# Healthy Food Environment Policy Index (Food-EPI): **Canada**

## Federal government

April 30, 2017

# Overview

This document was created for the **Healthy Food Environment Policy Index** (Food-EPI) Canada 2016 project, as a part of the Canadian arm of the International Network for Food and Obesity/non-communicable diseases Research, Monitoring and Action Support (known as **INFORMAS**). The INFORMAS network was founded by a group of international experts from 9 universities and 4 global NGOs in the area of food and nutrition, including Dr. L'Abbé, and this network has since expanded to include dozens of researchers from 19 countries across the globe. The objective of INFORMAS is to 'monitor and benchmark food environments and policies globally to reduce obesity, diet-related non-communicable diseases and their related inequalities', and the work aligns with overarching efforts of the United Nations and the World Health Organization to prioritize monitoring on NCDs and associated risk factors to improve population health[1].

The **Food-EPI Canada** project aims to assess provincial and federal government progress in implementing globally recommended policies relating to the food environment. Using a standardized, common Food-EPI process[2], the information on food policies that is compiled in this document will be used by experts in the areas of food and nutrition from across Canada to rate the extent of implementation by Canadian governments (provincial, territorial and federal) compared to international examples of 'good practices' established for each indicator. As time progresses, these international examples will continue to expand, as more governments implement innovative policies to support a healthy food environment.

This document summarizes policy actions that the federal government has taken relating to the food environment up until January 1, 2017. Because the texts and examples are global in nature, the wording reflects international terms rather than Canadian specific terminology (e.g., salt is used rather than sodium).

Any questions regarding this document can be directed to Dr. Lana Vanderlee (lana.vanderlee@utoronto.ca).

# Acknowledgements

The Food-EPI Canada study is led by Dr. Lana Vanderlee and Dr. Mary L'Abbé in the WHO Collaborating Centre of Nutrition and Chronic Disease Prevention at the Department of Nutritional Sciences, University of Toronto, with research support from Sahar Goorang, Kimiya Karbasy, and Alyssa Schermel. This research was funded by a grant from the Canadian Institutes of Health Research (CIHR) (#343709) and a CIHR Banting Postdoctoral Fellowship to Dr. Vanderlee. We would like to gratefully acknowledge the support of the INFORMAS research group, including Dr. Stefanie Vandevijvere, Prof. Boyd Swinburn and Dr. Gary Sacks.

We have verified the information presented in this document to the best of our ability with governmental representatives from various departments and ministries. We would like to extend our sincerest gratitude to the government representatives who have verified the information in this document.

As far as possible, when policy details are noted in the document, we have provided references to publicly-available sources or noted as a 'written communication' from relevant policy makers. While every effort has been taken to ensure the accuracy of the information in this document, any errors/omissions are the responsibility of the research team.

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Benchmarking food environments

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| **ADI** | Aboriginal Diabetes Initiatives |
| **AHSOR** | Aboriginal Head Start on Reserve |
| **ASC** | Advertising Standards Canada |
| **CAI** | Voluntary Food and Beverage Children's Advertising Initiative |
| **CCDSS** | Canadian Chronic Disease Surveillance System |
| **CCHS** | Canadian Community Health Survey |
| **CCR** | Canadian Cancer Registry |
| **CETA** | Comprehensive Economic and Trade Agreement |
| **CFG** | Canada's Food Guide |
| **CFG – FNIM** | Canada's Food Guide – First Nations, Indigenous and Métis |
| **CHMS** | Canadian Health Measures Survey |
| **CNF** | Canadian Nutrition File |
| **Code** | The Canadian Code of Advertising Standards |
| **CPNP** | Canada Prenatal Nutrition Program |
| **CPNP-FNIC** | Canada Prenatal Nutrition Program – First Nations Inuit Component |
| **CRTC** | Canadian Radio-television and Telecommunications Commission |
| **CSIMS** | Consultation and Stakeholder Information Management System |
| **EA** | Environmental Assessment |
| **ERC** | Evidence Review Cycle |
| **FET** | Fair and Equitable Treatment |
| **FEAC** | Food Expert Advisory Committee |
| **FNFNES** | First Nations Food, Nutrition and Environment Study |
| **FNIHB** | First Nations Inuit Health BRanch |
| **FNIRLHS** | First Nations and Inuit Regional Longitudinal Health Survey |
| **Food-EPI** | Food Environment Policy Index |
| **FTA** | Free Trade Agreement |
| **GATS** | General Agreement on Trades and Services |
| **GATT** | General Agreement on Tariffs and Trade |

## LIST OF ABBREVIATIONS (continued)

| | |
|---|---|
| **GST** | Goods and services tax |
| **HBSC** | Health Behaviours of School Aged Children Survey |
| **HIA** | Health Impact Assessment |
| **HiAP** | Health in All Policies |
| **HIR** | Health Inequalities Reporting |
| **HPCDP** | Health Promotion and Chronic Disease Prevention Branch |
| **HST** | Harmonized Sales Tax |
| **IHS** | Inuit Health Survey |
| **INAC** | Indigenous and Northern Affairs Canada |
| **INFORMAS** | International Network for Food and Obesity/non-communicable diseases Research, Monitoring and Action Support |
| **MIREC** | Maternal-Infant Research on Environmental Chemicals |
| **NAFTA** | North American Free Trade Agreement |
| **NCDs** | Non Communicable Diseases |
| **NGOs** | Non-Government Organisations |
| **NNC** | Nutrition North Canada |
| **ONPP** | Office of Nutrition Policy and Promotion |
| **PHAC** | Public Health Agency of Canada |
| **PHN** | Public Health Network |
| **SPS** | Sanitary and Phytosanitary Measures |
| **TBT** | Technical Barriers to Trade Agreement |
| **TPP** | Trans-Pacific Partnership |
| **WHO** | World Health Organization |
| **WTO** | World Trade Organization |

# POLICY DOMAINS

## Policy area: Food Composition

Food-EPI vision statement: There are government systems implemented to ensure that, where practicable, processed foods and out-of-home meals minimise the energy density and the nutrients of concern (salt, saturated fat, trans fat, added sugar)

### COMP1 Food composition targets/standards/restrictions for processed foods

Food-EPI good practice statement

The government has established food composition targets/standards for processed foods for the content of the nutrients of concern in certain foods or food groups if they are major contributors to population intakes of these nutrients of concern (*trans* fats and added sugars in processed foods, salt in bread, saturated fat in commercial frying fats)

| | | |
|---|---|---|
| **Definitions and scope** | - | Includes packaged foods manufactured in Canada or manufactured overseas and imported to Canada for sale |
| | - | Includes packaged, ready-to-eat meals sold in supermarkets |
| | - | Includes mandatory or voluntary targets, standards (e.g., reduce by X%, maximum mg/g per 100g or per serving) |
| | - | Includes legislated ban on nutrients of concern |
| | - | Excludes legislated restrictions related to other ingredients (e.g. additives) |
| | - | Excludes mandatory food composition regulation related to other nutrients (e.g. folic acid or iodine fortification) |
| | - | Excludes food composition of ready-to-eat meals sold in food service outlets (see COMP2) |
| | - | Excludes general guidelines advising food companies to reduce nutrients of concern |
| | - | Excludes the provision of resources or expertise to support individual food companies with reformulation (see 'RETAIL4') |
| **International examples** | - | **Argentina**: In December 2013, the Government adopted a law on mandatory maximum levels of sodium permitted in meat products and their derivatives, breads and farinaceous products, soups, seasoning mixes and tinned foods (Act 26905) which entered into force in December 2014. The law is applicable to salt levels in restaurant dishes. The law includes gradual reductions (between 5% and 18% of reduction). Infringements by producers and importers may be sanctioned, the most severe penalties being fines of up to one million pesos, in case of repeat infringements up to ten million pesos, and the closing of the business for up to five years [3, 4]. The text of the legislation and specific reduction targets can be found on the Ministry of Health of Argentina website [5]. The legislation is embedded into a wider initiative (Less Salt, More Life) which also includes the reduction of salt in processed foods through voluntary agreements with manufacturers, retailers and bakers, and public awareness of the health effects and the need to reduce discretional salt. To date about 60 companies representing 487 processed food products and more than 9000 bakeries have signed the voluntary agreement [4]. |

- **South Africa**: In 2013, the South African Department of Health adopted mandatory targets for salt reduction in 13 food categories (including bread, breakfast cereals, margarines and fat spreads, savoury snacks, processed meats as well as raw-processed meat sausages, dry soup and gravy powders and stock cubes) by means of regulation (Foodstuffs, Cosmetics and Disinfectants Act). There is a stepped approach with food manufacturers given until June 2016 to meet one set of category-based targets and another three years until June 2019 to meet the next [4, 6]. The specific reduction targets for each of the food groups can be found in the Staatskoerant of 20 March 2013 [7].
- **Denmark**: A law introduced in 2003 prohibits the sale of products containing *trans*-fats, a move that effectively bans its use in products destined for sale on the Danish market [4, 8]. The law is enforced by local authorities under the supervision of the Danish Veterinary and Food Administration. Infringement of the law may incur a fine or imprisonment, and companies can be prosecuted according to the Danish Penal Code.
- **EU & UK**: In 2012, under the directive 2012/12/EU of The European Parliament and the Council, an amendment of Council Directive 2001/112/EC outlined that addition of sugars is no longer authorised in fruit juice [9]. Similarly, added sugar in fruit juice is no longer permitted under The Fruit Juices and Fruit Nectars Regulations 2013 [10].
- **France**: As part of the French National Nutrition and Health Programme (PNNS), the Ministry of Health established a Charter of Engagement with the food industry (2008). One area of action is improving the nutritional composition of food products by reducing the amount of salt, sugar, total and saturated fats and increasing the amount of fibre. Any entity with an economic interest in the food industry is eligible to submit nutritional commitments. Nine principles are detailed: compliance, honesty, efficiency, retroactivity, fairness, transparency, monitoring, updating, and confidentiality. Commitments must be clear, accurate, precise, dated, and controllable. To date, over 35 companies have made voluntary commitments, which are reviewed and approved by an external committee of 24 public sector experts to ensure they are "significant". There is a strict follow-up. The approved charters are signed by the food industry and monitored by the Food Quality Observatory (created in 2008)[4, 11].

**Context**

**Food regulation mechanism**

Health Canada is responsible for establishing standards for the nutritional quality and safety of all foods sold in Canada, through the ***Food and Drugs Act***[12] and the ***Food and Drug Regulations (FDR)***[13]. Health and safety standards under the FDR are enforced by the Canadian Food Inspection Agency.

**Policy details**

**Mandatory food composition standards**

There are standards for several of the nutrients of concern for some types of foods, including infant foods, human milk substitutes, meal replacements, etc. The composition of these products is strictly regulated in the FDR in order to fulfil the nutritional needs of specific vulnerable groups. For example, there is a minimum requirement for sodium in infant formula and requirements around the fat content.

There are mandatory limits regarding the addition of sodium for some categories of infant foods. Infant foods which contain strained fruit, fruit juice, fruit drink or cereal cannot contain sodium, as per the Food and Drug Regulations[13]:

Sodium Content permitted in Infant Foods (Grams per 100 Grams of Food )

- Junior Desserts = 0.10 g
- Junior Meat, Meat Dinners, Dinners, and Breakfasts = 0.25 g
- Junior Vegetables, Junior Soups = 0.2 g
- Strained Desserts = 0.05 g
- Strained Meats, Meat Dinners, Dinners, and Breakfasts = 0.15 g
- Strained Vegetables, Strained Soups = 0.10 g

**Voluntary Reformulation/Composition Targets**

***Sodium***

In 2007, Health Canada created a multi stakeholder **Sodium Working Group** to identify approaches to decrease sodium consumption in Canada. This group developed the *Sodium Reduction Strategy for Canada* in 2010, which contained 33 recommendations, including 6 overarching recommendations, specific recommendations for the food supply, awareness and education activities, research and monitoring and evaluation, and a proposed structured voluntary sodium reduction strategy[14].

Since 2010, Health Canada has actively been working on increasing awareness of healthy eating, including specific messaging on sodium, which has included a voluntary approach to sodium reduction. In 2012, Health Canada published *Guidance for the Food Industry on Reducing Sodium in Process Foods* and *Guiding Benchmark Sodium Reduction Levels for Processed Food*[15], with Phase 3 reductions concluding in December, 2016. The targets aim to reduce the sales-weighted average by approximately 25 to 30%, which would result in a reduction of sodium intake by the majority of the population to less than the recommended daily Upper Limit (UL) of 2,300 mg. The guidance is meant to encourage reductions in sodium levels in 94 categories of processed foods in Canada. The food industry was encouraged to work towards these voluntary benchmark levels by the end of 2016.

Health Canada has conducted targeted monitoring and evaluation of industry's progress towards the voluntary sodium reduction targets in 2016[16], with a full evaluation planned for 2017 and ongoing monitoring and reporting to Canadians as part of the Healthy Eating Strategy. The interim evaluation identified progress towards reducing sodium in 15 priority food categories; however, the results varied across food categories. Overall, 13 of 15 categories decreased sodium levels by at least one-third, and 8 of 15 decreased by at least two-thirds of the expected reduction according to a sales-weighted average by December 31, 2016. Categories with little progress included frozen potatoes (e.g., French Fries) and some packaged deli meats. The report of results stated that the results should be interpreted with caution due to the small sample size[16].

***Trans fat***

In 2006, the Trans Fat Task Force, a multi-stakeholder group, developed recommendations for reducing *trans* fats in Canada. The Task Force recommended that *trans* fat in vegetable oils and soft, spreadable margarines be limited to 2% of total fat and that trans fat in all other foods be limited to 5% of total fat, in order to align with WHO recommendations that *trans* fat intakes be <1% of energy intake**.**

The 2% and 5% recommendations were adopted by Health Canada in 2007, and voluntary measures were established to encourage industry to reduce this amount within 2 years, with the threat of mandatory reduction if significant progress did not occur.

Findings from Health Canada's trans fat monitoring program from 2005 to 2009 of 1120 food samples in 31 food categories demonstrated that 78% of foods met the 2% and 5% targets[17]. More recent research showed that of approximately 10,000 prepackaged and restaurant foods on the Canadian market surveyed, 97% of foods were meeting the *trans* fat limits in 2010-2011[18].

**There are no existing targets for saturated fat or free/added sugars.**

**HEALTHY EATING STRATEGY**

As part of the **Healthy Eating Strategy** announced in in October 2016 (see additional detail in LEAD4), Health Canada announced that they would include specific foci on the quality of the food supply:

1. work with food processors and manufacturers to reduce sodium in packaged foods
2. eliminate the use of industrially produced trans fat in foods

A consultation had been conducted by Health Canada on the regulations for partially hydrogenated oil regulations online between November 14, 2016, and January 13, 2017. None of these policies were implemented at the deadline for inclusion in this project of January 1, 2017.

**Comments/ notes**

**Activity since January 1, 2017:**

On April 7, 2017, Health Canada introduced regulatory restrictions that prohibit the use of partially hydrogenated oils (PHOs) in the food supply, the primary source of industrially produced trans fat. A Notice of Proposal detailing the proposed regulation has been posted online to seek comments from Canadians, including stakeholders. Comments will be accepted from April 7 to June 21, 2017[19].

***Note that this has not been implemented as of January 1, 2017 and should not be included in rating.*

## COMP2 Food composition targets/standards/restrictions for out-of-home meals

### Food-EPI good practice statement

The government has established food composition targets/standards for out-of-home meals in food service outlets by the government for the content of the nutrients of concern in certain foods or food groups if they are major contributors to population intakes of these nutrients of concern (*trans* fats, added sugars, salt, saturated fat)

**Definitions and scope**

- Out-of-home meals include foods sold at quick service restaurants, dine-in restaurants and take-away outlets, coffee, bakery and snack food outlets (both fixed outlets and mobile food vendors). It may also include supermarkets where ready-to-eat foods are sold.
- Includes legislated bans on nutrients of concern
- Includes mandatory or voluntary targets, standards (i.e. reduce by X%, maximum mg/g per 100g or per serving)
- Excludes legislated restrictions related to other ingredients (e.g. additives)
- Excludes mandatory out-of-home meal composition regulations related to other nutrients, e.g. folic acid or iodine fortification
- Excludes general guidelines advising food service outlets to reduce nutrients of concern
- Excludes the provision of resources or expertise to support food service outlets with reformulation (see 'RETAIL4')

**International examples**

- **New York City, USA**: In 2006, New York City's Health Code was amended to restrict the amount of *trans*-fats allowed in food served by all food service establishments required to hold a license from the New York City Health Department, including restaurants, bakeries, cafeterias, caterers, mobile food vendors, and concession stands. The maximum amount of *trans*-fat allowed per serving is 0.5g. Violators are subject to fines of $200.00 to $2,000.00. A range of other US cities have since followed suit and banned restaurants from serving *trans* fats[20].
- **New York City, USA**: In 2009, New York City established voluntary salt guidelines for various restaurant and store-bought foods. In 2010, this city initiative evolved into the National Salt Reduction Initiative that encouraged nationwide partnerships among food manufacturers and restaurants involving more than 100 city and state health authorities to reduce excess sodium by 25% in packaged and restaurant foods. The goal is to reduce Americans' salt intake by 20% over five years. The National Salt Reduction Initiative has worked with the food industry to establish salt reduction targets for 62 packaged foods and 25 restaurant food categories for 2012 and 2014. The commitments and achievements of companies have been published online[21].
- **New Zealand**: In New Zealand, The Chip group, funded 50% by the Ministry of Health and 50% by industry, aims to improve the nutritional quality of deep-fried chips served by food service outlets by setting an industry standard for deep frying oils. The standard for deep frying oil is maximum 28% of saturated fat, 3% linoleic acid and 1% of *trans*-fat. The Chip group oil logo for use on approved oil packaging was developed in 2010[22].
- **The Netherlands**: On January 2014, the Dutch Ministry of Health, Welfare and Sport signed an agreement with trade organizations representing food manufacturers, supermarkets, hotels, restaurants, caterers and the hospitality industry to lower the levels of salt, saturated fat and calories in food products. The agreement includes ambitions for the period up to 2020 and aims to increase the healthiness of the food supply[4, 23].

**Context**

**Policy details**

**Healthy Eating Strategy**

As part of the **Healthy Eating Strategy** (see additional detail in LEAD4), Health Canada in October 2016 announced that they would include a specific focus on working with restaurants and food services to develop goals for reducing sodium in their food, which would include out-of-home meals. *This has not been implemented as of January 1, 2017.*

**Voluntary Composition targets**

***Sodium***

No voluntary sodium reduction targets have been established for out-of-home meals, although Health Canada has held discussions with an expert panel to discuss establishing targets (October, 2016)[16].

The sodium reduction approach outlined in COMP1 includes 'processed' foods only, and therefore includes: processed foods for consumer use; foods for further manufacturing, such as ingredients for processed foods; and foods for use by restaurants and foodservice in food preparation. Benchmarks were set for prepackaged products, as well as foods destined for foodservice or further processing (i.e. no specific levels set for foods being prepared and served in restaurant and foodservices settings)[15].

***Trans fat***

The recommended *trans* fat targets described in COMP1 apply to foods sold in restaurants and food services. Also, the monitoring program described in COMP1 includes restaurants, fast food chains, cafeterias, and establishments with ethnic cuisines.

**Comments/ notes**

There are additional efforts implemented at the provincial level, and this is examined in provincial evidence documents.

# Policy area: Food Labelling

## Food-EPI vision statement: There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to enable consumers to easily make informed food choices and to prevent misleading claims

### LABEL1 Ingredient lists/nutrient declarations

Food-EPI good practice statement

Ingredient lists and nutrient declarations (including warning labels) in line with Codex recommendations are present on the labels of all packaged foods

| | |
|---|---|
| **Definitions and scope** | - Includes packaged foods manufactured in Canada or manufactured overseas and imported to Canada for sale<br>- Nutrient declaration means a standardized statement or listing of the nutrient content of a food<br>- Excludes health and nutrition claims (see'LABEL2') |
| **International examples** | - **Many Countries**: In a wide range of countries producers and retailers are required by law to provide a comprehensive nutrient list on pre-packaged food products (with limited exceptions), even in the absence of a nutrition or health claim. The rules define which nutrients must be listed and on what basis (e.g. per 100g/per serving) [24].<br>- **Some Countries**: A more limited number of countries (about N=10), including Canada, require that nutrient lists on pre-packaged food must, by law, include the trans-fat content of the food. Specific rules generally define how the trans-fat content must be listed, and on what basis (e.g. per 100g/100ml or per serving). If the trans-fat content falls below a certain threshold, it may be listed as 0g (e.g. less than 0.5g per serving, or less than 0.3g per 100g of food product)[24].<br>- **US**: The US Food and Drug Administration proposed updates to the Nutrition Facts label on food packages. Information on the amount of added sugars (in grams and as percent Daily Value) now needs to be included on the label, just below the line for total sugars [25]. |
| **Context** | All packaged foods sold in Canada are regulated by the ***Food and Drug Regulations***, and must comply with labelling requirements. Food labelling requirements are enforced by the Canadian Food Inspection Agency.<br><br>Canada is a member of Codex Alimentarius, whose standards are recognised by the World Trade Organization (WTO), of which Canada is also a member. In Canada, participation in Codex is coordinated through the Office of the Codex Contact Point for Canada, which is part of the Food Directorate, Health Products and Food Branch of Health Canada.<br><br>**Health Canada *What We Heard* report**<br><br>In 2014, the federal government undertook consultations with parents and consumers on ways to improve the nutritional information presented on food labels and published the *What We Heard: Consulting Canadians to Modernize and Improve Food Labels*[26]. The report concluded that while some of the aspects of the Nutrition Facts table (NFt) were useful, there were considerable limitations, some of which included:<br>- Challenges with serving sizes and understanding the %DV<br>- No %Daily Value (DV) for sugar, and out of date %DVs for sodium |

- Confusion with ingredients, and requests for larger size print, consistent format and placement of the ingredients information, and using common names for ingredients.
- Requests for interpretive information, such as front-of-pack traffic-light systems to indicate the quantity of nutrients to aid in understanding of numeric amounts.

