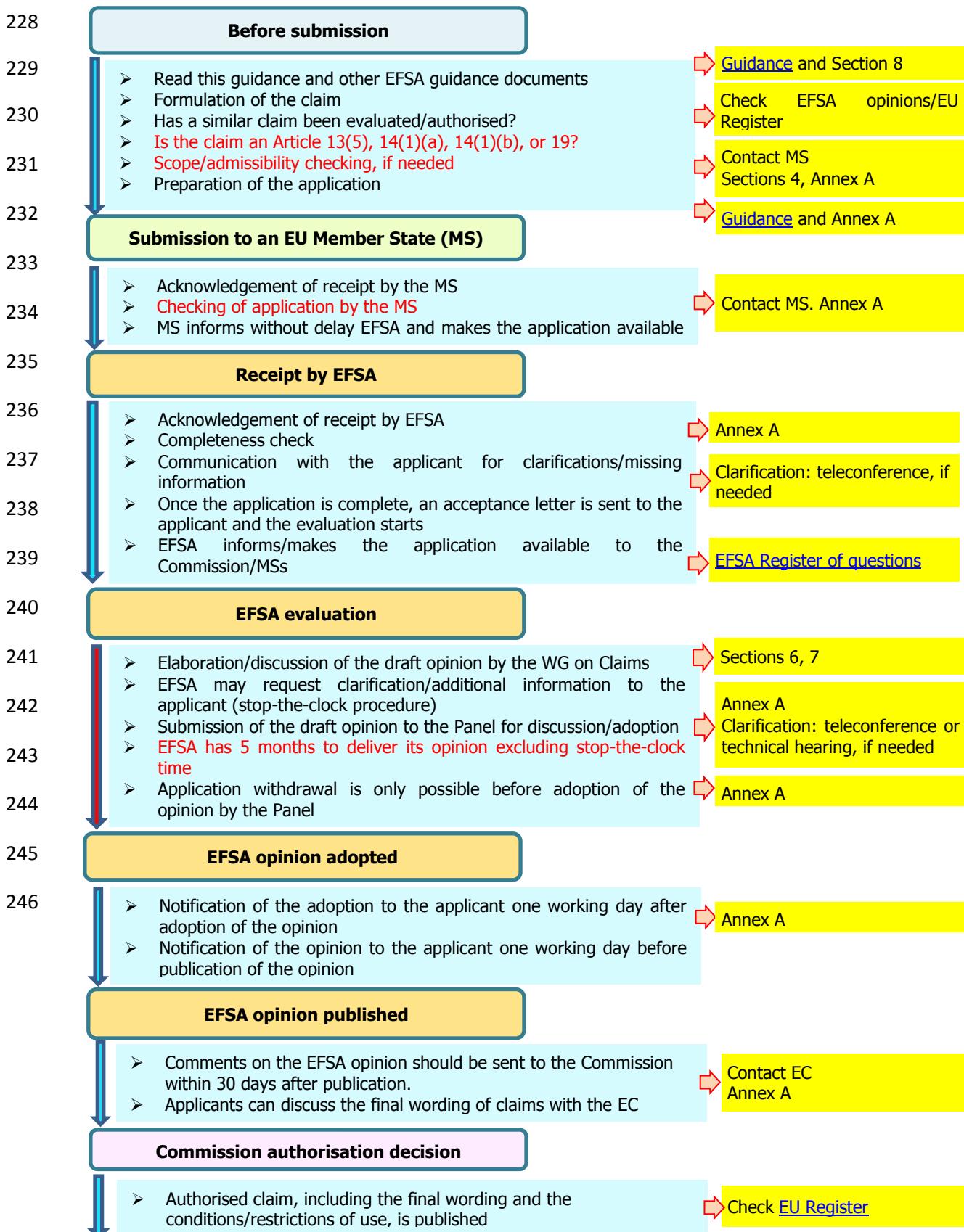
202 The process of authorisation of health claims made on food is governed by Regulation (EC) No
203 1924/2006¹⁴. **Figure 1** summarises the key steps of the process, as well as the main players at each
204 step. **Annex A** explains the administrative and procedural aspects of applications, from claim
205 formulation to authorisation.

206 It is the responsibility of risk managers (i.e. the European Commission and the Member States), but
207 **not** EFSA, to decide on whether or not a health claim falls under the scope of Regulation (EC) No
208 1924/2006, e.g. whether a health claim is/is not a medicinal claim. This responsibility includes
209 decisions on the admissibility of the target population for a claim (e.g. whether or not subjects under
210 medications can be the target population for health claims made on foods).

211 Regulation (EC) No 1924/2006 establishes that health claims should be scientifically substantiated by
212 generally accepted scientific evidence (Article 6.1), by taking into account the totality of the available
213 scientific data, and by weighing the evidence (Recital 17). Health claims should only be authorised for
214 use in the Community after a scientific assessment of the highest possible standard (Recital 23).
215 Regulation (EC) No 1924/2006 also establishes that, in order to ensure harmonised scientific
216 assessment of these claims, EFSA should carry out such assessments (Recital 23). Within this
217 framework, the NDA Panel applies similar criteria for all health claims and considers whether the
218 beneficial effect of a food/constituent on a function or a risk factor for disease is substantiated by
219 generally accepted scientific evidence, by taking into account the totality of the available scientific
220 data, and by weighing the evidence (see section 6). It should be noted that a safety assessment is not
221 foreseen under the framework of Regulation (EC) No 1924/2006.

¹⁴ <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:02006R1924-20121129&from=EN>

222 Decisions regarding the authorisation of health claims, including the final wording and the
223 conditions/restrictions of use, are taken by risk managers, and **not** EFSA. In order to make such
224 decisions, risk managers may take into account other legitimate factors, such as safety aspects (e.g.
225 to modify the conditions/restrictions of use) or consumer understanding (e.g. to modify the wording of
226 the claim), in addition to EFSA's scientific evaluation.

227 **Figure 1: Key steps in the process of authorisation of health claims made on food**

247 5. Scientific standards *versus* regulatory requirements

248 Article 7(3) of Regulation (EU) No 1169/2011¹⁵ states: food information to consumers shall not
 249 attribute to any food the property of preventing, treating or curing a human disease, nor refer to such
 250 properties. In addition, Article 2(6) of Regulation (EC) No 1924/2006 defines a 'reduction of disease
 251 risk claim' as any health claim that states, suggests or implies that the consumption of a food
 252 category, a food or one of its constituents significantly reduces a risk factor in the development of a
 253 human disease. The Regulation, therefore, indicates that, for the purpose of communicating the
 254 health properties of a food/constituent to consumers:

- 255 a) subjects with a disease cannot be the target population for health claims made on food;
- 256 b) function claims cannot refer to a disease;
- 257 c) disease risk reduction claims cannot refer to the reduction of the risk of a disease, but should refer
 258 to the reduction of a risk factor for disease¹⁶.

259 However, stakeholders have noted that this regulatory framework may be in contradiction to some
 260 basic scientific principles which have governed the assessment of the relationship between
 261 food/constituents and health, such as:

- 262 a) several studies investigating whether or not, and how, a food/constituent exerts a beneficial effect
 263 on a function have been conducted in subjects meeting the diagnostic criteria for a disease which
 264 negatively affects such function. In addition, the first-line therapy for patients with diet-related chronic
 265 diseases (e.g. obesity, type 2 diabetes, hypertension) is often dietary advice, and thus they could
 266 benefit the most from health claims made on foods;
- 267 b) in some cases, the relationship between a food/constituent and a function can be best measured
 268 by using disease outcomes¹⁷;
- 269 c) with respect to the likelihood that the consumption of a food/constituent would effectively modify
 270 the risk of the disease, disease outcomes provide stronger evidence than risk factors for disease. In
 271 addition, in some circumstances it may be easier to measure disease outcomes than risk factors for
 272 disease¹⁸.

273 In order to fill the gap between the above-mentioned scientific principles and regulatory requirements,
 274 the NDA Panel has worked with applicants during the evaluation of applications on the formulation of
 275 health claims which could allow a scientific evaluation with the type of human studies provided but
 276 also comply with the requirements of Regulation (EU) No 1169/2011, as follows:

- 277 a) studies conducted in subjects with a disease may be used to substantiate function claims for the
 278 general population or subgroups thereof (without the disease) as long as the effect of the
 279 food/constituent on the body function which is named in the claim is expected to occur in subjects
 280 without the disease and a rationale is given for such expectations¹⁹.

¹⁵ <http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32011R1169&from=EN>

¹⁶ For example, claims on the reduction of the risk for coronary heart disease (CHD) cannot be made, but they must refer to the reduction of a risk factor for CHD (e.g. LDL-cholesterol, blood pressure).

¹⁷ For example, the effect of a food/constituent on cardiac function can be measured by its effects on CHD disease outcomes <http://www.efsa.europa.eu/en/efsajournal/doc/1796.pdf>

¹⁸ For example, it may be easier to assess the incidence/severity/duration of lower urinary tract infections than the inhibition of bacterial adhesion to the bladder wall *in vivo* in humans.

