

Dietary intake and nutritional status of children and adolescents in Europe

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The objective of this project was to collect and evaluate data on nutrient intake and status across Europe and to ascertain whether any trends could be identified. Surveys of dietary intake and status were collected from across Europe by literature search and personal contact with country experts. Surveys that satisfied a defined set of criteria – published, based on individual intakes, post-1987, adequate information provided to enable its quality to be assessed, small age bands, data for sexes separated above 12 years, sample size over 25 and subjects representative of the population – were selected for further analysis. In a small number of cases, where no other data for a country were available or where status data were given, exceptions were made. Seventy-nine surveys from 23 countries were included, and from them data on energy, protein, fats, carbohydrates, alcohol, vitamins, minerals and trace elements were collected and tabulated. Data on energy, protein, total fat and carbohydrate were given in a large number of surveys, but information was very limited for some micronutrients. No surveys gave information on fluid intake and insufficient gave data on food patterns to be of value to this project. A variety of collection methods were used, there was no consistency in the ages of children surveyed or the age cut-off points, but most surveys gave data for males and females separately at all ages. Just under half of the surveys were nationally representative and most of the remainder were regional. Only a small number of local surveys could be included. Apart from anthropometric measurements, status data were collected in only seven countries. Males had higher energy intakes than females, energy intake increased with age but levelled off in adolescent girls. Intakes of other nutrients generally related to energy intakes. Some north–south geographical trends were noted in fat and carbohydrate intakes, but these were not apparent for other nutrients. Some other trends between countries were noted, but there were also wide variations within countries. A number of validation studies have shown that misreporting is a major problem in dietary surveys of children and adolescents and so all the dietary data collected for this project should be interpreted and evaluated with caution. In addition, dietary studies rely on food composition tables for the conversion of food intake data to estimated nutrient intakes and each country uses a different set of food composition data which differ in definitions, analytical methods, units and modes of expression. This can make comparisons between countries difficult and inaccurate. Methods of measuring food intake are not standardised across Europe and intake data are generally poor, so there are uncertainties over the true nutrient intakes of children and adolescents across Europe. There are insufficient data on status to be able to draw any conclusions about the nutritional quality of the diets of European children and adolescents.

Dietary intake: Nutritional Status: Children: Adolescents: Diet surveys

Introduction

There is little good, evidence-based information on the nutritional needs of healthy children and adolescents over the age of 2 years. Numerous dietary surveys to assess

nutrient intake have been conducted across Europe at both national and local level, which could help establish nutrient needs, especially if measurements of status are also carried out. However, estimation of dietary intake is fraught with difficulties (Biro *et al.* 2002) and it is now

Abbreviations: RE, retinol equivalents; SFA, saturated fatty acids.

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accepted that many published surveys do not accurately reflect true intakes. For this report, as part of an exercise to review data available in Europe that could be used to help develop dietary guidelines, information on nutrient intake and status across Europe was collected and evaluated to ascertain whether any trends could be identified.

Methodology

To gain insight into the dietary intake and nutritional status of children and adolescents, the first step was to collect data and to highlight the measurement tools used and biological parameters investigated for each data set individually, before a final selection of the most relevant surveys for further analysis was made. For this purpose, the information listed below was collected for each survey;

- Quality of the document and whether published.
- Dietary assessment method used.
- Range of intakes (mean values, standard deviations or other distribution characteristics).
- Food composition databases used for the conversion of food intakes to estimated nutrient intakes (national food composition databases, other country databases and/or manufacturer's database, duplicate portion technique with chemical analysis data; nutrient calculations inclusive or exclusive of the contribution of food supplements).
- Year and type of the survey, e.g. longitudinal or cross-sectional.
- Age ranges and cut-off ages, sex and sample size.
- Assessment of status: anthropometric data (measured or self-reported) and biochemical parameters.
- Geographical distribution: national, regional or local study; rural or urban.

Next, each member of the Working Group looked for the above-defined survey information and data on the energy and nutrients listed in Table 1 from their specified countries. Surveys to be assessed were collected between April and December 2001 by literature search and/or by contacting experts in this field. Once the available surveys were collected and related information was incorporated into the template by country, a selection of relevant surveys was made according to the criteria listed in Table 2.

Originally we aimed to focus also on fluid intake (e.g. water, other fluids, juices, soda) and meal pattern. However, only a few studies provided information about the

Table 1. Nutrients included in the inventory

Energy
Carbohydrates (total sugars, sucrose, starches, total available carbohydrates) and NSP/fibre
Lipids (total fat, saturated fatty acids, MUFA, PUFA, <i>trans</i> fatty acids, polyunsaturated fats:saturated fats, cholesterol)
Protein
Alcohol
Vitamins (biotin, folic acid, niacin, pantothenic acid, retinol equivalents, riboflavin, thiamin, vitamin B ₁₂ , vitamin B ₆ , vitamin C, vitamin D, vitamin E, vitamin K)
Minerals and trace elements (Ca, Mg, P, K, Na, chloride, iron, Cr, Cu, fluoride, I, Mn, Mo, Se, Zn)

Table 2. Inclusion and exclusion criteria

Unpublished surveys were included only if relevant (e.g. no published documents were available)
Control groups from studies of children with medical conditions were not used, even for rare nutrients or for nutrients for which no other data were available in the country
To assess nutrient intake, only surveys based on the individual level were included. Therefore only data obtained with a record method (weighed or estimated), 24 h recall, food frequency questionnaire and/or dietary history method were included
Surveys before 1987 were excluded unless specific information on food status was available
If too much information was missing in a document the survey was excluded, except if there was only a small number of surveys available for a specific country or a specific nutrient
Nutritional status data were included only if they could be linked to dietary intake data in the same or a similar study. In this particular case, a randomised selection of children should be ensured
Surveys with too broad age categories (e.g. 2–24 years) were excluded
Data were excluded when genders were mixed in children above 12 years of age
Surveys with a very small sample size ($n = 10-25$) were excluded

intake of water and other fluids. Sometimes these figures were related to total water (including water from food), whereas in other studies figures seemed to refer only to drinks including or excluding tap water. Furthermore, although some information on meal pattern was available, the kind of information was difficult to compare. Since the information on fluids and meal pattern could not be interpreted unequivocally we decided not to include this type of data.

In a final stage the results of the selected surveys were incorporated in tables by nutrient, using units according to the SI system, and each nutrient was reviewed.

The age group classification of the EU was used as guidance: 1–3 years, 4–6 years, 7–10 years, 11–14 years and 15–17 years (Reports of the Scientific Committee on Food, 1993). Data were collapsed if relevant (weighted means when only a small amount of data was available). When age categories were combined this was clearly indicated. Data of specific groups within countries, e.g. urban/rural, were collapsed in the case of minor differences.

For describing regional trends in dietary intake of children and adolescents, Europe was divided into four regions: Northern countries (Denmark, Finland, Norway, Sweden), Western countries (Austria, Belgium, France, Germany, Ireland, The Netherlands, Switzerland, the UK), Central and Eastern countries (Bulgaria, Czech Republic, Estonia, Hungary, Poland, Russia, Yugoslavia) and Southern countries (Greece, Italy, Portugal, Spain).

Results

Eighty surveys from twenty-three countries, which satisfied the selection criteria, were selected for inclusion in the review. These are listed by country in Table 3. Only surveys from the UK used 7 d weighed records. Most surveys gave data for males and females separately for all ages.

Table 3. Surveys included in the dietary intake and status review

Country	Survey no.	Year of survey	Reference	Dietary methodology	Gender	Age (years)		Sample size	Geographic distribution
						Range	Cut-off points		
Austria	A1	2002	Elmadfa & Wasserbuecher (2002)	7 d record, 1 x 24 h recall	m + f	4-18	4-6, 7-9, 10-12, 13-15, 15-18	2234	national
Belgium	B1	1992	Guillaume <i>et al.</i> (1998)	3 d record	m + f	6-12	8, 10	1028	regional
	B2	1991	De Henauw <i>et al.</i> (1997)	FFQ	m + f	6-12	-	1321	local
	B3	1995	Pavius <i>et al.</i> (2001)	1 d record	m + f	12-17	-	1526	regional
	B4	1997	De Henauw & Matthyss (1998), De Henauw <i>et al.</i> (2001)	7 d record	m + f	13-18	-	341	local, urban/rural
Bulgaria	BG1	1998	Petrova <i>et al.</i> (2000)	1 x 24 h recall	mix: 1-10; m + f; 11 +	1-18	3, 6, 10, 14	362	national
Czech Republic	CZ1	1998	Brazdova <i>et al.</i> (2000)	1 x 24 h recall, FFQ	f	6-9, 11-15	-	1564	national
	CZ2	N/A	Brazdova <i>et al.</i> (1992)	1 x 24 h recall	mix	3-6, 9-11	-	100	local
Denmark	DK1	1995	Andersen <i>et al.</i> (1996)	7 d record	m + f	1-18	3, 6, 10, 14	1413	national
	DK2	1995	Lyhne (1998)	7 d record	m + f	14-19	-	245	national
Estonia	EE1	1993-95	Grünberg <i>et al.</i> (1997)	1 x 24 h recall, FFQ, OCD	m + f	11-12, 14-15	-	341	regional
Finland	SF1	1996	Räsänen <i>et al.</i> (1991)	2 x 24 h recall	m + f	9-24	12, 15, 18	902	regional
	SF2	N/A	Rankinen <i>et al.</i> (1995)	4 d record	m + f	9-12	-	170	local
	SF3	1989	Ylönen <i>et al.</i> (1996)	3 d record	mix	1-7	3	77	regional
	SF4	1996/97	Lehtonen-Veromaa <i>et al.</i> (1999)	4 d record	f	9-15	-	191	national
	F1	1988	Herberg <i>et al.</i> (1991a)	DH	m + f	2-20	6, 10, 14, 18	207	local
	F2	1988	Herberg <i>et al.</i> (1991b)	DH	m + f	2-20	6, 10, 14, 18	207	local
	F3	1988	Herberg <i>et al.</i> (1994)	DH	m + f	2-20	6, 10, 14, 18	207	local
	F4	1988	Preziosi <i>et al.</i> (1994)	DH	m + f	2-20	6, 10, 14, 18	207	local
France	F5	1993/94	Rigaud <i>et al.</i> (1997)	1 d WR	m + f	2-20	6, 12, 17	271	national
	F6	1993/94	Couet <i>et al.</i> (2000)	1 d WR	m + f	2-20	6, 12, 17	271	national
	F7	1989/90	Volatier (2000)	1 d WR	m + f	3-14	6, 8, 11	1018	national
	F8	1985-93	Deheeger <i>et al.</i> (1994)	DH	m + f	2-20	4, 6, 8	278/112	local
	F9	1985-93	Deheeger <i>et al.</i> (1996)	DH	m + f	2-20	4, 6, 8	278/112	local
	D1	1998	Deutsche Gesellschaft für Ernährung eV (2000)	1 d WR, DH	m + f	4-19	7, 10, 13, 15	38 924	national
	D2	1985-88	Adolf <i>et al.</i> (1995)	7 d record	m + f	4-18	6, 9, 12, 14	24 632	national
	D3	1985-95	Kersting <i>et al.</i> (2000)	3 d record	m + f	1-18	3, 6, 9, 12, 14	627	local
Greece	D4	1985	Kersting <i>et al.</i> (1998a)	3 d record	m + f	1-18	3, 6, 9, 12, 14	627	local
	D5	1985	Kersting <i>et al.</i> (1998b)	3 d record	m + f	1-18	3, 6, 9, 12, 14	627	local
	GR1	1993/94	Roma-Giannikou <i>et al.</i> (1997)	1 d WR, OCD	m + f	2-14	3, 5, 7, 9, 11	1936	national
	GR2	1994	Kafatos <i>et al.</i> (2000)	1 x 24 h recall, OCD	m	12	-	98	regional
	GR3	1999	Moschandreass & Kafatos (2002)	1 x 24 h recall	m + f	9-16	9-12, 14-16	1054/799	regional
	GR4	1997	Hassapidou <i>et al.</i> (2001)	3 d WR, 1 x 24 h recall, OCD, FFQ	m + f	11-14	-	582	regional
Hungary	GR5	1987-88	Hassapidou <i>et al.</i> (1996)	3 d WR	m + f	13-14	-	20	local
	H1	1985	Gábor (1998)	3 x 24 h recall	m + f	13-14	13-14	414	regional
Ireland	IRL1	1988	Lee & Cunningham (1990)	DH, OCD	m + f	8-25	12, 15, 18	643	national