Following the publication of this report, broader and more extensive public consultations were held throughout 2014 and 2015 that led to amendments of nutrition and other food labelling regulations

**Policy details**

**Nutrient information**

- The Food and Drug Regulations (FDR) requires that the label of a pre-packaged product shall carry a Nutrition Facts table (NFt) that contains only the information as required in the FDR (section B.01.401).
- Canada regulated the mandatory display of the NFt in 2003 on most pre-packaged food, with full implementation by 2007[27].
- The NFt must be formatted as shown in the image below, according to section B.01.450(1) of the FDR, in conjunction with Schedule L, with exceptions for simplified formats, prepackaged foods for children under 2 years, prepackaged foods used in manufacturing other foods, foods for commercial and industrial enterprises and institutions and small packages <100cm$^2$:

**Nutrition Facts**
**Valeur nutritive**
Per 3/4 cup (175 g) par 3/4 tasse (175 g)

| Amount<br>Teneur | % Daily Value<br>% valeur quotidienne |
|---|---|
| **Calories / Calories** 170 | |
| **Fat / Lipides** 5 g | **1** % |
| Saturated / saturés 3.5 g<br>+ Trans / trans 0.2 g | **19** % |
| **Cholesterol / Cholestérol** 20 mg | |
| **Sodium / Sodium** 450 mg | **20** % |
| **Carbohydrate / Glucides** 23 g | **8** % |
| Fibre / Fibres 0 g | **0** % |
| Sugars / Sucres 3 g | |
| **Protein / Protéines** 7 g | |
| Vitamin D/ Vitamine D | **9** % |
| Calcium / Calcium | **17** % |
| Iron / Fer | **10** % |
| Potassium / Potassium | **4** % |

- The NFt requires information for energy plus 13 nutrients (total fat, saturated fat, *trans* fat, sodium, carbohydrate, fibre, sugar, protein, vitamin A, Vitamin C, calcium and iron), and must have information on the amount present for any nutrient that is involved in a health claim or nutrition claim.
- Notably, Canada is one of few countries that required the declaration of *trans* fat in the NFt, as of 2007.
- Nutrient information must be presented per serving, and the serving size must be indicated, standardized for food categories as set out in the Reference Amounts and Serving Sizes table[28].
- The DV is equivalent to the Recommended Daily intake (for vitamins and minerals) and the Reference Standard (for fat, saturated and *trans* fat, sodium, carbohydrates, and fibres). The Percent Daily Value (%DV) must be displayed for the above listed nutrients, as shown in the image above[29].

**Ingredient list**

In Canada, all prepackaged foods with more than one ingredient must declare their ingredients and components in a list (B.01.008(1), FDR). Ingredients must be listed in descending order of proportion by weight, and must be listed by their common names.

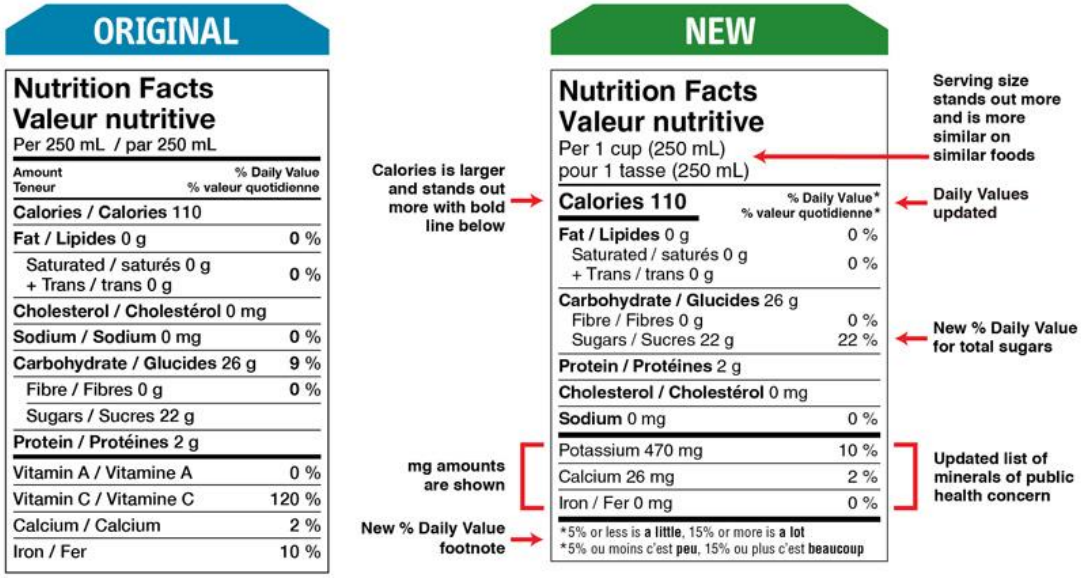
**UPDATE TO FOOD LABELLING REGULATIONS**

In 2014, Health Canada began the Food Labelling Modernization Initiative, and in 2015, Health Canada proposed changes to the NFt in *Canada Gazette I*, which was open for public consultation until August 27, 2015[30]. The final changes were announced on December 14, 2016[31]. There is a 5 year transition period permitted for companies to make these changes, and therefore labels may not change until December 2021.

The changes included:

- Incorporating by reference the Reference Amounts for foods, the Daily Values, and the Directory of the NFt format
- Updating serving size regulations so that serving sizes are more consistent between similar foods and reflect the amount that Canadians typically eat in one sitting
- Increasing the font size for serving size information
- Increasing the font size of calories with a thick underline
- Moving the information for nutrients that provide calories to be listed below calories, and sodium to the bottom of the NFt near potassium
- Revising DVs (reference standards) for sodium (from 2400 mg to 2300 mg for adults), and fat (from 65 g to 75 g for adults) and providing DVs for children 1 year of age or older but less than 4 years of age (44 g fat, 10g saturated + *trans* fat, 300mg cholesterol, 50 g sugars, 1500 mg sodium)
- Including a DV (reference standard) for total sugars based on a DV of 100g (no information was included for added sugars)
- Removing of Vitamins A and C, adding potassium information, as well as showing the amount of these micronutrients present in mg in addition to the %DV
- Including a 'quick rule' for %DV at the bottom of the NFt where 5% or less is "a little" and 15% or more is "a lot"
- Grouping of sugars in the ingredients list so that all types of sugar products will be listed together in parentheses and the total weight of all will determine placement in the ingredients list
- Bullet points were added as an option separate ingredients in ingredients lists
- Requiring food colours to be listed by name
- The text for ingredients lists must be in block font on white or neutral background, and companies must use both upper and lower case letters and minimum type height requirements for ingredients
- Companies may use bullets or commas to separate ingredients

An image of the required changes is shown below:



**EXEMPTIONS**

There are some food products that are exempt from nutrition labelling[32], including:

- Prepackaged products that are packed on retail premises from bulk
- Prepackaged individual portions of food served with meals or snacks by restaurants, airlines, etc.
- Individual servings of food prepared by commissaries and sold in mobile canteens and vending machines
- Prepackaged meat and meat by-products that are barbecued, roasted or broiled on retail premises
- Prepackaged poultry and poultry meat or poultry by-products that are barbecued, roasted or broiled on retail premises
- A beverage with an alcohol content of more than 0.5%
- Standardized vinegars
- Spices
- Coffee and tea (unsweetened)
- Some bottled water
- Fresh fruits and vegetables without added ingredients
- Raw single ingredient meat, meat by-product, poultry meat or poultry meat by-product
- Raw single ingredient marine or freshwater animal products, sold only in the retail establishment where the product is prepared and processed
- Foods produced and sold by very small enterprises
- Individual servings that are sold for immediate consumption and have not been subjected to a process to extend durable life including special packaging.
- Foods in very small packages
- Foods sold only at a road-side stand, craft show, flea market, fair, farmers' market or sugar bush by the individual who prepared and processed the product

**Comments/ notes**

## LABEL2 Regulatory systems for health and nutrition claims

Food-EPI good practice statement

Robust, evidence-informed regulatory systems are in place for approving/reviewing claims on foods, so that consumers are protected against unsubstantiated and misleading nutrition and health claims

**Definitions and scope**

- Nutrition claims include references to the nutritional content on food (e.g. low in fat)
- Health claims include function claims, such as 'calcium strengthens bones') and disease risk reduction and therapeutic claims, such as 'A healthy diet rich in a variety of vegetables and fruit may help reduce the risk of some types of cancer') claims that relate to the relationship between a diet, a food or a property of a food and a health effect
- Includes recognised endorsement symbols that are associated with healthy products
- Includes provisions that require companies to put 'warnings' on foods that are high in nutrients of concern
- 'Evidence-informed' refers to systems that utilise robust criteria (based on an extensive review of up-to-date research and expert input) or a validated nutrient profiling model to inform decision-making about nutrition or health claims

**International examples**

- **Australia/New Zealand**: A law (Standard 1.2.7)[33], approved in 2013, regulates the use of nutrition content and health claims on food labels in Australia and New Zealand. Health claims must be based on pre-approved food-health relationships or self-substantiated according to government requirements and they are only permitted on foods that meet nutritional criteria, as defined by a nutrient profiling model (Nutrient Profiling Scoring Criterion (NPSC)) taking into account energy, sodium, saturated fat and total sugar content of foods, as well as protein, fibre, fruit, vegetable, nut and legume content of foods. Although nutrition content claims also need to meet certain criteria set out in the Standard, there are no generalized nutritional criteria that restrict their use on "unhealthy" foods such as for health claims. The industry needed to comply with this new legislation by January 2016. Food Standards Australia New Zealand has developed an online calculator to help food businesses to calculate a food's nutrient profiling score[34].
- **Indonesia:** Regulation HK.03.1.23.11.11.09909 (2011) [35] on "The Control of Claims on Processed Food Labelling and Advertisements" establishes rules on the use of specified nutrient content claims (i.e. levels of fat for a low fat claim). The Regulation applies to any food product or beverage which has been processed. Generally, any nutrition or health claim may only be used on processed foods or beverages if they do not exceed a certain level of fat, saturated fat and sodium per serving (13g total fat, 4g saturated fat, 60mg cholesterol and 480mg sodium). The Regulation sets out certain exceptions from this rule, whereby products exceeding these limits may still contain certain nutrient or health claims ("low in [name of nutrient]" and "free from [name of nutrient]" claims; claims related to fibre, phytosterol and phytostanol; certain disease risk reduction claims)[24].
- **US**: Nutrient-content claims are generally limited to a list of nutrients authorized by the Food and Drug Administration (Food Labelling Guide 1994, as last revised in January 2013). Packages containing a nutrient-content claim must include a disclosure statement if a serving of food contains more than 13g of fat, 4g of saturated fat, 60mg of cholesterol, or 480mg of sodium. Health claims are generally not permitted if a food contains more than 13g of fat, 4g of saturated fat, 60mg of cholesterol, or 480mg of sodium. Sugar and whole grain content are not considered [24, 36].

**Context**

The international standard setting body Codex Alimentarius defines a claim as:

> "any representation which states, suggests or implies that a food has particular characteristics relating to its origin, nutritional properties, nature, production, processing, composition or any other quality."[37]

According to the *Food and Drugs Act*, all advertising and all statements on food packages are subject to subsection 5(1), which states:

*No person shall label, package, treat, process, sell or advertise any food in a manner that is false, misleading or deceptive or is likely to create an erroneous impression regarding its character, value, quantity, composition, merit or safety*[12].

And must also be in compliance subsection 7(1) of the *Consumer Packaging and Labelling Act* that states:

*No dealer shall apply to any prepackaged product or sell, import into Canada or advertise any prepackaged product that has applied to it a label containing any false or misleading representation that relates to or may reasonably be regarded as relating to that product*[38].

In Canada, regulations regarding health claims are developed by Health Canada and are enforced by the Canadian Food Inspection Agency.

**Policy details**

The *Food and Drug Act* provides the legislative framework for health and nutrient content claims in Canada. Food and Drug Regulations (FDR) for nutrient content and health claims include both packaged foods as well as restaurant foods, and also provides the legislative framework for any advertising of foods that include health claims. For some types of claims, there are specific provisions for how they must be described or displayed.

There are few provisions with regards to the overall nutritional quality or overall 'healthiness' of food products that are permitted to make claims on products beyond the single nutrient considered in the claim. The FDR do not define healthy, but rather set out certain nutritional criteria that must be met for certain claims.

**HEALTH CLAIMS**[39]

The regulations (Section B.01.601) regulate various types of health claims, and details for some are provided below[13]. In general:

- All claims must be truthful and not misleading according to section 5.1 of the Food and Drugs Act.
- Health Canada requires submission for approval and regulatory amendments only for claims related to diseases listed in Schedule A of the Food and Drugs Act.

**DISEASE RISK REDUCTION (DRR) CLAIMS**

- The FDR uses the Table of Disease Risk Reduction Claims[40], which allows claims for certain food and health relationships, from section B.01.601 of the FDR from subsection 3(1) and 3(2) of the FDA. Recently approved DRR claims and conditions for use and approved wording are on the Health Canada website at http://www.hc-sc.gc.ca/fn-an/label-etiquet/claims-reclam/assess-evalu/index-eng.php
- There is currently no objective definition of 'healthy' as defined by Health Canada for health claims. Foods must meet the compositional criteria for the specific claim, and there is no general 'healthy' criteria according to nutrient profiling methods for all nutrients of concern
    - For example, to state that "A healthy diet with adequate calcium and vitamin D, and regular physical activity, help to achieve strong bones and may reduce the risk of osteoporosis. (Naming the food) is high in calcium," the food must contain 275 mg or more of calcium per reference amount and per serving of stated size. There may or may not be additional requirements for other nutrients of concern. Criteria and conditions for claims rely on distinct compositional criteria that are relevant to claim. The claim on a diet rich in a variety of vegetables and fruit and reduce risk of heart disease has conditions criteria for levels of certain nutrients (e.g. sodium) that must be met in order for the claim to be made. These criteria and conditions are based on evidence that is relevant to the claim. This is to uphold the general provision in the Act that any claim must be truthful and not misleading. For example, sodium is linked to hypertension, which is a risk factor for heart disease; thus it is logical that vegetables and fruit eligible for the claim meet the sodium criteria. On the other hand, as sodium is not linked to bone

health, there is no application on limits for sodium criteria to the product carrying a health claim related to effect of calcium and vitamin D on bone health.
- DRR claims are not permitted on foods represented for use in very low energy diets nor are they permitted on foods that are intended solely to be consumed by children under two years of age [B.01.601(1)(c)(i), FDR].

**GENERAL HEALTH CLAIMS**

- These claims can be made for foods that are in line with dietary recommendations from Canada's Food Guide. This includes the use of the words "healthy" and "nutritious" on a food.
- There are no specific nutrient content criteria or overall healthfulness of the product; however, foods are assessed for consistency with dietary guidance according to a tier-system that uses nutrient thresholds.

**PROBIOTIC CLAIMS**

- These claims can be both strain-specific and non-strain specific, and are only permitted on products that contain at least the minimum amount of the probiotic microorganisms required to result in the claimed effect or health benefit.
- There are no criteria regarding the overall healthfulness of the product[41].

**PREBIOTIC CLAIMS**

- In order for a food to be labelled as a prebiotic, there has to be a specific and measurable health benefit demonstrated in humans, a change in gut bacterial composition or activities is demonstrated in humans, and the two have to be linked[42].

**NUTRIENT FUNCTION CLAIMS**

- General and specific nutrient function claims are permitted.
- The food is not required to be a source of that nutrient unless it has an established "source" claim criteria, as for protein and vitamin and mineral nutrients.
- These claims are limited in that they cannot refer to treatment, prevention or cure of any Schedule A disease, but rather describe the well-established role of energy or nutrients that are essential for good health and normal growth and development. These must also declare the amount of a nutrient, and must comply with the Table of Acceptable Nutrient Function Claims.
- There are also general rules restricting the use of implied health claims.

**NUTRIENT CONTENT CLAIMS[43]**

- Permitted nutrient content claims are laid out in Specific Nutrient Content Claims tables.
- There are restrictions on wording to avoid false advertisement, as well as the prominence and size of font (e.g., all words, signs and symbols that are part of the claim must be the same size and font, no box around the words in the claim, etc.).
- The specific information required for a claim must be included on a label or advertisement for a claim to be made.
- Comparative nutrient content claims can be made, but must involve similar reference foods, clearly identify the foods being compared and the difference, and be based on differences that are nutrition and analytically significant (e.g., less than 25% of nutrient content compared to the reference food).
- There are no general criteria for how 'healthy' a food must be to host a nutrient content claim. In practice, this permits the use of a claim on foods that could be low (or lower) in one nutrient of concern and higher in others.

New changes published in the *Canada Gazette Part II* regarding changes to the NFt also included an amendment allowing for health claims to be made about fresh fruits and vegetables that do not carry a NFt.

**APPROVING/REVIEWING HEALTH CLAIMS ON FOODS**

**Pre-market approval of health claims**

Health claims are also subject to Section 3 of the Food and Drugs Act that prohibits the labelling and advertising of any food to the general public, as a treatment, preventative or cure for any diseases and health conditions listed in Schedule A of the Food and Drugs Act (e.g., cancer, diabetes). Therefore, claims about diseases and health conditions listed in Schedule A cannot be directed to the general public unless authorized in regulations. These claims are subject to pre-market assessment which would involve preparing and submitting an application to Health Canada's Food Directorate in accordance with the Guidance Documents for Preparing Health Claim Submissions. Function claims and claims about diseases or health conditions not listed in Schedule A are subject to the same level of standards of evidence as claims about Schedule A diseases or conditions, but pre-market review is voluntary.

Communication from Health Canada stated:

> *It has been a common practice among health claims petitioners to submit a dossier for Health Canada review even when this is not a requirement. Upon review of the dossier, Health Canada posts a summary of assessment on its website at [http://www.hc-sc.gc.ca/fn-an/label-etiquet/claims-reclam/assess-evalu/index-eng.php].*

**Approval of new health claims**

Approvals of **new health claims** are processed by the Food Directorate's Submission Management and Information Unit (SMIU) at Health Canada. The onus for creating applications for the approval of foods that can carry health claims is on industry. The *Guidance Document for Preparing a Submission for Foods with Health Claims* was published in 2009 to assist companies or organizations in understanding what is required for the review process of new health claims[44]. Additionally, in 2011 a guidance document was developed to assist companies in understanding whether or not they can use a current systematic review as evidence for a health claim[45].

Evidence to inform the health claims review process is based upon human studies. The company must provide details of the literature search strategy used to inform the evidence presented, and studies must be rated for quality. Each health claim is then reviewed and approved (or not) by a committee from Health Canada's Food Directorate made up of the Bureau of Microbial Hazards, Bureau of Chemical Safety, and the Bureau of Nutritional Sciences. For transparency, once a health claim is approved/accepted (or not), the synthesized evidence is distributed to relevant stakeholders and placed on the Health Canada website[46].

**MONITORING OF COMPLIANCE**

The **Canadian Food Inspection Agency** (CFIA) carries out inspection activities at different levels of trade, including domestic processors, importers and, to some extent, retailers. The CFIA conducts proactive (planned) labelling inspections and also responds to consumer and/or trade complaints or other triggers.

Random inspections are conducted for monitoring purposes, while targeted inspections focus on areas where non-compliance is suspected.

CFIA label inspection activities include verifying the completeness and accuracy of labelling information and may include product sampling for laboratory analysis.

When non-compliant products are identified, the CFIA takes appropriate enforcement action. Enforcement actions are based on harm, history and intent of the violation. These actions can range from verbal and/or written notifications to warning, detention of product, product recall and/or prosecution (written communication, April 2017).