¹⁹ For example, studies in obese subjects could be used to substantiate a claim on the reduction of body weight addressed to overweight adults <http://www.efsa.europa.eu/en/search/doc/1798.pdf>, whereas studies on subjects with arthritis of various origins (rheumatoid arthritis, psoriatic arthritis, arthritis of infectious origin) and which relate to the treatment of symptoms of the disease cannot be considered for the scientific substantiation of health claims on joint function for the general population.

289 b) longitudinal (observational and intervention) studies on the relationship between a food/constituent
 290 and the incidence²⁰ of disease in subjects free of disease at recruitment may be used to substantiate
 291 claims on a function which affects the development of the disease²¹.

292 c) studies on the relationship between a food/constituent and the incidence²² of disease in subjects
 293 free of disease at recruitment may also be used to substantiate disease risk reduction claims²³ (see
 294 section 7.2.2).

295 **6. What are the general principles applied by the Panel to decide 296 whether a health claim is substantiated?**

297 The general principles applied by the NDA Panel for the assessment of claims on established functions
 298 of essential nutrients differ from those applied for the assessment of claims on non-established
 299 functions of essential nutrients, and of claims on other substances. Such differences refer to the
 300 requirements for the definition of the claimed effect, for the scientific substantiation of the claim, and
 301 for establishing conditions of use (see also sections 6.1, 6.2, 7.2.1, and 7.8).

302 **6.1. Claims on essential nutrients**

303 Essential nutrients have unique roles in physiological processes based on a large body of scientific
 304 evidence including deficiency symptoms in humans. The scientific substantiation of these claims is
 305 based on the well-established biochemical role of such nutrients and/or on deficiency symptoms, and
 306 in such cases the NDA Panel does not review the primary scientific studies submitted on the
 307 relationship between the food/constituent and the claimed effect and it does not weigh the evidence.
 308 These claims will not be discussed further in this guidance, except in sections 7.2 (characterisation of
 309 the claimed effect) and 7.8 (conditions of use).

310 Claims related to non-established functions of essential nutrients²⁴ are assessed by the NDA Panel
 311 following the same general principles applied to claims on other substances (see section 6.2).

312 **6.2. Claims on other substances**

313 In assessing each specific food/health relationship which forms the basis of a claim, the NDA Panel
 314 makes a scientific judgement on the extent to which a cause and effect is established between the
 315 consumption of the food/constituent and the claimed effect (i.e. for the target group under the
 316 proposed conditions of use) by considering the strength, consistency, specificity, dose-response, and
 317 biological plausibility of the relationship, and by weighing the totality of the evidence. A grade is not
 318 assigned to the evidence.

319 Pertinent human (intervention and observational) studies are central for health claim substantiation
 320 and pertinent human intervention studies are at the top of the hierarchy that informs decisions on
 321 substantiation²⁵. The reason is that it is most important to show that the food/constituent can
 322 influence the claimed effect in humans and that the effect is specific for the food/constituent. Since
 323 the impact of introducing or replacing a single food/constituent in the whole diet on the claimed effect
 324 is expected to be modest, it is only possible to provide such evidence from human intervention studies.
 325 Intervention (and observational) studies can also provide evidence for a dose response relationship
 326 and for consistency of the effect (or the association) across studies. Efficacy studies in animals and

²⁰ Severity and duration of the disease can also be considered for acute disease states which generally resolve, such as acute infections or allergic reactions.

²¹ For example, studies on the incidence of dental caries can be used to substantiate claims on the maintenance of normal tooth mineralisation.

²² Severity and duration of the disease can also be considered for acute disease states which generally resolve, such as acute infections or allergic reactions.

²³ For example, evidence that a food/constituent decreases the risk of lower urinary tract infections could be used for the substantiation of disease risk reduction claim. In this context, evidence that the food/constituent decreases bacterial adhesion *in vitro* could be used as a risk factor in the wording of the claims (as required by Regulation (EU) No 1169/2011) because it may be plausibly involved in the pathogenesis of the disease, and in this case evidence that the modification of *in vitro* bacterial adhesion also modifies the incidence of the disease is not required.

²⁴ E.g. vitamin C and function of the immune system assessed as a reduction in the incidence of common cold during and after extreme physical exercise; <http://www.efsa.europa.eu/en/efsajournal/doc/1226.pdf>

²⁵ Guidance for the preparation and presentation of health claim applications:
<http://www.efsa.europa.eu/en/efsajournal/doc/2170.pdf>

327 non-efficacy studies in humans, animals and/or *in vitro* (e.g. evidence for a mechanism by which a
328 food could exert the claimed effect) may be part of the totality of the evidence only if pertinent
329 human studies showing an effect of the food/constituent are available.

330 The outcome of each assessment is one of three possible conclusions:

331 (i) A cause and effect relationship has been established between the consumption of the
332 food/constituent and the claimed effect.

333 The NDA Panel considers that the evidence provided is convincing and sufficient for a positive
334 outcome.

335 (ii) The evidence provided is insufficient to establish a cause and effect relationship between
336 the consumption of the food/constituent and the claimed effect.

337 The Panel considers that, although there is some evidence in favour of the claim, such evidence is
338 neither convincing nor sufficient for a positive outcome.

339 (iii) A cause and effect relationship has not been established between the consumption of the
340 food/constituent and the claimed effect.

341 The NDA Panel considers that there is no, or at most very limited, scientific evidence in favour of the
342 claim.

343 **7. What are the main issues addressed by the NDA Panel for the 344 evaluation of health claims?**

345 In assessing each specific food/health relationship which forms the basis of a health claim the NDA
346 Panel considers the following key questions:

347 (i) the food/constituent is defined and characterised;

348 (ii) the claimed effect is a well-established function of an essential nutrient; OR

349 the claimed effect is defined and is a beneficial physiological effect for the target
350 population, and can be measured *in vivo* in humans;

351 (iii) a cause and effect relationship is established between the consumption of the
352 food/constituent and the claimed effect (for the target group under the proposed
353 conditions of use).

354 Each of these three questions needs to be assessed by the NDA Panel with a favourable outcome
355 for a claim to be substantiated. In addition, an unfavourable outcome of the assessment of
356 questions (i) and/or (ii) precludes the scientific assessment of question (iii).

357 If a cause and effect relationship is considered to be established, the NDA Panel considers whether:

- 358 • the quantity of food/pattern of consumption required to obtain the claimed effect can
359 reasonably be consumed within a balanced diet;
- 360 • the proposed wording reflects the scientific evidence;
- 361 • the proposed wording complies with the criteria for the use of claims specified in the
362 Regulation;
- 363 • the proposed conditions/restrictions of use are appropriate;
- 364 • the data claimed as proprietary by the applicant were needed to reach the conclusion.

365 **7.1. Characterisation of the food/constituent**

366 **7.1.1. To what extent should a food/constituent be characterised?**

367 The NDA Panel considers whether the information provided in relation to the food/constituent includes
368 those characteristics which may influence the specific physiological effect that is the basis of the
369 claim. Such characteristics may depend on the nature of the food constituent, but also on the specific
370 claimed effect.

- 371 • If the claim is for an individual constituent, the source and specifications (e.g. physical and
372 chemical properties) should be provided. Characterisation of essential nutrients would relate
373 mainly to the chemical form of the nutrient naturally present in foods and forms that are
374 approved for addition to foods²⁶.
- 375 • If the claim is for a specific formulation or a fixed combination of constituents, then studies
376 are needed on the specific formulation or combination, whereas studies on the individual
377 constituents or combinations of constituents other than the combination for which the claim is
378 proposed are not required. However, if individual constituent(s) in the specific formulation
379 have an established role on the claimed effect (e.g. evidence for their role on the claimed
380 effect has been already evaluated by the Panel with a positive outcome), the NDA Panel also
381 considers whether: i) the effect could be explained by the individual constituent(s), regardless
382 of the source; ii) other constituent(s) in the specific formulation are required for/contribute to
383 the claimed effect (i.e. whether the specific formulation has an effect beyond what could be
384 expected from the presence of the individual constituent(s) with an established role on the
385 claimed effect²⁷).
- 386 • For a food category (e.g. "dairy products"²⁸), the NDA Panel considers whether the
387 information provided sufficiently addresses the variability between individual foods regarding
388 those characteristics which may influence the specific claimed effect.
- 389 • For plant products²⁹, the NDA Panel considers whether the information provided includes the
390 scientific (latin) name (full systematic species, name incl. botanical family, genus, species,
391 variety, subspecies, author's name, and chemotype, where relevant; e.g. *Punica granatum* L,
392 Lythraceae (Punicaceae)), the part used (e.g. fruit, root, leaf, seed), complete specifications
393 of the manufacturing process (e.g. dried, hydroalcoholic extraction, plant extract ratio), and
394 how the product is standardised (e.g. by its content of one or more specific constituents).
- 395 • For microorganisms (e.g. bacteria and yeast), the NDA Panel considers whether, in addition to
396 species identification, sufficient information is provided for characterisation (genetic typing) at
397 strain level by internationally accepted molecular methods, and regarding the naming of
398 strains according to the International Code of Nomenclature³⁰. In the case of a combination of
399 two or more microorganisms, the Panel considers that if one of the microorganisms used in
400 the combination is not sufficiently characterised, the combination proposed is also not
401 sufficiently characterised³¹.
- 402 • For comparative claims, both the food/constituent that is the subject of the claim and the
403 comparator, or the food/constituent it should replace in foods in order to obtain the claimed
404 effect, should be sufficiently characterised for a scientific evaluation with respect to the
405 factors which may have an impact on the claimed effect. Applicants should take into account
406 the Commission guidance on the implementation of Regulation (EC) No 1924/2006, of
407 December 2007 for the use of comparative claims³².