Table 3. Continued

Country	Survey no.	Year of survey	Reference	Dietary methodology	Gender	Age (years)		Sample size	Geographic distribution
						Range	Cut-off points		
Italy	IT1	1996	Bellù <i>et al.</i> (1996)	FFQ	m + f; 7; mix: 10	7, 10	-	35 072	national
	IT2	1992	Ratsch <i>et al.</i> (1992)	4 d record	mix	3, 7, 10	-	93	national
	IT3	1991	Leclercq & Ferro-Luzzi (1991)	1 x 24 h recall	mix	10-11	-	178	national
	IT4	1988	Agostoni <i>et al.</i> (1998)	1 x 24 h recall	m + f; 11; mix: 15	11, 15	-	120	local
The Netherlands	NL1	1997/98	Hulshof <i>et al.</i> (1998)	2 d record	m + f	2-19	3, 6, 9, 12, 15	1538	national
	NL2	1984	Meulmeester (1989)	1 x 24 h recall	m + f	8	-	135	local
	NL3	1999	Brussaard <i>et al.</i> (1999)	1 x 24 h recall	m + f	7-9	-	202	local
Norway	N1	N/A	Frost Anderson <i>et al.</i> (1995)	1 d WR, FFQ	m + f	18	-	1564	national
	N2	N/A	Frost Anderson <i>et al.</i> (1997)	FFQ	m + f	13	-	1705	national
	N3	N/A	Johansson <i>et al.</i> (1997)	1 d WR	m + f	16-29	-	845	national
	PL1	1991-94	Szponar & Rychlik (1996a)	1 x 24 h recall	m	11-14	11, 12, 13, 14	401	national
	PL2	1991-94	Szponar & Rychlik (1996b)	1 x 24 h recall	f	11-14	11, 12, 13, 14	725	national
	PL3	1996-98	Hamuika & Gronowska-Senger (2000)	1 x 24 h recall, FFQ	m + f	9-11	9, 11	224	regional
	PL4	1996-98	Hamuika & Gronowska-Senger (1999)	1 x 24 h recall, FFQ	m + f	9-11	9, 11	224	regional
	PL5	1996/97	Hamuika <i>et al.</i> (1998)	1 x 24 h recall, FFQ	m + f	13-15	13, 15	104	urban, rural
	PL6	N/A	Hamuika <i>et al.</i> (2000)	1 x 24 h recall	m	17-18	17, 18	215	local
	PL7	N/A	Smigiel <i>et al.</i> (1994)	1 x 24 h recall	m	17-18	17, 18	236	local
	PL8	1990/91	Rogalska-Niedźwiedz <i>et al.</i> (1992)	1 x 24 h recall	m + f	11-15	11, 15	7562	local
	PL9	N/A	Czeczlewski <i>et al.</i> (1995)	1 x 24 h recall	m + f	13-15	13, 15	78	local
	PL10	N/A	Ilow <i>et al.</i> (1999)	1 x 24 h recall	mix	3-7	3, 7	822	national
	PL11	N/A	Werker (2000)	1 x 24 h recall	m + f	15-18	15, 18	600	regional
	PL12	N/A	Stopnicka <i>et al.</i> (1998)	1 x 24 h recall	m + f	15-18	15, 18	600	regional
	PL13	N/A	Charzewska <i>et al.</i> (1992)	FFQ	m + f	9-14	9, 14	672	regional
Portugal	P1	1995	Amorim Cruz (2000)	1 x 24 h recall	m + f	13-18	-	78	local
Russia	Rus1	2000	B Popkin (unpublished results)	1 x 24 h recall	m + f	1-20	2, 3, 4, etc.	2779	national
Spain	E1	1989/92	Aguilera <i>et al.</i> (1994)	FFQ	mix	2-7	3, 6	264	local
	E2	1988	Gonzalez <i>et al.</i> (1994)	1 x 24 h recall, OCD	m + f	6-14	7, 8, 9, etc.	2608	local
	E3	1988	Vázquez <i>et al.</i> (1996)	1 x 24 h recall	m + f	6-16	7, 12	164	local
	E9	1989/90	Arançeta & Perez (1996)	7 d record	m + f	14-17	17	731	regional
Sweden	S1	1993/94	Bergström <i>et al.</i> (1993)	7 d record	m + f	15	-	398	regional
	S2	1993/94	Samuelson <i>et al.</i> (1996a)	7 d record	m + f	15	-	398	regional
	S3	1993/94	Samuelson <i>et al.</i> (1996b)	7 d record	m + f	15	-	93	regional
	S4	N/A	Samuelson <i>et al.</i> (2001)	7 d record	m + f	13-21	15, 19	1862	regional
Switzerland	CH1	1994/95	Societe Suisse de la Nutrition (1998)	7 d record	m + f	7-12	11	227	local
	UK1	1988	Nelson <i>et al.</i> (1990)	7 d WR	m + f	12	-	61	local
UK	UK2	1989	McNeil <i>et al.</i> (1991)	7 d WR	m + f	11-12	-	379	local
	UK3	1990	Adamson <i>et al.</i> (1992)	2 x 3 d record	m + f	2-5	3, 5	153	local
	UK4	1988/90	Payne & Belton (1992a)	7 d WR	m + f	2-5	3, 5	153	local
	UK5	1988/90	Payne & Belton (1992b)	7 d WR	m + f	2-5	3, 5	153	local
	UK6	1986/87	Crawley (1993)	4 d record	m + f	16-17	-	4760	national

Table 3. Continued

Country	Survey no.	Year of survey	Reference	Dietary methodology	Gender	Age (years)		Sample size	Geographic distribution
						Range	Cut-off points		
UK	UK7	1989	Davies <i>et al.</i> (1994)	4 d WR	m + f	1.5-4.5	2.5, 3.5	81	local
	UK8	1990	Strain <i>et al.</i> (1994)	DH	m + f	12, 15	-	1015	regional
	UK9	1986/87	Crawley & White (1995)	4 d record	m + f	16-17	-	3288	national
	UK10	1992/93	Gregory <i>et al.</i> (1995)	4 d WR	m + f	1.5-4.5	2.5, 3.5	1675	national
	UK11	1990	McNulty <i>et al.</i> (1996)	DH	m + f	12-15	-	1015	regional
	UK12	1991/92	Ruxton <i>et al.</i> (1996)	7 d WR	m + f	7-8	-	136	local
	UK13	1997	Gregory & Lowe (2000)	7 d WR	m + f	4-18	6, 10, 14	1701	national
Yugoslavia	YU1	1998	Pavlovic <i>et al.</i> (2001)	1 d record	mix	10	9, 11	5834	national
	YU2	1998	Pavlovic <i>et al.</i> (1999)	1 d record	mix	9-10	9, 11	492	local
	YU3	1994/95	Pavlovic (1999)	1 d record	mix	4-6	4, 6	123	local
	YU4	1998	Pavlovic (2000)	1 d record	mix	9-10	9, 11	375	local
	YU4b								

N/A, not available; FFCQ, food frequency questionnaire; OCD, other country food composition database; DH, diet history; WR, weighed food record; m, male; f, female; mix, genders not separated.

There was no consistency in the ages of the children surveyed or the age cut-off points. Thirty-four of the selected surveys were nationally representative and most of the remainder were regional. Only a small number of local surveys could be included. Thirteen (16%) surveys provided data on children and adolescents living in Northern countries of Europe, fourteen (18%) provided data on those living in Southern Europe, twenty-nine (37%) on those in Western Europe and twenty-three (29%) on those living in Central and Eastern Europe, although many of the surveys from the latter region were local surveys or surveys using 1 d records or 24 h recalls. All intake data are presented as a mean daily intake, unless otherwise stated. In some surveys, only a daily median was provided.

Apart from anthropometric data, some surveys provided additional information on status. Data from the UK were given for individuals for age groups between 1.5 and 18 years and for Austria for 6-18 years. For France and The Netherlands, status data were available only for the nutrients folic acid, vitamins A, E and C, β -carotene, riboflavin, thiamin, pyridoxine and Fe. Status data for vitamin B₁₂ and some lipid parameters were also available for The Netherlands but these data related only to a small age group. Greece discussed status data on lipids and vitamin E only. Sweden provided status data for Fe and cholesterol and Finland for vitamin D.

Appendix B tabulates the intake data by nutrient for children and adolescents across Europe. For brevity, in the appendix tables, the surveys reviewed are given a survey number; Table 3 links the survey numbers and sources. The latter are given in the reference list of the present paper.

Energy

Data were obtained from sixty-seven surveys for males and fifty-nine for females. Most surveys provided data on energy intakes for a number of age categories. Making allowances for the different age categories used in the surveys, the intake of energy was consistent within the European countries. Approximately half the surveys provided data on children and adolescents living in Western Europe, while a further third reported on the intakes of those living in Southern Europe. Children (2-10 years) and adolescents (11-18 years) were equally represented in terms of the number of surveys.

There were fewer data sets available on the energy intakes of 2- to 3-year-olds compared with the other age categories.

When expressed in absolute terms, reported energy intakes (kJ/d) increased with increasing age in both males and females; when the data were expressed relative to body weight (kJ/kg per d), the opposite trend was apparent. Within each age category there was a wide range in reported energy intake (kJ/d) and this variability increased in magnitude with increasing age. Energy intakes of males were in the following ranges: 4200-6900 kJ/d (2-3 years); 5300-7700 kJ/d (4-6 years); 7000-10 100 kJ/d (7-10 years); 7740-15 000 kJ/d (11-14 years); and 9000-16 500 kJ/d (15-18 years). The corresponding intakes for females were: 4100-5400 kJ/d (2-3

years); 5100–9600 kJ/d (4–6 years); 6700–9600 kJ/d (7–10 years); 6800–10900 kJ/d (11–14 years); and 6800–10600 kJ/d (15–18 years). Overall, while energy intakes appeared to increase during adolescence in males, no further increases were apparent from the age of 11 years in females.

On the other hand, the magnitude of the variability in energy intakes decreased with increasing age when intakes were expressed relative to body weight. In children (2–10 years) relative energy intakes were similar in males and females and typically these were in the range of 315–480 kJ/kg per d (2–3 years), 250–380 kJ/kg per d (4–6 years) and 210–340 kJ/kg per d (7–10 years). In adolescents there was greater divergence between males and females in relative intakes. The range of values for males was 175–290 kJ/kg per d in 11- to 14-year-olds and 140–255 kJ/kg per d in 15- to 18-year olds. The corresponding values for females were 150–225 kJ/kg per d (11–14 years) and 115–190 kJ/kg per d (15–18 years). In general, the variability in energy intakes was greatest in children and adolescents from Western Europe but this may simply be a reflection of the greater number of data sets available. Otherwise, there were no clear differences in intake across the different regions of Europe.

Carbohydrate and dietary fibre

Data for absolute intakes (g/d) and percentage of total energy were collected for total carbohydrate, total sugars, sucrose and starch. Only the percentage energy from each is presented as this corrects for any differences due to total energy intake and to some extent for misreporting, assuming misreporting is not macronutrient-specific.

Where the percentage energy was not provided, it was calculated from the absolute intake and total energy per day. The energy value used for 1 g carbohydrate was either 16 or 17 kJ, depending on which provided the nearest to 100% when added to the percentage energy from fat (37 kJ/g) and protein (17 kJ/g). This calculation was required for most of the surveys and hence only a limited number of values for standard deviations are available. The surveys provided data on fibre intakes as g dietary fibre/d or, in the case of most UK surveys, NSP. This was converted to g/MJ.

Boys ate more carbohydrate and fibre than did girls in absolute amounts, but relative to energy intakes they were very similar. Data for both are given, but the descriptions below refer to data for males, unless specified, for simplicity. Within surveys there were large differences between individuals in absolute intakes, but much of this can be explained by variations in energy intake.