PROPOSED CHANGES TO HEALTH CLAIMS

Health Canada has proposed several changes regarding claims under the Healthy Eating Strategy that were included in the front-of-package (FOP) consultation which ended in January, 2017[47]. These included:

- Changes to prevent foods being able to claim that they have no added sugars or are unsweetened by aligning definitions of added sugar
- Allowing claims for products that are low in sugar or lightly sweetened
- Prohibiting claims of 0 g trans fat or sugar,
- Allowing the use of the word 'lean' on food packages for weight maintenance products

**Comments/ notes**

## LABEL3 Front-of-pack labelling

### Food-EPI good practice statement

A single, consistent, interpretive, evidence-informed front-of-pack (FOP) supplementary nutrition information system, which readily allows consumers to assess a product's healthiness, is applied to all packaged foods

**Definitions and scope**

- Nutrition information systems include traffic light labelling (overall or for specific nutrients); star or points rating; percent daily intake
- 'Evidence-informed' refers to systems that utilise robust criteria (based on an extensive review of up-to-date research and expert input) or a validated nutrient profiling model to inform decision-making about the product's healthiness

**International examples**

- **UK:** Traffic light labelling has been recommended for use in the UK since 2006. In 2013, the Government published national guidance for voluntary 'traffic light' labelling for use on the front of pre-packaged food products. The label uses green, amber and red to identify whether products contain low, medium or high levels of energy, fat, saturated fat, salt and sugar. The format of the label and thresholds for nutrients of concern for red, amber and green can be found elsewhere [48]. A combination of colour coding and nutritional information is used to show how much fat, salt and sugar and how many calories are in each product. The voluntary scheme is used by all the major retailers and some manufacturers [48]. Traffic lights are displayed on about two thirds of UK food products.
- **Ecuador**: A regulation of the Ministry of Public Health published in November 2013 (No. 4522, El Reglamento de Etiquetado de Alimentos Procesados) requires packaged foods to carry a "traffic light" label in which the levels of fats, sugar and salt are indicated by red (high), amber (medium) or green (low). Full compliance with the regulation was required by 29 August 2014 [24]. The legislation including format of the label and thresholds for nutrients of concern for red, amber and green can be found online [49].
- **Australia/New Zealand**: The government approved a 'Health Star Rating' (HSR) system as a voluntary scheme for industry adoption. The system takes into account four aspects of a food associated with increasing risk for chronic diseases; energy, saturated fat, sodium and total sugars content along with certain 'positive' aspects of a food such as fruit and vegetable content, and in some instances, dietary fibre and protein content. Star ratings range from ½ star (least healthy) to 5 stars (most healthy). Implementation of the HSR system began in June 2014 and is overseen by the Australia and New Zealand Ministerial Forum on Food Regulation, the Front-of-Pack Labelling Steering Committee, the Trans-Tasman Health Star Rating Advisory Committee, the New Zealand Health Star Rating Advisory Group and a recently established Technical Advisory Group. The Technical Advisory Group is currently evaluating progress as well as conducting a formal review of the HSR system, including an assessment of the underlying algorithm. In New Zealand, as of March 2016, about 900 products have stars on them (March 2016) [50].
- **Chile**: In 2012, the Chilean Government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606)[51]. In June 2015, the Chilean authority approved the regulatory norms required for the law's implementation (Diario Oficial No 41.193). The regulatory norms define limits for calories (275 calories/100g or 70 calories/100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered "high" in foods and beverages. All foods that exceed these limits need to have a front-of-package black and white warning message inside a stop sign that reads "HIGH IN" followed by CALORIES, SATURATED FAT, SUGAR or SODIUM, as well as "Ministry of Health". A warning message needs to be added to products per nutrient of concern exceeding the limit (e.g. a product high in fat and sugar will have 2 stop signs). The regulatory norms provide specifications for the size, font, and placement of the warning message on products. The limits for calories, saturated fat, sugar and sodium are being implemented using an incremental approach, reaching the defined limits by 1 July 2018 [24]. Although no studies are available yet, the regulation is reported to be already well implemented with many products already carrying the warning labels.

**Context**

In 2009, Health Canada conducted a consultation regarding health claims and front of package (FOP) labelling on food. The consultations suggested that there was interest in a FOP system; however, there was a lack of nutritional criteria on which FOP symbols and claims could be based, and no regulations or recommendations were implemented.

In March 2016, the Standing Senate Committee on Social Affairs, Science and Technology recommended that the Minister of Health undertake a review of FOP labelling approaches that have been developed and identified as the most effective, and to implement FOP labelling on all foods that required the NFt[52].

**Policy details**

As of January 1, 2017, there are **no regulations regarding supplementary nutrition information systems** in Canada. The market is currently unregulated; an analysis of the number of FOP systems on food products in Canada identified 158 unique FOP systems, and 19% of products had at least one FOP system[53]. Research suggests that these systems do not necessarily indicate the healthfulness of food items[54].

A recent announcement from Minister of Health Jane Philpott (October 24, 2016) suggested that the government is considering a consistent FOP labelling scheme to implement in Canada as a key initiative in the *Healthy Eating Strategy*[47]. On November 14, 2016, Health Canada launched a public consultation regarding mandatory FOP labelling. Consultation documents suggest that Health Canada is considering labelling for nutrients of concern (sugars, sodium and saturated fat), using a Warning Label type on foods[55].

The threshold to trigger the warning for prepackaged foods would be products with greater than 15% of the DV for sugars (15 g), sodium (345mg) or saturated fat (3g) for most product categories. This threshold would be 30% for prepackaged meals or combination dishes (i.e., double). The thresholds would be slightly lower for foods targets to children ages 1-3 years (7.5 g of sugar, 225 mg of sodium, 1.5 grams of saturated fat per reference amount and per serving of stated size. Additionally, for foods with small reference amounts, the threshold would be based on 50g or 50 ml, with the exception of oils and oil-based products[55].

Consultation closed as of January, 2017.

**Comments/ notes**

## LABEL 4 Menu labelling

### Food-EPI good practice statement

A consistent, single, simple, clearly-visible system of labelling the menu boards of all quick service restaurants (e.g., fast food chains) is applied by the government, which allows consumers to interpret the nutrient quality and/or energy content of foods and meals on sale

**Definitions and scope**

- Quick service restaurants: In the Canadian context this definition includes fast food chains as well as coffee, bakery and snack food chains. It may also include supermarkets where ready-to-eat foods are sold.
- Labelling systems: Includes any point-of-sale (POS) nutrition information such as total kilojoules; percent daily intake; traffic light labelling; star rating, or specific amounts of nutrients of concern
- Menu board includes menu information at various points of purchase, including in-store, drive-through and online purchasing
- Includes endorsement schemes (e.g., accredited healthy choice symbol) on approved menu items

**International examples**

- **South Korea**: Since 2010, the Special Act on Safety Control of Children's Dietary Life has required all chain restaurants with 100 or more establishments to display nutrient information on menus including energy, total sugars, protein, saturated fat and sodium[24].
- **Taiwan**: Since July 2015, convenience store chains, drink vendor chains and fast food chains have to label the sugar and caffeine content of prepared-when-ordered drinks (e.g. coffee-and-tea-based drinks, fruit and vegetable juices) according to a regulation based on the Food Safety and Sanitation Act. The amount of sugar added to drinks (specified in sugar cubes) and its calorie content have to be displayed on drink menus and/or notice boards in a prescribed minimum font. In addition, different colours have to be used to signal the level of caffeine contained in coffee drinks[24].
- **USA**: Section 4205 of the Patient Protection and Affordable Care Act (2010)[56] requires that all chain restaurants with 20 or more establishments display energy information on menus. The implementing regulations were published by the Food and Drug Administration on 1 December 2014. Implementation has been delayed several times and is now set for 5 May 2017. Two states (California and Vermont), seven counties (e.g. King County, WA and Albany County NY) and two municipalities (e.g. New York City, Philadelphia) have already implemented regulations requiring chain restaurants (often chains with more than a given number of outlets) to display calorie information on menus and display boards. These regulations will be pre-empted by the national law once implemented; local governments will still be able to enact menu labelling regulations for establishments not covered by national law. The regulations also require vending machine operators of more than 20 vending machines to post calories for foods where the on-pack label is not visible to consumers by 26 July 2018[24].
- **Australia**: Legislation in Australian Capital Territory (Food Regulation 2002) and the States of New South Wales (Food Regulation 2010) and South Australia (Food Regulation 2002) requires restaurant chains (e.g. fast food chains, ice cream bars) with ≥20 outlets in the state (or seven in the case of ACT), or 50 or more across Australia, to display the kilojoule content of food products on their menu boards. Average adult daily energy intake of 8700kJ must also be prominently featured. Other chains/food outlets are allowed to provide this information on a voluntary basis, but must follow the provisions of the legislation[24].
- **New York City, USA**: Following an amendment to Article 81 of the New York City Health Code (addition of section 81.49), chain restaurants are required to put a warning label on menus and menu boards, in the form of a salt-shaker symbol (salt shaker inside a triangle), when dishes contain 2,300 mg of sodium or more. It applies to food service establishments with 15 or more locations nationwide. In addition, a warning statement is required to be posted conspicuously at the point of purchase: "Warning: [salt shaker symbol] indicates that the sodium (salt) content of this item is higher than the total daily

recommended limit (2300 mg). High sodium intake can increase blood pressure and risk of heart disease and stroke." This came into effect 1 December 2015[24, 57].

**Context**

There is a national voluntary menu labelling initiative in Canada. The *Informed Dining* program is available in several chain restaurants across Canada, and has not been endorsed by Health Canada. Restaurants participating in the Informed Dining program should display an "Informed Dining" logo and provide nutrition information to consumers upon request. Nutrition information provided must include energy and 13 nutrients that are listed on the Nutrition Facts table, with an emphasis on calories and sodium. Informed Dining is not endorsed by Health Canada. Participating chains in the voluntary Informed Dining program include: Tim Hortons, Boston Pizza, White Spot, DQ, Pizza Pizza, ABC Country restaurant, Booster Juice, Extreme Pita, McDonalds, Quiznos, The Keg, A&W, Subway, Moxie's, Dairy Queen/Organ Julius and include more than 10,000 outlets nationally[58]. Informed Dining is similar to other voluntary efforts by non-participating restaurants which provide nutrition information online or in brochures upon request.

***Note that this is not a government initiative, and should not be considered in ratings.*

**Policy details**

There is currently no federal policy on menu labelling in Canada. Several actions have been taken by Health Canada with regards to menu labelling:

- In 2011, Health Canada convened a Think Tank on the Provision of Nutrition Information in Restaurants and Foodservices with industry, academics provincial, federal and US government officials and health organizations to discuss the provision of nutrition information in restaurants and foodservices, and identify knowledge gaps and research opportunities[59]. This led to the formation of a Federal/Provincial/Territorial (FPT) Task Group on Provision of Nutrition Information in Restaurants and Foodservices to explore the possibility of developing a national framework for the consistent provision of nutrition information in restaurants and foodservices. This group is not currently active and has not released any guidelines or recommendations regarding menu labelling.
- Between January 2014 and July 2014, the Task Group engaged a team of health literacy experts to design a simplified, point of purchase nutrition labelling approach that would address the varying capacities of Canadians to access, understand and use nutrition information and the challenges that small and medium businesses face in providing and displaying this information.

**Comments/ notes**

There are additional efforts implemented at the provincial level, and this are examined in provincial evidence documents.

# Policy area: Food Promotion

## Food-EPI vision statement: There is a comprehensive policy implemented by the government to reduce the impact (exposure and power) of promotion of unhealthy foods to children (<16 years) across all media

### PROMO1 Restrict promotion of unhealthy food: broadcast media

Food-EPI good practice statement

Effective policies are implemented by the government to restrict exposure and power of promotion of unhealthy foods to children through broadcast media (TV, radio)

**Definitions and scope**

- Includes mandatory policy (i.e. legislation or regulations) or voluntary standards, codes, guidelines set by government or by industry where the government plays a role in development, monitoring, enforcement or resolving complaints
- Includes free-to-air and subscription television and radio only (see PROMO2 for other forms of media)

**International examples**

- **Norway / Sweden**: Under the Broadcasting Act, advertisements (food and non-food) may not be broadcast on television directed to children or in connection with children's programs. This applies to children 12 years and younger[60].
- **Quebec, Canada**: In Quebec, most citizens speak French and it is the only province in Canada, where children below 13 years old are protected under the Consumer Protection Act since 1980[61]. In Québec, the Consumer Protection Act prohibits commercial advertising (including food and non-food) directed at children less than 13 years of age through television, radio and other media. To determine whether or not an advertisement is directed at persons under thirteen years of age, account must be taken of the context of its presentation, and in particular of: a) the nature and intended purpose of the goods advertised; b) the manner of presenting such advertisement; and c) the time and place it is shown. A cut-off of 15% share of children audience is used to protect children from TV advertising[62]. Any stakeholder involved in a commercial process (from the request to create an advertisement to its distribution, including its design) may be accused of not complying with the legislation in force. Per indictment, that person is liable to: a fine ranging from $600 to $15,000 (in the case of a natural person); a fine ranging from $2,000 to $100,000 (in the case of a legal person). Notably, for the rest of Canada, child-directed food marketing is self-regulated using the Canadian Children's Food and Beverage Advertising Initiative (CAI) by Advertising Standards Canada (ASC) through The Broadcast Code for Advertising to Children.
- **Chile**: In 2012, the Chilean government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606)[51]. In June 2015, the Chilean authority approved the regulatory norms required for the law's implementation (Diario Oficial No 41.193). The regulatory norms define limits for calories, saturated fat, sugar and sodium content considered "high" in foods and beverages. The regulatory norms define limits for calories (275 calories/100g or 70 calories/100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered "high" in foods and beverages. The law restricts advertising directed to children under the age of 14 years of foods in the "high in" category. The regulatory norms define advertising targeted to children as programmes directed to children or with an audience of greater than 20% children, and according to the design of the advertisement. Promotional strategies and incentives, such as cartoons, animations, and toys that could attract the attention of children are included in the ban. The regulation is scheduled to take effect 1 July 2016[20]. Chile outlaws Kinder Surprise eggs and prohibit toys in McDonald's 'Happy Meals' as part of this law[63].

- **Ireland**: Advertising, sponsorship, teleshopping and product placement of foods high in fats, sugars and salt, as defined by a nutrient profiling model, are prohibited during children's TV and radio programmes where over 50% of the audience are under 18 years old (Children's Commercial Communications Code, 2013 revision). In addition, there is an overall limit on advertising of foods high in fats, sugars and salt adverts at any time of day to no more than 25% of sold advertising time and to only one in four advertisements. Remaining advertising targeted at children under the age of 13 must not include nutrient or health claims or include licensed characters[20].
- **South Korea**: TV advertising to children less than 18 years of age is prohibited for specific categories of food before, during and after programmes shown between 5-7pm and during other children's programmes (Article 10 of the Special Act on the Safety Management of Children's Dietary Life, as amended 2010)[20, 64].

**Context**

The Canadian Radio-television and Telecommunications Commission (CRTC) is a public organization that regulates and supervises broadcasting and telecommunications in the public interest, and enforces the *Broadcasting Act*[65].

The *Food and Drugs Act* could be a vehicle by which the federal government could prohibit advertising to children.

**Political context**

On November 12, 2015, the Prime Minister of Canada issued a Mandate Letter to the Minister of Health stating that legislation should be developed that would include "introducing new restrictions on the commercial marketing of unhealthy food and beverages to children, similar to those now in place in Quebec"[66]. The Senate Standing Committee on Social Affairs, Science and Technology recommended a ban on marketing food and beverages to children (2015)[52].

**Non-governmental context**

**Food industry voluntary codes**

- In Canada, marketing to children is not regulated at the federal level, and is self-governed by the voluntary, industry-led ***Children's Food & Beverage Advertising Initiative*** (CAI)[67].
- The CAI was created in 2007 by 16 large food and beverage companies including one fast food restaurant.
- Participating companies pledge to advertise only products classified as "better for you" in various media including television, the Internet, online games, on DVDs among others.
- Participants pledge to NOT advertise in elementary schools.
- In 2014, stronger Uniform Nutrition Criteria were developed by the CAI and these were to be fully implemented in December 2015[68]. These new criteria require products considered 'better for you' to limit negative nutrients such as fat, sodium and sugar, and increase positive nutrients such as vitamins, minerals and fibre.

**Limitations to the voluntary pledge**

The CAI has been criticized for having considerable gaps, including:

- The CAI only restricts marketing to children under 12 years of age
- The CAI allows companies to self-define the proportion of the audience that must be under 12 years of age for their pledges to be in effect (e.g., 35% of viewers must be under 12 years for it to be considered children's programming). This range is currently between 25% to 35% of audience under 12 for the participating companies. This does not include any programming that is directed at both adults and children (for example, sporting events).
- Participation is limited to a small number of all food manufacturing and foodservice companies, although they do represent several of the largest food companies in Canada[69].
- The pledge does not consider all types of marketing (e.g. promotions on food packages).
- Although compliance is assessed, there are no sanctions if companies are not fulfilling pledge commitments

- The impact of the new common nutritional criteria implemented in 2015 has yet to be evaluated

**Compliance**

Advertising Standards Canada, who administers the CAI, releases annual compliance reports for all participating companies, which have suggested "outstanding compliance" with the program[70].

Independent research from Canada has suggested that over the period of implementation of the CAI program, there was a slight decrease in the number of advertising 'spots' on children's specialty channels (5%), but that children's exposure to advertising increased both on children's specialty channels and overall exposure[71]. Foods advertised to children are still of poorer nutritional quality, and the nutritional quality of foods advertised by CAI-participating companies did not change between 2006 and 2011[72].

***Note that the CAI is not a government initiative or policy and should not be considered in ratings.*

**Policy details**

Advertising foods and beverages in Canada cannot be in violation of the Canadian Food Inspection Agency Food Labelling for Industry document; however, the regulations do not include any restrictions on marketing or advertising foods to children

**Current marketing restrictions or programs in place:**

**Canadian Radio-television and Telecommunications Commission**

According to the CRTC, broadcasters must adhere to the ***Broadcast Code for Advertising to Children*** **(Children's Code)** published by Advertising Standards Canada[73]. In this code, "Children" refers to those under 12 years of age, and applies to television and radio broadcasting only.

The **Children's Code** mostly refers to the method of advertising or advertising techniques for advertising aimed at children, but does not include what content can be advertised to children, other than:

- Products not intended for use by children, or drugs, proprietary medicines or vitamins
- Advertising cannot use puppets, persons or characters well-known to children to endorse or personally promote products, but they can be present other than those characters created by advertisers. Characters can present factual and relevant generic statements about nutrition, safety, education, etc in children's advertising.
- Advertising must encourage or portray a range of values consistent with moral, ethical and legal standards of contemporary Canadian society

The Children's Code is not specific to food or nutrition, and there are no provisions for the 'healthiness' of foods that can be advertised. Clause 11 of the **Children's Code** refers to social values, and has specific implications for advertising food:

- "Child-directed messages for food products in broadcast advertising that are inconsistent with the pertinent provisions of the Food and Drugs Act and Regulations, or the Canadian Food Inspection Agency's Food Labelling for Industry (CFIA Industry Labelling Tool) shall be deemed to violate Clause 11 (Social Values) of the Children's Code. This Interpretation Guideline is intended, among other purposes, to ensure that advertisements representing mealtime clearly and adequately depict the role of the product within the framework of a balanced diet, and snack foods are clearly presented as such, not as substitutes for meals"[73].
- "Advertising of food products should not discourage or disparage healthy lifestyle choices or the consumption of fruits or vegetables, or other foods recommended for increased consumption in Canada's Food Guide, and Health Canada's nutrition policies and recommendations applicable to children under 12"[73].
- "The amount of food product featured in a "child-directed message" should not be excessive or more than would be reasonable to acquire, use or, where applicable, consume, by a person in the situation depicted"[73].

- "If an advertisement depicts food being consumed by a person in the advertisement, or suggests that the food will be consumed, the quantity of food shown should not exceed the labelled serving size on the Nutrition Facts Panel (where no such serving size is applicable, the quantity of food shown should not exceed a single serving size that would be appropriate for consumption by a person of the age depicted)"[73].

All broadcast advertising directed to children under 12 years of age must conform to the *Children's Code* as a condition of the broadcast license issued by the Canadian Radio-television and Telecommunications Commission. Commercials directed to children under 12 must first be precleared by ASC's Children's Clearance Committee, before a broadcaster will accept them for airing.

The **Children's Code** is designed to complement the general principles for ethical advertising outlined in the ***Canadian Code of Advertising Standards***[73], which applies to all advertising. This includes general provisions for marketing to children such as:

> "Advertising must not exploit their [children's] credulity, lack of experience or sense of loyalty, or present information or illustrations that might result in their physical, emotional, or moral harm"[73].

Both codes are published and administered by Advertising Standards Canada (ASC)[67]. ASC is "an industry body committed to creating and maintaining community confidence in advertising." Compliance with the Canadian Code of Advertising Standards is monitored by ASC, based on a consumer complaint process. Compliance with the Broadcast Code for Advertising to Children is achieved through preclearance of finished commercials by ASC's Children's Clearance Committee.

**Proposed Bill S-228**

Senate Bill S-228, the *Child Health Protection Act* was introduced into the Senate on September 27, 2016. This Act would prohibit marketing of any food to children under 13 years of age, including broadcast advertisements or media.

**Health Eating Strategy**

As part of the Healthy Eating Strategy announced in October 2016, the proposal to restrict the marketing to children is a key initiative under the pillar of Protecting Vulnerable Populations. Public webinars were held February 29 and March 1, 2017 with regards to marketing to children, and experts have been engaged to develop preliminary policy and nutrient profile model (personal communication, April 2017).

***Note that several of these activities do not fall within the time for this Food-EPI process and should not be included in ratings.*

**Round table discussions on Marketing to Children policy**

In November 2016, Health Canada hosted round table discussions with experts from across the country to discuss the regulation of marketing to children.

**Comments/ notes**

There are additional efforts implemented at the provincial level, and this is examined in provincial evidence documents.