408 The NDA Panel also considers whether the specific food/constituent is sufficiently characterised in
409 order to:

²⁶ Regulation (EC) No 1925/2006 of the European Parliament and of the Council on the addition of vitamins and minerals and of certain other substances to foods, as amended. OJ L 183, 12.7.2002, p. 51

²⁷ E.g. whether the consumption of soy lecithin preparations (in which phosphatidyl cholines are the most abundant phospholipid) has an effect on blood cholesterol concentrations beyond what could be expected from their content of linoleic acid <http://www.efsa.europa.eu/en/scdocs/doc/1741.pdf>

²⁸ <http://www.efsa.europa.eu/en/efsajournal/doc/2243.pdf>

²⁹ EFSA Scientific Committee; Guidance on safety assessment of botanicals and botanical preparations intended for use as ingredients in food supplements, on request of EFSA. EFSA Journal 2009; 7(9):1249. [19 pp.]. doi:10.2093/j.efsa.2009.1249. <http://www.efsa.europa.eu/en/efsajournal/doc/1249.pdf>

³⁰ See International Committee on Systematics of Prokaryotes: <http://icsp.org/>

³¹ See also the Guidance on the scientific requirements for health claims related to the gastro-intestinal tract, the immune system, and defence against pathogenic microorganisms <http://www.efsa.europa.eu/en/calls/docs/150209.pdf>

³² Guidance on the implementation of Regulation (EC) No 1924/2006 on nutrition and health claims made on foods – Conclusions of the Standing Committee on the Food Chain and Animal Health, 14 December 2007. http://ec.europa.eu/food/food/labellingnutrition/claims/index_en.htm

410 (i) establish that the studies submitted for the substantiation of the claim were performed
 411 with a food/constituent which complies with the specifications given for the food/constituent
 412 for which the claim is proposed (e.g. the microbial strain(s) used).

413 (ii) define appropriate conditions of use for the claim.

414 (iii) allow control authorities to verify that the food/constituent which bears a claim is the
 415 same as that which was the subject of a Community authorisation, although this aspect is
 416 not required for the substantiation of a claim (e.g. it is strongly recommended that microbial
 417 strains are deposited in an internationally recognised culture collection³³ with access number
 418 for control purposes).

419 It is the responsibility of the applicant to provide this information along with information regarding the
 420 manufacturing process and stability of the food/constituent, where applicable, in order to show
 421 consistency in the final product for those characteristics considered to influence the specific claimed
 422 effect.

423 **7.1.2. In what context can food/constituents be characterised in relation to the 424 claimed effect?**

425 In principle, food/constituents cannot be characterised on the basis of the claimed effect (e.g. non-
 426 cariogenic carbohydrates, antioxidant foods, microorganisms which contribute to the defence against
 427 pathogens in the respiratory tract).

428 However, in specific circumstances, the food/constituent(s) could be characterised on the basis of a
 429 property which could explain their contribution to the claimed effect (i.e. when the mechanism by
 430 which the claimed effect is achieved is known)³⁴.

431 **7.2. Characterisation of the claimed effect**

432 According to Regulation (EC) No 1924/2006, the use of health claims shall only be permitted if the
 433 food/constituent, for which the claim is made, has been shown to have a beneficial physiological
 434 effect.

435 In assessing each claim, the NDA Panel makes a scientific judgement on whether the claimed effect is
 436 considered to be a beneficial physiological effect, as described in the information provided by the
 437 applicant and by taking into account the target population for which the claim is intended. In principle,
 438 the target population of claims made on food is the general population or subgroups thereof defined
 439 on the basis of age, sex, physiological conditions and/or lifestyle (e.g. children, men, post-menopausal
 440 women, adults performing endurance exercise). Decisions on the admissibility of a different target
 441 population for a claim (e.g. subjects with a disease) are taken by the risk managers (see section 4)
 442 and are out of the scope of this guidance.

443 **7.2.1. Characterisation of the claimed effect for function claims**

444 For function claims, the beneficial physiological effect relates to the maintenance, reduced loss or
 445 improvement of a body function.

446 For claims which are based on the well-established biochemical role of essential nutrients, and/or on
 447 deficiency symptoms, the claimed effect can refer to general functions of organs, tissues or systems
 448 (i.e. does not need to be a specific function which is testable and measurable *in vivo* in humans by
 449 generally accepted methods) because symptoms of deficiency of a nutrient can result from broad
 450 effects on one or more organs and/systems and it is sometimes not possible or appropriate to single
 451 out a precise function that is affected by deficiency of that nutrient.

³³ <http://www.wfcc.info/collections/>

³⁴ For example, non-digestible carbohydrates have been defined on the basis of a property (non-digestibility in the small intestine) which explains their contribution to the reduction of post-prandial blood glucose responses when replacing digestible carbohydrates in foods <http://www.efsa.europa.eu/en/search/doc/3513.pdf>; some food/constituents have been characterised on the basis of their α -amylase inhibitory activity, which was considered to explain their potential effect on body weight changes <http://www.efsa.europa.eu/it/search/doc/2999.pdf>; <http://www.efsa.europa.eu/en/efsajournal/doc/3754.pdf>

452 For function claims on other substances, and for function claims on non-established functions of
453 essential nutrients, the NDA Panel considers whether the claimed effect:

454 i) refers to a specific body function (i.e. it is not general and non-specific), as required by
455 Regulation (EC) No 1924/2006, and whether it is sufficiently defined for a scientific evaluation. Claims
456 referring to general wellbeing or unspecified functions of organs, tissues and systems are not
457 considered by the NDA Panel as sufficiently defined for a scientific evaluation³⁵;

458 ii) is a beneficial physiological effect for the target population for which the claim is
459 intended³⁶;

460 iii) can be assessed *in vivo*³⁷ in humans by generally accepted methods. To this end, the Panel
461 considers the appropriateness of the outcome variable(s) and of the methods of measurement
462 proposed to assess the claimed effect in human studies.

463 In this context, it should be noted that:

464 a) some claimed effects, which are considered as beneficial physiological effects, cannot be evaluated
465 by the Panel if no generally accepted methods for the assessment of the outcome variable(s) of
466 interest *in vivo* in humans have been provided³⁸.

467 b) changes in outcome variable(s), which can be measured *in vivo* in humans by generally accepted
468 methods, may not be considered beneficial physiological effects *per se*, and thus cannot be the
469 claimed effect (i.e. constitute the only basis for the scientific substantiation of a health claim)³⁹.
470 Changes in such outcome variable(s) should be accompanied by evidence of a beneficial physiological
471 effect or clinical outcome. Alternatively, they could be proposed as part of the mechanisms by which a
472 food may exert the claimed effect, i.e. induce a beneficial change on a function. In certain
473 circumstances, however, changes in outcome variable(s) measured *in vivo* in humans, and which do
474 not refer to a function directly, may be the claimed effect if evidence is provided that changes in such
475 variable(s) generally induce a beneficial change in a function⁴⁰.

476 In principle, if a body function which is the subject of the claim (e.g. maintenance of normal
477 defecation) is best described by a number of outcome variables which are interrelated (e.g. stool
478 frequency, faecal bulk, stool consistency and transit time), and which in combination could provide
479 information about the function and eventually about the underlying mechanism of action, the Panel
480 will consider the information provided on all these variables to evaluate the claim. However, the
481 selection of the outcome variable(s) to be tested in a study and the decision to treat such variable(s)
482 as primary or as secondary outcomes would depend, among other considerations, on the study
483 objectives (e.g. exploratory, confirmatory), the study population, and the information which is already
484 available (in the literature, or to the applicant) regarding the relationship between the consumption of
485 the food/constituent and the claimed effect (e.g. whether a mechanism of action by which the
486 food/constituent could exert the claimed effect is already known).

³⁵ For example, "gut health", "natural defences", "immune function" or "skin health".

³⁶ For example, "a reduction of gastric acid levels" or "a reduction of inflammation" could represent therapeutic objectives for the management or treatment of some disease conditions, but they are not considered by the NDA Panel as beneficial physiological effects for the target population (i.e. the general population or subgroups thereof).

³⁷ It includes the measurement of functional outcome variables *in vivo* and the measurement (ex *vivo*) of outcome variables in biological samples following an intervention *in vivo*.