Total carbohydrate. Data were obtained from sixty-four surveys for males and sixty-three for females. Carbohydrate energy ranged from 40.3 to 61.6% of total energy for males and from 39 to 60% for females. In both cases the lowest values were from a Spanish survey (González *et al.* 1994) and the highest from the Russian survey (B Popkin, unpublished results). These represented the geographical trend. The lowest intakes tended to be in the Southern European countries, ranging from 40.3% of energy in Spanish 8-year-olds to 53% in Italian 11-

12-year-olds (Agostini *et al.* 1998), and the highest in the Central and Eastern countries, ranging from 44.6% of energy in Yugoslavian 9- to 10-year-olds (Pavlovic, 2000) to 61.6% in Russian 8-year-olds. In Northern countries, intakes ranged from 46.1% of energy, in Finnish 12-year-olds (Rankinen *et al.* 1995), to 55.1%, in Norwegian 13- to 15-year-olds (Frost Anderson *et al.* 1997). Intakes in Western countries were from 42.7% of energy in German 10- to 12-year-olds (Adolf *et al.* 1995) to 55% in Dutch 2- to 3-year-olds (Hulshof *et al.* 1998).

In the surveys where a number of age groups were included, the majority demonstrated a decline in percentage energy from carbohydrate with age. However, in Russia where intakes were the greatest, the survey indicated that the lowest intakes were in the under-sevens and over-sixteens. A reduction with age was also less likely in Southern European countries where intakes were already low at a young age.

Total sugar. Data were available from twenty surveys for males and females. Some UK surveys could not be included as they provided only non-milk extrinsic sugars, which excludes lactose and sugars in fruits and vegetables, and therefore are not comparable with the data from the rest of Europe. There were no data for Scandinavian countries.

Intakes tended to be lowest in Southern European countries. There was a clear trend of declining intake with age, except in Spain (Aranceta & Pérez, 1996) where intakes were mostly less than 12% of energy. Intakes in 2- to 3-year-olds ranged from 22.9% of energy in Greece (Roma-Giannikou *et al.* 1997) to 33.2% in The Netherlands (Hulshof *et al.* 1998). Intakes among older children ranged from 10.9% of energy in Spanish 6- to 7-year-olds to 27 and 24.9% of energy in Dutch adolescents aged 13–15 and 16–19 years, respectively (Hulshof *et al.* 1998).

Sucrose. Data were provided by fifteen surveys for males and females. As with total sugars the lowest intakes were found in Southern European countries, but there were no obvious geographical trends amongst the other regions. Similarly, there was a decline in intake with age. The smallest intakes were 6% of energy by a group of UK 7- to 8-year-olds (Ruxton *et al.* 1996) and 7.1% by Italian 7-year-olds (Leclercq & Ferro-Luzzi, 1991). However, it should be noted that, of the many UK surveys included in this review, this was the only one that provided data on sucrose. Other UK surveys only provided non-milk extrinsic sugars, which include glucose and fructose found in fruit juices. Greatest sucrose intakes were 19% of energy by 4- to 6-year-old Austrians (Elmadfa & Wasserbacher, 2002) and 17.6% of energy amongst Finnish 4- to 7-year-olds (Ylönen *et al.* 1996).

Starch. Data for males came from twenty-one surveys and for females from twenty surveys. Intakes were greatest in the Spanish, Russian and Polish surveys and smallest in the Finnish surveys. There was a clear trend of increasing intake with age, except in the Spanish survey (Aranceta & Pérez, 1996). In younger children, intakes ranged from 18% of energy in Finnish 2- to 3-year-olds (Ylönen *et al.* 1996) to 28 and 28.8% in Russian 2- and 3-year-olds, respectively, and 35% in Spanish 4- to 5-year-olds.

For the older children, they ranged between 22.8 and 34.6 % of energy in Finnish (Räsänen *et al.* 1991) and Russian 18-year-olds, respectively. There were no clear differences in intakes between those Southern and Western European countries that reported intakes.

Fibre. Data were obtained from fifty-four surveys for males and fifty-two for females. Intakes ranged from 0.9 to 3.5 g dietary fibre/MJ, with no discernible trends between countries or ages. Differences in methodology for determining fibre may partly explain why regional differences were not apparent. Values for NSP within the UK surveys ranged from 1.1 to 2.2 g/MJ.

Fat

Total fat. Data originated from sixty surveys for males and females. Males' and females' intakes of fat, when expressed as percentage of total energy, were similar, although some values were lower in females when compared with their male counterparts from the same survey. The lowest fat intakes were recorded in the Norwegian and Swedish surveys. Mediterranean countries, particularly Spain and Greece, and some surveys from the UK recorded the highest fat intakes; that is, more than 40 % of energy. Fat intake and age of children did not seem to be associated.

Saturated fatty acids. Data were provided for males and females by twenty-nine surveys. Reported consumption of saturated fatty acids (SFA) in Belgium and France was quite high (about 17 % of energy), while Finland reported the highest intake, i.e. 20 % of energy. Southern Mediterranean countries (Greece, Spain and Italy) reported intakes of 12–13 %. Yugoslavia reported the lowest SFA intakes at 10 % of total energy, and similar values were found in Poland (10–11 %).

MUFA. Data for the intake of MUFA were available from thirty surveys for males and twenty-nine surveys for females. In Southern European countries where intakes of SFA were low, the reported consumption of MUFA was greatest. Reported consumption in Spain was 16–17 % and in Greece up to 18 % of total energy. For the other countries, 11–13 % of energy seemed to be the most common range of consumption. Low intakes of MUFA were found in Denmark, Norway and Sweden, and also in Hungary, where the intake of MUFA was 10 % of energy.

PUFA. Data for males were obtained from thirty surveys and for females from twenty-nine surveys. In most countries, intakes of PUFA ranged from 4 to 6 % of energy. Poland showed some peculiarities since two surveys (Smigiel *et al.* 1994; Hamułka *et al.* 2000) reported high intakes of PUFA (9 % of energy), while others (Szponar & Rychlik, 1996a,b) reported the lowest of all the surveys (3 % of energy). Yugoslavian surveys also reported a wide range of PUFA intakes (5–8 % of energy). On the whole, surveys from Central and Eastern Europe reported the greatest intakes of PUFA; for example, the reported consumption of PUFA in Estonia was almost 10 % of energy.

Some differences in the composition of high-fat diets between Mediterranean countries and other regions were evident. Hyperlipidic diets in Mediterranean countries

were associated in general with high intakes of both SFA and MUFA, while high-fat diets in Central and Eastern and Northern Europe showed quite high levels of SFA with relatively lower levels of both MUFA and PUFA.

Cholesterol. Data were reported in thirty-one surveys for males, twenty-four for females and eight for males and females together. There was a relatively homogeneous pattern of cholesterol consumption within all European countries. Within both Northern and Southern Europe there are countries with dietary intakes in the higher and lower ranges. Some surveys reported an intake of up to 400 mg/d for males in Northern, Central and Eastern and Southern European countries. The highest intakes were reported for Spain (Aranceta & Pérez, 1996; Vázquez *et al.* 1996). Lower intakes were reported in surveys from The Netherlands, Poland, the UK and Denmark.

Status data for cholesterol were available from five countries (Austria, Greece, The Netherlands, Sweden and the UK). Lipid status data were given as the parameters plasma total cholesterol, HDL-cholesterol, LDL-cholesterol, triacylglycerols and more for different age groups.

Protein

Data for protein intake were available from sixty-four surveys for males and fifty-eight surveys for females. Most surveys provided data on protein intakes for a number of age categories. Approximately half of the surveys provided data on children and adolescents living in Western Europe, while a further third reported on the intakes of children living in Southern Europe. Although children (2–10 years) and adolescents (11–18 years) were equally represented in terms of the number of surveys, there were fewer data sets available on the protein intakes of 2- to 3-year-olds compared with the other age categories. Northern countries (especially Sweden) and some surveys from France and Spain showed the highest protein intakes, more than 16 % of energy. Otherwise, protein intake (percentage energy) was generally very similar within each country.

There was an approximately twofold difference between the reported protein intakes of both males and females in the youngest age categories (2–6 years) and of males in the older age groups (7–18 years). The magnitude of the variability in intake decreased slightly in females in the older age groups. In absolute terms, the range in protein intakes (g/d) was broadly similar in both males and females aged 2–10 years. Typically, the range was 32–64 g/d in 2- to 3-year-olds, 38–72 g/d in 4- to 6-year-olds and 53–85 g/d in 7- to 10-year-olds. Thereafter, intakes increased with age in males, from 61–118 g/d (11–14 years) to 71–127 g/d (15–18 years). However, the intake ranges in females aged 7–18 years were similar (53–88 g/d).

When expressed relative to body weight, protein intakes decreased from 2.3–4.5 g/kg per d in 2- to 3-year-olds to 1–1.9 g/kg per d in 15- to 18-year-olds. In all age categories, the range in protein intakes (g/kg per d) was broadly similar in males and females. Protein ranged from 11 to 16.6 % of energy and from 11 to 17.8 % for energy in males and females, respectively. In general, the lowest intakes of protein were reported in the German

and UK studies while the Spanish studies reported the highest intakes, particularly in the youngest age categories.

Alcohol

Alcohol intakes were reported in sixteen studies, of which the majority were from countries in Western Europe (eleven studies) and the remainder from countries in Scandinavia (four studies) and Central Europe (one study). The surveys provided data on alcohol intakes for a number of age categories. Overall, alcohol intakes were highly variable both within and between studies. The only clear trends were an increase in alcohol intakes from 11 years, with males consuming more alcohol than females. Typically, alcohol intakes increased from 1.5 g/d (0.5 % of energy) in 11-year-old males and females to 10 g/d (3.3 % of energy) in 15- to 18-year-old males and 6 g/d (1.8 % of energy) in 15- to 18-year-old females. In general, the highest intakes were reported in studies from Germany, The Netherlands and the UK, while studies from Norway and Sweden reported the lowest intakes.

Water-soluble vitamins

Biotin. Intake data were obtained from five surveys for males and six surveys for females. No status data were available. In general, biotin intake increased with age and was very similar within a country. Highest biotin intakes were observed in Austria and Germany; in comparison, intakes in UK and Yugoslavian boys and girls were approximately 40 % less.

Intakes in 2- and 3-year-old boys were 17 µg/d (UK), while intakes in 4- to 14-year-old boys ranged from 15 to ~40 µg/d. The three surveys in the age category 15–18 years reported intakes of between 29 and 45 µg/d. Intakes of girls in all age categories ranged from 12 to 39 µg/d. The biotin intake of Austrian girls in the age category of 15–18 years was the lowest observed in the country survey for Austria and thus presented an exception that biotin intakes increase with age.

Folic acid. Intake data for male and female children and adolescents were obtained from twenty-eight surveys. Intake data refer to free folic acid (older surveys) as well as to dietary folate in the more recent surveys of Austria and Germany. The dietary folate (and folic acid) equivalent (DFE) was developed to take into account the differences in absorption of naturally occurring dietary folate and the more bioavailable synthetic folic acid: 1 µg DFE = 1 µg dietary folate = 0.5 µg synthetic folic acid. Accordingly, intake data and recommended daily allowances for dietary folate are twice as high as for folic acid. As most of the literature gives values for free folic acid, the following narrative refers to free folic acid.

There were no clear geographical trends in folic acid intake. The greatest intakes were observed in Danish, Irish and some UK surveys, whereas the lowest intakes were reported for Bulgaria, Spain, Sweden and also for some UK surveys.

In general, folic acid intake increased with age. Intakes in 2- and 3-year-old boys ranged from 95 to 190 µg/d. Intakes in 4- to 6-year-olds ranged from 120 to ~200 µg/d. Among

boys aged 7–10 years, intakes of 100–250 µg/d were reported. For 11- to 14-year-old boys, intakes varied from 105 to 300 µg/d. In 15- to 18-year-olds, low intakes of about 140 µg/d were reported for Germany, Sweden and Hungary. The highest intakes, of ~300 µg/d, were reported in Denmark, Ireland and the UK.