## PROMO2 Restrict promotion of unhealthy food: non-broadcast media

Food-EPI good practice statement

Effective policies are implemented by the government to restrict exposure and power of promotion of unhealthy foods to children through non-broadcast media (e.g. Internet, social media, food packaging, sponsorship, outdoor and public transport advertising)

**Definitions and scope**

- Non-broadcast media promotion includes: print (e.g. children's magazines), online (e.g. social media, branded education websites, online games, competitions and apps) outdoors and on/around public transport (e.g. signage, posters and billboards), cinema advertising, product placement and brand integration (e.g. in television shows and movies), direct marketing (e.g. fundraising in schools, provision of show bags, samples or flyers), product design and packaging (e.g. use of celebrities or cartoons, competitions and give-aways) or point-of-sale (POS) displays
- Where the promotion is specifically in a children's setting, this should be captured in 'PROMO3'

**International examples**

- **Chile**: In 2012, the Chilean government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606)[51]. In June 2015, the Chilean authority approved the regulatory norms required for the law's implementation (Diario Oficial No 41.193). The regulatory norms define limits for calories, saturated fat, sugar and sodium content considered "high" in foods and beverages. The regulatory norms define limits for calories (275 calories/100g or 70 calories/100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered "high" in foods and beverages. The law restricts advertising directed to children under the age of 14 years of foods in the "high in" category. The regulatory norms define advertising targeted to children as websites directed to children or with an audience of greater than 20% children, and according to the design of the advertisement. Promotional strategies and incentives, such as cartoons, animations, and toys that could attract the attention of children are included in the ban. The regulation took effect 1 July 2016 and applies to all advertising media[20]. Chile outlaws Kinder Surprise eggs and prohibit toys in McDonald's 'Happy Meals' as part of this law[63].
- **Quebec, Canada**: In Quebec, most citizens speak French and it is the only province in Canada, where children below 13 years old are protected under the Consumer Protection Act since 1980[61]. In Québec, the Consumer Protection Act prohibits commercial advertising directed at children less than 13 years of age through all media. To determine whether or not an advertisement is directed at persons under thirteen years of age, account must be taken of the context of its presentation, and in particular of: a) the nature and intended purpose of the goods advertised; b) the manner of presenting such advertisement; and c) the time and place it is shown[62]. Any stakeholder involved in a commercial process (from the request to create an advertisement to its distribution, including its design) may be accused of not complying with the legislation in force. Per indictment, that person is liable to: a fine ranging from $600 to $15,000 (in the case of a natural person); a fine ranging from $2,000 to $100,000 (in the case of a legal person).Notably, for the rest of Canada, child-directed food marketing is self-regulated using the Canadian Children's Food and Beverage Advertising Initiative (CAI) by Advertising Standards Canada (ASC) through The Broadcast Code for Advertising to Children.

**Context**

See PROMO1.

The voluntary CAI does restrict promotion of unhealthy foods via print and Internet advertising, including company-owned websites, video and computer games, DVDs of movies, and mobile media among participants. It does not include product packaging.

***Note that this is not a governmental initiative and should not be considered in ratings.*

**Policy details**

The Canadian Code of Advertising Standards applies to all forms of advertising, including **internet, social media, sponsorship, outdoor advertising, etc[73].** The Canadian Code of Advertising Standards does not apply to packaging, wrappers and labels or point-of-sale displays within retail establishments, but does apply to point-of-sale signage.

Pursuant to *Interpretation Guideline # 2 – Advertising to Children*[74] to Clause 12 of the Canadian Code of Advertising Standards:

- "Child-directed messages for food products in advertising that are inconsistent with the pertinent provisions of the Food and Drugs Act and Regulations, or the Canadian Food Inspection Agency's Food Labelling for Industry (CFIA Industry Labelling Tool) shall be deemed to violate Clause 12 (Advertising to Children) of the Canadian Code of Advertising Standards Code. This Interpretation Guideline is intended, among other purposes, to ensure that advertisements representing mealtime clearly and adequately depict the role of the product within the framework of a balanced diet, and snack foods are clearly presented as such, not as substitutes for meals."
- "Advertising of food products should not discourage or disparage healthy lifestyle choices or the consumption of fruits or vegetables, or other foods recommended for increased consumption in Canada's Food Guide, and Health Canada's nutrition policies and recommendations applicable to children under 12."
- "The amount of food product featured in a "child-directed message" should not be excessive or more than would be reasonable to acquire, use or, where applicable, consume, by a person in the situation depicted."
- "If an advertisement depicts food being consumed by a person in the advertisement, or suggests that the food will be consumed, the quantity of food shown should not exceed the labelled serving size on the Nutrition Facts Panel (where no such serving size is applicable, the quantity of food shown should not exceed a single serving size that would be appropriate for consumption by a person of the age depicted)."

*Consumer Package and Labeling Act* does not include any restrictions regarding advertising to children on packaging of food products.

**Comments/ notes**

The tabled Senate Bill S-228, the *Child Health Protection Act* would apply to food labelling or packaging directed at children, sponsorship of events or activities, in facilities intended for children such as schools or daycares, sales promotions, or in gifts, games or contests.

## PROMO3 Restrict promotion of unhealthy foods: children's settings

Food-EPI good practice statement

Effective policies are implemented by the government to ensure that unhealthy foods are not commercially promoted to children in settings where children gather (e.g. preschools, schools, sport and cultural events)

| | |
|---|---|
| **Definitions and scope** | - Children's settings include: areas in and around schools, preschools/ kindergartens, day-care centres, children's health services (including primary care, maternal and child health or tertiary settings), sport, recreation and play areas/ venues/ facilities and cultural/community events where children are commonly present<br>- Includes restrictions on marketing in government-owned or managed facilities/venues (including within the service contracts where management is outsourced)<br>- Includes restriction on unhealthy food sponsorship in sport (e.g. junior sport, sporting events, venues) |
| **International examples** | - **Chile**: In 2012, the Chilean government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606)[51]. In June 2015, the Chilean authority approved the regulatory norms required for the law's implementation (Diario Oficial No 41.193). The regulatory norms define limits for calories, saturated fat, sugar and sodium content considered "high" in foods and beverages. The regulatory norms define limits for calories (275 calories/100g or 70 calories/100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered "high" in foods and beverages. The law restricts advertising directed to children under the age of 14 of foods in the "high in" category on school grounds, including preschools, primary and secondary schools. Promotional strategies and incentives, such as cartoons, animations, and toys that could attract the attention of children are included in the ban. The law is scheduled to take effect 1 July 2016(21).<br>- **Spain**: In 2011 the Spanish Parliament approved a Law on Nutrition and Food Safety (Ley 17/2011), which stated that kindergartens and schools should be free from all advertising. Criteria for the authorisation of food promotion campaigns, nutritional education and promotion of sports or physical activity campaigns were developed jointly by the Spanish Agency for Consumer Affairs, Food Safety and Nutrition (AECOSAN) and the Regional Health Authorities and implemented in July 2015. AECOSAN and the Spanish Regional Education and Health Administrations monitor the enforcement of the law[20].<br>- **Uruguay**: In September 2013, the government of Uruguay adopted Law No 19.140 "Alimentación saludable en los centros de enseñanza" (Healthy foods in schools)[75]. The law prohibits the advertising and marketing of foods and drinks that don't meet the nutrition standards [referenced in Article 3 of the law, and outlined in school nutrition recommendations published by the Ministry of Health in 2014]. Advertising in all forms is prohibited, including posters, billboards, and use of logos/brands on school supplies, sponsorship, and distribution of prizes, free samples on school premises and the display and visibility of food. The implementation of the law started in 2015[20].<br>- **Hungary**: Based on Section 8 of Act XLVIII on Basic Requirements and Certain Restrictions of Commercial Advertising Activities (2008), Hungary prohibits all advertising directed at children under 18 in child welfare and child protection institutes, kindergartens, elementary schools and their dormitories. Health promotion and prevention activities in schools may only involve external organizations and consultants who are recommended by the National Institute for Health Development according to Section 128(7) of the Ministerial Decree 20/2012 (VIII.31.) on the Operation of Public Education Institutions and the Use of Names of Public Education Institutions[60]. |
| **Context** | See PROMO1 |
| **Policy details** | There are currently no federal regulations limiting promotion of unhealthy foods to children in settings where children gather. Under the voluntary CAI, participants pledge to not advertise in elementary schools from pre-kindergarten to Grade 6. |

The Federal government has committed to restrict marketing to children, and is considering settings, including schools, in its policy development (written communication, April 2017).

**Comments/ notes**

Some provinces and territories have policies and regulations in this area (see Provincial documents) which are not considered in this document.

# Policy area: Food Prices

## Food-EPI vision statement: Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices

### PRICES1 Reduce taxes on healthy foods

Food-EPI good practice statement

Taxes or levies on healthy foods are minimised to encourage healthy food choices where possible (e.g. low or no sales tax, excise, value-added or import duties on fruit and vegetables)

**Definitions and scope**

- Includes exemptions from excise tax, ad valorem tax or import duty
- Includes differential application of excise tax, ad valorem tax or import duty
- Excludes subsidies (see 'PRICES3') or food purchasing welfare support (see 'PRICES4')

**International examples**

- **Australia**: Goods and services tax (GST) exemption exists for basic foods (including fresh fruits and vegetables)[76].
- **Tonga**: In 2013, as part of a broader package of fiscal measures, import duties were lowered from 20% to 5% for imported fresh, tinned or frozen fish in order to increase affordability and promote healthier diets[77].
- **Poland**: In Poland, the basic rate of tax on goods and services is 22%, while the rate is lower (7%) for goods related to farming and forestry and even lower (3%) for unprocessed and minimally processed food products[78].
- **Fiji**: To promote fruit and vegetable consumption, Fiji has removed the excise duty on imported fruits, vegetables and legumes. It has also decreased the import tax for most varieties from the original 32% to 5% (exceptions: 32% remains on tomatoes, cucumbers, potatoes, squash, pumpkin and 15% remains on coconuts, pineapples, guavas, mangosteens) and removed it for garlic and onions[77].

**Context**

Taxes on products in Canada are governed by the *Excise Tax Act* and its regulations, which are also typically applied to food products.

In Canada, a Goods and Service Tax (GST) applies to most supplies of goods and services in Canada, at a rate of 5%. There is a Harmonized Sales Tax (HST), which harmonizes provincial sales tax with GST in several participating provinces at the following rates: 13% in Ontario, and 15% in New Brunswick, Newfoundland and Labrador, Nova Scotia and Prince Edward Island. Also effective April 1, 2013, the 12% HST in British Columbia was reverted back to GST and a provincial sales tax.

**Policy details**

***Value-added tax (Goods and services tax – GST)***

For food products, the application of GST and HST is considered based on whether or not foods are considered 'basic groceries'. Currently Canada's GST and HST legislation exempts some 'healthy' foods. Section 1 of Part III of Schedule VI defines the exemptions, generally defined as "*Supplies of food or beverages for human consumption (including sweetening agents, seasonings and other ingredients to be mixed with or used in the preparation of such food or beverages*)" with a number of exceptions. The list of foods exempt from GST/HST include fresh, frozen, canned and vacuum sealed fruits and vegetables, breakfast cereals, most milk products, fresh meat, poultry and fish, eggs and coffee beans.

All foods that are prepared and sold in food service outlets are subject to GST/HST.

There are some aspects of the Act that do not align with profiling of 'healthful' or 'less healthful' foods, such as:

- Unflavoured, carbonated water is taxable
- Non-carbonated fruit-flavoured water, and plain bottled water is taxable when served in single-serve containers. For GST/HST purposes, a single serving for beverages includes all servings under 600 mL in volume.
- Additionally, foods packaged for immediate consumption (i.e., single serving) are subject to GST and HST; multiple packs of similar products are not.

***Import taxes on fruits and vegetables***

According to World Trade Organization Agreements and Free Trade Agreements, import duties are low or zero for most fresh fruits and vegetables.

**Comments/ notes**

## PRICES2 Increase taxes on unhealthy foods

Food-EPI good practice statement

Taxes or levies on unhealthy foods (e.g. sugar-sweetened beverages, foods high in nutrients of concern) are in place and increase the retail prices of these foods by at least 10% to discourage unhealthy food choices where possible, and these taxes are reinvested to improve population health

**Definitions and scope**

- Includes differential application of excise tax, ad valorem tax or import duty on high calorie foods or foods that are high in nutrients of concern

**International examples**

- **Mexico**: In December 2013, the Mexican legislature passed two new taxes as part of the national strategy for the prevention of overweight, obesity and diabetes. An excise duty of 1 peso ($0.80) per litre applies to sugary drinks. Sugary drinks are defined under the new law as all drinks with added sugar, excluding milks or yoghurts. This is expected to increase the price of sugary drinks by around 10%. An ad valorem excise duty of 8% applies to foods with high caloric density, defined as equal to or more than 275 calories per 100 grams. The food product categories that are affected by the tax include chips and snacks; confectionary; chocolate and cacao based products; puddings; peanut and hazelnut butters. The taxes entered into force on 1 January 2014. The aim is for the revenue of taxes to be reinvested in population health, namely providing safe drinking water in schools, but there is no evidence (yet) that this is the case as the taxes are not earmarked[77, 79].
- **Hungary**: A "public health tax" adopted in 2012 is applied on the salt, sugar and caffeine content of various categories of ready-to-eat foods, including soft drinks (both sugar- and artificially-sweetened), energy drinks and pre-packaged sugar-sweetened products. The tax is applied at varying rates. Soft drinks, for example, are taxed at $0.24 per litre and other sweetened products at $0.47 per litre. The tax also applies to products high in salt, including salty snacks with >1g salt per 100g, condiments with >5g salt per 100g and flavourings >15g salt per 100g[77, 80].
- **French Polynesia**: Various food and beverage taxes have been in place since 2002 to discourage consumption and raise revenue e.g. domestic excise duty on sweetened drinks and beer; import tax on sweetened drinks, beer and confectionery; tax on ice cream. Between 2002 and 2006, tax revenue went to a preventive health fund; from 2006, 80% has been allocated to the general budget and earmarked for health. The tax is 40 CFP (around $0.44) per litre on domestically-produced sweet drinks, and 60 CFP (around $0.68) per litre on imported sweet drinks[77].
- **St. Helena**: In effect since 27 May 2014, a £0.75 per litre excise duty (about $1.14) is applied to high-sugar carbonated drinks in St Helena (Customs and Excise Ordinance Chapter 145, Section 5). High sugar carbonated drinks are defined as drinks containing ≥15 grams of sugar per litre[77].
- **UK**: The Government announced a sugar tax on the soft drinks industry as part of the 2016 Budget[81]. Soft drinks manufacturers will be taxed according to the volume of the sugar-sweetened drinks they produce or import. Drinks will fall into two bands: one for total sugar content above 5g per 100ml (to be taxed at 18 pence per L), and a second, higher band for the most sugary drinks with more than 8g per 100ml (to be taxed at 24 pence per L). The tax will come into force in 2017 in order to give companies time to change the ingredients of their products. The measure will raise an estimated £520 million a year, and will be spent on doubling funding for sport in primary schools. Secondary schools will meanwhile be encouraged to offer more sport as part of longer school days. Pure fruit juices and milk-based drinks will be excluded, as well as small producers.

**Context**

| | |
|---|---|
| **Policy details** | There are currently no federally-imposed taxes or levies on unhealthy foods or nutrients of concern. |
| **Comments/ notes** | |

## PRICES3 Existing food subsidies favour healthy foods

Food-EPI good practice statement

The intent of existing subsidies on foods, including infrastructure funding support (e.g. research and development, supporting markets or transport systems), is to favour healthy rather than unhealthy foods in line with overall population nutrition goals

**Definitions and scope**

- Includes agricultural input subsidies, such as free or subsidised costs for water, fertiliser, seeds, electricity or transport (e.g., freight) where those subsidies specifically target healthy foods
- Includes programs that ensure that farmers receive a certain price for their produce to encourage increased food production or business viability
- Includes grants or funding support for food producers (i.e. farmers, food manufacturers) to encourage innovation via research and development where that funding scheme specifically targets healthy food
- Includes funding support for wholesale market systems that support the supply of healthy foods
- Includes population level food subsidies at the consumer end (e.g. subsidising staples such as rice or bread)
- Excludes incentives for the establishment of, or ongoing support for, retail outlets (including greengrocers, farmers markets, food co-ops, etc. See 'RETAIL2').
- Excludes subsidised training, courses or other forms of education for food producers
- Excludes the redistribution of excess or second grade produce
- Excludes food subsidies related to welfare support (see 'PRICES4')
- Should be in line with population nutrition goals related to the prevention of obesity and diet-related NCDs (e.g., reducing intake of nutrients of concern, and should not related to micronutrient deficiencies)

**International examples**

- **Singapore**: The government, through the Health Promotion Board (HPB) increases the availability and use of healthier ingredients through the "Healthier Ingredient Scheme" (formerly part of the "Healthier Hawker" programme, launched in 2011), which provides in the first instance transitional support to oil manufacturers and importers to help them increase the sale of healthier oils to the food service industry[82]. The Healthier Ingredient Subsidy Scheme offers a subsidy to suppliers stocking healthier items. Cooking oil is the first ingredient under the scheme, which subsidises oils with a saturated fat level of 35 per cent or lower.

**Context**

The Mandate letter to the Minister of Agriculture and Agri-Food has a clause to *"Develop a food policy that promotes healthy living and safe food by putting more healthy, high-quality food, produced by Canadian ranchers and farmers, on the tables of families across the country."*[83]

**Policy details**

Currently, supply management systems for the dairy, poultry and eggs sectors support market price through tariffs and production quotas. The program does not have any objectives specific to improving the nutritional quality of the food supply in Canada.

**Nutrition North Canada**

The **Nutrition North Canada (NNC)** program was established in 2011 to provide increased food access to isolated Northern communities in Canada. This replaced the previously implemented Food Mail program, which had a number of recognized weaknesses in promoting healthy diets. The initiative is funded jointly by Indigenous and Northern Affairs Canada (INAC) and Health Canada, and since 2016, the Public Health Agency of Canada has

joined the program as a new partner. INAC and administers the NNC retail subsidy, while Health Canada and Public Health Agency of Canada (PHAC) fund the complementary Nutrition Education Initiatives component of NNC. PHAC has joined to fund communities that fall outside the mandate of Health Canada. Health Canada First Nations and Inuit Health Branch (FNIHB) also provides technical/nutrition advice to INAC on NNC.

NNC provides a retail subsidy to help Northerners living in isolated communities access perishable, healthy food at a reduced cost. The subsidy applies to perishable, nutritious foods (fresh, frozen, refrigerated, or foods that have a limited shelf life) that are shipped by air. Country / traditional food is also subsidized when processed in government regulated and/or approved-for-export commercial plants. The subsidy must be passed on to consumers through the retailer reducing the price of subsidized foods in stores.

**Additional details of NNC:**

- Registered retailers in the North, country food processors/distributors located in eligible communities, and food suppliers in the South who supply small retailers, institutions and individuals in these eligible isolated communities, can apply for a subsidy based on the weight of eligible foods shipped by air to eligible northern communities. These subsidies are to be passed on to northern consumers by appropriate reductions in the selling prices of eligible foods.
- The main objective of NNC is to help make perishable healthy food more accessible and affordable than it would otherwise be to Northerners in isolated communities (through the subsidization of healthy foods).
- Each year, a sample of retailers in the program undergoes a compliance review. The results from this review suggest some compliance, and some challenges on passing the entire subsidy on to the consumer.
- NNC subsidizes a list of foods which prioritizes perishable and nutritionally dense food items (fruit, vegetables, milk, eggs, meat and cheese) that are typically shipped by air to eligible communities. There are two levels of subsidies, with a higher subsidy rate applied to the most nutritious perishable foods[84].
- The program also subsidizes 'country' or traditional foods such as Arctic char, musk-ox and caribou shipped by air to eligible communities[85].
- Individuals or groups (companies, daycares, etc.) in eligible communities can purchase these foods from Southern suppliers who are registered with the Canadian Revenue Agency (CRA) and are a part of the program.
- The program resulted in a decreased cost of a household food basket (the cost of a nutritious diet for a family of four for one week using 67 standard food items) by 5% among eligible communities, and the weight of eligible items shipped to northern isolated communities increased by 25% between 2011 and 2015. About 127.8 million kilograms of eligible items were subsidized, an average increase of about 5.5 million kilograms annually since 2011; and 103 isolated northern communities benefited from NNC[86].
- 96% of NNCs food subsidy was spent on perishable nutritious food: 37% of the subsidy goes towards perishable fruits and vegetables (including juice), 25% to milk and perishable dairy, 22% to perishable meat and alternatives, and 12% to bread, cereal and perishable grain products[86].
- To be eligible for NNC, a community must meet the following criteria:
    - Lacking year-round surface access, excluding isolation due to freeze-up and break-up [of ice surrounding a community] normally less than four weeks at a time
    - Meets the territorial or provincial definition of northern community
    - All eligible communities must have either an airport or post office, or grocery store
    - All eligible communities must have year-round population according to the national census

- Nutrition North Canada was expanded to an additional 37 isolated northern communities as of October 1, 2016. The previous number of communities was 84, and as of the new program expansion on October 1, the number on eligible communities was 121.
- In addition to the subsidy component of NNC, funding is available to communities eligible for NNC to support culturally appropriate retail and community-based nutrition education activities (See RETAIL3).