³⁸ An example is the lack of generally accepted methods for the measurement of the inhibition of adhesion of P-fimbriated *E. coli* to uroepithelial cells *in vivo* in humans, even though this particular effect was considered a beneficial physiological effect in a particular application for a claim on the reduction of bacterial colonisation of the urinary tract by inhibition of the adhesion of P-fimbriated *E. coli* to uroepithelial cells. The reasons for the Panel's conclusions can be found in the published opinion: <http://www.efsa.europa.eu/en/efsajournal/doc/3082.pdf>

³⁹ Examples of outcome variable(s) which can be measured *in vivo* in humans by generally accepted methods but do not refer to a benefit on specific functions and thus cannot constitute the only basis for the scientific substantiation of a health claim include, but are not limited to, changes in macular pigment optical density, changes in stool pH and short-chain fatty acid production in the gut, and changes in the composition of the gut microbiota.

⁴⁰ For example, changes in skeletal muscle glycogen stores, which can be measured *in vivo* in humans by generally accepted methods but do not refer to a benefit on a function directly, can be used as an appropriate outcome variable for claims on the recovery of normal muscle function after strenuous exercise because evidence has been provided that changes in skeletal muscle glycogen stores lead to the recovery of normal skeletal muscle function after exercise: <http://www.efsa.europa.eu/en/efsajournal/doc/3409.pdf>

487 **7.2.2. Characterisation of the claimed effect for reduction of disease risk claims**

488 For reduction of disease risk claims, the beneficial physiological effect is the reduction (or beneficial
 489 alteration) of a risk factor for the development of a human disease (not the reduction of the risk of
 490 disease).

491 Whether or not the alteration of a factor is considered by the NDA Panel to be beneficial in the
 492 context of a reduction of a disease risk claim depends on the extent to which it is established that:

493 i) the factor is an independent predictor of the risk of disease (such a predictor may be
 494 established from intervention and/or observational studies);
 495 ii) the relationship between the factor and the development of the disease is biologically
 496 plausible.

497 If there is evidence from intervention (drug or dietary) studies that a reduction of the risk factor
 498 generally reduces the risk of disease and the involvement of the risk factor in the development of the
 499 disease is biologically plausible, a reduction of the risk factor is considered beneficial in the context of
 500 a reduction of disease risk claim. In this case, evidence that the dietary intervention with the specific
 501 food/constituent induces a reduction (or beneficial alteration) of the risk factor would be sufficient for
 502 the scientific substantiation of the claim⁴¹.

503 If there is no such evidence from intervention studies, but there is evidence for an independent
 504 association between the proposed risk factor and the incidence of the disease from observational
 505 studies and the involvement of the risk factor in the development of the disease is biologically
 506 plausible, a reduction of the risk factor may be considered a beneficial physiological effect in the
 507 context of a reduction of disease risk claim. In this case, however, evidence that the dietary
 508 intervention with the specific food/constituent induces a reduction (or beneficial alteration) of the risk
 509 factor and also a reduction of the risk of disease needs to be provided⁴².

510 **7.3. What is the evidence required for the scientific substantiation of
 511 health claims?**

512 Each relationship between a food/constituent and a claimed effect is assessed by the NDA Panel
 513 separately on a case by case basis for specific claim applications. Pertinent human studies are an
 514 absolute requirement for the scientific substantiation of health claims, and pertinent human efficacy
 515 studies are at the top of the hierarchy that informs decisions on substantiation. However, there is no
 516 pre-established formula as to how many or which types of studies are needed for substantiation. The
 517 reproducibility of the effect of the food/constituent as indicated by the consistency of the findings
 518 (within and across studies) and the biological plausibility of the effect needs to be considered.

⁴¹ For example, it is well established that elevated blood LDL-cholesterol concentration is independently associated with an increased risk of coronary heart disease (CHD), and that reducing blood LDL-cholesterol concentration (by dietary modification or drugs) would generally reduce the risk of development of CHD. It is also well established that elevated (systolic) blood pressure is independently associated with an increased risk of CHD and stroke, and that reducing (systolic) blood pressure (by dietary modification and drugs) would generally reduce the risk of development of CHD and stroke. Reduction in blood LDL-cholesterol concentration, therefore, is considered beneficial in the context of a reduction of disease risk claim for CHD, and reduction in (systolic) blood pressure is considered beneficial in the context of a reduction of disease risk claim for CHD and stroke. <http://www.efsa.europa.eu/en/search/doc/2474.pdf>. It is also well established that falling is a risk factor for bone fractures in the elderly, and that reducing the risk of falling (e.g. by dietary modification, by drugs, by modification of architectural barriers) reduces the risk of bone fractures. <http://www.efsa.europa.eu/en/efsajournal/doc/2382.pdf>.

⁴² For example, there is some evidence that low blood HDL-cholesterol concentration, elevated blood concentration of triglycerides, or elevated blood homocysteine concentration is associated with an increased risk of coronary heart disease (CHD). Reduction in blood concentration of triglycerides, reduction in blood homocysteine concentration, or an increase in blood HDL-cholesterol concentration, have been associated with a decreased incidence of CHD following certain dietary interventions in some human intervention studies. However, changes in any of these factors (by dietary modification or drugs) have not generally been shown to reduce the risk of CHD. Therefore, human studies on the risk of CHD are required for the substantiation of these disease risk reduction claims in order to validate the association between these variables and the risk of disease in the context of a particular nutritional intervention. <http://www.efsa.europa.eu/en/efsajournal/doc/2474.pdf>

519 The scientific opinions on health claim applications evaluated by the NDA Panel with a positive
 520 outcome provide examples as to the number, type and quality of the studies which may be needed for
 521 the scientific substantiation of health claims in the context of specific applications⁴³.

522 For example, a claim on arabinoxylan and a reduction on post-prandial blood glucose responses was
 523 substantiated on the basis of: i) a single well-designed and scientifically sound human intervention
 524 study showing a dose-response effect of the food/constituent in a study group which is representative
 525 of the target population, ii) a human study showing an effect of the food/constituent on an outcome
 526 variable which was only indirectly related to the claimed effect, and iii) strong evidence for a plausible
 527 mechanism of action⁴⁴. In contrast, three well-designed and scientifically sound human intervention
 528 studies showing a consistent effect of the food/constituent across study groups which are
 529 representative of the target population or from which the results could be extrapolated to the general
 530 population were sufficient to substantiate a claim on Limicel® and reduction of blood LDL-cholesterol
 531 concentrations, even if no evidence for a mechanism by which the food/constituent may have exerted
 532 the claimed effect was provided⁴⁵. A health claim on EPA and DHA and maintenance of normal cardiac
 533 function was substantiated on the basis of a wealth of human observational studies showing a
 534 consistent association between the consumption of the food/constituent and coronary heart disease
 535 outcomes in the target population plus human intervention studies showing an effect of the food in
 536 diseased subjects under medication⁴⁶.

537 **7.4. How does the NDA Panel identify pertinent human studies?**

538 As mentioned in the previous section, pertinent human studies are central for the scientific
 539 substantiation of health claims. In order to identify such studies among those submitted in an
 540 application, the NDA Panel evaluates:

- 541 i) whether the food/constituent investigated in the study complies with the specifications of
 542 the food/constituent for which the claim is proposed;
- 543 ii) whether the outcome variable(s) are well-defined and appropriate to assess the claimed
 544 effect, and whether they have been measured using valid methods;
- 545 iii) the design and quality of the study in relation to the risk of bias;
- 546 iv) whether the study population is representative of the target population for the claim, or
 547 whether extrapolation of the results from the study population to the target population is
 548 scientifically plausible;
- 549 v) how the conditions under which the study has been conducted relate to the conditions of
 550 use (e.g. quantity and pattern of consumption of the food/constituent) proposed for the
 551 claim.

552 Well-designed and conducted randomised controlled trials (i.e. at low risk of bias) investigating the
 553 effect of a food/constituent which complies with the specifications of the food/constituent for which
 554 the claim is proposed on appropriate outcome variables for the claimed effect, in a suitable study
 555 group, and under the conditions of use proposed for the claim are at the top of the hierarchy which
 556 informs decisions on substantiation⁴⁷. In principle, the study duration should be adequate in order to
 557 exclude: i) adaptation to the continuous consumption of the food/constituent through compensatory
 558 mechanisms; ii) chance findings (e.g. for fluctuating outcome measures). The quality of reporting,
 559 although not inherently linked to the quality of the study, will have an impact on the outcome of the
 560 NDA Panel's assessment⁴⁸.

⁴³ Examples of health claims substantiated using different types and amount of studies include, but are not limited to:
<http://www.efsa.europa.eu/en/efsajournal/pub/2809.htm>; <http://www.efsa.europa.eu/it/efsajournal/doc/1101.pdf>;
<http://www.efsa.europa.eu/en/efsajournal/pub/2382.htm>; <http://www.efsa.europa.eu/en/scdocs/doc/1776.pdf>;
<http://www.efsa.europa.eu/en/efsajournal/doc/1885.pdf>.