Folic acid intakes of 2- to 6-year-old girls ranged from 100 to ~200 µg/d. In 7- to 10-year-old girls, intakes ranged from 130 to 250 µg/d. For girls aged 11–14 years, the lowest levels of ~100 µg/d were reported in the UK, Sweden and Hungary. Other surveys reported intakes from about 140 µg/d in Spain and the UK (Nelson *et al.* 1990) to about 250 µg/d in Denmark (Andersen *et al.* 1996) and France (Volatier, 2000). In 15- to 18-year-olds, low intakes of ~105–120 µg/d were reported for Sweden, Hungary and one UK survey (Crawley, 1993). Most surveys report intakes of 200–240 µg/d. The greatest intakes, of about 260 µg/d, were reported in Denmark (Andersen *et al.* 1996) and the UK (Gregory *et al.* 1995).

Status data from four countries (Austria, France, UK and The Netherlands) for folic acid were also available. Most status data were in the range of 3.8–6.8 ng serum folate/ml (Austria) and 2.3–23.4 ng serum folate/ml (France) and about 11 nmol folic acid/l (The Netherlands). Status data for the UK were given as red-cell folate (573 (SD 203.9) nmol/l for females and 626 (SD 209.5) nmol/l for males) and serum folate (20.6 (SD 8.16) nmol/l for females and 21.7 (SD 7.64) nmol/l for males).

Niacin. Intake data for male and female children and adolescents were obtained from thirty-eight surveys. No status data were available. There were no obvious geographical trends. The highest niacin intakes were reported in Ireland and Spain, whereas the lowest intakes were reported in Belgium, France, The Netherlands, Poland and Russia. In general, niacin intake increased with age.

Intakes in 2- and 3-year-old boys and girls ranged from 7 to 20 mg/d and in 4- to 6-year-old boys and girls from about 10 to 25 mg/d. For boys and girls aged 7–10 years, the lowest intakes of about 6–10 mg niacin/d were reported in Belgium, The Netherlands, Poland and Russia. Most reported intakes were in the range of 20 to 25 mg niacin/d. Intakes of about 35 mg/d were reported for Ireland and Yugoslavia (Pavlovic, 2000).

In 11- to 18-year-olds a difference between genders was noticeable, which is probably a reflection of an overall increase in food and energy intake. Intakes among 11- to 14-year-old boys varied from 12 to 49 mg niacin/d. Most intakes were in the range of 25–33 mg/d. In boys aged 15–18 years the lowest intakes were reported for Belgium (8 mg/d) and Russia (13–16 mg/d). The highest intakes of 52 mg/d were observed in Ireland. Most intakes in 15- to 18-year-olds were between 30 and 40 mg niacin/d. Intakes in 11- to 14-year-old girls varied from 10 mg/d (Russia) to 36 mg/d (Spain). Most intakes were in the range of 24–27 mg/d. In girls aged 15–18 years the lowest intakes were reported for Belgium (6 mg/d) and Russia (10–11 mg/d). The greatest intakes of 32–34 mg/d were observed in the UK and Ireland. Most intakes in this age group were between 23 and 27 mg niacin/d.

Pantothenic acid. Data for male and female children and adolescents were obtained from eight surveys. No

status data were available. Highest intakes were observed in Yugoslavia, whereas lowest intakes were reported in France and Germany. In general, intakes increased with age (except Austria) and were very similar within a country. There was no obvious geographical trend between the European regions.

Intakes among 2- and 3-year-old boys and girls were investigated in only one UK survey, which reported mean intakes of 2.7 mg/d. Intakes in 4- to 6-year-old female and male children ranged from 2.7 to 5 mg/d. In 7- to 10-year-old-girls and boys, the lowest intakes of about 3.3 mg/d were observed in Germany. Most reported intakes were in the range of 4–4.8 mg/d. The highest intakes of 5.1 and 6.9 mg/d were reported for Yugoslavia (Pavlovic, 2000).

Among boys aged 11–14 years intakes varied from 4 to 5.8 mg/d. In 15- to 18-year-old male adolescents intakes were between 4.9 mg/d in Germany (Deutsche Gesellschaft für Ernährung eV, 2000) and 6 mg/d in Austria (Elmadfa & Wasserbacher, 2002). Intakes among 11- to 14-year-old females varied from 3.5 to 5 mg/d. One Polish survey reported the highest intake for girls of this age category of about 10 mg/d. In girls aged 15–18 years, intakes were in the range of 4 mg/d in one UK survey (McNulty *et al.* 1996) to 4.4 mg/d in Austria.

Riboflavin. Data were obtained from forty-two surveys for males and forty-four surveys for females. In seven surveys the data for boys and girls were combined. The highest riboflavin intakes were recorded in Ireland and the lowest in Russia. In general, riboflavin intake increased with age. The data were very homogeneous within a survey and a country. There were no obvious geographical trends.

Intakes in 2- and 3-year-old boys and girls ranged from about 0.8 to 1.7 mg/d. Intakes among 4- to 6-year-olds ranged from about 1.0 to 1.9 mg/d. Most intakes were in the range of 1.0–1.7 mg riboflavin/d. For girls and boys aged 7–10 years, the lowest reported intakes were about 1 mg/d. Most reported intakes were in the range of 1.2–1.8 mg/d. The highest intakes of ~2.6 mg/d were reported for Irish males and in Yugoslavia (Pavlovic, 2000).

Intakes in 11- to 14-year-old boys varied from 1 mg/d in Russia to 2.9 mg/d in Norway. Most reported intakes were in the range of 1.3–1.9 mg/d. In 15- to 18-year-old boys, the lowest intakes were reported for Greece and Russia (1.3 mg/d). The highest intakes of about 3 mg/d were observed in Ireland, Norway and Sweden. Most intakes in this age group were between 1.6 and 2.3 mg/d.

Riboflavin intakes in girls aged 11–14 years varied from 0.9 mg/d in Russia to 1.9 mg/d for Finland, Ireland and Sweden. Most intakes were in the range of 1.2–1.7 mg/d. In 15- to 18-year-old females the lowest intakes were reported for Greece and Russia (1 mg/d). The highest intakes of about 2 mg/d were observed in Norway. Most intakes in this age group were between 1.3 and 1.8 mg/d.

Status data from four countries (Austria, France, The Netherlands, UK) for riboflavin were available. Most status data were in the range 1.1–1.5 erythrocyte glutathione reductase activation coefficient.

Thiamin. Data were obtained from forty-one surveys for males and forty-three surveys for females. Seven surveys included data for males and females combined.

There were no clear geographical trends in intakes between those Southern, Northern and Western European countries with reported intakes. The highest thiamin intakes were observed in Norway, Poland, Estonia and Ireland, whereas the lowest intakes were reported for Bulgaria. In general, thiamin intake increased with age.

Intakes among 2- and 3-year-old girls and boys ranged from about 0.5 to 1 mg/d. Mean daily intakes were in the range of 0.6–0.8 mg. Intakes in 4- to 6-year-olds ranged from about 0.7 to 1.4 mg/d and most reported intakes were in the range of 0.8–1.2 mg/d. For girls and boys aged 7–10 years, daily intakes ranged from 0.9 to 2.7 mg, and most reported intakes were in the range of 1.0–1.4 mg.

Intakes in 11- to 14-year-old boys varied from 0.9 mg/d in Hungary to 2.1 mg/d in Norway and Spain. Greece reported intakes of about 2.9 mg/d for 9- to 12-year-old boys. Most intakes in boys aged 11–14 years were between 1.2 and 1.5 mg/d. In 15- to 18-year-old boys, the lowest intakes were reported for Bulgaria (1.2 mg/d). The highest intakes of about 2.4–2.5 mg/d were observed in Greece and Poland. Most intakes in this age group were between 1.4 and 1.8 mg/d.

Intakes among 11- to 14-year-old girls varied from 0.8 to 2.1 mg/d. Most intakes in this age group were between 1.1 and 1.4 mg/d. In girls aged 15–18 years, intakes ranged from 0.9 to 2.5 mg/d and most intakes were between 1.2 and 1.5 mg/d.

Status data from four countries (Austria, France, The Netherlands, UK) for thiamin were available. Most status data were about 1.1 erythrocyte transketolase activation coefficient.

Vitamin B₁₂. Data for male and female children and adolescents were obtained from twenty-nine surveys, of which three represented data for both genders combined. The highest vitamin B₁₂ intakes were observed in Austria, Spain and Sweden, whereas the lowest intakes were reported for Hungary, The Netherlands and by some UK reports. In general, vitamin B₁₂ intake increased with age but was consistent within an age group and each survey considered. There was no evidence for any geographical trend.

Intakes in 2- and 3-year-old girls and boys ranged from about 2.4 µg/d in the UK (Payne & Belton 1992b; Crawley 1993) to 5.6 µg/d in France. Intakes in 4- to 6-year-olds ranged from about 2.5 µg/d in the UK to 7.5 µg/d in France. Most intakes ranged between 3.0 and 4.3 µg/d. For 7- to 10-year-old girls and boys, the lowest intakes of about 2.6 µg/d were observed in the UK. Most intakes were reported were in the range of 3.5–5 µg/d. The highest intakes, of 6.1 µg/d (females) and 9 µg/d (males), were reported in a French survey (Hercberg *et al.* 1991b, 1994).

Intakes in 11- to 14-year-old boys varied from 2.8 to 11 µg/d. Most intakes in this age group ranged between 3.5 and 5.3 µg/d. For 15- to 18-year-old boys, the lowest intakes were reported for Hungary (3.2 µg/d). Intakes of about 8.7 µg/d were observed in the UK, but the greatest intake was 11 µg/d by 16- to 29-year-olds in Norway. Most intakes in this age group were in the range of 5–7 µg/d.

Intakes in 11- to 14-year-old girls varied from 2.6 µg/d in a UK survey (McNulty *et al.* 1996) to 9.6 µg/d in

Spain (Vázquez *et al.* 1996), but most intakes were between 3.3 and 5.5 µg/d. The lowest intakes in 15- to 18-year-old girls were reported for the UK and Hungary (~2.5 µg/d). The highest intake of about 7.1 µg/d was observed in Norway (16- to 29-year-olds) but most intakes in this age group were between 3.4 and 5 µg/d.

Status data for vitamin B₁₂ were available from three countries (Austria, The Netherlands, UK). Most status data were in the range of 400–560 pg serum cobalamin/ml (Austria) and 290–410 pmol/l (The Netherlands). Status data from the UK also averaged about 400 pmol/l.

Vitamin B₆. Data for male and female children and adolescents were obtained from thirty-six surveys, of which four surveys presented combined data. No particular pattern of intake of vitamin B₆ was apparent. The highest intakes were observed in France, Ireland and Poland, whereas Germany reported the lowest intakes. In general, the vitamin B₆ intake increased with age.

Intakes in 2- and 3-year-old girls and boys ranged from ~0.6 mg/d in Germany to ~1.1 mg/d in the UK and France. Among 4- to 6-year-olds intakes ranged from ~0.7 mg/d in the Czech Republic and Germany to ~1.7 mg/d in the UK (Gregory *et al.* 1995). Most intakes were between 1.0 and 1.4 mg/d.

In 7- to 10-year-old girls and boys the lowest intakes of about 0.8 mg/d were observed in the Czech Republic. Most intakes were between 1.1 and 1.4 mg/d, and the highest intake of about 2.4 mg/d was reported in a Yugoslavian study (Pavlovic, 2000).

Intakes in 11- to 14-year-old boys ranged from 1.1 mg/d in Germany to 2.2 mg/d in Ireland and the UK. Most intakes by this age group were in the range of 1.3–1.9 mg/d. For 15- to 18-year-old boys, the lowest intakes were reported in Germany (1.4 mg/d) and the highest in the UK, Ireland and Poland (2.6 mg/d). Most intakes by the older group were between 1.6 and 2.2 mg/d.