**Comments/ notes**

## PRICES4 Food-related income support is for healthy foods

Food-EPI good practice statement

The government ensures that food-related income support programs are for healthy foods

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|---|---|
| **Definitions and scope** | - Includes programs such as 'food stamps' or other schemes where individuals can utilise government-administered subsidies, vouchers, tokens or discounts in retail settings for specific food purchasing.<br>- Excludes general programs that seek to address food insecurity such as government support for, or partnerships with, organisations that provide free or subsidised meals (including school breakfast programs) or food parcels or redistribute second grade produce for this purpose.<br>- Excludes food subsidies at the consumer end (e.g. subsidising staples at a population level – see 'PRICES3') |
| **International examples** | - **UK**: The British Healthy Start programme provides pregnant women and/or families with children under the age of four with weekly vouchers to spend on foods including milk, plain yoghurt, and fresh and frozen fruit and vegetables. Participants or their family must be receiving income support/jobseekers allowance or child tax credits. Pregnant women under the age of 18 can also apply. Full national implementation of the programme began in 2006[77].<br>- **USA**: In 2012, the USDA piloted a "Healthy Incentives Pilot" as part of the Supplemental Nutrition Assistance Program (SNAP, formerly "food stamps"). Participants received an incentive of 30 cents per US$ spent on targeted fruit and vegetables (transferred back onto their SNAP card). The Pilot included 7500 individuals[77]. In New York City and Philadelphia, "Health Bucks" are distributed to farmers markets. When customers use income support (e.g. Food Stamps) to purchase food at farmers markets, they receive one Health Buck worth 2USD for each 5USD spent, which can then be sued to purchase fresh fruit and vegetable products at a farmers market[77]. In Philadelphia, the programme has been expanded to other retail settings like supermarkets and corner stores.<br>- **USA**: In 2009, the U.S. Department of Agriculture's implemented revisions to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to improve the composition and quantities of WIC-provided foods from a health perspective. The revisions include: Increase the dollar amount for purchases of fruits and vegetables, expand whole-grain options, allow for yoghurt as a partial milk substitute, allow parents of older infants to buy fresh produce instead of jarred infant food and give states and local WIC agencies more flexibility in meeting the nutritional and cultural needs of WIC participants[77]. |
| **Context** | In Canada, social assistance is typically administered at the provincial level. |
| **Policy details** | **Canada Prenatal Nutrition Program (CPNP)**<br>The **CPNP** program was created in 1995 to support the needs of pregnant women who face unique challenges that may afflict their health or the health of their infants. One of the potential support mechanisms includes the provision of food and food coupons. The services provided by CPNP are much broader than merely food related income support: CPNP supports include nutrition counselling, prenatal vitamins, food and food coupons, counselling in prenatal health and lifestyle, breastfeeding education and support, food preparation training, education and support on infant care and child development, and referrals to other agencies and services.<br>CPNP is managed by a Joint Management Committee consisting of representatives from F/P/T ministries and communities, and is overseen by the Division of Health Promotion at the Public Health Agency of Canada (PHAC). CPNP provides funding and support for provinces and territories to develop and implement targeted social assistance programs relating to the above mentioned areas specific to pregnant women, which are typically organized and coordinated at the provincial level. |

According to the CPNP website:

> *Each provincial/territorial government signed protocols that identify the priorities of their region and set out the terms and conditions for managing CPNP sites in their respective province/territory*[87].

**CPNP-First Nations and Inuit Component (CPNP-FNIC)**,

CPNP-FNIC specifically targets First Nations and Inuit populations, and is administered through the First Nations and Inuit Health Branch (FNIHB) at Health Canada. CPNP-FNIC is available to pregnant First Nations and Inuit women, mothers of infants, and infants up to twelve months of age who live on reserve or in Inuit communities, particularly those identified as high risk. The program also includes First Nations and Inuit women of childbearing age on-reserve and in Inuit communities. The CPNP-FNIC includes education on food and food coupons for healthy foods, food preparation training, and referrals to other agencies and services.

It also supports improved maternal and infant health through activities relating to nutrition screening, education, and counselling; maternal nourishment including prenatal vitamins and counselling in prenatal health and lifestyle; and breastfeeding promotion, education and support.

**Comments/ notes**

There are a number of provincial programs that relate to income assistance, and these are addressed in the respective provincial documents.

# Policy area: Food Provision

## Food-EPI vision statement: The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies

### PROV1 Policies in schools promote healthy food choices

Food-EPI good practice statement

The government ensures that there are clear, consistent policies (including nutrition standards) implemented in schools and early childhood education and care services for food service activities (canteens, food at events, fundraising, promotions, vending machines etc.) to provide and promote healthy food choices

**Definitions and scope**

- Early childhood education and care services (0-5): includes all early childhood care services which may be regulated and required to operate under the National Quality Framework
- Schools include government and non-government primary and secondary schools (up to year 12)
- Includes policies and nutrition standards to provide and promote healthy food choices or to limit or restrict the provision or promotion of unhealthy food choices
- Includes policies that relate to school breakfast programs, where the program is partly or fully funded, managed or overseen by the government
- Excludes training, resources and systems that support the implementation of these policies (see 'PROV3')

**International examples**

- **Chile**: In 2012, the Chilean government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606)[51]. In June 2015, the Chilean authority approved the regulatory norms required for the law's implementation (Diario Oficial No 41.193). The regulatory norms define limits for calories, saturated fat, sugar and sodium content considered "high" in foods and beverages. The regulatory norms define limits for calories (275 calories/100g or 70 calories/100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered "high" in foods and beverages. The law prohibits the sale of foods in the "high in" category in schools. These were scheduled to take effect 1 July 2016[88].
- **Finland**: In 2008, the National Nutrition Council approved nutrition recommendations for school meals. These include food and nutrient recommendations for salt, fibre, fat, starch, fat and salt maximums for meat and processed meat, and drinks. There are also criteria for snacks provided in schools[88].
- **Australia**: There are no national mandatory standards. However, six states and territories have implemented mandatory standards, which are either based on the national voluntary guidelines or nutrient and food criteria defined by the state: Australian Capital Territory (2015), New South Wales (2011), Northern Territory (2009), Queensland (2007), South Australia (2008), and Western Australia (2014). All of these states and territories identify 'red category' foods, which are either completely banned in schools or heavily restricted (e.g. offered no more than one or two times per term)[88]. The New South Wales (NSW) policy for school canteens prohibits availability of red foods, high in saturated fats, sugars, or sodium. Foods provided in school canteens should be at least 50% green foods to ensure that canteens do not increase the number of "amber" foods. Green foods include low-fat carbohydrates, fruits and vegetables, and lean meat as well as small

portions of pure fruit juice. Also Queensland's Smart Choices school nutrition standards ensure that "red" foods and drinks are eliminated across the whole school environment.

- **Mauritius**: In 2009, a regulation was passed banning soft drinks, including diet soft drinks, and unhealthy snacks from canteens of pre-elementary, elementary and secondary schools[88].
- **UK**: England, Scotland, Wales and Northern Ireland have mandatory nutritional standards for school food, which also apply to food provided in schools other than school lunches. These standards apply to most state schools (with the exception of around 4,000 academies established between September 2010 and June 2014, which are exempt) and restrict foods high in fat, salt and sugar, as well as low quality reformed or reconstituted foods[88].
- **Brazil**: The national school feeding programme[89] places great emphasis on the availability of fresh, traditional and minimally processed foods. It mandates a weekly minimum of fruits and vegetables regulates sodium content and restricts the availability of sweets in school meals. A school food procurement law[90], approved in 2001, limits the amount of processed foods purchased by schools to 30%, and bans the procurement of drinks with low nutritional value, such as sugary drinks. The law requires schools to buy locally grown or manufactured products, supporting small farmers and stimulating the local economy. Resolution no 38 (16 July 2009) sets food- and nutrition-based standards for the foods available in the national school meal programme (Law 11.947/2009). Article 17 prohibits drinks of low nutritional value (e.g. soda), canned meats, confectionary and processed foods with a sodium and saturated fat content higher than a specified threshold.
- **Costa Rica**: Executive Decree No 36910-MEP-S (2012) of the Costa Rican Ministries of Health and Education sets restrictions on products sold to students in elementary and high schools, including food with high levels of fats, sugars and salt, such as chips cookies candy and carbonated sodas. Schools are only permitted to sell food and beverages that meet specific nutritional criteria. The restrictions were upheld by the Constitutional Court in 2012 following a challenge by the food industry[88].
- **Hungary**: Since 2012, food and beverages subject to the public health product tax may not be sold on school premises or at events organized for school children, including out of school events based on the Ministerial Decree 20/2012 (VIII.31) on the Operation of Public Education Institutions and the Use of Names of Public Education Institutions. Section 130(2) of the Decree requires the head of the educational institution to consult the school health service prior to entering into agreements with vending machine operators or food vending businesses. The school health service verifies whether the products to be sold meet the nutritional guidelines set by the National Institute of Pharmacy and Nutrition. Products that do not comply are prohibited[88].
- **Uruguay**: In September 2013 the government of Uruguay adopted Law No 19.140 on "healthy eating in schools". It mandated the Ministry of Health to develop standards for food available in canteens and kiosks in schools, prohibited advertising for these same foods and restricted the availability of salt shakers. The school food standards were elaborated in March 2014 in two further documents: Regulatory Decree 60/014 and the National Plan of Health Promoting Schools. The standards aimed to promote foods with natural nutritional value with a minimum degree of processing and to limit the intake of free sugars, saturated fat, trans fat and sodium. Limits are set per 100g of food, 100ml for drinks and also per 50g portion. Prohibited foods include sugary beverages and energy drinks, confectionery, salty snacks, cakes and chocolate. The school food standards and restrictions on advertising began to be implemented in public schools in 2015 and are being monitored for compliance[88].

**Context**

In Canada, education is largely decentralized to the provinces and territories, and there is no federal Department of Education. Therefore, setting nutrition standards in schools currently falls largely on provincial governments, and Ministries of Education and/or Ministries of Health or the equivalent in each province are responsible for developing criteria for nutritional standards in schools. It is not explicit whether or not regulations could be implemented at the federal level, but it is likely that guidelines would be the most feasible policy lever for this indicator.

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| **Policy details** | **Schools:**<br><br>There are currently no federal regulations regarding policies to provide and promote healthy choices in schools or ECEs. However, the Federal/Provincial/Territorial Nutrition Working Group on Improving the Consistency of School Food and Beverage Criteria created a technical document, the **Provincial and Territorial Guidance Document for the Development of Nutrient Criteria for Foods and Beverages in Schools 2013**, to guide and support provinces as they create and revise their guidelines[91]. This document was agreed upon by provinces and territories, with the exception of Quebec, who intends to remain solely responsible for the development and implementation of policies or guidelines. The extent to which this guidance has been applied across provinces is unclear.<br><br>This document provides guideline criteria for 'Choose most often' and 'Choose sometimes' with specific criteria for each of the four food groups (vegetables and fruit, grain products, milk and alternatives, meat and alternatives) and for combination dishes representing two or more food groups. The document also provided support to industry and others who are responsible for sourcing food for the school food policies.<br><br>**School Feeding Programs**<br><br>There are no national school feeding programs, and no national standards for federally-funded feeding programs.<br><br>**Early Childhood Education**<br><br>There are no national school or ECE feeding programs. |
| **Comments/ notes** | There are additional efforts implemented at the provincial level, and this is examined in provincial evidence documents. |

## PROV2 Policies in public settings promote healthy food choices

Food-EPI good practice statement

The government ensures that there are clear, consistent policies in public sector settings for food service activities (canteens, food at events, fundraising, promotions, vending machines, public procurement standards etc.) to provide and promote healthy food choices.

**Definitions and scope**

- Public sector settings include:
  - Government-funded or managed services where the government is responsible for the provision of food, including public hospitals and other in-patient health services (acute and sub-acute, including mental health services), residential care homes, aged and disability care settings, custodial care facilities, prisons and home/community care services
  - Government-owned, funded or managed services where the general public purchase foods including health services, parks, sporting and leisure facilities, community events etc.
  - Public sector workplaces
- Includes private businesses that are under contract by the government to provide food
- Excludes 'public settings' such as train stations, venues, facilities or events that are not funded or managed by the government (see 'RETAIL4')
- Excludes school and early childhood settings (see 'PROV1')
- Includes policies and nutrition standards to provide and promote healthy food choices or to limit or restrict the provision or promotion of unhealthy food choices
- Includes the strategic placement of foods and beverages in cabinets, fridges, on shelves or near the cashier
- Includes the use of signage to highlight healthy options or endorsements (such as traffic lights or a recognised healthy symbol)
- Includes modifying ingredients to make foods and drinks more healthy, or changing the menu to offer more healthy options

**International examples**

- **Latvia**: In 2012, the government set salt levels for all foods served in hospitals and long-term social care institutions. Levels may not exceed 1.25g of salt per 100g of food product; fish products may contain up to 1.5g of salt per 100g of product[88].
- **Bermuda**: In 2008, the Government Vending Machine Policy was implemented in government offices and facilities to ensure access to healthy snacks and beverages for staff. The policy requires that all food and beverages in vending machines on government premises meet specific criteria based on levels of total fat, saturated fat, *trans* fat, sodium and sugar. Criteria exclude nuts & 100% fruit juices[88].
- **New York City, USA**: New York City's Food Standards (enacted with Executive Order 122 of 2008) set nutritional standards for all food purchased or served by city agencies, which applies to prisons, hospitals and senior care centres. The Standards include: maximum and minimum levels of nutrients per serving; standards on specific food items (e.g. only no-fat or 1% milk); portion size requirements; the requirement that water be offered with food; a prohibition on the deep-frying of foods; and daily calorie and nutrient targets, including population-specific guidelines (e.g. children, seniors)[88, 92]. As of 2015, 11 city agencies are subject to the NYC Food Standards, serving and selling almost 250 million meals a year. The Food Policy Coordinator has the responsibility of ensuring adherence with the Food Standards. Self-reported compliance with the standard is 96%.
- **Wales**: Vending machines dispensing crisps, chocolate and sugary drinks are prohibited in National Health Service hospitals in Wales. The Welsh government issued a guidance defining what is allowed and not allowed, and has liaised with major vending providers to find ways to introduce healthier food and drink options (Health Promoting Hospital Vending Directions and Guide 2008).

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| | - **UK**: The UK Government Buying Standard for Food and Catering Services (GBSF of 2014, updated March 2015) by the Department of Environment, Food and Rural Affairs, sets out standards for the public sector when buying food and catering services. It is supported by the Plan for Public Procurement: Food and Catering Services (2014), which includes a toolkit consistent of the mandatory GBSF, a balanced scorecard, an e-marketplace, case studies and access to centralised framework contacts in order to improve and facilitate procurement in the public sector. The nutrition requirements have to be followed by schools, hospitals, care homes, communities and the armed forces. To improve diets, the GBSF sets maximum levels for sugar in cereals and generally for saturated fat and salt, in addition to minimum content of fibre in cereals and fruit in desserts. Meal deals have to include vegetables and fruit as dessert and menus fish on a regular basis[60]. |
| **Context** | In Canada, provinces receive funding for health services through the Canada Health Transfer, and therefore provincial governments are largely responsible for policy in hospital or health care settings.<br><br>Nationally, the federal government is responsible for federal prisons under Correctional Service Canada. |
| **Policy details** | **Procurement standards:** Federal procurement policies must abide by the North American Free Trade Agreement, the World Trade Organization – Agreement on Government Procurement, and the Agreement on Internal Trade. In the Government of Canada's contracting policy, there is no mention of nutrition or diet, and no nutrition standards for procurement.<br><br>**Public sector workplaces:** There is no federal policy discussing food service activities at the federal level with regards to food at events, fundraising, vending machines on federal property, etc.<br><br>**Hospitals:** The provincial governments are typically responsible for policy within hospital settings; no federal policies or guidelines have been developed.<br><br>**Correctional Facilities:** According to Correctional Services Canada, food services within correctional facilities must provide nutritionally balanced meals based on Canada's Food Guide[93]. Menus must be reviewed by a registered dietitian to ensure that the menus meet the Recommended Nutrient Intakes for Canadians. |
| **Comments/ notes** | There are additional efforts implemented at the provincial level, and this is examined in provincial evidence documents. |

## PROV3 Support and training systems (public sector settings)

### Food-EPI good practice statement

The government ensures that there are good support and training systems to help schools and other public sector organisations and their caterers meet the healthy food service policies and guidelines

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| **Definitions and scope** | - Includes support for early childhood education services as defined in 'PROV1'<br>- Public sector organisations includes settings defined in 'PROV2'<br>- Support and training systems include guidelines, toolkits, templates (e.g. policy/guidelines or contracts), recipes and menu planning tools, expert advice, menu and product assessments, online training modules, cook/caterer/other food service staff information and training workshops or courses |
| **International examples** | - **Australia**: The Healthy Eating Advisory Service supports settings such as childcare centres, schools, workplaces, health services, food outlets, parks and sporting centres to provide healthy foods and drinks to the public in line with Victorian Government policies and guidelines. The Healthy Eating Advisory Service is delivered by experienced nutritionists and dieticians at Nutrition Australia Victorian Division. The support includes training cooks, chefs, foods service and other key staff, discovering healthier recipes, food ideas and other helpful resources to provide healthier menus and products[94].<br>- **Japan**: In Japanese, "Shoku" means diet and "iku" means growth and education. In 2005, Basic Law on Shokuiku was enacted and it was the first law that regulates one's diets and eating habits. It involved Cabinet Office as the leading office to plan, formulate and coordinate Shokuiku policy and strategy, in collaboration with Ministry of Health, Labour and Welfare, Ministry of Education, Culture, Sports, Science and Technology (MEXT) and Ministry of Agriculture, Forestry and Fisheries. The laws included several concepts, which are promotion of Shokuiku at home, schools or nursery schools and promotion of interaction between farm producers and consumers[95]. Dietitian and registered dietitian are playing important roles to implement Shokuiku programs by providing dietary guidance in various setting. In Japan, at least one dietitian should be assigned at the facility with mass food service over 100 meals/time or over 250 meals/ day, whereas at least one registered dietitian needed when it is over 500 meals/time or 1500 meals/day. In specific setting such as school, the Ministry of Education, Culture, Sports, Science and Technology established the Diet and Nutrition Teacher System in 2007. Diet and Nutrition Teachers are responsible to supervise school lunch programs, formulate menus and ensure hygiene standards in public elementary schools and junior high schools in accordance with the needs of local communities. They also deal with dietary education issues in collaboration with nutrition experts such as registered dietitian and dietitian[96]. Under the revised School Lunch Act 2008, it included School Lunch Practice Standard which stipulates proper school lunch including reference intake values of energy and each nutrient as per age groups[97]. Moreover, it outlined costs of facilities and manpower (e.g. cooks) to be covered by municipalities and guardians only cover the cost of ingredients which amounting an estimate of 4000 yen/month/student for school lunch program[98]. |
| **Context** | The federal government does not have policies relating to public sector organizations regarding healthy food service policies and guidelines. |
| **Policy details** | N/A |
| **Comments/ notes** | There are additional efforts implemented at the provincial level, and this is examined in provincial evidence documents. This will not be evaluated at the Federal level. |

## PROV4 Support and training systems (private companies)

Food-EPI good practice statement

Government actively encourages and supports private companies to provide and promote healthy foods and meals in their workplaces

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| **Definitions and scope** | - For the purpose of this indicator, 'private companies' includes for-profit companies and extends to non-government organisations (NGOs) including not-for-profit/charitable organisations, community-controlled organisations, etc.<br>- Includes healthy catering policies, fundraising, events<br>- Includes support and training systems including guidelines, toolkits, templates (e.g. policy/guidelines or contracts), recipes and menu planning tools, expert advice, menu and product assessments, online training modules, cook/caterer/other food service staff information and training workshops or courses (where relevant to the provision of food in a workplace)<br>- Excludes the provision or promotion of food to people not employed by that organisation (e.g. visitors or customers)<br>- Excludes support for organisations to provide staff education on healthy foods |
| **International examples** | - **UK**: The UK responsibility deal included collective pledges on health at work, which set out the specific actions that partners agree to take in support of the core commitments. One of the pledges is on healthier staff restaurants, with 165 signatories to date[99].<br>- **Victoria, Australia**: 'Healthy choices: healthy eating policy and catering guide for workplaces' is a guideline for workplaces to support them in providing and promoting healthier foods options to their staff. The guideline is supported by the Healthy Eating Advisory Service that helps private sector settings to implement such policies. Menu assessments and cook/caterer training are available free of charge to some eligible workplaces[100].<br>- **Singapore**: The National Workplace Health Promotion Programme, launched in Singapore in 2000, is run by the Health Promotion Board. Both private and public institutions are encouraged to improve the workplace environment by providing tools and grants. Grants are awarded to help companies start and sustain health promotion programmes. Tools include a sample Healthy Workplace Nutrition Policy, a sample Healthy Workplace Catering Policy, and a detailed Essential Guide to Workplace Health, setting out ways to transform the workplace into a health-supporting work environment[88]. |

**Context**

**Policy details**

The Canadian Centre for Occupational Health and Safety (CCOHS) was established in 1978 by the *Canadian Centre for Occupational Health and Safety Act* to create an institute to represent the health and safety of workers nationally. The CCOHS established a website, the Healthy Eating at Work site, which states that healthy eating programs should focus on the main messages from Canada's Food Guide and make sure their services offer healthier food choices. The site further provides tips on what to include in the healthy eating programs and suggestions on what to offer and what to limit at meetings. There is no official policy or guidelines recommended by the federal government[101].

No other programs or policies were identified.

**Comments/ notes**

There are additional efforts implemented at the provincial level, and this is examined in provincial evidence documents.