⁴⁴ <http://www.efsa.europa.eu/en/efsajournal/doc/2205.pdf>

⁴⁵ <http://www.efsa.europa.eu/en/efsajournal/pub/3327.htm>

⁴⁶ <http://www.efsa.europa.eu/en/efsajournal/doc/1796.pdf>

⁴⁷ Scientific and technical guidance for the preparation and presentation of health claim applications:
<http://www.efsa.europa.eu/en/efsajournal/doc/2170.pdf>

⁴⁸ Guidelines for adequate reporting of research studies can be found at <http://www.equator-network.org> and EFSA Guidance on Statistical Reporting: <http://www.efsa.europa.eu/en/efsajournal/doc/3908.pdf>

561 **7.5. How meta-analyses can be used to inform decisions on**
 562 **substantiation?**

563 The NDA Panel considers the results of meta-analyses of (observational and/or intervention) human
 564 studies as part of the body of evidence if the meta-analyses specifically evaluate the relationship
 565 between the particular food/constituent and the claimed effect by including all the human studies
 566 from which conclusions can be drawn for the substantiation of the claim⁴⁹. Information derived from
 567 meta-analyses has been used by the Panel in published opinions to summarise the overall evidence
 568 provided by individual studies and to establish conditions of use for the claim (e.g. to define the
 569 effective dose) when a cause and effect relationship between the consumption of the food/constituent
 570 and the claimed effect has been established on the basis of the primary data provided in the
 571 application (e.g. the individual studies included in the meta-analyses from which conclusions can be
 572 drawn plus the supporting evidence)⁵⁰.

573 **7.6. Extrapolation of the results from the study group to the target**
 574 **population**

575 The study group refers to subjects recruited for human studies that are submitted for the scientific
 576 substantiation of the claim. When a particular study has been conducted in a study group (e.g.
 577 subjects with a disease) which is different from the target population for a claim (e.g. the general
 578 population or subgroups thereof), the NDA Panel considers whether the results from that study can be
 579 extrapolated to the target population for the claim. In principle:

- 580 (i) results from studies performed in *non-diseased subjects*, including *subjects at high risk* for
 581 disease⁵¹ (e.g. women with high frequency of lower urinary tract infections (LUTI) in the
 582 previous year but free of LUTI at recruitment) in whom the function targeted by the claim
 583 (e.g. defence against pathogens in the lower urinary tract) may be affected, could be
 584 extrapolated to the target population (e.g. adult women in the general population).
 585 However, as this decision is made by the Panel on a case-by-case basis, accurate
 586 information on the selection criteria used in these studies to identify and recruit *subjects*
 587 *at high risk for disease* should be provided to allow the Panel to decide whether
 588 extrapolation of the results from the study population to the target population is
 589 biologically plausible.
- 590 (ii) results from studies performed in *subjects with a disease* (i.e. type 2 diabetic patients)
 591 that affects the function mentioned (e.g. reduction of post-prandial blood glucose
 592 responses) in the claim can be extrapolated to the target population for a claim (e.g. the
 593 general population) as long as the effect of the food/constituent on the beneficial
 594 physiological effect which is mentioned in the claim is also reasonably expected to occur
 595 in subjects without the disease. If subjects with a disease are under pharmacological
 596 treatment, the Panel considers whether the effect of the food/constituent is also
 597 reasonably expected to occur in subjects without medication.
- 598 (iii) results from studies performed *exclusively* in healthy subjects selected on the basis of a
 599 genetic (e.g. sex), demographic (e.g. age⁵²), physiological (e.g. pregnancy, menopause)
 600 or lifestyle (e.g. level of physical activity⁵³, diet⁵⁴) characteristic, or on the basis of
 601 ethnicity, may be pertinent to the scientific substantiation of health claims addressed to a
 602 different target population (e.g. the general population) only if the effect of the
 603 food/constituent is also observed in subjects who are representative of the target
 604 population (e.g. in other studies submitted in the application) or if extrapolation of the
 605 results from the study group to the target population is biologically plausible. Biological
 606 plausibility will be considered by the NDA Panel on a case-by-case basis.

⁴⁹ <http://www.efsa.europa.eu/en/supporting/doc/569e.pdf>

⁵⁰ Examples can be found in published opinions: <http://www.efsa.europa.eu/en/search/doc/2053.pdf>;
<http://www.efsa.europa.eu/en/scdocs/doc/781.pdf>

⁵¹ Subjects at high risk for disease means individuals with one or more risk factors for a disease who do not meet the diagnostic criteria for such disease.

⁵² E.g. children, adults, elderly.

⁵³ E.g. athletes.

⁵⁴ E.g. vegetarians, vegans.

607 If an application includes one or more human studies showing a relationship between the
 608 consumption of the food/constituent on the claimed effect in the target group under the proposed
 609 conditions of use (see section 7.4), the Panel may also consider studies conducted in study groups
 610 from which the results could not be extrapolated to the target population as part of the evidence for
 611 the claim⁵⁵.

612 **7.7. How are comparative claims evaluated by the NDA Panel?**

613 Claims for a beneficial effect of the absence (or reduced content) of a food/constituent in a food or
 614 category of foods are evaluated as comparative claims. Substantiation may be based on evidence for
 615 an independent role of the food/constituent in an adverse effect. For example, for claims related to a
 616 reduced content of saturated fatty acids (SFAs) in relation to blood LDL-cholesterol concentrations,
 617 SFAs have been shown to increase blood LDL-cholesterol concentrations when compared to
 618 carbohydrates, which have no effect on LDL-cholesterol concentrations, and therefore SFAs have an
 619 independent role in the adverse effect.

620 Claims for a beneficial effect of a food/constituent used to replace a food/constituent with an
 621 independent role in an adverse effect are also evaluated as comparative claims. Substantiation may be
 622 based on evidence for an independent role on an adverse effect of the food/constituent which is being
 623 replaced, together with evidence for the lack of an effect or a reduced effect of the food/constituent
 624 which is used for replacement. Examples include claims for unsaturated fats and reduced blood LDL-
 625 cholesterol concentrations when replacing saturated fats, for low-fermentable carbohydrates and
 626 maintenance of tooth mineralisation ('non-cariogenic') when replacing fermentable sugars, and for
 627 low-digestible carbohydrates and reduced post-prandial blood glucose when replacing digestible
 628 carbohydrates.

629 Claims related to a comparison between a "test" food and a "control" food (e.g. for changes in
 630 appetite ratings after food consumption) are also comparative claims. Both the test and the control
 631 food should be sufficiently characterised for a scientific evaluation with respect to the factors (e.g.
 632 energy, volume, appearance and taste) which may have an impact on the claimed effect.

633 In presenting such claims, applicants should take into account the Commission guidance on the
 634 implementation of Regulation (EC) No 1924/2006, of December 2007⁵⁶ for the use of comparative
 635 claims, including characterisation of the appropriate reference or comparator food/constituent (see
 636 also 7.1.1).

637 **7.8. On what basis does the NDA Panel propose conditions of use for 638 health claims evaluated with a favourable outcome?**

639 For claims on established functions of essential nutrients conditions of use are set on the basis that
 640 any significant amount of the essential nutrient in the diet will contribute to the claimed effect (e.g.
 641 conditions of use can be linked to nutrition claims).

642 For all other claims, including claims on other substances and claims on non-established function of
 643 essential nutrients, conditions of use are set on the basis of the human studies submitted for
 644 substantiation by considering the minimum amount of the food/constituent (and pattern of
 645 consumption, where appropriate), which consistently exerts an effect on the function that is
 646 mentioned in the claim. In this case, the NDA Panel also considers whether such an amount can be
 647 reasonably consumed in the context of a balance diet (e.g. whether the consumption of the
 648 food/constituent in the amounts required to achieve the claimed effect is realistic and unlikely to
 649 induce a nutritional imbalance).

650 **7.9. On what basis does the NDA Panel propose wordings for health 651 claims evaluated with a favourable outcome?**

652 The NDA considers whether the wording of the claim proposed by the applicant reflects the scientific
 653 evidence. If not, the NDA Panel proposes a different wording. However, wordings proposed by the

⁵⁵ <http://www.efsa.europa.eu/it/search/doc/2809.pdf>

⁵⁶ http://ec.europa.eu/food/food/labellingnutrition/claims/index_en.htm

654 Panel, although scientifically correct, do not take into account consumer understanding and may not
655 be appropriate for consumer communication. As explained in section 4 and Annex A, the applicants
656 can negotiate with risk managers for alternative wordings during the authorisation process.

657 **7.10. Can the conditions of use for an authorised claim be extended or 658 modified?**

659 For the modification or extension of the conditions of use (CoU) of an authorised claim, applications
660 can be submitted pursuant to Article 19 of Regulation (EC) No 1924/2006. The request may refer to
661 the extension or modification of the authorised CoU with respect to e.g. the (chemical) form of the
662 food constituent, the food matrix, the effective dose, the pattern of consumption, the target
663 population, or the restrictions of use. In order to evaluate whether the CoU for an already authorised
664 health claim could be modified, the NDA Panel needs to be assured that the claimed effect assessed in
665 the original opinion can also be achieved by the consumption of the food/constituent under the "new"
666 conditions proposed by the applicant. The nature and amount of information needed for that purpose
667 may depend on the food/constituent, the matrix, the claimed effect, the target population, and the
668 proposed mechanisms by which the claimed effect may be achieved (short-and long-term efficacy).
669 Examples of Article 19 applications can be found in EFSA published opinions⁵⁷.