Intakes among 11- to 14-year-old girls ranged from 1.0 mg/d in Germany to 1.9 mg/d in the UK, but most intakes were between 1.3 and 1.4 mg/d. For 15- to 18-year-olds, the lowest intakes were reported in Germany (1.3 mg/d) and the highest intake of ~2 mg/d was observed in the UK (McNulty *et al.* 1996). Most intakes in this age group were between 1.4 and 1.6 mg/d.

Status data were available from four countries (Austria, France, The Netherlands, UK) for vitamin B₆ and were in the range of 1.3–2.0 for erythrocyte aspartate aminotransferase activation coefficient.

Vitamin C. Data were obtained from fifty-six surveys for males and fifty-three surveys for females, of which seven included data for males and females combined. In general, vitamin C intake increased with age. No geographical trends were apparent and intakes among children and adolescents appear to be very heterogeneous within Europe.

For 2- and 3-year-old girls and boys, intakes ranged from ~35 mg/d in Russia and one UK survey (Payne & Bellon, 1992b) to ~95 mg/d in France and Spain (Aguilera *et al.* 1994). Most reported intakes were between 50 and 70 mg/d.

Intakes among 4- to 6-year-olds ranged from about 30 mg/d in the Czech Republic to 115 mg/d in Austria

and Finland, and most intakes were between 50 and 90 mg/d. For 7- to 10-year-old girls and boys, the lowest intakes, of about 50 mg/d, were observed in Russia. The highest intakes of about 125 mg/d were reported for Yugoslavia (Pavlovic, 2000). Most reported intakes were between 60 and 100 mg vitamin C/d. Intakes among girls and boys aged 11–14 years ranged from 30 to 185 mg/d and most were in the range of 60–90 mg/d.

Among 15- to 18-year-old male and female adolescents, the lowest intakes were reported for Estonia (50 mg/d) and the highest were observed for Switzerland (males 163 mg/d, females 146 mg/d). Most intakes in this age group were between 70 and 100 mg/d.

Status data for vitamin C were available from four countries (Austria, France, The Netherlands, UK). Values were 15–17 mg ascorbate/l plasma (Austria), 1–18 µg ascorbic acid/ml serum (France), ~50 µmol vitamin C/l (The Netherlands), and 56 µmol vitamin C/l plasma for boys and 5 µmol vitamin C/l plasma for girls (UK).

Fat-soluble vitamins

Vitamin A. Surveys presented data on vitamin A intake, retinol, β-carotene or retinol equivalents (RE). The majority (fifty-four for girls, forty-seven for boys and one for both sexes combined) reported RE. In nine surveys β-carotene and retinol intakes were presented from which RE were calculated. Data on RE and β-carotene only are reported in this review.

Mean daily RE ranged from 0.39 mg in Yugoslavia (Pavlovic, 2000) to ~2.00 mg. Low intakes were found in Belgium, The Netherlands, Austria, Germany (>12 years), the UK and Yugoslavia, and high intakes in Norway, Sweden and Denmark (early childhood and 7–12 years). The lowest intakes tended to be in the Western European countries and the highest in Northern European countries. There were wide variations in intakes reported from different surveys within Germany and Poland. Differences in intake between the age groups in the surveys were slight. Intakes tended to be higher in boys, but the differences between the two sexes were not great.

Intakes in 4- to 6-year-old boys ranged from about 0.5 mg RE/d in Germany to about 1.4 mg RE/d in Poland. In 7- to 10-year-old boys, the lowest intakes of about 0.39 mg RE/d were observed in Yugoslavia. The greatest intakes of ~1.4 mg RE/d were reported for Denmark. Among boys aged 11–14 years, mean daily RE varied from 0.4 mg in the UK to 1.6 mg in Denmark. In 15- to 18-year-olds the lowest intakes were reported in Germany and the UK (~0.6 mg RE/d) and the greatest of 1.8 mg RE/d (median) was reported in Norway.

Intakes in 4- to 6-year-old girls ranged from about 0.4 mg RE/d in Germany to 1 mg RE/d in Denmark. In 7- to 10-year-old girls, lowest intakes of about 0.5 mg RE/d were reported in Yugoslavia, Germany and the UK. The greatest intakes of ~1.3 mg RE/d were reported for Denmark. Intakes in girls aged 11–14 years varied from 0.48 mg RE/d in Germany to 1.25 mg RE/d (median) in Norway. Among 15- to 18-year-olds the lowest intakes were reported for the UK and Germany (~0.5 mg RE/d).

The highest intake of 1.32 mg RE/d (median) was observed in Norway.

Status data from four countries were available. The values were 280–360 µg retinol/l serum (Austria), 0.75–1.16 µmol retinol/l serum (France), 0.84 µmol retinol/l serum (The Netherlands) and 1.0–1.29 µmol/l plasma (UK).

β-Carotene intake of boys was recorded in nineteen surveys, of girls in fourteen surveys and of both sexes combined in five surveys. Mean reported daily β-carotene intake ranged from 0.35 mg in one UK survey (Ruxton *et al.* 1996) to 8.4 mg in one Yugoslavian survey (Pavlovic, 2000). A very high intake of β-carotene was found in Yugoslavia in comparison with other countries. Low intakes were reported in Belgium. Some large differences were noted between surveys in Germany (*Ergebnisse der nationalen Verzehrsstudie*, 1995; Deutsche Gesellschaft für Ernährung eV, 2000), France (Herberg *et al.* 1991b, 1994; Volatier, 2000) and the UK (Ruxton *et al.* 1996; Gregory & Lowe, 2000). Relatively high intakes were found in Denmark and relatively low intakes in France. There did not appear to be any geographical trend.

Within each survey, intakes were similar in all age groups, indicating that the younger, smaller children had greater intakes relative to their body weight. No large differences in β-carotene intake between sexes were observed, with three exceptions: one Danish survey where intakes were greater in females aged 7–10 years and 15–18 years (Andersen *et al.* 1996), one French survey where intakes were greater in males aged 15–18 years (Herberg *et al.* 1991b, 1994) and one Greek survey where intakes were greater in females aged 11–14 years (Hassapidou & Fotiadou, 2001).

β-Carotene intakes in 4- to 6-year-old boys ranged from about 1.1 mg/d in the UK to 2.9 mg/d in Denmark. In 7- to 10-year-old boys the lowest intakes of about 0.35 mg/d were reported for the UK and the greatest intakes of about 2.9 mg/d were reported for Denmark. For boys aged 11–14 years, intakes varied from 0.85 mg/d in France to 3.2 mg/d in Denmark. In 15- to 18-year-olds the lowest intakes were reported in Belgium (0.9 mg/d) and the highest in Poland (2.5 mg/d).

Intakes of β-carotene among 4- to 6-year-old girls ranged from about 1.1 mg/d in the UK to 2.6 mg/d in Denmark. In 7- to 10-year-old girls the lowest intakes of about 0.1 mg β-carotene/d were observed in France. The highest intakes of about 4.1 mg/d were reported for Denmark. For girls aged 11–14 years, intakes varied from 0.9 mg/d in France to 2.9 mg/d in Denmark. In 15- to 18-year-olds the lowest intakes were reported from Belgium (0.8 mg/d) and the highest intakes from Denmark (3.6 mg/d).

Status data for β-carotene were available from four countries (Austria, France, The Netherlands, UK). The values were about 22–40 µmol/l serum in Austria and France, total carotenoids of 1.53 (SD 0.69) µmol/L plasma in The Netherlands and 0.312–0.626 µmol/l plasma in the UK.

Vitamin D. Vitamin D intake was recorded in twenty-two surveys for boys and girls separately, and in five for both sexes combined. Mean vitamin D intake ranged from 0.7 µg/d in Spain (boys) to 6.5 µg/d in

Sweden (Bergström *et al.* 1993). The highest intakes were found in Northern European countries (Sweden, age >12 years), Estonia and The Netherlands. The lowest intakes were recorded in Spain (age <8 years), Austria (age >12 years), Ireland and the UK. Intakes increased with age and, in most surveys, were higher in boys than in girls.

Boys aged 2–3 years were investigated in only two surveys and these reported intakes of 1.7 and 2.0 µg/d. Intakes in 4- to 6-year-old boys ranged from ~0.7 µg/d in Austria to ~3 µg/d in Germany. In 7- to 10-year-old boys the lowest intakes of about 1.7 µg/d were observed in Austria. The highest intakes of about 3.5 µg/d were reported for Germany. For boys aged 11–14 years, intakes ranged from 1.7 µg/d in Spain to 5.8 µg/d in Sweden; Spanish boys aged 13–14 years had similarly high intakes. Among 15- to 18-year-old boys the lowest intakes were reported for Germany and Austria (~1.8 µg/d) and the highest intakes for Sweden (6.5 µg/d).

Intakes in 2- and 3-year-old girls were reported in two Northern European surveys only and were 1.8–2.2 µg/d. Intakes of 4- to 6-year-old girls ranged from about 1.2 µg/d in Austria to 2.9 µg/d in Germany. The lowest intakes among girls aged 7–10 years were about 1.3 µg/d, reported by Austria and one UK survey. However, another UK survey reported the highest intake of 5.9 µg/d. Intakes of 11- to 14-year-old girls ranged from 1.2 µg/d in the UK to 4.4 µg/d in Sweden. For girls aged 15–18 years, the lowest intakes were reported by Austria (~1.4 µg/d) and highest intakes by Sweden (4.6 µg/d).

Vitamin E. Vitamin E intake was recorded in twenty-five surveys for boys, twenty-one surveys for girls and six surveys for both sexes combined. These provided data for fourteen countries. Most of the studies expressed the data as tocopherol equivalents and only three surveys used α-tocopherol (Deheeger *et al.* 1994, 1996; Kafatos *et al.* 2000; Moschandreas & Kafatos, 2002). The mean α-tocopherol equivalent intake ranged from 3.2 mg/d (Kersting *et al.* 1998 *a,b*, 2000) to 32.4 mg/d (Smigiel *et al.* 1994). The greatest intakes were found in Bulgaria, a Polish survey (Szponar & Rychlik, 1996a) and Yugoslavia, and the lowest in the Czech Republic, France, Sweden, the UK and Denmark. Girls tended to consume less than boys and intakes increased with age.

Vitamin E:PUFA (mg/g) was calculated where data for both values were available. The lowest ratios were found in Hungary (0.41) and the highest in Yugoslavia and Bulgaria (2.06). In most of the countries the ratios did not change with age, except in Bulgaria where ratios increased with age. The ratios were also very similar in both sexes.

Vitamin K. Data were provided only by Yugoslavia, which recorded vitamin K intake in both sexes combined for children aged 9–10 years.

Minerals

Calcium. Data were obtained from forty-five surveys for males, fifty for females and eight surveys for males and females together. In general, Ca intake increased with age.

In boys and girls aged 2–3 years, mean daily Ca intake ranged from about 500–600 mg in Bulgaria, Italy and

Russia to about 1000 mg in France and Spain. The UK average intake was about 650 mg/d whereas intakes between 700 and 1000 mg/d were observed in Denmark, Finland, Greece and The Netherlands. There were no obvious geographical trends across Europe. Intakes of children aged 4–6 years hardly differed from those of younger children. In this age category data were also available for the Czech Republic and Germany, where mean intakes were in the range of 600–700 mg/d.

Among children aged 7 years and over and among adolescents, the daily Ca intake of males was often about 100–200 mg higher than that of females. In boys aged 7–10 and 11–14 years, Ca intake ranged from ~500 mg/d (Russia) to ~1200 mg/d (Denmark, Finland, France, Ireland, Sweden, Yugoslavia) or more (Norway: 1624 mg/d). Intakes of between 800 and 1000 mg/d were reported in Austria, Germany, Greece, The Netherlands and the UK. Among girls aged 11–14 years intakes below 600 mg/d were mostly found in Central and Eastern European countries whereas the greatest intakes (~1000 mg/d and higher) were recorded in Ireland, Northern European countries, Greece and one French study. Although the Ca intakes of males aged 15–18 years were mostly slightly higher than of those aged 11–14 years, the general picture regarding lower and higher ranges was roughly the same. Intakes in 15- to 18-year-old female adolescents were more or less comparable with intakes of the younger age group.