# Policy area: Food Retail

## Food-EPI vision statement: The government has the power to implement policies and programs to support the availability of healthy foods and limit the availability of unhealthy foods in communities (outlet density and locations) and in-store (product placement)

### RETAIL1 Robust government policies and zoning laws: unhealthy foods

Food-EPI good practice statement

Zoning laws and related policies provide robust mechanisms and are being used, where needed, by local governments to place limits on the density or placement of quick serve restaurants or other outlets selling mainly unhealthy foods in communities

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| **Definitions and scope** | - Includes the consideration of public health in State/Territory Planning Acts that guide the policies, priorities and objectives to be implemented at the local government level through their planning schemes<br>- Includes the consideration of public health in State/Territory subordinate planning instruments and policies<br>- Includes a State/Territory guideline that sets the policy objective of considering public health when reviewing and approving fast food planning applications<br>- Excludes laws, policies or actions of local governments |
| **International examples** | - **South Korea**: In 2010 the Special Act on Children's Dietary Life Safety Management established the creation of 'Green Food Zones' around schools, banning the sale of foods (fast food and soda) deemed unhealthy by the Food and Drug Administration of Korea within 200 metres of schools[64, 102]. In 2016, Green Food Zones existed at over 10000 schools.<br>- **Dublin, Ireland**: Fast-food takeaways will be banned from opening within 250 metres of schools, Dublin city councillors have ruled. The measure to enforce "no-fry zones" will be included in a draft version of the council's six-year development plan. City planners will be obliged to refuse planning permission to fast food businesses if the move is formally adopted after public consultation[103].<br>- **USA**: In Detroit, the zoning code prohibits the building of fast food restaurants within 500 ft. of all elementary, junior and senior high schools[20].<br>- **UK**: Around 15 local authorities have developed "supplementary planning documents" on the development of hot food takeaways. The policies typically exclude hot food takeaways from a 400m zone around the target location (e.g. primary schools). For example, Barking and Dagenham's Local Borough Council, London, adopted a policy in 2010 restricting the clustering of hot food takeaways and banning them entirely from 400m exclusion zones around schools. In 2009, the Local Borough Council of Waltham Forest, London developed a planning policy in 2009 restricting the development of hot food takeaways in local centres, and excluding them completely from areas within 10min walks from schools, parks or other youth centres. St Helens Council adopted a planning document in 2011 and Halton in 2012[20]. |
| **Context** | In Canada, zoning laws are typically administered at the provincial or local level. Although this varies between provinces, provincial or territorial governments typically set overarching zoning legislation, and local governments are responsible for creating, implementing and enforcing municipal policies that are in line with the provincial mandates. |

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| **Policy details** | No federal policies exist to support adoption of zoning laws to address limiting the density of placement of outlets that sell generally unhealthy foods. |
| **Comments/ notes** | |

## RETAIL2 Robust government policies and zoning laws: healthy foods

### Food-EPI good practice statement

Zoning laws and related policies provide robust mechanisms and are being used, where needed, by local governments to encourage the availability of outlets selling fresh fruit and vegetables

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| **Definitions and scope** | - Outlets include supermarkets, produce markets, farmers' markets, greengrocers, food co-operatives<br>- Includes fixed or mobile outlets<br>- Excludes community gardens, edible urban or backyard gardens (usually regulated by local governments)<br>- Includes State/Territory policies to streamline and standardise planning approval processes or reduce regulatory burdens for these outlets<br>- Includes policies that support local governments to reduce license or permit requirements or fees to encourage the establishment of such outlets<br>- Includes the provision of financial grants or subsidies to outlets<br>- Excludes general guidelines on how to establishment and promote certain outlets<br>- Excludes laws, policies or actions of local governments |
| **International examples** | - **USA**: In February 2014 the US Congress formally established the Healthy Food Financing Initiative (following a three year pilot) which provides grants to states to provide financial and/or other types of assistance to attract healthier retail outlets to underserved areas. The pilot distributed over 140 million USD in grants to states to provide financial and other types of assistance to attract healthier retail outlets in underserved areas. To date, 23 US states have implemented financing initiatives[20]. For example, the New Jersey Food Access Initiative provides affordable loans and grants for costs associated with building new supermarkets, expanding existing facilities, and purchasing and installing new equipment for supermarkets offering a full selection of unprepared, unprocessed, healthy foods in under-served areas; the initiative targets both for-profit and not-for-profit organisations and food cooperatives.<br>- **New York City, USA**: The 'Green Cart Permit' was developed with reduced restrictions on zoning requirements to increase the availability of fresh fruits and vegetables in designated, underserved neighbourhoods[20]. In 2008 New York City made 1000 licences for green carts available to street vendors who exclusively sell fresh fruit and vegetables in neighbourhoods with limited access to healthy foods[20]. In addition, in 2009, New York City established the food retail expansion to support health program of New York City (FRESH). Under the programme, financial and zoning incentives are offered to promote neighbourhood grocery stores offering fresh meat, fruit and vegetables in under-served communities. The financial benefits consist of an exemption or reduction of certain taxes. The zoning incentives consist of providing additional floor area in mixed buildings, reducing the amount of required parking, and permitting larger grocery stores in light manufacturing districts.<br>- **Scotland**: In 2004, a small group of suppliers and retailers in Scotland established a pilot project called Healthy Living Neighbourhood Shops to increase the availability of healthier food options throughout Scotland, in both deprived and affluent areas, where little or no option existed to buy. The programme received funding from the Scottish Executive and worked closely with the Scottish Grocers' Federation, which represents convenience stores throughout Scotland. Through a number of different trials, the programme established clear criteria for increasing sales and also developed bespoke equipment/point of sale (POS) materials which were given to participating retailers free of charge. This has led to around 600 convenience stores across Scotland improving their range, quality and stock of fresh fruit and vegetables and other healthier eating products[104]. |

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| **Context** | In Canada, zoning laws are typically administered at the provincial or local level. Although this varies between provinces, provincial or territorial governments typically set overarching zoning legislation, and local governments are responsible for creating, implementing and enforcing municipal policies that are in line with the provincial mandates. |
| **Policy details** | No federal policies exist to support adoption of zoning laws to encourage the availability of outlets selling fresh fruit and vegetables. |
| **Comments/ notes** | |

## RETAIL3 In-store availability of healthy and unhealthy foods

Food-EPI good practice statement

The government ensures existing support systems are in place to encourage food stores to promote the in-store availability of healthy foods and to limit the in-store availability of unhealthy foods

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| **Definitions and scope** | - Food stores include supermarkets, convenience stores (including 'general stores' or 'milk bars'), greengrocers and other speciality food retail outlets<br>- Support systems include guidelines, resources or expert support<br>- In-store promotion includes the use of key promotional sites such as end-of-aisle displays, checkouts and island bins as well as the use of shelf signage, floor decals or other promotional methods<br>- In-store availability includes reducing or increasing supply (volume) of a product such as reducing the amount of shelf-space dedicated to sugar-sweetened drinks and confectionary, or offering fresh produce in a convenience store |
| **International examples** | - **USA**: The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) requires WIC authorised stores to stock certain healthier products (e.g. wholegrain bread)[77]. |
| **Context** | In 2013, Health Canada commissioned a document titled ***Working with Grocers to Support Healthy Eating*** to better understand the literature on interventions in the food retail environment to support healthy eating in grocery stores[105]. |
| **Policy details** | **Nutrition North Canada (NNC) Retail and Education Initiatives**<br>NNC (described in PRICES3) also supports in-store availability of healthy foods, through NNC nutrition education initiatives, however, that is a relatively much smaller part of the program compared to the food subsidy program. As part of NNC, Health Canada supports culturally appropriate retail and nutrition education activities in isolated northern communities. These initiatives complement the NNC subsidy by supporting increased knowledge of healthy eating, developing skills in selecting and preparing healthy store-bought and traditional or country foods, and strengthening retail-community partnerships. Through NNC Nutrition Education Initiatives, funded activities may include promotion of in-store taste tests and grocery store tours (which may include nutrition label reading).<br><br>Indigenous and Northern Affairs Canada (INAC) provides retailers communications materials (e.g., poster, shelf talkers that attach to grocery store shelves) to use in store, but these are aimed at raising awareness of the subsidy and of which foods are subsidized, rather than on general nutrition information or labelling.<br><br>As of 2016, the Public Health Agency of Canada has joined the Nutrition North Canada program to fund Nutrition Education Initiatives in 10 communities eligible for NNC that fall outside Health Canada's mandate.<br><br>There were no other systems to encourage retailers to promote the availability of healthy foods in stores identified in the online search. |
| **Comments/ notes** | There are additional efforts implemented at the provincial level, and this is examined in provincial evidence documents. |

## RETAIL4 Food service outlet availability of healthy and unhealthy foods

Food-EPI good practice statement

The government ensures support systems are in place to encourage food service outlets to increase the promotion and availability of healthy foods and to decrease the promotion and availability of unhealthy foods

**Definitions and scope**

- Food service outlets include for-profit quick service restaurants, eat-in or take-away restaurants, pubs, clubs
- Support systems include guidelines, resources or expert support
- Includes settings such as train stations, venues, facilities or events frequented by the public
- Excludes settings owned or managed by the government (see 'PROV2' and 'PROV4')
- Includes the strategic placement of foods and beverages in cabinets, fridges, on shelves or near the cashier
- Includes the use of signage to highlight healthy options or endorsements (such as traffic lights or a recognised healthy symbol)
- Includes modifying ingredients to make foods and drinks more healthy, or changing the menu to offer more healthy options

**International examples**

- **Singapore**: 'Healthier Hawker' program involved the government working in partnership with the Hawker's Association to support food vendors to offer healthier options such as reduced saturated fat cooking oil and wholegrain noodles and rice, reduced salt soy sauce and increased vegetable content. As part of the "Healthier Dining Programme" launched in June 2014 (formerly called the "Healthier Hawker" programme launched in 2011), food operators are encouraged to offer lower calorie meals and use healthier ingredients such as oils with reduced fat content, and/or whole grains without compromising taste and accessibility. To participate, food and beverage companies must complete an application form and implement nutrition guidelines set by the Health Promotion Board (HPB) in all outlets for a period of two years. Following HPB's approval the "Healthier Choice Symbol Identifiers" can be used next to the healthier dishes in all menu and marketing materials (e.g. "We serve lower-calorie options", "We use healthier oil"). To date, the HPB has partnered with 45 widely known food service providers (food courts, coffee shops, restaurants) to offer lower calorie and healthier meals across 1500 outlets and stalls. Between the launch of the programme and September 2015, the number of healthier meals sold more than doubled, from 525000 in June 2014 to 1.1 million in September 2015.
- **USA**: In December 2011, San Francisco implemented the Health Food Incentives Ordinance which bans restaurants, including takeaway restaurants, to give away toys and other free incentive items with children's meals unless the meals meet nutritional standards as set out in the Ordinance: meals must not contain more than 600 calories, 640mg sodium, 0.5g trans-fat, 35% total calories from fat and 10% calories from saturated fat and include a min amount of fruits and vegetables, while single food items and beverages must have <35% total calories from fat and <10% of calories from added caloric sweeteners. Incentives are defined as physical and digital items that appeal to children and teenagers as well as coupons, vouchers or similar which allow access to these items. In 2010 Santa Clara county, California banned restaurants from providing toys or other incentives with m menu items high in calories, sodium, fast or sugars. The law (Ordinance No NS300-820) sets nutrition standards prohibiting restaurants from linking toys or other incentives with single food items or meals with excessive calories (more than 200 for single food items and more than 485 calories for meals), excessive sodium (more than 480mg for single food item and more than 600mg for a meal), excessive fat (more than 35% for total fat), excessive saturated fat (>10%) and sugar ( more than 10% total calories from caloric sweeteners) or more than 0.5g of trans fats. It also applies to drinks with excessive calories (more than 120 calories) and fat ( more than 35% from fat) and excessive sugars (more than 10% from caloric sweeteners) added non-nutritive sweeteners or caffeine[60].

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| | - **France**: Since January 2017 France has banned unlimited offers of sweetened beverages for free or at a fixed price in public restaurants and other facilities accommodating or receiving children under the age of 18. Sweetened beverages are defined as any drink sweetened with sugar or artificial (caloric and non-caloric ) sweeteners , including flavoured carbonated and still beverages, fruit syrups, sport and energy drinks, fruit and vegetable nectars, fruit- and vegetable-based drinks, as well as water- milk- or cereal-based beverages[20]. |
| **Context** | |
| **Policy details** | There are no federal policies or programs to encourage food service outlets to increase the promotion and availability of healthy foods. |
| **Comments/ notes** | |

# Policy area: Food Trade & Investment

## Food-EPI vision statement: The government ensures that trade and investment agreements protect food sovereignty, favour healthy food environments, are linked with domestic health and agricultural policies in ways that are consistent with health objectives, and do not promote unhealthy food environments

### TRADE1 Trade agreement impacts assessed

Food-EPI good practice statement

The government undertakes risk impact assessments before and during the negotiation of trade and investment agreements to identify and evaluate the direct and indirect impacts of such agreements on population nutrition and health

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| **Definitions and scope** | - Includes policies or procedures that guide the undertaking of risk impact assessments before or during negotiation to assess risks and benefits in relation to public health and population nutrition<br>- Includes policies or procedures that guide the evaluation of trade and investment agreements after an agreement is finalised to monitor the impact for the purpose of informing future negotiations or reviews<br>- Includes policies or procedures that guide public consultation procedures before and during negotiations<br>- Any trade or economic agreements negotiated within the last **3 years** are considered |
| **International examples** | - **US/EU**: It is mandatory in the US and countries of the EU to undertake Environmental Impact Assessments for all new trade agreements. These assessments sometimes incorporate Health Impact Assessments[106]. |
| **Context** | In Canada, the Executive Branch is responsible for the negotiation, signature and ratification of international treaties, and Parliament is responsible for federal implementation of such treaties. Some treaties require legislation for implementation, while others do not.<br><br>According to the Global Affairs Canada:<br><br>*The Minister of Foreign Affairs will initiate the tabling of all instruments, accompanied by a brief Explanatory Memorandum in the House of Commons following their adoption by signature or otherwise, and prior to Canada's expression of its consent to be bound by ratification, acceptance, approval or accession*[107].<br><br>When treaties do not require implementing legislation, the Government will observe a waiting period of at least twenty-one sitting days after a treaty is tabled before taking legal steps to bring the treaty into force.<br><br>Trade agreements are negotiated by the Department of Global Affairs Canada, and more specifically the Minister of International Trade. |
| **Policy details** | The Government of Canada consults broadly on potential free trade agreements (FTAs), and officials are responsible for assessing the full range of potential implications and impacts for Canada of FTAs, taking into account information and views received through public |

consultations processes and through targeted consultations aimed at specific sectors or groups of stakeholders.

Recent examples of public consultations on FTAs can be found here.

Communication from Global Affairs Canada stated:

> Although there is no specific directive on health or health risk assessments for FTAs, as with all proposed Government of Canada policies, meaningful consultation and horizontal collaboration between federal departments/agencies is required. Consultations are not only held with the public and interested stakeholders but also other government departments/agencies, including regulatory agencies responsible for health and safety policies and regulations in Canada (e.g. Health Canada, the Canadian Food Inspection Agency). The potential impacts on Canadian health and safety related policies, regulations or laws from FTA discussions, negotiations or agreements are considered at all stages of an FTA, whether identified through consultations with Canadian regulators or health policy experts, or identified through public consultations with Canadian stakeholders (written communication, April 2017).

**Comments/ notes**

In addition, strategic environmental impact assessments are required under the Cabinet Directive on the Environmental Assessment of Policy, Plan and Program Proposals[108].

For Environmental Assessments (EAs), the EA guide establishes a process to gather and analyze the data necessary to inform policymakers of the likely and important environmental implications in an ex ante fashion (undertaken before the negotiations are completed) to help inform Canada's negotiators throughout the trade negotiation process. Adopting an ex ante approach is in keeping with the Government of Canada's efforts to 'mainstream' environmental issues with trade policy rather than attempting to address them in an isolated fashion. The Final EA Report is issued after the negotiation is concluded and after the text of the agreement is released.

**The EAs currently developed do not include aspects of population health or nutrition.**

## TRADE2 Protect regulatory capacity – nutrition

Food-EPI good practice statement

The government adopts measures to manage investment and protect their regulatory capacity with respect to public health nutrition

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|---|---|
| **Definitions and scope** | - Includes provisions in trade or economic agreements that protect the capacity of government to implement domestic policy in relation to food environments. This includes protections with respect to tariffs, non-tariff measures (such as quotas, regulations, standards, testing, certification, licensing procedures) and measures related to foreign direct investment |
| **International examples** | - **Many Countries**: Sanitary and phytosanitary (SPS) clauses in World Trade Organization (WTO) agreements. However, this usually does not apply to public health nutrition.<br>- **Ghana**: Ghana has set standards to limit the level of fats in beef, pork, mutton and poultry in response to rising imports of low quality meat following liberalization of trade. The relevant standards establish maximum percentage fat content for de-boned carcasses/cuts for beef (<25%), pork (<25%) and mutton (<25% or <30% where back fat is not removed), and maximum percentage fat content for dressed poultry and/or poultry parts (<15%)[109]. |
| **Context** | Canada has been a member of the World Trade Organization (WTO) since January 1, 1995.<br><br>Currently, Canada engages in Free Trade Agreements with a large number of countries, most notably the North American Free Trade Agreement (NAFTA) with the US and Mexico, and the Comprehensive Economic and Trade Agreement (CETA) with the EU. Given recent political changes, the future of the Trans-Pacific Partnership (TPP) is unclear. |
| **Policy details** | the cost of a nutritious diet for a family of four for one week using 67 standard food items<br><br>There are a number of provisions in trade agreements that protect the ability of government to implement and enforce public health policy relating to obesity and nutrition, such as general exceptions, specific exceptions, objectives, preambular text, etc. See comments below on SPS, TBT and investment provisions, which provide detail on how trade agreements frame and address the right to regulate in the public interest (which would include the right to regulate in the interest of public health nutrition and NCD prevention).<br><br>**General Exceptions**<br><br>The **General Agreement on Trades and Services** (GATS) (Article XIV) and the **General Agreement on Tariffs and Trade** (GATT) (Article XX) provide general exceptions which specify that nothing in the GATS or GATT prevents the adoption or enforcement of measures necessary to protect public morals or maintain public order (GATS Article XIV only) or to protect human, animal or plant life or health, as long as these measures are not "*applied in a manner which would constitute a means of arbitrary or unjustifiable discrimination between countries where like conditions prevail, or a disguised restriction on trade in services*"[110, 111]. However, the utility of such measures is unclear as there is a large burden on the responding state in any challenge, and the use of a general exception has a low success rate[112]. The process to analyze claims for general exceptions can be found here.<br><br>**Relevant chapters/agreements**<br><br>Canada abides by the **World Trade Organization Sanitary and Phytosanitary Measures** (SPS Agreement) and the **Technical Barriers to Trade Agreement (TBT)**, which were annexed to the Agreement Establishing the World Trade Organization and that are relevant to market access[113].<br><br>***Sanitary and Phytosanitary Measures (SPS Agreement)***<br><br>The **WTO SPS Agreement** protects a Member's right to put in place regulations and other measures to protect food safety and animal and plant health, while also ensuring that regulations are based on science, are applied only to the extent necessary to protect human, |

animal or plant life or health, and do not arbitrarily or unjustifiably discriminate between countries where identical or similar conditions prevail.

Examples from the SPS Agreement of flexibilities include:

- Article 3.2 states that a measure that conforms with an international standard shall be deemed to be necessary to protect human, animal or plant life or health, and will be presumed to be consistent with the SPS Agreement.
- Article 3.3 allows Members to have higher levels of sanitary or phytosanitary protection than those achieved through the relevant international standard, provided that there is a scientific justification or that it is based on a science-based, evidence-based risk assessment.
- Where there is insufficient scientific evidence available, Article 5.7 allows a Member to provisionally adopt SPS measures on the basis of available information, provided the Member seeks the additional information required to complete a risk assessment and reviews the provisional measure within a reasonable time.

For additional factual material describing the scope and provisions of the WTO SPS Agreement, you may visit here.

***Technical Barriers to Trade (TBT) Agreement***

The WTO TBT Agreement protects a Member's right to regulate while also ensuring that the implementation of measures that fall within the scope of the TBT Agreement do not discriminate nor result in unnecessary obstacles to trade.

Examples from the TBT Agreement of flexibility include:

- Article 2.1 requires Members to not discriminate between domestic and foreign products in their regulation making, but allows Members to draw legitimate regulatory distinctions (LRD) as part of their right to regulate, as reflected in the LRD test (see US – Tuna II);

- Article 2.2 protects a Member's right to pursue legitimate objectives, subject to the disciplines that such regulations do not create unnecessary obstacles to trade.

- Article 2.5 creates a rebuttable presumption that a regulation prepared, adopted or applied for a legitimate objective identified in Article 2.2, and is in accordance with relevant international standards, does not create an unnecessary obstacle to trade.

**INVESTORS RIGHTS PROVISIONS**

**Context**

Any investor, foreign or domestic, that invests in the affected sector(s) in Canada must comply with all Canadian regulations. Through its international investment treaties Canada (along with its treaty partners) commits to certain treatment of foreign investment. At the core are minimum standards of treatment at customary international law, principles of non-discrimination and protection from expropriation without compensation. These commitments do not impinge on any of Canada's laws or regulation. However, in its treaties (e.g. CETA), Canada clearly re-affirms its right to regulate in the public interests and uses other mechanisms (e.g. exceptions and reservations) to protect sensitive policy areas. The only time where a tribunal can consider an investor claim in relation to Canada's conduct towards an investment is where it is alleged that Canada has violated any of its obligations in an investment treaty. Canada does not take any obligations in its investment treaties with respect to food/nutrition or health, other than not to relax the standards in an effort to attract investment. Finally, any investor in Canada, foreign or domestic, can challenge any Canadian law or regulation in domestic courts and such law or regulation may be modified or overturned as a result. By contrast, the tribunals under Canada's investment treaties can only enforce obligations contained in those treaties; they cannot challenge domestic laws under this mechanism. Moreover, this mechanism only allows tribunals to award monetary compensation for breaches of international treaty obligations by the state. Tribunals do not have the authority to overturn laws or regulations.