670 **8. What are the key scientific aspects to consider for preparing a 671 health claim application?**

672 Before submitting a health claim application, applicants are advised to consider, step-wise, a series of
673 elements which are needed for the compilation of applications (**Figure 2**).

674 The **first** step is to consider whether or not the food/constituent is an essential nutrient, and whether
675 or not the claimed effect refers to a well-established function of the nutrient. In this context, it is
676 important to reflect on whether the nutrient:

- 677 i) plays a unique (biochemical or structural) role in a function (e.g. as known from *in vitro* studies,
678 from animal studies, from symptoms of deficiency in humans) and
- 679 ii) cannot be synthesised by the human body, or not in sufficient amounts to cover the needs for the
680 function in the target population for the claim.

681 If both of the above-mentioned conditions are met, the relationship between the consumption of the
682 food/constituent and the maintenance of the function (claimed effect) is likely to be established (see
683 section 6.1). However, if the claimed effect refers to a function of the essential nutrient that is not
684 well-established, human studies on the relationship between the consumption of the food/constituent
685 and the claimed effect are required for the scientific substantiation of the claim (see section 7.4). The
686 remainder of this section focuses on how to prepare applications for this type of claims.

687 The **second** step is the characterisation of the food/constituent. The characterisation of essential
688 nutrients relates mainly to the chemical form of the nutrient naturally present in foods and forms that
689 are approved for addition to foods⁵⁸. For the characterisation of other substances, it is important to
690 consider: i) its composition and characteristics, and particularly those characteristics which may
691 contribute to or be responsible for the claimed effect. To this end, it is important that applicants have
692 good information about the digestion, absorption, metabolism, excretion and/or bioavailability of the
693 food/constituent, its metabolic fate, and an hypothesis/data regarding the mechanism by which the
694 food/constituent could exert the claimed effect; ii) the manufacturing process (if applicable), e.g. that
695 the food/constituent can be manufactured consistently to the stated specifications and it is stable
696 during processing, storage, and preparation for consumption (e.g. cooking).

697 The **third** step is the formulation of the claimed effect. To this end, applicants are advised to conduct
698 an exploratory review of the human studies available to identify the health/disease outcome(s) which
699 have been investigated in relation to the food/constituent and for which the available evidence may

⁵⁷ <http://www.efsa.europa.eu/en/efsjournal/doc/1689.pdf>; <http://www.efsa.europa.eu/en/efsjournal/doc/3654.pdf>
<http://www.efsa.europa.eu/en/efsjournal/doc/3577.pdf>

⁵⁸ Regulation (EC) No 1925/2006 of the European Parliament and of the Council on the addition of vitamins and minerals and of certain other substances to foods, as amended. OJ L 183, 12.7.2002, p. 51

700 be strong. Applicants are then advised to reflect on whether the outcome(s) investigated⁵⁹ may
701 describe a beneficial physiological effect⁶⁰ (claimed effect) in the context of function and/or reduction
702 of disease risk claims (see section 7.2), the extent to which the outcome variable(s)⁶¹ used in the
703 studies are direct measures of the claimed effect, and whether the methods of assessment⁶² are
704 appropriate.

705 The **fourth** step is to conduct a comprehensive review of (published and unpublished) human studies
706 on the relationship between the food/constituent and the health/disease outcome(s) which best
707 describe the claimed effect in order to identify all human studies that may be pertinent for
708 substantiation.

709 It is important to ensure that the studies have investigated food/constituents which comply with the
710 specifications provided in the application. If not, applicants should consider changing the specifications
711 of the food/constituent for which the claim is requested⁶³.

712 If human studies on the relationship between the consumption of the food/constituent and
713 health/disease outcome(s) are available, then it is important to consider, for each study, whether or
714 not it has been conducted in a suitable study group i.e. a study group which is representative of the
715 target population for the claim or a study group from which extrapolation of the results to the target
716 population is biologically plausible.

717 If all or some of the studies have been conducted in suitable study groups, then proceed to the next
718 step. In this context, studies not conducted in suitable groups may be used as supportive evidence for
719 the claim. If extrapolation of the results from the study group to the target population is not
720 biologically plausible because the study subjects have a certain disease⁶⁴ and only studies in patients
721 with this disease are available, such studies will not be pertinent to the claim. If extrapolation of the
722 results is not biologically plausible because the study subjects belong to a different subgroup of the
723 general population⁶⁵ and no studies in the target subgroup are available, these studies could be
724 pertinent for a claim on a different target subgroup.

725 The **fifth** step is to evaluate the quality of each individual human study in relation to:

726 i) whether the outcome variable(s) are well-defined and appropriate to assess the claimed
727 effect, and whether they have been measured using valid methods⁶⁶;

728 ii) the risk of bias⁶⁷

729 Studies of low quality may not allow conclusions to be drawn for the scientific substantiation of the
730 claim, and thus may not be pertinent to the claim (i.e. may not be part of the totality of the evidence).

731 The **sixth** step is to identify studies (in humans, in animals, *in vitro*) which may be used to develop a
732 rationale for the biological plausibility of the claim (e.g. in the context of all that is known about the
733 food/constituent and about the claimed effect). These include efficacy studies in humans the results of

⁵⁹ E.g. coronary heart disease

⁶⁰ E.g. cardiac function

⁶¹ E.g. fatal myocardial infarction, non-fatal myocardial infarction, sudden death, angina, heart failure

⁶² E.g. self-reported, clinical records, death certificates

⁶³ For example, if a claim is requested for a fixed combination of ingredients but all human studies available have investigated one of them only and not the fixed combination, applicants should consider to request the claim for the single ingredient only; the claim could then be used in a product with the fixed combination of ingredients if it complies with the conditions of use for the single ingredient.

⁶⁴ Please note that extrapolation of the results obtained in diseased subjects to the target population of the claim may or may not be biologically plausible depending on the disease and/or the medications taken by the subjects. A decision on whether extrapolation of the results from diseased to non-diseased subjects is biologically plausible is taken by the NDA on a case-by-case basis upon consideration of the evidence/data/rationale provided by applicants in specific applications to support such extrapolation. Providing a complete list of cases in which such extrapolation is/is not biologically plausible is beyond the scope of this general scientific guidance.

⁶⁵ Please note that extrapolation of the results obtained in subjects from a particular subgroup of the general healthy population to another may depend on the claimed effect. Providing a complete list of cases in which such extrapolation is/is not biologically plausible is beyond the scope of this general scientific guidance.

⁶⁶ Applicants are encouraged to consult experts in the particular research field.

⁶⁷ Including study design (e.g. randomisation, blinding, control for confounders), statistical analyses, completeness of reporting, etc. Several tools to assess the risk of bias of human studies are available in the literature; applicants are also encouraged to consult epidemiologists/biostatisticians for that purpose.

734 which could not be extrapolated to the target population, efficacy studies in animals, and studies on
735 bioavailability and plausible mechanisms of action.

736 As a **seventh** step, applicants are advised to review all the evidence available to them (pertinent
737 human studies plus other studies) and make a scientific judgement on whether or not such evidence
738 may be appropriate/sufficient for the scientific substantiation of the claim⁶⁸. If the answer is yes,
739 applicants should proceed to the next step. If the answer is no, a careful analysis of the gaps in the
740 data available to the applicant can provide an idea of the type and amount of *ad-hoc* research which
741 may be needed to fill those gaps, and which may vary widely from application to application (see
742 section 7.3).