Only Austria provided information on Ca excretion in urine as a status parameter. The mean values varied from 0.9 (SD 0.85) mmol/g creatinine (boys 13–14 years) to 2.01 (SD 1.23) mmol/g creatinine (girls aged 6 years), and all mean values were within the normal range (0.5–6.6 mmol/g creatinine).

Magnesium. Data were collected from thirty surveys for males, twenty-nine for females and four for males and females combined. Across Europe there were no obvious geographical trends. In general, Mg intake increased with age.

For boys aged 2–3 years mean daily Mg intake ranged from 123 mg (Bulgaria) to about 320 mg (Russia). In most surveys the mean intake figures for children aged 2–6 years and 7–10 years were between 175 and 275 mg/d and 225 and 300 mg/d, respectively. Older boys generally had higher intakes than did older girls. For males, mean intakes were mostly in the range of 300–325 mg/d (11–14 years) and 350–375 mg/d (15–17 years). For females, intakes were mostly in the range of 250–275 mg/d. In five studies, from Norway (Johansson *et al.* 1997), Yugoslavia (Pavlovic, 2000), Estonia (Grünberg *et al.* 1997), Poland (Smigiel *et al.* 1994) and Russia (B Popkin, unpublished results), values exceeded 400 mg/d in some male groups, some of which had a large standard deviation.

Data on Mg as a status parameter was available for Austria. Excretion in urine ranged from 6.26 (SD 2.8) mg/g creatinine (boys aged 15–18 years) to 10.8 (SD 16.1) mg/g creatinine (girls aged 10–12 years); normal range is 4–11 mg/g creatinine.

Phosphorus. Data were obtained from twenty-four and twenty surveys for males and females, respectively, and

from four surveys where no distinction was made between genders.

For children aged 2–6 years, mean intake of P ranged from about 700 to 1200 mg/d in the youngest and from 700 to 1400 mg/d in those aged 4–6 years. Most values fell between 700 and 1000 mg/d. Similar intakes were reported for children aged 7–10 years, but in this group the overall range was broader. The highest intakes were found in Denmark and Yugoslavia. In 11- to 14-year-old boys average intakes were mostly between 1400 and 1600 mg/d. Among girls most values fell in the range of 1200–1400 mg/d. In male adolescents mean intakes above 1800 mg/d were not exceptional, whereas in female adolescents the highest intakes were between 700 and 1200 mg/d. The highest values were often observed in Northern European countries.

Potassium. Data were obtained from fifteen surveys for males, thirteen for females and three for males and females combined. In most countries the intake of K by males was slightly higher than by females and intakes increased with age. No obvious geographical trends were seen across Europe.

In boys and girls aged 2–6 years, most mean values fell in the range of 2200–2400 mg/d and 2000–2200 mg/d, respectively. The range of intakes among 7- to 10-year-olds was broader, but still most values were in the same range as for the younger children. Studies in Yugoslavia recorded the highest figures (>3000 mg/d). In boys aged 11–14 years, mean intakes were mostly between 2400 and 2600 mg/d, although in several studies values between 2600 and 3200 mg/d were found, whereas intake figures for 15- to 17-year-old boys were mostly between 3200 and 3800 mg/d. For females, mean intakes were mostly in the range of 2000–2800 mg/d (11–14 years) and 2200–3000 mg/d (15–17 years). Highest intakes were observed in Denmark, Sweden and The Netherlands.

Information on K status was available only for Austria. The excretion in urine ranged from 45.9 (SD 36.9) mmol/g creatinine (boys aged 15–18 years) to 80.6 (SD 40.2) mmol/g creatinine (boys aged 6 years). Mean values were within the normal range of 30–84 mmol/g creatinine.

Sodium. Data were provided for males by nine surveys, for females by nine surveys and for males and females combined by three surveys. Among young children data for average intakes ranged from about 1400 mg/d to nearly 2600 mg/d and increased with age. In adolescents the intake ranged from about 1800 to 4800 mg/d. In most surveys, Na intake was higher among males than among females. Generally, the lowest intake figures were observed in the UK and the highest in Russia and Yugoslavia. No general geographical trend was obvious.

Chloride. Two surveys in the UK and one survey in Germany presented intakes of chloride. Mean intakes ranged from 2000 to ~3150 mg/d for young children, from ~3600 to nearly 5500 mg/d for males aged 7–18 years, and from ~3200 to 4130 mg/d for females aged 7–18 years.

In Austrian boys the excretion in urine varied from 245 (SD 153) mmol/g creatinine (boys aged 7–9 years) to 497 (SD 429) mmol/g creatinine (boys aged 10–12 years). In all age groups mean values exceeded the upper value of the normal range (135–150 mmol/g creatinine).

Fluoride. In only two countries were intake figures for fluoride reported. In Finland, young children had a mean intake of 255 $\mu\text{g}/\text{d}$ (2- to 3-year-olds) and 313 $\mu\text{g}/\text{d}$ (4- to 6-year-olds). In Germany, mean values varied among males from 434 $\mu\text{g}/\text{d}$ (4- to 10-year-olds) to 642 $\mu\text{g}/\text{d}$ (15- to 18-year-olds) and among females from 369 $\mu\text{g}/\text{d}$ (4- to 6-year-olds) to 548 $\mu\text{g}/\text{d}$ (15- to 18-year-olds).

Iron. Data were available from forty-seven surveys for males, forty-six for females and four for males and females combined. Intakes were highest among boys in Finland, urban regions of Estonia and Sweden. Among adolescents, the Fe intake of males was often much higher than that of females and adolescent girls had lower intakes than did their younger compatriots. There was a clear trend of increasing intake with age in males. There were no clear differences in intakes between Southern and Northern European countries.

Intakes in 2- to 3-year-olds ranged from about 5 to 10 mg/d and those of 4- to 6-year-old boys and girls from about 6 to 13 mg/d. Among boys aged 7-10 years, the lowest intake of about 8.7 mg/d was observed in France. The greatest intake of Fe by girls aged 7-14 years was reported in Russia, and the greatest intake by 15- to 18-year-old girls (15.2 mg/d) was reported in Sweden.

Status data for Fe were available from five countries (Austria, France, The Netherlands, Sweden, UK). In Austria, Fe in serum varied from 651 (SD 420) $\mu\text{g}/\text{l}$ (boys aged 6 years) to 1078 (SD 400) $\mu\text{g}/\text{l}$ (boys aged 15-18 years) and from 700 (SD 420) $\mu\text{g}/\text{l}$ (girls aged 6 years) to 972 (SD 449) $\mu\text{g}/\text{l}$ (girls aged 15-18 years). In France and the UK, Fe status data were available as Hb, mean corpuscular volume, serum Fe, transferrin saturation, erythrocyte protoporphyrin and serum ferritin. For The Netherlands and Sweden status data were also described differently (mean corpuscular volume, serum ferritin, haematocrit %).

Zinc. Data were obtained from twenty-eight surveys for males and twenty-seven surveys for females. Three surveys combined the data for girls and boys. Zn intake increased with age. The Zn intakes across Europe appear very inconsistent. There are no clear differences in intakes between the South, West, East or North. The highest intakes were recorded for boys (19 mg/d) and girls (15 mg/d) in Finland (age 11-17 years). The lowest intakes for both sexes within this age category (~11-18 years) were reported for The Netherlands and the UK.

Zn intakes for 2- and 3-year-old boys and girls were reported only for The Netherlands (5.8 mg/d males, 5.5 mg/d females). Intakes in girls and boys aged 4-6 years ranged from about 5.6 to 8.5 mg/d.

Status data for Zn were available for Austria and the UK. This was in the range of 0.97-1.13 mg Zn/l serum (normal range 0.8-1.6 mg/l) for Austria and about 54 μmol Zn protoporphyrin/mol haem for the UK. The UK also described the status data as μmol Zn/l plasma.

Copper. Data were available from eleven surveys for males, twelve for females and two for males and females combined, but these represented only six countries. Cu intakes increased with age in males and females. The Cu intake of the children and young people appeared to be quite uniform within a country and was about 1-2 mg/d.

Status data for Cu were available only for Austria and the value was in the range of 0.94-1.28 mg Cu/l serum (normal range 0.8-1.2 mg/l).

Iodine. Data were available for males and females from five countries. These were obtained from nine surveys for boys and girls separately and from three surveys for both genders combined. Intakes varied within the countries. Recorded intakes were the highest (330-470 $\mu\text{g}/\text{d}$) in Finland (Rankinen *et al.* 1995) and the lowest in German male and female children and adolescents (62-92 $\mu\text{g}/\text{d}$).

Status data for I were only available for Austria, where the range was from 206 to 85 $\mu\text{g}/\text{g}$ creatinine (I excretion/urine).

Chromium. Data for males and females were available only for two countries. Data for boys and girls were obtained from two surveys and two surveys showed results for both genders combined. Cr intake increased with age. In Yugoslavia the daily Cr intake was very low (1-2 μg) and in Finland the mean daily intake ranged from about 17 to 40 μg .

No status data for Cr were available.

Selenium. Data for Se intakes were obtained from seven countries, from fifteen surveys for boys, thirteen surveys for girls and two surveys for both genders combined. Se intake of children and adolescents varied from country to country and seemed generally low. The lowest intakes were found in Eastern European countries, e.g. Yugoslavia. Within countries intake increased with age. The highest intakes were 90 (SD 20) $\mu\text{g}/\text{d}$ by Finnish children (12-year-old athletes) and 80 (SD 20) $\mu\text{g}/\text{d}$ among British adolescent boys.

Status data for Se were available only from Austria; values were in the range of 55-89 μg Se/l serum (normal range 50-130 μg Se/l serum).

Molybdenum. No data for Mo intake or status were available.

Manganese. No data for Mn intake or status were available.

Discussion

Availability of the data

The aim of this project was to obtain information on dietary intakes of children and adolescents across the whole of Europe. Our particular interest was to have data from different regions of Europe to make some comparisons between countries and regions. The geographical regions were chosen for their likely similarity in eating patterns. They are large and not all parts of each country will necessarily fit the region. However, with so much variation in nutrient intakes recorded for children and adolescents between and within countries, the use of regions is a helpful tool for examining trends in nutrient consumption.

We tried to find publications through literature searches, but many publications did not appear in databases such as Medline. Most publications were harvested through contacts with local experts in each country. Each author was responsible for selecting the surveys from his or her allotted countries and the use of the pre-set criteria in Table 1 limited selection bias by authors. However, we did include some exceptions, where selection was more subjective, if it was felt the survey would make a useful

contribution to our review. We looked for published surveys, but in the case of Russia (B Popkin, unpublished results) we included recent good-quality data that should be published soon. One pre-1987 survey from The Netherlands was included as it contained data on nutritional status. Many surveys were published in local languages but were still assessed according to the set quality criteria.

Our aim was to obtain information not only on energy and macronutrient intakes, which was available in most of the surveys, but also on micronutrient intakes, some of which was included only in selected publications. This was one reason for including some small surveys. We would have preferred to include nationally representative studies only, but chose to widen the net to regional and local studies in order to obtain a good spread across Europe. Despite our efforts, some of the smaller local studies may be of lower quality. Ideally, we would have only included surveys for which there were anthropometric data, so that we had something against which to check reliability of reporting. However, children were weighed in an insufficient number of studies for us to insist on this criterion for inclusion.

By literature search and personal contacts of the authors, we believe all suitable surveys have been included in this paper. Finding the surveys involved a considerable amount of effort, especially for Central and Eastern European countries and for countries in which none of the authors resided, but we acknowledge that some useful ones could have been missed. Nevertheless, we have managed to survey the breadth of Europe so there are few countries for which we have no data.

We are aware that there are limitations to all surveys however good the methodology appears to be. We have attempted to reduce these as much as possible by our selection process, but have not been so restrictive as to end up with no surveys at all.

A particular problem was the comparison of data from different studies according to age categories, as these varied from survey to survey and rarely matched the age group classification of the EU.