**Provisions**

Several attempts have been made to protect a government's ability to regulate, and thereby implement public health policies, within investor rights provisions in free trade agreements, and attempts have been made to rebalance state rights in Investor State Dispute Settlements (ISDS). However, ambiguous text in these agreements has potential for interpretation among tribunals who make decisions on trade agreement challenges, which has been noted as reducing the ability of Canada to regulate in its agreements with ISDS, such as NAFTA. There has been a move to improve the protections around indirect expropriation (e.g., CETA Investment Annex X.11.3, still untested); however, there have been fewer improvements around the definition of 'fair and equitable treatment' (FET) in trade agreements. With regards to FET, Canada has taken two agreement approaches. Within NAFTA and TPP, FET is linked to customary international law, while in CETA, FET is linked to an autonomous treaty standard (see below). Defining FET clearly within an autonomous treaty standard is considered by many to be more effective than customary international law, which has evolved and changed over time[114].

**Comprehensive Economic and Trade Agreement (CETA) example:**

Recent provisions in CETA are described below as an example of recent policy action in free trade in Canada.

Regarding the Canada-European Union, government documents state "*CETA also builds in protections that will ensure that Canada's municipalities, provinces, territories and federal government can continue to regulate in the public interest, whether in matters of health and safety, environmental protection, cultural identity or other areas Canadians hold dear*."

Several elements of CETA have been introduced to increase the ability of governments to regulate:[115]

- CETA makes clear that the EU and Canada preserve their right to regulation to achieve legitimate policy objectives, such as public health, safety, environment, public morals, social or consumer protection and the promotion and protection of cultural diversity (Art. 8.9).
- CETA provides a precise and specific standard of treatment by providing a definition of "fair and equitable treatment" that is clear and defines precisely the standard of treatment, with less room for interpretation or discretion by the Members of the Tribunal than previous trade agreements (Art. 8.10). However, the FET still gives significant discretion to arbitration courts[116].
- CETA includes a clear definition for what constitutes "indirect expropriation" to avoid claims against legitimate public policy measures. This includes a clause that the sole fact that a measure increase costs for investors cannot give rise in itself to a finding of expropriation (Annex 8.12 and Annex 8-A).
- Unique to CETA, a Joint Management Committee for Sanitary and Phytosanitary Measures (the "Joint Management Committee"), has been established under Article 26.2.1, made up of regulatory and trade representatives of each signing Party responsible for SPS measures. This agreement includes additional details on the procedure for Investor-state dispute settlement (ISDS), with an aim to encourage early settlement of disputes without arbitration, and facilitate a transparent ISDS process. Under the new ISDS procedure, the tribunal for ISDS is selected from a roster of 15 members selected by Canada and the EU, including members from Canadian, EU and non-Party countries (and not arbitrators nominated by the investor and defending state, as in other FTAs in Canada). The roster allows members to ensure that the tribunal members have appropriate qualifications and are sensitive to government issues. There is a policy of transparency in dispute settlement proceedings (Art 8.36). This is thought to have potential to address some of the procedural issues that have been identified in these tribunals, such as conflict of interest[117]. However, it does not address all of the substantive challenges of FTAs (Art. 8.27, 8.28 and 8.29).

The advantages and disadvantages to these various protections are still under analysis, and come with both strengths and weaknesses to protect health.

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| **Comments/ notes** | While not really about the issue of trade agreement limits, the Canadian Cabinet Directive on Regulatory Management requires federal regulators to, when regulating, protect and advance the public interest. |

# INFRASTRUCTURE SUPPORT DOMAINS

## Policy area: Leadership

Food-EPI vision statement: The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

### LEAD1 Strong, visible, political support

Food-EPI good practice statement

There is strong, visible, political support (at the Head of State / Cabinet level) for improving food environments, population nutrition, diet-related NCDs and their related inequalities

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| **Definitions and scope** | - Visible support includes statements of intent, election commitments, budget commitments, establishing priorities and targets, demonstration of support in the media, other actions that demonstrate support for new or strengthened policy<br>- Documents that contain evidence of strong political support include media releases, speeches, pre-election policy papers, introduction of a bill, State-level strategic plans with targets or key performance indicators<br>- In this case, the Head of State is considered to be the Prime Minister |
| **International examples** | - **New York City, USA**: As Mayor of New York City, Michael Bloomberg prioritised food policy and introduced a number of ground breaking policy initiatives including 'Health Bucks', a restriction on trans fats, establishment of an obesity taskforce, a portion size restriction on sugar-sweetened beverages, public awareness campaigns, etc. He showed strong and consistent leadership and a commitment to innovative approaches and cross-sectoral collaboration[118].<br>- **Brazil**: The Minister of Health showed leadership in developing new dietary guidelines that are drastically different from the majority of dietary guidelines created by any nation to date, and align with some of the most commonly cited recommendations for healthy eating[119].<br>- **CARICOM Countries**: Active NCD commissions exist in six of the 20 CARICOM member states (Bahamas, Barbados, Bermuda, British Virgin Islands, Dominica, Grenada) which are all housed in their Ministries of Health, with members recommended by the Minister of Health and appointed by the Cabinet of Government for a fixed duration; all include government agencies and to a varying degree, civil society and the private sector. |
| **Context** | |

**Policy details**

Over the past several years, various actions have demonstrated political support from the Federal government:

In 2010, the Public Health Agency of Canada led the establishment the ***Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights***, which was endorsed by Federal/Provincial/Territorial Ministers and which included a mandate for "increasing the availability and accessibility of nutritious foods and decreasing the marketing to children of foods and beverages that are high in fat, sugar and/or sodium"[120].

In 2015, the **Standing Senate Committee on Social Affairs, Science and Technology** published *Obesity in Canada: A Whole-of-Society Approach for a Healthier Canada* with recommendations to address the currently high levels of obesity within Canadian borders[52]. The report contained many recommendations for food environment policies, including restrictions on advertising to children, taxation and fiscal measures to decrease the sales of unhealthy food items, and improvements to Canada's Food Guide and nutrition labels.

**Prime Minister Justin Trudeau** included aspects of public health nutrition and food environment policy in the **Mandate Letter to the Minister of Health**, published in November, 2015, which included introducing new restrictions on the commercial marketing of unhealthy food and beverages to children; bringing in tougher regulations to eliminate trans fats and to reduce salt in processed foods; and improving food labels to give more information on added sugar[121]. The mandate and commitment was also recognized by Dr. Jane Philpott, Minister of Health in a letter to the editor in the Canadian Medical Association Journal[122]. There was also a **Mandate Letter to the Minister of Agriculture and Agri-Food Canada** which included a mandate to develop a food policy that promotes healthy living and safe food by putting more healthy, high-quality food, produced by Canadian ranchers and farmers, on the tables of families across the country[83].

In October, 2016, the **Minister of Health Jane Philpott** announced Health Canada's ***Healthy Eating Strategy***[47], which demonstrated support for the implementation of policies to address healthy food choices, with specific mention of the relevance of the strategy to address obesity and diet-related NCDs[47]. The strategy employs various policy levers, including legislation, regulation, guidance and education in a consistent and mutually reinforcing manner to more effectively achieve public health objectives. This is part of the Government of Canada's ***Vision for a Healthy Canada***, which includes components of Healthy Eating, Healthy Living, and Healthy Mind.

**Trilateral Cooperation on Childhood Obesity**

In 2014, the **Minister and Secretaries of Health from Canada, Mexico and the U.S**. committed to work together to address childhood obesity, which is a top public health priority in all three countries. Since then, a working group of technical officials has actively exchanged information, best practices and lessons learned on respective national approaches including multi-sectorial partnerships, the U.S. Let's Move initiative, and public awareness campaigns in Mexico targeting food portion sizes and physical activity.

In June 2016 at the **North American Leaders Summit**, the leaders reaffirmed their commitment to prevent childhood obesity and promote healthy living. This past September, the Pan American Journal of Public Health published an article about the work of the Trilateral Childhood Obesity working group as well as an editorial co-written by Minister Philpott, Secretary Narro Robles, and Secretary Burwell.

Currently, the working group is exploring opportunities to implement a multi-sectorial partnership with a non-governmental organization operating in all three countries. The initiative would focus on family-oriented physical activity and health education.

**Comments/ notes**

## LEAD2 Population intake targets established

Food-EPI good practice statement

Clear population intake targets have been established by the government for the nutrients of concern to meet WHO and national recommended dietary intake levels

**Definitions and scope**

- Includes targets which specify population intakes according to average reductions in percentage or volume (e.g. mg/g) for salt/sodium, saturated fat, *trans* fats or added or free sugars**
- Excludes targets to reduce intake of foods that are dense in nutrients of concern (See COMP1 and COMP2)
- Typically requires the government to establish clear dietary guidelines on the maximum daily intake of nutrients of concern

******Free sugar*** *is defined as is the sugar no longer in its naturally-occurring state (i.e., no longer in whole fruits, vegetables, unsweetened dairy, and grains) and can be consumed as is or incorporated into other foods. Examples include table sugar, syrup, honey, fruit juice and nectars.* ***Added sugar*** *is defined as the free sugar that has been added to foods, however regulatory definitions vary widely under different jurisdictions, some of which are currently under review. These differ from* ***naturally occurring sugars****, defined as the sugar found naturally within whole foods (i.e., within whole fruits, vegetables, dairy, and some grains)*[123].

**International examples**

- **Brazil**: The "Strategic Action Plan for Confronting NCDs in Brazil, 2011-2022 specifies a target of increasing adequate consumption of fruits and vegetables, from 18.2% to 24.3 % between 2010 and 2022 and reduction of the average salt intake of 12 g to 5 g, between 2010 and 2022[124].
- **South Africa**: The South African plan for the prevention and control of non-communicable diseases includes a target on reducing mean population intake of salt to <5 grams per day by 2020[125].
- **UK**: In July 2015, the government adopted as official dietary advice the recommendation of the Advisory Committee on Nutrition that sugar should make up no more than 5% of daily calorie intake (30g or 7 cubes of sugar per day). Current sugar intake makes up 12 to 15% of energy. An evidence review by Public Health England outlines a number of strategies and interventions[126].

**Context**

This indicator is trying to identify population intake targets, and not reformulation/composition targets. For composition targets, see COMP1 and COMP2.

WHO recommendations

- The WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020 and Global Monitoring Framework includes a target of a 30% relative reduction in mean population salt intake. The WHO's recommendation is less than 5 grams of salt per person per day (approximately 2,000 mg).
- In March 2015, the WHO released new policy guidance recommending that governments establish policy that encourages reduction of daily intake of free sugars to less than 10 per cent of total energy intake. There is a conditional recommendation that suggests that a further reduction to below 5% or roughly 25 grams (6 teaspoons) per day would provide additional health benefits[127].
- According to WHO, the risk of developing NCDs is lowered by reducing saturated fats to less than 10% of total energy intake and *trans* fats to less than 1% of total energy intake[128, 129].

**Dietary Reference Intakes (DRIs)**

The Dietary Reference Intakes (DRIs) are a set of scientifically based nutrient reference values for healthy populations. **These are not considered population-level targets and should not**

**be included in ratings, but are provided here for information only.** They are established by panels of Canadian and American scientists through a review process overseen by the U.S. National Academies, which is an independent, nongovernmental body. Health Canada uses the DRIs in a variety of policies and programs that benefit the health and safety of Canadians. Canadian DRIs have been published for all age groups, and include specific recommendations for pregnant and lactating women. The DRIs for various groups of nutrients have been developed over a span of time, with reports on all of the nutrients published between 1997 and 2004 and updated values for calcium and Vitamin D published in 2010. DRIs have four types of reference values: **Estimated Average Requirement** (EAR), **Recommended Dietary Allowance** (RDA), **Adequate Intake** (AI) and **Tolerable Upper Intake Level** (UL). Acceptable Macronutrient Distribution Ranges (AMDR) are used for some macronutrients, defined as "a range of intakes for a particular energy source that is associated with reduced risk of chronic disease while providing adequate intake of essential nutrients"[130].

*Sodium*

The AI for sodium ranges from 1000 – 1500 mg/day for people over one year of age.

The UL for adults is 2300 mg/day of sodium[131].

*Total, trans and saturated fat*

For adults 19 to 50, the AMDR for total fat is between 20-35% of total energy intake, and ULs were not set for these nutrients. However, saturated and *trans* fatty acids and dietary cholesterol are recommended to be as low as possible while consuming a nutritionally adequate diet[131].

*Added Sugar/ Free Sugar*

A UL was not set, however, according to additional macronutrient recommendations, added sugars are suggested to be limited to no more than 25% of total energy[131]. There are no current recommendations for free sugars.

*Energy intake*

The DRIs include equations to estimate energy requirements for age and sex groups, which are communicated to the general public in Canada's Food Guide via the Estimated Energy Requirements, based on age, sex, and physical activity level[132]. No population intake targets have been set for reductions in energy intake.

**Historical Context**

In 2005, as part of the **Integrated Pan-Canadian Healthy Living Strategy,** provinces developed targets for increasing physical activity, and in some cases (such as BC, AB, NS, NB, and PEI), nutrition targets for healthy eating or intakes of fruits and vegetables to be met by 2010[133].

**Policy details**

In 2013, the Federal Government endorsed the **WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020 and Global Monitoring Framework**, therefore implicitly endorsing the 30% relative reduction in mean population sodium intake.

**Population intake reduction targets**

***Sodium***

The Sodium Working Group, led by Health Canada and others, recommended an interim average intake of sodium of 2,300 mg per day by 2016, and longer term goal to lower sodium intakes to a population mean whereby as many individuals as possible (greater than 95% of the population) have a daily intake that is below the Tolerable Upper Intake Level (UL) of

2,300 mg per day. The federal Minister of Health publicly adopted only the recommendation towards reducing the average sodium intake of Canadians to 2300 mg/day by 2016[14].

In the Guidance for Food Industry on Reducing Sodium in Processed Foods, one of the Roles of Government is to "Support reduction of Canadians' average sodium intake to 2300 mg per day by 2016"[15].

***Trans fat***

The Trans Fat Task Force issued recommendations for targets for *trans* fat in the food supply to align with the WHO recommendations for *trans* fats that suggest limiting intake to less than 1% of total energy intake[134]. This was accepted by the Minister of Health.

***Saturated fat***

There are no population-level targets for saturated fat intake.

***Added/free sugars***

There are no population-level targets for added or free sugar intake.

**Comments/ notes**

See **COMP1** to examine the composition targets for the food supply (not included in this indicator).

## LEAD3 Food-based dietary guidelines implemented

Food-EPI good practice statement

Clear, interpretive, evidence-informed food-based dietary guidelines have been established and implemented

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|---|---|
| **Definitions and scope** | - Food-based dietary guidelines should be for both genders and key age groups including infants and pregnant women<br>- Evidence-informed includes extensive review of up-to-date research and mechanisms to seek expert input |
| **International examples** | - **Brazil**: The national dietary guidelines of Brazil address healthy eating from a cultural, ethical and environmental perspective, rather than based on number of servings per food group. The main recommendations are: 'Make natural or minimally processed foods the basis of your diet'; 'use oils, fats, salt, and sugar in small amounts for seasoning and cooking foods'; 'use processed foods in small amounts'; 'avoid ultra-processed foods'. They also provide advice on planning, shopping and sharing meals, as well as warning people to be wary of food marketing and advertising[135, 136]. |
| **Context** | Currently, Health Canada communicates it's guidance on healthy eating through Canada's Food Guide as well as through life stage specific documents including the Prenatal Nutrition Guidelines, including the Gestational Weight Gain Guidelines, and Nutrition for Healthy Term Infants. Canada's Food Guide (CFG) represents Canada's official food-based dietary guidelines, and were last updated in 2007, titled *Eating Well with Canada's Food Guide*. |
| **Policy details** | **Eating Well with Canada's Food Guide**<br>- CFG contains recommendations for number of servings and type to consume from each of the four food groups (Vegetables and fruits, Grain products, Milk and alternatives, and Meat and alternatives) as well as a small amount of unsaturated fat each day. The food intake pattern in the 2007 Food Guide was developed in accordance with the DRIs and to reduce the risk of chronic disease. The pattern was developed using a two-step process. First, food composites were established to create a food intake patterns with satisfactory nutrient intakes for each of the 16 age and gender groups, which was then simulated using 500 diets for each of the age and gender groups. These were then assessed relative to the DRI values[137].<br>- CFG is available in 10 additional languages (Arabic, Chinese, Farsi, Korean, Punjabi, Russian, Spanish, Tagalog, Tamil and Urdu).<br>- CFG includes recommendations across the life course, with specific recommendations for children, women of child bearing age and men and who over 50 years old.<br>- CFG contains a recommendation to limit "foods and beverages high in calories, fat, sugar or salt (sodium) such as cakes and pastries, chocolate and candies, cookies and granola bars, doughnuts and muffins, ice cream and frozen desserts, french fries, potato chips, nachos and other salty snacks, alcohol, fruit flavoured drinks, soft drinks, sports and energy drinks, and sweetened hot or cold drinks"[138].<br>- To support use of CFG, Health Canada released several websites to support consumer knowledge and awareness of the CFG. The *Eat Well Plate* was introduced to help demonstrate food group proportions and encourages making half of the plate vegetables and fruit[139]. They also have interactive webpages on how to choose foods[140], including tips and ideas on how to use CFG for planning meals, shopping tips, fast and easy meal ideas, smart snacking, eating out and counting food guide servings in a meal[141]. Additional printable resources include the *My Food Guide Servings Tracker* for individuals to compare their diet to recommendations from CFG[142].<br>- From 2013 to 2015, Health Canada reviewed the evidence relevant to dietary guidance published since 2006. This was recently published in the document ***Evidence review for dietary guidance: summary of results and implications for Canada's Food Guide***[143]. This review identified that there are challenges in understanding and applying certain aspects of guidance; the current format isn't meeting the needs of all |

audiences; and the scientific basis for the CFG is largely consistent with the latest diet and health.

- The Food Guide has also been tailored for First Nations, Inuit and Métis populations, resulting in **Eating Well with Canada's Food Guide – First Nation, Inuit and Metis (CFG-FNIM)**, which is available in 4 Indigenous languages, along with English and French (Objibwe, Woods Cree, Plains Cree and Inuktitut).
- An outcome assessment of CFG-FNIM in 2013 showed that:
    - CFG-FNIM is popular and widely used to support healthy eating awareness and education,
    - CFG-FNIM heathy eating recommendations are integrated into a range of programs, initiatives and tools covering all age groups. (and across a variety of community organizations), and
    - CFG-FNIM dietary guidance is integral to practitioners' work on healthy eating and nutrition issues.

**HEALTHY EATING STRATEGY - REVISIONS TO CANADA'S FOOD GUIDE**

In October 2016, Health Canada has announced they will be revising Canada's Food Guide as part of Canada's *Healthy Eating Strategy*[144]. The first public consultation was open from October 24 to December 8.

The revision of Canada's Food Guide will be completed in phases. In Fall 2017, Health Canada will release an online dietary guidance policy report for health professionals and policy makers, along with supporting key messages and resources for Canadians. In fall 2018, new healthy eating patterns (recommended amounts and types of foods) and resources for Canadians will be released (Written communications, April 2017).

**Comments/ notes**

## LEAD4 Comprehensive implementation plan linked to state/national needs

Food-EPI good practice statement

There is a comprehensive, transparent, up-to-date implementation plan (including priority policy and program strategies) linked to state/national needs and priorities, to improve food environments, reduce the intake of the nutrients of concern to meet WHO and national recommended dietary intake levels, and reduce diet-related NCDs

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|---|---|
| **Definitions and scope** | - Includes documented plans with specific actions and interventions (i.e. policies, programs, partnerships)<br>- Plans should be current (i.e. maintain endorsement by the current government and/or are being reported against)<br>- Plans may be at the state/department/branch/unit/team level and ownership may or may not be shared across government<br>- Plans should refer to actions to improve food environments (as defined in the policy domains above) and should include both policy and program strategies<br>- Excludes overarching frameworks that provide general guidance and direction |
| **International examples** | - **EU:** The European Food and Nutrition Action Plan 2015-20 outlines clear strategic goals, guiding principles, objectives, priorities and tools. The Plan aligns with the WHO Global Action Plan and under 'Objective 1 – Create healthy food and drink environments' there are clear policy and program actions identified[145]. |

**Context**

The Mandate letter to the Minister of Agriculture and Agri-Food has a clause to *"Develop a food policy that promotes healthy living and safe food by putting more healthy, high-quality food, produced by Canadian ranchers and farmers, on the tables of families across the country"*[83].

The Mandate letter to the Minister of Health introducing new restrictions on the commercial marketing of unhealthy food and beverages to children; bringing in tougher regulations to eliminate trans fats and to reduce salt in processed foods; and improving food labels to give more information on added sugar[121].