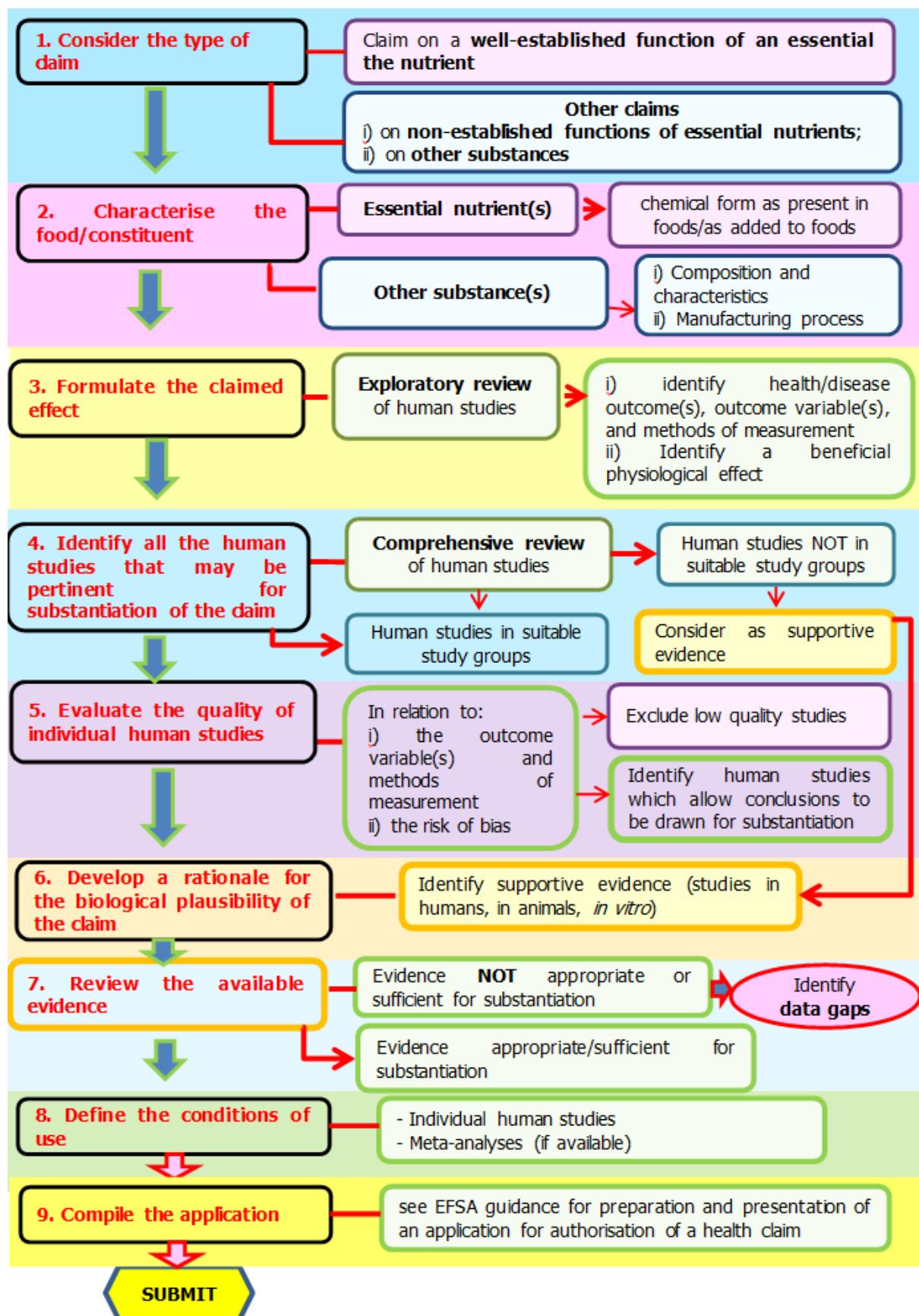
743 The **eighth** step is to define the conditions of use for the claim, i.e. the dose and pattern of
744 consumption of the food/constituent which is required to achieve the claimed effect. The conditions of
745 use should be defined on the basis of the individual human studies used for substantiation and/or
746 meta-analysis of such studies (see sections 7.5 and 7.8).

747 The **ninth** and final step is to compile the application, having regard of the Scientific and technical
748 guidance for the preparation and presentation of an application for authorisation of a health claim
749 (revision 1)⁶⁹.

750 **Annex A** explains in detail the administrative and procedural aspects of applications, from claim
751 formulation to authorisation.

⁶⁸ Relevant EFSA guidance documents as well as published opinions on evaluations performed by the NDA Panel on previous applications, and particularly those evaluated with a positive outcome, may help applicants to make such judgement.

⁶⁹ <http://www.efsa.europa.eu/en/efsajournal/pub/2170.htm>

Figure 2: key scientific aspects for preparing a health claim application

754 **9. Conclusions**

755 The general guidance document represents the views of the NDA Panel based on the experience
756 gained to date with the evaluation of health claims, and it may be further updated, as appropriate,
757 when additional issues are addressed.

758

759 **Annex A – Administrative and procedural aspects governing the life cycle**
 760 **of a claim application from claim formulation to authorisation**

761 **A.1 Before submitting an application**

762 **A.1.1 Guideline checking**

763 Applicants who wish to submit an application for authorisation of a health claim under Article 13.5 or
 764 14 of Regulation (EC) No 1924/2006 or for modification of an existing authorisation pursuant to Article
 765 19 should read carefully the NDA Panel guidance documents which are published on EFSA's website⁷⁰:

766 ➤ ***Scientific and technical guidance for the preparation and presentation of an***
 767 ***application for authorisation of a health claim (revision 1)***⁷¹, which presents a common
 768 format for the organisation of the information to assist the applicants for the preparation of a
 769 well-structured application (i.e. technical dossier) for authorisation of health claims. This guidance
 770 outlines:

- 771 ▪ the information and scientific data which must be included in the application;
- 772 ▪ the hierarchy of different types of data and study designs (reflecting the relative strength
 773 of evidence which may be obtained from different types of studies) and the key issues
 774 which should be addressed in the application to substantiate the health claim;
- 775 ▪ the number of claims allowed in an application.

776 ➤ ***Specific guidance on the scientific requirements for health claims***, which are intended to
 777 assist applicants in preparing their applications for the authorisation of health claims in specific
 778 areas, such as those related to:

- 779 ▪ gastrointestinal tract, the immune system, and defence against pathogenic
 780 microorganisms (currently under revision)⁷²;
- 781 ▪ antioxidants, oxidative damage and cardiovascular health⁷³;
- 782 ▪ appetite ratings, weight management and blood glucose concentrations⁷⁴;
- 783 ▪ bone, joints, skin and oral health⁷⁵;
- 784 ▪ physical performance⁷⁶;
- 785 ▪ functions of the nervous system, including psychological functions⁷⁷.

786 These guidance documents present examples drawn from past evaluations to illustrate the
 787 approach of the NDA Panel in the evaluation of health relationships and outcome variables
 788 which may be acceptable in these areas, as well as the conditions under which they may be
 789 acceptable. A better understanding of such an approach could help applicants in preparing
 790 applications on health relationships and related outcome variables.

791 **A.1.2 The language and the format required for a claim application**

792 In order to facilitate the processing of the application (i.e. technical dossier) and make the assessment
 793 more efficient, applications should preferably be submitted in **English**. Should the applicant not
 794 submit the application in English, EFSA will proceed with the English translation. However, it should be
 795 noted that the responsibility for validating the English translation of the application provided by EFSA
 796 rests with the applicant.

⁷⁰ <http://www.efsa.europa.eu/en/nda/ndaguidelines.htm>

⁷¹ <http://www.efsa.europa.eu/en/efsjournal/pub/2170.htm>

⁷² <http://www.efsa.europa.eu/en/supporting/pub/758e.htm>; <http://www.efsa.europa.eu/en/consultationsclosed/call/150209.htm>

⁷³ <http://www.efsa.europa.eu/en/efsjournal/pub/2474.htm>

⁷⁴ <http://www.efsa.europa.eu/en/efsjournal/pub/2604.htm>

⁷⁵ <http://www.efsa.europa.eu/en/efsjournal/pub/2702.htm>

⁷⁶ <http://www.efsa.europa.eu/en/efsjournal/pub/2817.htm>

⁷⁷ <http://www.efsa.europa.eu/en/efsjournal/pub/2816.htm>

797 Claims applications which adhere to the format of the Scientific and technical guidance for the
 798 preparation and presentation of an application for authorisation of a health claim (see section A.1.1)
 799 must be submitted on a standard electronic medium such as a CD ROM, DVD or USB key. All
 800 applications submitted via a Member State to EFSA for evaluation should include the original of a
 801 signed cover letter with the table of contents and the mandate⁷⁸.

802 **A.1.3 Where to submit a claim application?**

803 Applications for authorisation of health claims pursuant to Articles 14, 13(5) and 19 of the Regulation
 804 (EC) No 1924/2006 shall be submitted to the National Competent Authority of a Member State in the
 805 European Union in accordance with Articles 15 and 18, respectively.

806 Applicants are invited to check the scope and admissibility of the claim with the recipient Member
 807 State **at the earliest possible stage** before submitting the application (see also section 4). The
 808 National Competent Authority will check admissibility before making the application and any
 809 supplementary information supplied by the applicant available to EFSA.

810 The list of competent authorities of the Member States within the framework of Regulation (EC) No
 811 1924/2006 is published on EFSA's website⁷⁹.

812 **A.2 What happens to a claim application upon receipt by EFSA?**

813 Upon receipt of a claim application via a Member State, EFSA checks the completeness of the
 814 application⁸⁰.

815 The completeness check includes administrative compliance, clear identification of the
 816 food/constituent for which the claim is made (consistency throughout the application), clear definition
 817 of the claimed effect (a defined claimed effect including identification of outcome variable(s) and
 818 methods of measurement, identification of (a) risk factor(s) for disease risk reduction claims), and
 819 definition of the conditions of use.

820 In the event that EFSA requires additional data, information or clarification in order to consider an
 821 application complete, the applicant will be asked to supply these data, information or clarifications
 822 within a notified time limit. EFSA may also communicate with applicants regarding studies which are
 823 claimed as confidential (see also section A.4 on EFSA's handling of confidential and proprietary data).
 824 Applicants can request a teleconference to clarify a request from EFSA for missing information.

825 During the completeness check, EFSA may consult the Commission Services on points of interpretation
 826 of EU legislation particularly in relation to the scope.

827 Once EFSA considers that the application is complete for a scientific evaluation, EFSA sends an
 828 acceptance letter to the applicant. EFSA makes the application and any supplementary information
 829 supplied by the applicant available to Member States and the Commission. EFSA publishes relevant
 830 information for the identification of the application in the Register of Questions, and assigns it an
 831 official question number. Applicants and stakeholders can follow the status of each application via
 832 EFSA's Register of Questions.