In the end we collected a large number of surveys, which enabled us to analyse dietary intakes of almost all nutrients and attempt to make comparisons between countries and European regions. For most of the macronutrients we obtained a large volume of data which added to their value. We also found a relatively large number of surveys on vitamin intake, although for some individual vitamins there were few studies (vitamin K, biotin, pantothenic acid). There were other micronutrients that were reported in only a few surveys (Cu, Se, fluoride, Cr, chloride), which did not allow many conclusions to be drawn. Another problem was the comparison of nutrient intake with status, as hardly any studies included status data. These were selected surveys from Austria, France, Greece, The Netherlands, Sweden and the UK, which described the micronutrient status together with micronutrient intake (we did not include studies on status alone).

Quality of data

As demonstrated in Table 3, there is large diversity in the methodologies used to assess the individual dietary intakes

of children and adolescents. Overall these fall into four main classes: 24 h recalls (retrospective); food frequency questionnaires (retrospective); dietary history (retrospective); and dietary records of 1, 2, 3, 4 and 7 days (prospective). Because the different methods apply to different time frames, this inevitably resulted in variance in both the quality and the quantity of available data and hampered comparisons within and between countries.

Moreover, evaluation of the data sets is necessarily complicated by another phenomenon. In all studies, food composition tables were used for the conversion of food intake data to the estimated nutrient intakes. Most European countries have their own national food composition databases, which are compiled using country-specific procedures and traditions. Recent comparisons and evaluations of national food composition tables have shown that nutrients differ in definition, analytical methods, units and mode of expression, all of which could potentially result in different nutrient values between tables (Deharveng *et al.* 1999). In turn, these differences may have an impact on the precision of nutrient estimations and make between-country comparisons difficult and inaccurate (Ireland *et al.* 2002). In studying the comparability of food composition tables, Deharveng *et al.* (1999) distinguished three groups of nutrients. The first group is those that can legitimately be compared even though the definition and analytical method may be slightly different. This group includes N, lactose, alcohol, water, cholesterol, fat, fatty acids, retinol, vitamin D, tocopherols, tocotrienols, thiamin, riboflavin, vitamin B₆, vitamin B₁₂, Ca, Fe and K. The second group is those that are not readily comparable due to discrepancies in the calculation or mode of expression, and comprise protein, carbohydrates, starch, sugars, energy, carotenes, vitamin A and vitamin E. Finally, there are nutrients that are not comparable at all due to the analytical method or definition used, namely folate and fibre.

In addition, dietary studies tend to overestimate true intakes of Na, primarily due to the inability to account precisely for added salt and the fact that much salt is discarded with the cooking water. Salt may also be lost when manufactured foods are cooked. Therefore, to assess the intake of Na, it is recommended that measurements of Na excretion are made (Ovesen & Boeing, 2002). However, none of the surveys reporting Na intake included Na excretion as a status parameter.

Consequently, in the present paper these issues were taken on board in the evaluation of the information on nutrient intake. For instance, in the reviewed papers the modes of expression for vitamin A, vitamin E and folate were not always made explicit in the source documents. Therefore, for vitamins A and E only, data that specifically referred to RE and α -tocopherol were used. For Austria and Germany dietary folate was converted to free folic acid. However, despite these precautions, differences such as the conversion factors used to assess the intakes of protein, carbohydrates and energy and the analytical quality of the data (possible use of outdated analytical methods) cannot be excluded, and prudence is called for in the interpretation of the figures given.

In general, the present findings are in line with earlier observations that there is a lack of internationally

comparable food consumption data (Löwik & Brussaard, 2002) and support the need for better data for the evaluation of dietary intake on a European level.

Most dietary intake studies of children and adolescents have, at least until recently, tacitly assumed that the data are representative and valid measures of habitual food consumption. Unfortunately, epidemiological studies of food habits and dietary intake in children and adolescents face a number of difficulties that are more-or-less specific to these age groups and which are highly likely to bias the outcome measurements (Livingstone & Robson, 2000; Livingstone & Black, 2003; Livingstone, 2004). On the basis of recent validation studies, it is now widely accepted that misreporting is a major problem in dietary surveys of children and adolescents. Consequently, the dietary data presented in this review need to be interpreted and evaluated with caution.

Trends

Despite the concerns mentioned above over the information obtained from the surveys included in this review, some observations on trends can be made. Data on energy-related intake (percentage of energy) were similar across the European countries. Reported energy intakes increased with age and when data were expressed in relation to body weight, the opposite trend was true. In children up to 10–12 years the energy intakes for both genders were quite similar. In adolescent males, the increase in absolute energy intake continued up until the age of 18 years. In girls, however, reported energy intakes began to level off in early adolescence and decline in late adolescence, suggesting that under-reporting and dietary restriction in this age group probably occurs across Europe. Within each age group there was a large range in reported intakes for all nutrients, which partly reflected differences in body weight, but also reporting errors, that are known to be a common problem in all dietary surveys. No surveys had attempted to exclude under-reporters.

The percentage of energy from carbohydrate, total sugars and sucrose tended to decrease and the percentage of energy from starch to increase with age. Boys ate more carbohydrate and fibre than did girls in terms of absolute amount (g); however, their intakes were very similar in relation to energy intake. Within surveys throughout Europe there were large differences between individuals in absolute carbohydrate intakes, but much of this can be explained by variations in energy intake. The intake of carbohydrate, total sugars and sucrose tended to be lowest in Southern European countries. Apart from some Southern European surveys, with increasing age there was a clear trend of declining intake of sugars and sucrose and increased intake of starch.

Children and adolescents in Southern European countries tended to report the highest intakes of total fat and MUFA (sometimes with cholesterol too, as in the case of Spain). Central and Eastern countries reported the greatest intakes of PUFA and lowest intakes of SFA. The lowest fat intakes were recorded in Northern Europe, except Finland where SFA intakes were greatest. As there is no information on food these differences cannot be explained from our data, although it is generally

known that the consumption of olive oil, a major source of MUFA, is highest in Mediterranean countries. It should be noted that these are only general trends as there were large variations in reported intakes within countries and between countries of the same region.

Within countries, the protein intake (as a percentage of energy) was usually quite similar. There were some differences between the European regions. Intakes in some countries in the South and North of Europe reached about 17–19% of energy, respectively. The Western European countries, like Austria, Germany, The Netherlands and the UK, reached more moderate protein intakes of about 11–15% of energy.

Alcohol intakes were highly variable both within and between studies. Children up to the age of 11 years consumed hardly any alcohol. There was a clear trend of increasing alcohol intakes from 11 years of age onwards, with males consuming more alcohol than females.

Reported intakes of vitamins by children and adolescents were inconsistent across Europe. No clear regional trends could be described. In general, it can be said that intakes of most vitamins increase with age in both males and females, in parallel with energy intake. For some vitamins, such as folic acid, the intake is higher in some countries (UK and Ireland) than in others. Higher intakes of vitamins, especially within one country and/or within an investigation, may be explained by seasonal food patterns, by specific food-technological achievements such as micronutrient enrichment of cereal foods or by the use of supplements.

Some geographical trends were noted for vitamin A intake. Vitamin D intake was greatest in Northern countries and low in some Western countries. This may be related to a higher consumption of milk and milk products by children living in Northern regions, vitamin D fortification of food or the use of supplements. Vitamin E intake was highest in some Central and Eastern European countries, which may have reflected the higher consumption of PUFA.

Intake of minerals is also very variable across Europe. No clear regional trends were distinguishable. Like vitamins, the intake of minerals increases with age, which is related to increased food consumption. In the case of Ca, the variation in intake within the studied population groups differed considerably. Roughly, the coefficient of variation varied from 10% to about 60%. Also, there was a considerable variation in Fe intake. This might be due to inaccurate reporting and/or different eating patterns of children and adolescents within Europe. Adolescent girls therefore do not appear to consume more vitamins or minerals than their younger counterparts and, in the case of Fe, may consume less. Some countries of the North reported higher intakes of Fe than Western countries, which could be due to food fortification or higher meat intakes.

Nutritional status

The literature has shown that the correlations between blood analytes and dietary intakes are generally weak, and if a relationship between the analyte and intake data is found it may not necessarily be causal. Some factors, in particular the young person's health at the time of

investigation, may affect the degree of correlation. Status values and normal ranges are dependent on assay method, which makes it difficult to compare values directly between different surveys conducted within Europe. In addition, the number of investigations and surveys published is too small to be able to describe and/or compare the nutritional status of children and adolescents within Europe.

The differences in information on measured status may have an impact on the precision of nutrient estimations and make comparisons imprecise. In the case of vitamin D, not only diet, but also endogenous synthesis under the influence of sunlight can influence status. Studies show that status during the winter is therefore lower than that during the summer (Lehtonen-Veromaa *et al.* 1999).

Moreover, it is also important to take into account that different technical equipment and statistical software packages were used to run the data analyses (status and intake). Not all data were expressed as mean (SD). In some cases medians or ranges (minimum and maximum) were used, making it difficult to compare status data.

Conclusions

Many surveys of food and nutrient intake in children and adolescents have been undertaken over the past ten to twenty years. Of those published, the data from many have no meaningful use due to small and/or unrepresentative samples, poor methodology and failure to provide sufficient details on subjects and methods. The studies that have been included in this review provide some useful information on energy and nutrient intakes of children and adolescents across Europe and suggest some interesting trends. However, their value for discovering average intakes of European children and adolescents, or making comparisons between countries or regions, is severely limited. The reported values for many nutrients varied widely both within and between surveys, so it was impossible to know how much of this was real and how much due to recording error. Apart from the inherent problems found in even the most carefully conducted dietary surveys, there were several other reasons why surveys could not easily be compared. These included: different methods for measuring intake; different age cut-off points; use of a variety of food composition tables based on different analytical techniques for measuring food composition; failure to exclude under-reporters; and few truly nationally representative samples.

The value of the surveys for assessing the nutritional adequacy of the diets of European children and adolescents was limited due to the lack of measurements of nutritional status, although this has been rectified in some more recent surveys. Comparisons with sets of country-specific Recommended Daily Amounts are of little value since the methods used to establish many of these have been called into question (Prentice *et al.* 2004).

A European Nutrient Database would be a useful first step towards being able to compare food intake data (Charrondiere *et al.* 2002). This would also help in defining analytical methodology and in the harmonisation of units for specific nutrients such as dietary fibre, folic acid and

vitamins A and E. The routine collection of status data at the same time as food intake is assessed would help in comparisons of the status situation in different countries. Aligned methodologies for nutrient status would make a comparison at an international level more precise.

Acknowledgements

This work was supported by a grant from the Nutritional Needs of Children Task Force of the European branch of the International Life Sciences Institute (ILSI Europe). Industry members of this task force are Barilla, Coca-Cola, Danone Vitapole, Friesland Coberco, Masterfoods, Nestlé and Numico. Further information about ILSI Europe can be obtained from +32 (0)2 771 00 14 or info@ilsieurope.be. The opinions expressed herein are those of the authors and do not necessarily represent the views of ILSI and ILSI Europe.

The authors of the paper would like to thank Dr Brigitte Wasserbacher, Ms Valérie Rolland and Ms Arianna Bonazzi for their contribution to this publication.

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NUTRITIONAL NEEDS OF CHILDREN - EXPERT GROUP 2
Dietary Intake Survey Template - Nutrient by Nutrient

Dr MBE Livingstone		ALCOHOL (g%)																					
Name of Expert:	NUTRIENT:	Survey No.	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	Comments		
Belgium	DK1																						
Denmark	DK2																						
Ireland	IRL1																						
Netherlands	NL1																						
Norway	NO1																						
Sweden	SE1																						
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NUTRITIONAL NEEDS OF CHILDREN - EXPERT GROUP 2
 Dietary Intake Survey Template - Nutrient by Nutrient

Name of Expert: Dr. Edvurga Krause

NOTRENT: Folic Acid (µg)

Male

Female

Weighted mean

Mean (SD)

95% CI

90% CI

80% CI

70% CI

60% CI

50% CI

40% CI

30% CI

20% CI

10% CI

0% CI

Survey No.

