January 29, 2018

The Honorable Sonny Perdue  
Secretary  
U.S. Department of Agriculture  
1400 Independence Ave., S.W.  
Washington, DC 20250

Dear Secretary Perdue:

We, the undersigned scientists and academics, oppose the three-year delay (from School Year 2017-2018 to School Year 2021-2022) of the second sodium reduction targets (Target 2) for the National School Lunch and Breakfast programs proposed by the U.S. Department of Agriculture (USDA) in the “Child Nutrition Programs: Flexibilities for Milk, Whole Grains, and Sodium Requirements” interim final rule (IFR) (82 FR 56703). The delay is inconsistent with expert nutrition recommendations and the evidence base on the effects of high sodium on children’s health.

Sodium is an essential nutrient, but the average amounts children consume far exceed biologic needs and maximum recommended levels.1,2 Schools have been encouraged (but not required) to lower sodium since 1995. In 2010, the Healthy, Hunger-Free Kids Act made the first major changes to school nutrition in 15 years. The updated standards released in 2012 by USDA align school meals with the latest nutrition science. As part of that alignment, the USDA set sodium limits for school meals. Sodium levels are to gradually decrease in three phases until final target levels are reached in School Year 2022-2023. These sodium reduction levels are based on recommendations from the National Academy of Medicine’s (formerly, Institute of Medicine) 2009 report, School Meals: Building Blocks for Healthy Children3 and aligned with the 2010 and 2015 Dietary Guidelines for Americans4 and other expert recommendations.

The 2015 DGA recommends that children consume no more than 1,900 to 2,300 mg of sodium per day.5 Unfortunately, children on average consume considerably more than that: between 2,500 to 4,200 mg of sodium per day, well over the recommended levels.6 Along with the

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DGAs, the Centers for Disease Control and Prevention, the World Health Organization, the American Heart Association, and other experts recommend limiting sodium intake to less than 2,300 mg. At the current levels (Target 1), an elementary school lunch has on average 1,230 mg, or about two-thirds a day’s worth of sodium for a child in one meal. A high school lunch has on average 1,420 mg, or about half a day’s worth. The Target 2 sodium levels align with the DGA by lowering high levels of sodium in school meals to support a healthy diet and do not constitute a low-sodium diet.

Nine out of ten children consume excess sodium. Excess sodium consumption is strongly associated with the development and worsening of high blood pressure and an increased risk of coronary heart disease, stroke, heart failure, kidney failure, gastric cancer, and osteoporosis. A substantial number of studies show that as dietary sodium intake rises, so does blood pressure. Studies have shown a link between high blood pressure in childhood and high blood pressure in adulthood, and high blood pressure in childhood is linked to early development of heart disease and risk for premature death later in life.

The American Heart Association reviewed studies that reported inconsistent findings regarding sodium and cardiovascular disease and found an average of three to four methodological issues per study. Those flaws limit the usefulness of those studies in setting, much less reversing, sodium intake recommendations. On balance, a vast body of diverse research indicates that lowering sodium intake lowers blood pressure, a major risk factor for heart disease, in adults and children.

The prevalence of high blood pressure is increasing in American children. Approximately one in six children aged 8-17 have raised blood pressure. Children who eat high-sodium diets are about 40 percent more likely to have elevated blood pressure than children who eat lower-sodium diets.

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13 Id., Whelton PK.
16 Id., Rosner B.
Lowering sodium consumption can have a tremendous impact on public health. Studies have shown that reduced sodium intake can lower blood pressure, control hypertension, and prevent cardiovascular disease. In addition, lowering sodium consumption, and thereby lowering blood pressure, can reduce medical costs. From 2012 to 2013, high blood pressure cost the United States an estimated $51.2 billion in direct and indirect costs. The U.S. is lagging behind other countries to bring sodium down to safe levels; more than 50 countries have adopted reductions in the sodium content of certain foods.

Taste preferences for salty foods may be established early in life, so children’s liking for salt may remain lower if they are exposed to less sodium in their diets at a young age. Repeated exposure to lower-sodium foods can lead to decreased preference for salty taste over time, consistent with the gradual, phased-in approach to reduce sodium in school meals.

Sodium does occur naturally in some foods, but more than 75 percent of the sodium in Americans’ diets is added to food during processing. Luckily a variety of methods and technologies are available to help reduce this amount in many food categories.

The totality of the existing body of high-quality scientific research supports reducing sodium intake to moderate levels for better health. Thus, we urge USDA not to delay sodium reduction in school meals.

23 Id., Institute of Medicine. Strategies to Reduce Sodium Intake in the United States.
Sincerely,

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