833 The applicant will also be notified of the name of the scientific officer in the Nutrition Unit in charge of
 834 the application and related communications with the applicant. All communication between EFSA and
 835 the applicant during the life-cycle of an application is through the assigned scientific officer (not the
 836 NDA Panel experts).

837 **A.3 What happens during the evaluation process?**

838 Once the application is considered complete, the scientific evaluation starts. EFSA shall ensure that
 839 the Opinion of the NDA Panel is given **within 5 months** (excluding the stop-the-clock time for the
 840 applicant to provide answers to questions from EFSA, if needed).

⁷⁸ <http://www.efsa.europa.eu/en/press/news/140924.htm>

⁷⁹ <http://www.efsa.europa.eu/en/ndaguidance/docs/ndacompetentauthorities.pdf>

⁸⁰ <http://www.efsa.europa.eu/en/apdeskapplworkflow/docs/apdeskapplworkflownutrihealthclaims.pdf>

841 **A.3.1 When does the stop-the-clock procedure apply?**

842 During the evaluation, EFSA may request the applicant to provide supplementary information on the
 843 application ('stop-the-clock' procedure). Requests from EFSA to applicants for supplementary
 844 information are made on the basis of a case-by-case judgement by the NDA Panel or its Working
 845 Group on Claims in the context of specific applications.

846 Based on an analysis of the stop-the-clock letters sent to applicants⁸¹, the issues identified by the NDA
 847 Panel which have triggered in the stop-the-clocks are: clarifications on the studies submitted for
 848 substantiation (75%); clarifications on the claimed effect and/or the target population (13%); and
 849 clarifications on the characterisation of the food/constituent for which the claim was proposed (12%).

850 Issues related to, for example, the definition of the food/constituent, of the claimed effect, of risk
 851 factors for disease, or of the conditions of use may only become apparent during the scientific
 852 assessment of the application by the NDA Panel and not necessarily during the completeness check.
 853 The NDA Panel may work with the applicants on the re-formulation of health claims based on the
 854 human studies provided for substantiation, if needed.

855 Therefore, communication between EFSA and the applicant during this phase is critical for both the
 856 applicants and the NDA Panel. To this end, upon receipt of EFSA's letter requesting supplementary
 857 information, applicants can request a teleconference to clarify a request from EFSA for additional
 858 information. After submitting additional or supplementary information, applicants may be invited by
 859 EFSA to attend a meeting of an EFSA working group or scientific panel to clarify issues related to the
 860 newly submitted material (i.e. *Applicants technical hearing*).

861 The applicant should respond to requests for missing or additional information using electronic
 862 formats (CD-ROMs, DVDs or USB keys). If the applicant fails to provide the supplementary information
 863 within the time limit specified by EFSA, the NDA Panel will issue an opinion based on the data
 864 available to the Panel.

865 EFSA applies stop-the-clock timelines in accordance to Regulation (EC) No 1924/2006 and EFSA
 866 guidance on 'Indicative timelines for submitting additional or supplementary information to EFSA
 867 during the risk assessment process of regulated products'⁸².

868 **A.3.2 Can a claim application be withdrawn?**

869 Article 7b of Regulation (EC) No 353/2008⁸³ specifies the rules for the withdrawal of applications i.e.:

870 (1) An application submitted under Article 15 or 18 of Regulation (EC) No 1924/2006 may be
 871 withdrawn by the applicant up to the moment the Authority adopts its opinion pursuant to Article
 872 16(1) or Article 18(3) of Regulation No 1924/2006.

873 (2) A request for withdrawal of an application must be submitted to the national competent authority
 874 of a Member State, to which the application was submitted in accordance with Article 15(2) or Article
 875 18(2) of Regulation (EC) No 1924/2006.

876 **A.4 How confidential and proprietary data are handled by EFSA?**

877 Many studies submitted for scientific substantiation of health claims have been claimed as confidential
 878 by applicants. In this respect, EFSA would like to clarify that, in order to comply with its requirements
 879 for transparency as outlined in Article 38 of Regulation (EC) No 178/2002⁸⁴ and Article 16 of
 880 Regulation (EC) No 1924/2006⁸⁵, key data from key studies which are considered essential for the
 881 scientific assessment of a health claim may need to be disclosed in the final scientific opinion

⁸¹ <http://www.efsa.europa.eu/en/events/documents/131120-p03.pdf>

⁸² <http://www.efsa.europa.eu/en/press/news/140414a.htm>

⁸³ Commission Regulation (EC) No 353/2008 of 18 April 2008 establishing implementing rules for applications for authorisation of health claims as provided for in Article 15 of Regulation (EC) No 1924/2006 of the European Parliament and of the Council. OJ L 109, 19.4.2008, p. 11.

⁸⁴ Regulation (EC) No 178/2002 of the European Parliament and of the Council of 28 January 2002 laying down the general principles and requirements of food law, establishing the European Food Safety Authority and laying down procedures in matters of food safety, as last amended.

⁸⁵ Corrigendum to Regulation (EC) No 1924/2006 of the European Parliament and of the Council of 20 December 2006 on nutrition and health claims made on foods (OJ L 404, 30.12.2006), as last amended.

882 published by EFSA. Confidentiality can only be given to specific parts of a study if duly justified, and
883 not to an entire study.

884 In practice, when applicants submit studies for the scientific substantiation of a health claim that are
885 claimed as confidential, EFSA requests applicants to identify and justify which elements of the studies
886 are claimed as confidential during the completeness check. If the request for confidential treatment
887 for those elements identified by the applicant is accompanied by verifiable justification and this is
888 accepted by EFSA, those elements will be kept confidential. Should the applicant disagree with EFSA's
889 conclusions on their request, they may withdraw their application before a scientific opinion is
890 adopted, file a request addressed to EFSA to review this decision, or avail themselves of the ordinary
891 means of legal redress (i.e. challenging the legality of EFSA's decision under the conditions set out in
892 Article 263 of the Treaty on the Functioning of the European Union, or bringing a complaint for
893 alleged maladministration before the European Ombudsman).

894 Once a scientific opinion for a health claim is adopted by the NDA Panel, and before its publication on
895 the EFSA website, the scientific opinion is sent to the applicant in order to check whether the scientific
896 opinion discloses any data that EFSA had accepted to keep confidential.

897 It should be noted that, in principle and without prejudice to Regulation (EC) No 1049/2001 on public
898 access to documents, if a study has not yet been published and its disclosure would undermine the
899 commercial interests and rights of the applicant, EFSA will not make such a study available to third
900 parties.

901 With respect to the handling, use and protection of proprietary data (e.g. requirements needed for
902 data exclusivity), it should also be noted that where evidence for substantiation includes a request for
903 the protection of proprietary data, the NDA Panel considers only whether the claim could have been
904 substantiated with or without the data claimed as proprietary by the applicant. The decision on
905 granting the protection of proprietary data falls under the responsibility of the European Commission
906 when authorising the claims.

907 **A.5 Adoption and publication of EFSA opinion on claims**

908 EFSA informs the applicant that EFSA's NDA Panel has adopted a scientific opinion on its application
909 one working day after adoption (i.e. *Notification email on adoption of scientific output*).

910 The applicant receives the adopted scientific opinion under embargo one working day before
911 publication of the opinion on EFSA's website (i.e. *Pre-notification of publication*).

912 Following the publication of an adopted scientific opinion, a teleconference with EFSA can be
913 requested by the applicant to clarify the rationale for the decision of the NDA Panel and explain the
914 evidence and other factors that influenced the outcome (i.e. *Teleconference post-adoption*).

915 **A.5.1 Can stakeholders and the public comment on EFSA opinions?**

916 According to Article 16 of Regulation (EC) No 1924/2006, the applicant or members of the public may
917 make comments on EFSA-published scientific opinions. Comments should be sent to the Commission
918 within 30 days of publication of the EFSA opinion in question. If considered appropriate, the
919 Commission may decide to ask EFSA to address the comments relating to scientific issues. Comments
920 are made public by the Commission on its webpage⁸⁶.

921 EFSA responses to the requests received from the Commission are also published on EFSA's website⁸⁷.

922 **A.6 Process for health claim authorisation**

923 Upon publication of EFSA opinions that have a favourable outcome, any issues related to the final
924 wording of health claims including consumer understanding aspects should be addressed to the
925 Commission (see section 4).

926 The Commission prepares a draft decision and submits it to the Standing Committee on the Food
927 Chain and Animal Health after EFSA publishes its opinion.

⁸⁶ <http://ec.europa.eu/nuhclaims/?event=claimsBeingProcessed>

⁸⁷ <http://www.efsa.europa.eu/en/publications/supporting.htm>

928 After a favourable opinion of the Standing Committee on the Food Chain and Animal Health, the
929 European Parliament and the Council have the right of scrutiny on the Commission's draft decision.

930 If there is no objection, the Commission adopts the draft decision.

931 Authorised health claims, their conditions of use and applicable restrictions, if any, are published in
932 the EU Register of claims⁸⁸.

⁸⁸ <http://ec.europa.eu/nuhclaims/>