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AT																				
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BE								0.85+0.13												
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Denmark

Estonia

Finland

France

Germany

Greece

Hungary

Ireland

Netherlands

Norway

Poland

Portugal

Romania

Slovenia

Spain

Sweden

Switzerland

United Kingdom

Yugoslavia

NUTRITIONAL NEEDS OF CHILDREN - EXPERT GROUP 2
 Dietary Intake Survey Template - Nutrient by Nutrient

Dr. Barbara Krause
 Vienna B12 (kg)

Name of Expert:
 SURVEY No.
 Name

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Comments
AT	3.05	3.16	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
BE	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
BR	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
CA	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
CH	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
DE	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
DK	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
FR	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
GR	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
IE	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
IT	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
JP	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
KR	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
LT	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
LU	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
NL	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
NO	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
PL	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
PT	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
RO	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
RU	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
SE	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
SI	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
SK	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
UK	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
US	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
UZ	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
VE	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	
ZA	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.2	

max: 1000g
 min: 100g

Name of Expert:
SURVEY

Male

Belgium
Germany

Denmark
France

Greece
Hungary

Ireland
United Kingdom

Finland

Belgium
Germany

Denmark
France

Greece
Hungary

Ireland
United Kingdom

Pietr Socha
Retinol (mg)

Survey	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
E1																		
D1				0.5			0.6		0.7					0.572±0.277				
D2				0.44						0.8								
D3-4-5		0.276		0.319			0.358		0.51	0.8								
BK1		0.658±0.002		0.688±0.003			0.928±0.008		0.487						0.514			
F7		0.472				0.602		0.928±0.008	0.577		1.386±0.010	0.881			1.014±0.017			
GR4											0.988±1.928							
R1											0.770±0.460		0.523					
SF2 smokers																		
UK (ave. smokers)																		
UK13	0.40±0.00	0.43±0.03	0.4±0.03	0.44							0.385			0.465				
UK11											0.344±0.530							
UK13				0.245±0.327±			0.348±0.285								0.348±0.246			
E1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
D1				0.5			0.5		0.6					0.471±0.230				
D2				0.30			0.44		0.47									
D3-4-5		0.255		0.277			0.382		0.309									
DK1		0.530±0.003																
F7			0.372	0.667±0.003		0.602	0.628±0.003		0.677		0.856±0.005	0.881			0.668±0.008			
GR2											0.559±0.850							
R1											0.576		0.473					
SF2 smokes											0.890±0.880							
UK (ave. smokers)																		
UK10	0.46±0.01	0.43±0.03	0.4±0.03	0.44											0.665±0.023			
UK11											0.265			0.304				
UK13				0.307±0.218			0.299±0.288				0.271±0.367				0.289±0.347			

Name of Export:
SURVEY
Unit: (kg/day)

Country	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
AT					1.55±0.6		1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3	1.8±0.3
BE					1.9		1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8
DE					1.14		1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1
DK					2.587±0.02		2.324	2.349±0.024	2.469	2.469	2.469	2.411	2.411	2.411	2.411	2.411	2.411	2.411	2.411	2.411
FR					1.87		2.224	2.349±0.024	2.469	2.469	2.469	2.411	2.411	2.411	2.411	2.411	2.411	2.411	2.411	2.411
GR					0.92±0.15		0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04	0.8±0.04
IT					5		5	5	5	5	5	5	5	5	5	5	5	5	5	5
PL					1.12±0.04		0.345±0.481	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04	1.12±0.04
UK					1.17±0.638		1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638	1.17±0.638
YU					3.26		3.26	3.26	3.26	3.26	3.26	3.26	3.26	3.26	3.26	3.26	3.26	3.26	3.26	3.26
FR					6.41		6.41	6.41	6.41	6.41	6.41	6.41	6.41	6.41	6.41	6.41	6.41	6.41	6.41	6.41
FR					1.21		1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21
FR					1.6		1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6
FR					1.3		1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3
FR					1.24		1.24	1.24	1.24	1.24	1.24	1.24	1.24	1.24	1.24	1.24	1.24	1.24	1.24	1.24
FR					2.648±0.002		2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002	2.648±0.002
FR					4.13±0.008		4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008	4.13±0.008
FR					0.105±0.016±0.917		0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917	0.105±0.016±0.917
FR					2.705±0.983		2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983	2.705±0.983
FR					1.524		1.524	1.524	1.524	1.524	1.524	1.524	1.524	1.524	1.524	1.524	1.524	1.524	1.524	1.524
FR					0.92±0.05		0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05
FR					5		5	5	5	5	5	5	5	5	5	5	5	5	5	5
FR					0.92±0.05		0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05	0.92±0.05
FR					1.06±0.634		1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634	1.06±0.634
FR					1.76±0.685		1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685	1.76±0.685
FR					5.88		5.88	5.88	5.88	5.88	5.88	5.88	5.88	5.88	5.88	5.88	5.88	5.88	5.88	5.88
FR					8.41		8.41	8.41	8.41	8.41	8.41	8.41	8.41	8.41	8.41	8.41	8.41	8.41	8.41	8.41

Austria
Belgium
Germany
Denmark
France
Greece
Poland
United Kingdom
Yugoslavia
France
Belgium
Germany
Greece
Poland
United Kingdom
Yugoslavia

NUTRITIONAL NEEDS OF CHILDREN - EXPERT GROUP 2
Dietary Intake Survey Template - Nutrient by Nutrient

Name of Expert: Nutrient: Male	Floor Socha Vitamin B (µg)																		
	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	19+
Atisha																			
Germany				1.85 ± 0.03	1.77 ± 0.03	1.72 ± 0.03	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05	1.69 ± 0.05
				2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3
Spain				2.88	2.88	2.88	2.88	2.88	2.88	2.88	2.88	2.88	2.88	2.88	2.88	2.88	2.88	2.88	2.88
				0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1	0.7 ± 0.1
Denmark				2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02	2.9 ± 0.02
Estonia																			
EE1 Urban																			
EE1 total																			
F7				1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8
France																			
Hungary																			
Ireland																			
Norway																			
Sweden																			
Finland																			
Netherlands																			
ML																			
United Kingdom																			
UK3																			
UK9																			
UK10																			
UK11																			
UK17																			
UK19																			
Y44b																			
Yugoslavia																			
Y44b																			
Female																			
Austria																			
D1																			
Germany																			
U2																			
U3																			
Syria																			
E2																			
Denmark																			
DR:																			
DK8																			
Estonia																			
EE1 Urban																			
EE1 total																			
FR1																			
Hungary																			
Ireland																			
Norway																			
Sweden																			
S1																			
S2 Upside																			
S2 Total																			
S2 Coastal																			
SF3																			
F7																			
France																			
Netherlands																			
UK2																			
UK3																			
UK10																			
UK11																			
UK12																			
UK13																			
Y44b																			
Yugoslavia																			
Y44b																			

male and female

m+f

m+f

m+f

m+f

m+f

male and female

m+f

m+f

m+f

m+f

m+f

Polif. Rocha
 vii SP/IFA (RGS)

	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	male and female
male																				
survey																				
A1		1.11					0.77		0.19		0.68		0.71		0.82					male and female
BG1				1.27				1.52			1.27				2.03					male and female
C22				0.97					0.24											male and female
D1				0.66				0.85		0.53										male and female
D2				1.02				1.01		0.97										male and female
DK1		0.58		0.70				0.64		0.69										male and female
DK2				0.83																male and female
FR							0.52		0.56											male and female
GR4																				male and female
HI																				male and female
PL11																				male and female
SI																				male and female
BA2								0.75		0.73			0.70		0.75		0.68			male and female
UK12		0.70	0.75																	male and female
UK13																				male and female
UK17				0.77																male and female
YJ79								0.53												male and female
YJ79																				male and female
survey																				male and female
A1		3	3	5	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
BG1				0.88			0.78		0.85	1.0	0.71		0.78		0.69					male and female
D1															0.54					male and female
D2				0.88						0.84										male and female
DK1				1.0						0.94										male and female
DK2				0.63						0.98										male and female
HI																				male and female
UK12		0.81																		male and female
UK14																				male and female
UK17																				male and female

NUTRITIONAL NEEDS OF CHILDREN - EXPERT GROUP 2
 Dietary Intake Survey Template - Nutrient by Nutrient

Name of Expert:		K. Hulshof	
SURVEY:		Sodium (mg)	
Male		Survey	
Denmark	DK2		4400 ± 1600
France	FR3		3200
Germany	DE3		2185 ± 951
Greece	GR5		
Italy	IT1	3124 ± 803.926 / 71058278 ± 4897	
Poland	PL1	1850 ± 278	
Russia	RU1	1815 ± 156.2476 ± 17.2804 ± 5213.2583 ± 219.2673 ± 151.2878 ± 168.2838 ± 1318331 ± 11188 ± 577 ± 88.3401 ± 788.3826 ± 227.4044 ± 1004.6893 ± 2234687 ± 246.4008 ± 138.4724 ± 822.4887 ± 487	
Sweden	SE1		3075 ± 942
United Kingdom	UK10	1578 ± 18.7157 ± 26.6	
	UK13	2658 ± 586	
	UK15	2402 ± 632	
	UK16	2683 ± 727	
	UK18	3286 ± 586	
Portugal	PT2		3100 ± 1000
Germany	DE2		
Spain	ES2		
Greece	GR2		
Poland	PL2	1835 ± 714	
Russia	RU2	2338 ± 745	
Sweden	SE2	2403 ± 747	
United Kingdom	UK1	1915 ± 155.2473 ± 17.2804 ± 5213.2583 ± 219.2673 ± 151.2878 ± 168.2838 ± 1318331 ± 11188 ± 577 ± 88.3401 ± 788.3826 ± 227.4044 ± 1004.6893 ± 2234687 ± 246.4008 ± 138.4724 ± 822.4887 ± 487	
	UK2		2236 ± 538
	UK3	1533 ± 19.71632 ± 31.8	
	UK4	1857 ± 484	
United Kingdom	UK11	265 ± 19 ± 1560 ± 16.7183 ± 31.8	
	UK12	1877 ± 154	
	UK14	2458 ± 498	
	UK17	2272 ± 606	
	UK19	2281 ± 632	
	UK20	2281 ± 632	
	UK21	2281 ± 632	
	UK22	2281 ± 632	
	UK23	2281 ± 632	
	UK24	2281 ± 632	
	UK25	2281 ± 632	
	UK26	2281 ± 632	
	UK27	2281 ± 632	
	UK28	2281 ± 632	
	UK29	2281 ± 632	
	UK30	2281 ± 632	
	UK31	2281 ± 632	
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	UK37	2281 ± 632	
	UK38	2281 ± 632	
	UK39	2281 ± 632	
	UK40	2281 ± 632	
	UK41	2281 ± 632	
	UK42	2281 ± 632	
	UK43	2281 ± 632	
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	UK45	2281 ± 632	
	UK46	2281 ± 632	
	UK47	2281 ± 632	
	UK48	2281 ± 632	
	UK49	2281 ± 632	
	UK50	2281 ± 632	
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	UK67	2281 ± 632	
	UK68	2281 ± 632	
	UK69	2281 ± 632	
	UK70	2281 ± 632	
	UK71	2281 ± 632	
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	UK92	2281 ± 632	
	UK93	2281 ± 632	
	UK94	2281 ± 632	
	UK95	2281 ± 632	
	UK96	2281 ± 632	
	UK97	2281 ± 632	
	UK98	2281 ± 632	
	UK99	2281 ± 632	
	UK100	2281 ± 632	

23 years older than males and females mean ± se

UK10 = Trunkton

UK13 = Trunkton

UK15 = Trunkton

UK16 = Trunkton

UK18 = Trunkton

UK19 = Trunkton

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UK97 = Trunkton

UK98 = Trunkton

UK99 = Trunkton

UK100 = Trunkton

NUTRITIONAL NEEDS OF CHILDREN - EXPERT GROUP 2
 Dietary Intake Survey Template - Nutrient by Nutrient

Name of Expert: NUTRIENT: Rata	K. Kulshof Fluoride (µg) Survey males	Age Group																	
		2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19+
Finland Germany	SF3	255 +/- 02			313 +/- 72														
	D1	434			434					506		593				642			
Finland Germany	SF3	255 +/- 02			313 +/- 72														
	D1	360			360			395		437		513				548			

