

mandatory requirement. As far as we are aware, Australia is the only country which specifies a maximum level of folic acid in addition to the minimum level, in its mandatory fortification standard. The standard prescribes a range of 200-300 µg folic acid per 100g of wheat flour.⁶ This was done to prevent overages.

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We thank Mackerras and Dugbaza for their interest in our work and appreciate the clarifications that the authors have made.¹ It was not our intention to misrepresent work undertaken by FSANZ – work we have generally found to be detailed and thorough. In particular, we regret any implication from our paper² that we are critical of the work of FSANZ – the original modelling³ undertaken by that organisation was the motivation for our own activity.

We are aware of the deficiencies of information gathered from food frequency questionnaires and assert that other methods of estimating usual dietary intake for individuals or populations are also sub-optimal. In deriving an individual estimate for usual folic acid intake from the food frequency questionnaire, we used a 'typical' serve size for each food category sourced from the widely used Australian nutrient analysis software 'Foodworks' (Xyris Software (Australia) Pty Ltd). The same serving size was applied to all women in our age range of interest which was 16-44 years.

The purpose of our work was to explore the impact of various proposed scenarios involving food fortification on folic acid intake of a demographic group of interest. We do not suggest that simulation modelling should take the place of appropriate evaluation of the impact of population level food fortification by well-designed

measurement which might be informed by the scenarios proposed in our recent paper.² We stand by our concluding statements that it is not known how population folic acid intake will be affected by mandatory folic acid fortification. Monitoring outcomes and population behaviour is important to inform the future review of this public health policy.

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doi: 10.1111/j.1753-6405.2012.00924.x

Serving-size information on nutrition labels in Australia

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In December 2002, food labelling became mandatory for all manufactured foods sold in Australia and New Zealand. However, the recent *Labelling Logic*¹ report identified some shortcomings of current labelling practices and singled out serving-size information as an area that consumers struggle to understand. According to the US Food and Drug Administration, the term 'serving' or 'serving size' means the 'amount of food customarily consumed per eating occasion'.² In Australia and New Zealand, serving-size information must be expressed in grams for solid and semi-solid foods. Manufacturers can also include additional information about serving size (e.g. 1 biscuit, 1 cup of rice), but this supplementary information is not required.³ In contrast, US² and Canadian⁴ guidelines mandate that serving sizes must be expressed in common household measures appropriate to the food (e.g. cup, tablespoon, piece). This approach may assist consumers in understanding serving-size suggestions by providing a more user-friendly alternative to weighing foods. A significant step forward was made when food labelling became mandatory in Australia and New Zealand in 2002 but, 10 years on, it is important to assess how these labelling standards have played out in practice.

We conducted a product survey in two leading national supermarket chains to identify the serving-size information provided on the nutrition labels of foods sold in Australia. Coles and Woolworths stores located in eastern Sydney were surveyed between February and May 2011. Only solid and semi-solid foods were examined because, for these products, serving sizes must be stated in grams but there is no requirement for manufacturers to provide additional serving-size information.³ All solid and semi-solid foods were included if they

were: (1) foods intended for consumption on their own (e.g. cereal) or (2) foods involving some preparation before consumption (e.g. pasta). Foods were not included if they were: (1) ingredients (e.g. flour), (2) foods packaged for individual consumption or immediate consumption (e.g. cup of soup, fresh-baked cookies) or (3) specialty items (e.g. holiday foods). (For additional details, see the Supplementary Information weblink: http://www2.psy.unsw.edu.au/Users/lvartanian/Publications/Vartanian&Sokol.supplementary_information.pdf.)

Information was collected from 3,344 grocery items from 22 broad food categories. Serving-size information in common household units was only provided on 701 products (21.0%; see the Supplementary Information weblink). Importantly, there was considerable variability across product types and manufacturing companies. For example, of the 610 Coles brand products surveyed, only 34 (5.6%) contained additional serving-size information and only 67 of the 447 Woolworths brand products surveyed (15.0%) carried additional information. Even within a specific product category, the inclusion of additional serving-size information varied by manufacturing company. For example, Cadbury provided additional serving-size information for 94.7% of their confectionary products, but additional serving-size information was not provided on any of the Mars Snackfood Australia confectionary products surveyed. Finally, there was also variability within companies across food categories. For example, virtually none (2.1%) of the Coles brand confectionary products surveyed provided additional information, but 43.3% of Coles brand bread products did provide additional information.

These findings indicate that serving-size information is only provided in the required format (grams) on the vast majority of products surveyed. Thus, the practice in Australia strongly contrasts with food labelling practices in the US² and Canada⁴ where governments mandate that serving-size information be expressed in common household measures. There was also considerable variability in how serving-size information was provided between manufacturing companies, within manufacturing companies across food categories, and even within manufacturing companies for their products in a specific category. This variability can be a source of confusion among consumers. Another source of consumer confusion can arise from incongruity between package-size and serving-size units. For example, the majority of products in the ice cream category (73.3%) provided package-size information in litres or millilitres but provided serving-size information in grams. Serving-size information can be challenging for consumers to interpret in the best of cases and providing incongruous units may further aggravate the problem. The variability in how serving-size information is provided could be avoided by mandating that serving-size information be provided in common household units (and in grams) for all solid and semi-solid foods. At a minimum, manufacturers should be required to state the net size and serving size of a product in the same unit (e.g. grams or millilitres). Any policy changes should also be accompanied by consumer education to facilitate understanding and proper use of serving-size information.

Consumers may want to use serving-size information for a variety of reasons, such as guiding decisions about how much is appropriate to eat on a given occasion, or assisting them in their efforts to regulate their food intake. Regardless of consumers' motivations, nutrition labels should be user-friendly, easy to understand and should assist consumers in achieving their food goals; this may not be the case with current labelling practices. Further research is needed to specifically assess the benefits and potential limitations of providing serving-size

information in common household units, both in terms of consumer understanding and in terms of facilitating regulation of individuals' food intake. We also hope that the data presented here will inform the debate concerning further developments and revisions to food labelling standards, and will generate important questions and paths for future research in the area of nutrition labelling.

Acknowledgements

The authors thank Sandra Shannon, Lee Catlin, Shanta Dey, Daniela Ho Tan, Chantelle Martyn and Emily Upton for their assistance with data collection.

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doi: 10.1111/j.1753-6405.2012.00925.x

Paediatric influenza vaccination program suspension: effect on childhood vaccine uptake

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Trivalent influenza vaccination of children aged less than 5 years was suspended in Australia between 23 April 2010 and 30 July 2010, after an increased incidence of fever and convulsions in children in this age group following administration of one brand of influenza vaccine (Fluvax®).¹ Many of these adverse events occurred in Western Australian (WA) due to the relatively high rates of vaccine uptake associated with a state-funded program, initiated in 2008, that provides free trivalent influenza vaccination to all children aged 6-59 months.² We aimed to assess the impact of suspending the paediatric influenza vaccination program in 2010 on parental attitudes and behaviours regarding childhood vaccination.

In June 2011 we surveyed parental attitudes using computer assisted telephone interviews of WA Health and Wellbeing Surveillance System (HWSS)³ respondents with children aged 6-59 months who had consented to be recalled for additional surveys (93% of respondents).