**Policy details**

***Healthy Eating Strategy***

The Minister of Health announced a new *Healthy Eating Strategy* on October 24, 2016[146]. This includes revising Canada's Food Guide, restricting marketing of unhealthy foods to children, increasing health claims regarding fruits and vegetables, changes to the Nutrition Facts table and implementation of Front of Package labelling, continued voluntary sodium reduction in packaged foods with government oversight and evaluation of progress, and elimination of industrially produced *trans* fat from the food supply. The Strategy also includes supporting increased access to and availability of nutritious foods through the Nutrition North Canada program, and references the expansion to 37 additional isolated northern communities effective October 2016.

This announcement includes a broad timeline for some commitments, including revising Canada's Food Guide by the end of 2018; however, no detailed implementation plan for the proposed policies has been published.

***National Food Policy***

There is currently a national food policy being development by Agriculture Canada, chaired by Greg Meredith, the assistant deputy minister at Agriculture Canada. The committee is currently focusing on 4 key areas: food security, the environment, sustainable growth in the food and agriculture section, and health. *Additional details will be provided in the workshop.*

**Comments/ notes**

A communication from the PHAC stated:

> PHAC is involved in and contributes to these national strategies. As well, PHAC has many programs that integrate the nutrition policy of these other Federal departments. Our focus, however, is population health chronic disease prevention and health promotion, which acknowledges the importance of a range of common risk factors of which nutrition is one (written communication, April 2017).

## LEAD5 Priorities for reducing inequalities

Food-EPI good practice statement

Government priorities have been established to reduce inequalities or protect vulnerable populations in relation to diet, nutrition, obesity and NCDs

**Definitions and scope**

- Frameworks, strategies or implementation plans specify aims, objectives or targets to reduce inequalities including taking a preventive approach that addresses the social and environmental determinants of health
- Frameworks, strategies or implementation plans identify vulnerable populations or priority groups
- Implementation plans specify policies or programs that aim to reduce inequalities for specific population groups
- Excludes priorities to reduce inequalities in secondary or tertiary prevention

**International examples**

- **New Zealand**: The Ministry of Health reports the estimates derived from health surveys and nutrition surveys by four subpopulation groups including age group, gender, ethnic group and an area level deprivation index. Similarly, estimates derived from other data types (e.g. mortality) are presented by these subpopulation groups. The contracts between MoH and NGOs or other institutions include a section on Maori Health and state: "An overarching aim of the health and disability sector is the improvement of Maori health outcomes and the reduction of Maori health inequalities. You must comply with any: a) Maori specific service requirements, b) Maori specific quality requirements and c) Maori specific monitoring requirements". In addition, the provider quality specifications for public health services include specific requirements for Maori:" C1 Services meet needs of Maori, C2 Maori participation at all levels of strategic and service planning, development and implementation within organisation at governance, management and service delivery levels, C3: support for Maori accessing services". In the specific contract between the Ministry of Health and Agencies for Nutrition Action the first clause is on Maori Health: "you must comply with any Maori specific service requirements, Maori specific quality requirements and Maori specific monitoring requirements contained in the Service specifications to this agreement".
- **Australia**: The National Indigenous Reform Agreement (Closing the Gap) is an agreement between the Commonwealth of Australia and the States and Territories. The objective of this agreement is to work together with Indigenous Australians to Close the Gap in Indigenous disadvantage. The targets agreed to by COAG relate to health or social determinants of health. For the target 'Closing the life expectancy gap within a generation (by 2031)', one of the performance indicators is the prevalence of overweight and obesity.

**Context**

In Canada, there are considerable health inequities between Indigenous and non-Indigenous populations, as well as inequities across levels of socio-economic status.

Health Canada has the First Nations and Inuit Health Branch (FNIHB) that works to:

- Ensure the availability and access to health services for First Nations and Inuit communities
- Assist First Nations and Inuit communities to address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations
- Build strong partnerships with First Nations and Inuit to improve the health system.

**Policy details**

The **Healthy Eating Strategy** includes support for the Nutrition North Canada program to reduce inequities among individuals living in isolated northern communities (see PRICES3 and RETAIL3) and a pillar on Protecting Vulnerable Populations (broad goal) and includes under it an initiative to restrict marketing of unhealthy foods and beverages to children.

**Canada's Northern Strategy: Our North, Our Heritage, Our Future**[147]

Canada's Northern Strategy was launched in 2009 to describe the Government of Canada's vision for the north, and included several directives relating to health, and which mentions the provision of healthy, nutritious foods to those living in Northern regions. The Northern Strategy includes the Nutrition North Canada (NNC) program and the NNC Nutrition Education Initiatives[148].

In the 2016-2017 main estimates, Health Canada included budget items for a number of targeted initiatives titled First Nations and Inuit Health Programs, including:

*Chronic Disease Prevention and Management - Aboriginal Diabetes Initiative (ADI)*

The overall goal of the Aboriginal Diabetes Initiative (ADI) is to improve the health status of First Nations and Inuit individuals, families and communities through actions aimed at reducing prevalence and incidence of diabetes and its risk factors. ADI includes a focus on Healthy Eating, which includes a range of nutrition activities to develop skills and increase knowledge about healthy eating[149]. Also, ADI supports community-led food security planning to support First Nations and Inuit communities in defining ways to address their food security needs, and to improve access to healthy food, including store-bought and country / traditional food.

Other programs such as **CPNP** (see Prices4 for additional information) and **Aboriginal Head Start on Reserve** (AHSOR) also fund and support community-based and culturally-relevant activities that aim to improve health outcomes for First Nations and Inuit infants, children, families (including pregnant women) and communities by providing increased access to a continuum of supports which include nutrition.

**Public Health Agency of Canada**

PHAC has a mandate to reduce health inequalities in Canada. The Social Determinants and Science Integration directorate is the Agency lead on developing and implementing Agency plans to advance health equality. This is not specific to nutrition, but to health more generally.

**Comments/ notes**

# Policy area: Governance

## Food-EPI vision statement: Governments have structures in place to ensure transparency and accountability, and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities

### GOVER1 Restricting commercial influence on policy development

Food-EPI good practice statement

There are robust procedures to restrict commercial influences on the development of policies related to food environments where they have conflicts of interest with improving population nutrition

| | |
|---|---|
| **Definitions and scope** | - Includes government policies, guidelines, codes of conduct or other mechanisms to guide actions and decision-making by government employees, for example conflict of interest declaration procedures<br>- Includes procedures to manage partnerships with private companies or peak bodies representing industries that are consulted for the purpose of developing policy, for example committee procedural guidelines or terms of reference<br>- Includes publicly available, up-to-date registers of lobbyist and/or their activities |
| **International examples** | - **USA**: Mandatory and publicly accessible lobby registers exist at the federal level, as well as in nearly every state. Financial information must be disclosed, and the register is enforced through significant sanctions. A number of pieces of legislation uphold compliance with the register including Lobbying Disclosure Act of 1995 and the Honest Leadership and Open Government Act 2007.<br>- **New Zealand**: The State Services Commission has published Best Practice Guidelines for Departments Responsible for Regulatory Processes with Significant Commercial Implications. They cover the development and operation of a regulatory process and include specific references to principles around stakeholder relationship management[150].<br>- **Australia**: The Australian Public Service Commission's Values and Code of Conduct includes a number of relevant sections such as the Conflict of Interest, Working with the Private Sector and other Stakeholders and the Lobbying Code of Conduct. |
| **Context** | Control of Corruption is one of six Worldwide Governance Indicators collected by the World Bank. It is a composite index drawing on a range of global data sources and reflects perceptions of the extent to which public power is exercised for private gain. This includes both petty and grand forms of corruption, as well as "capture" of the state by elites and private interests.[151] For 2015, Canada scored 1.85 (point estimates range from about -2.5 to 2.5. Higher values correspond to better governance outcomes) and was ranked in the 94$^{th}$ percentile worldwide.[151] |
| **Policy details** | Health Canada is implementing a **new openness and transparency policy related to the Healthy Eating Strategy**, including a new approach to disclosing stakeholder meetings[152] (beyond the *Lobbying Act* – see below). All other correspondence and all meetings with stakeholders will be published monthly online in list format including the organization name, date, subjects and purpose of the meeting. This includes correspondence and meetings in which opinions and information (including requests for information) are relayed with the intent to inform the development of policies, guidance or regulations related to healthy eating initiatives. The title of any documents provided during meetings will also be published[153]. This has been implemented since October, 2016. |

Note also that Health Canada's ONPP staff are not meeting with food industry stakeholders on the recommendations in Canada's Food Guide, to maintain credibility of the recommendations among Canadians.

**Lobbying Act**

The ***Lobbying Act*** requires all lobbyists to file a return including information regarding the name and business of both the lobbyist and the client, name of businesses or corporations, or the name and business address of each corporation or organization that is a member of a coalition represented by the lobbyist, and the subject matter. Returns must be filed within 10 days of communication with the government official.

"Lobbyists" are described as *any individual that, for payment, on behalf of any person or organization, undertakes to communicate with a public office holder in respect of (a) developing legislative proposals, introductions of Bills or resolutions, amending regulations, policies or programs, awarding grants or contracts, or (b) arrange a meeting between a public office holder and any other person.* There is a 5-year prohibition from lobbying for former designated public office holders, which is strictly enforced.

Information on lobbying will be retained in the **Registry of Lobbyists,** which is publicly available (www.lobbycanada.gc.ca). This registry includes information on food companies or lobbyists working on behalf of food companies or public interest groups and documentation of meetings under the *Lobbying Act*, including what ministries or departments are lobbied, frequency of meetings, and specific content of acts that are being lobbied.

**Declaration of political donations**

Unions and corporations are no longer permitted to make political contributions to registered political parties and leadership contestants. They can make modest contributions (up to $1,000) in any calendar year to constituency associations, candidates and nomination contestants of a particular registered political party, collectively[154].

**Framework for assessing public-private partnerships with the food and beverage industry**

The Framework was developed by a Task Team under the Federal-Provincial-Territorial Healthy People and Communities Steering Committee (under the Pan Canadian Public Health Network). The Framework consists of the following two documents:

- Public Health and Food Industry Engagement: A Tool to Assess Partnership Opportunities and Challenges[155]
- Discussion Document: Public Private Partnerships with the Food Industry[156]

The document is used by some officials at Health Canada to inform decisions on whether or not to engage with industry.

**Health Canada Policy on External Advisory Bodies (2011)**

This policy outlines how external members to an advisory board are selected. Relevant advisory committees include the **Food Expert Advisory Committee** (See PLATF2 for additional detail).

- Members on Advisory Boards are required to complete and sign an *Affiliations and Interests Declaration Form.* A potential member must use the form to disclose all affiliations and interests, and direct financial interests. These might include financial support received from a commercial enterprise, participation in an activity sponsored by a commercial enterprise, or published or publicly stated points of view related to the advisory body's mandate.
- Affiliations and interests do not necessarily preclude membership of an advisory body, but these interests must be declared. This policy recognizes that, sometimes, people with affiliations and interests related to the mandate of the advisory body have valuable knowledge, expertise, or experience and may have a worthwhile

contribution to make to the advisory body's work. Affiliations and interest documents or summaries are not publicly released.
- Individuals with a direct financial interest may not participate in any advisory body or formulation of advice related to that interest. A person has a direct financial interest when the person, the person's spouse or common law partner, or the person's dependent family member has a direct financial interest in the outcome of the advisory body's work, for example through current employment, investments in companies, partnerships, equity royalties, joint ventures, trusts, real property, stocks, shares, or bonds.

**This does not apply to F/P/T task groups which are not considered advisory boards.**

**Conflict of Interest Act[157] for public officials**

The ***Conflict of Interest Act*** establishes rules for conflict of interest while in public office and immediately post-employment. All public office holders must disclose assets, sources of income, activities before the appointment, including philanthropic, charitable and non-commercial activities, etc. According to the Act:

- For the purposes of this Act, a public office holder is in a conflict of interest when he or she exercises an official power, duty or function that provides an opportunity to further his or her private interests or those of his or her relatives or friends or to improperly further another person's private interests.
- Every public office holder shall arrange his or her private affairs in a manner that will prevent the public office holder from being in a conflict of interest.

This includes decision-making, abstention from voting, preferential treatment, insider information, influence, offers of outside employment, or gifts or other advantages. This would include conflict of interest with the food industry.

**Policy on Conflict of Interest and Post-Employment[158]** and **Values and Ethics Code for the Public Sector[159] for public servants**

These policies help public servants deal with "real, potential and apparent conflict of interest in situations during and after employment to maintain public trust and confidence in the impartiality and integrity of the public service." Public servants are required to prevent and avoid situations that "could give the appearance of a conflict of interest, results in a potential for a conflict of interest, or result in an actual conflict of interest"[160]. According to the **Policy on Conflict of Interest and Post-Employment**, public servants must take all possible steps to recognize, prevent, report and resolve any real, apparent or potential conflicts of interest, and must report to the deputy head all outside activities, assets, liabilities and interests that might give rise to conflict of interest in relation to official duties. Public servants who are designated by the deputy heads as being at risk post-employment are subject to a one-year limitation period after leaving office and must report offers of employment to the deputy head.

According to the ***Values and Ethics Code for Public Sector Servants***, federal public servants are expected to conduct themselves in accordance with the values of the public sector, including: respect for democracy, respect for people, integrity, stewardship and excellence. All public servants much accept these values and adherence to the expected behaviors as a condition of employment.

**Comments/ notes**

## GOVER2 Use of evidence in food policies

Food-EPI good practice statement

Policies and procedures are implemented for using evidence in the development of food policies

| | |
|---|---|
| **Definitions and scope** | - Includes policies, procedures or guidelines to support government employees in the use of evidence for policy development including best practice evidence review methodology (including types and strength of evidence needed) and policy implementation in the absence of strong evidence (where the potential risks or harms of inaction are great)<br>- Includes policies, procedures or guidelines that stipulate the requirements for the establishment of a scientific or expert committee to inform policy development<br>- Includes the use of evidence-based models, algorithms and tools to guide policy development or within policy to guide implementation (e.g. nutrient profiling model)<br>- Includes government resourcing of evidence and research by specific units, either within or across government departments |
| **International examples** | - **Australia**: The National Health and Medical Research Council Act 1992 (NHMRC Act) requires NHMRC to develop evidence-based guidelines. These national guidelines are developed by teams of specialists following a rigorous nine-step development process[161]. |
| **Context** | In 2013, Health Canada published a document titled ***Measuring the Food Environment in Canada***[162] to describe the current Canadian evidence on geographical access to nutritious food in Canada and to describe how the built food environment is being assessed in Canada, among other objectives. |
| **Policy details** | Health Canada's **Food Directorate** and **Office of Nutrition Policy and Promotion** are primarily responsible for developing and implementing food policies. Health Canada's policy development process is based on many considerations such as scientific decisions (including the use of risk assessments); however, this is typically related to health risks associated with products regulated by Health Canada, contaminants and exposure risks, and less related to obesity and population health[163]. Health Canada also conducts laboratory research, surveillance and monitoring as part of their work.<br><br>**Public consultations** for activities such as the Healthy Eating Strategy provide an opportunity for experts to provide evidence to inform policy decisions. This has been demonstrated for recent regulations relating to the changes to the Nutrition Facts table, revisions to Canada's Food Guide, FOP labelling and restrictions on partially hydrogenated vegetable oils.<br><br>Health Canada, in collaboration with Statistics Canada fund and oversee **national nutrition surveys** approximately every 10 years (Canadian Community Health Survey (CCHS) Nutrition 2004, and CCHS Nutrition 2015) and the national Canadian Health Measures Survey (CHMS) as well as a national Canadian Nutrient File (CNF), a database of the generic nutritional composition of Canadian foods, which is periodically updated. These surveys provide evidence regarding the dietary habits and nutritional status of the Canadian population to inform policy efforts.<br><br>The **Evidence Review Cycle for Dietary Guidance** (ERC) is Health Canada's formalized process for reviewing evidence underpinning dietary guidance. This process helps to ensure that guidance from Health Canada remains scientifically sound, current, relevant, and useful. It also helps to ensure that future decisions related to guidance are based on a systematic and documented approach. |

The **Public Health Agency of Canada's** Health Promotion and Chronic Disease Prevention Branch (HPCDP) has a governance structure in place to prioritize, plan and implement science activities that align with our policy and program priorities, as well as a structure to ensure the generation and application of sound research for the development and improvement of policies and programs. This governance structure was established with the HPCDP Branch Science Plan (2013-16), from which the HPCDP Branch Research Agenda (2015-18) was developed to identify the Branch's priority areas of focus. Key thematic research activities identified in the Branch Research Agenda (2015-18) related to food include: healthy living interventions, healthy behaviours, obesity, diabetes, mental health, built environment, and early child development, in particular with a lens on equity among vulnerable populations. Currently, there are 2 ongoing food-related research projects in the HPCDP Branch: (1) Epidemiology of neural tube defects after folic acid food fortification in Canada; and (2) Toronto Public Health FoodReach Initiative, for which the HPCDP provided research funding to study the impact of this initiative designed to address food insecurity. The Branch Science Plan is currently being updated for 2017-22, and the Branch Research Agenda will be updated for 2019-24 following a series of workshops designed to inform our future research priorities.

**Comments/ notes**

The Government of Canada recently launched a search for a Chief Science Advisor who will be responsible for providing scientific advice to the Prime Minister, Minister of Science and members of cabinet[164].

## GOVER3 Transparency for the public in the development of food policies

Food-EPI good practice statement

Policies and procedures are implemented for ensuring transparency in the development of food policies

| | |
|---|---|
| **Definitions and scope** | - Includes policies or procedures to guide the online publishing of private sector and civil society submissions to government around the development of policy and subsequent government response to these<br>- Includes policies or procedures that guide the use of consultation in the development of food policy<br>- Includes policies or procedures to guide the online publishing of scoping papers, draft and final policies<br>- Include policies or procedures to guide public communications around all policies put forward but not progressed |
| **International examples** | - **Australia / New Zealand**: Food Standards Australia New Zealand (FSANZ) is required by the Food Standards Australia New Zealand Act 1991 to engage stakeholders in the development of new standards. This process is open to everyone in the community including consumers, public health professionals, and industry and government representatives. FSANZ has developed a Stakeholder Engagement Strategy 2013-16 that outlines the scope and processes for engagement. Under the Stakeholder Engagement Priorities 2013-16, it outlined "maintain our open and transparent approach" as one of the first priorities[165]. |

**Context**

**Canada's third Biennial Plan to the Open Government Partnership (2016-2018)**

The Office of the Prime Minister's Speech from the Throne in December 2015 called on ministers to cultivate an open and transparent government[121]. Open Government is considered a priority for the current government. This includes the creation of a Chief Science Officer by the Minister of Science to ensure that government science is fully available to the public[166]. This has yet to be implemented.

The expectation for Open Government was documented in the Mandate Letters presented to the governmental ministries in 2015[167]. A manual, titled *Open and Accountable Government*, has been collated to provide Ministers with an overview of their roles and responsibilities relating to Open Government[168].

In 2015, Canada ranked 4th out of 92 on the Open Data Barometer which measures 1) readiness to implement open data initiatives, 2) Implementation of open data programs, and 3) Impact that open data is having on business, politics and civil society. The Barometer was created by the World Wide Web Foundation[169].

**Policy details**

The Government of Canada has a website, www.open.canada.ca, which includes information on how to become involved in the policy making process. This includes a list of all open consultations and What We Heart reports[170].

**Guidelines on Public Engagement and Consultation by Health Canada (including food policies)**

Health Canada and the Public Health Agency of Canada (PHAC) have created some specific guidelines for public engagement[171].

**Example: Canada's *Healthy Eating Strategy***

In a recent commitment to openness and transparency, Health Canada announced a new approach to communication with stakeholders in the new *Healthy Eating Strategy*. The

statement suggested that during the development of the new Food Guide, Health Canada would only seek expert advice from and consult with academics, health professional associations, federal, provincial and territorial officials and non-governmental organizations interested in health. This is followed with open formal consultations, including data calls, workshops, online questionnaires, pre-regulatory consultations and *Canada Gazette Part I* consultations[47].

In this process, formal written submissions will be summarized in reports that will be made publicly available. Individual submissions will only be released upon request under the Access to Information Act. According to the *Health Eating Strategy* website, "*All other correspondence and all meetings with stakeholders will be published monthly online in list format including the organization name, date, subjects and purpose of the meeting. This includes correspondence and meetings in which opinions and information (including requests for information) are relayed with the intent to inform the development of policies, guidance or regulations related to healthy eating initiatives. The title of any documents provided during meetings will also be published*"[47]. This excludes consultation with experts in the field (with no industry affiliations).

Recent consultations for changes and proposals to food labelling on the Nutrition Facts table, front of package labelling, changes to Canada's Food Guide and the prohibition of partially hydrogenated oils from the food supply included structured questionnaires for consumers and for experts. Health Canada also held a meeting with a group of Food Supply Chain representatives in order to discuss the proposed front-of-pack nutrition labelling approach.

This level of public engagement is supported by the 2016-2021 Strategic Plan for the Health Products and Food Branch.

Health Canada and PHAC have recently created the Consultation and Stakeholder Information Management System, whereby interested stakeholders can register to receive direct communications regarding Health Canada and PHAC consultations and other health-related information.

**Development of FPT Trask Groups**

FPT work is triggered in a number of ways, and that the approach varies (written communication, April 2017).

**Comments/ notes**

## GOVER4 Access to government information

Food-EPI good practice statement

The government ensures public access to comprehensive information and key documents (e.g. budget documents, annual performance reviews and health indicators) related to public health nutrition and food environments

| | |
|---|---|
| **Definitions and scope** | - Includes policies and procedures to guide the timely, online publishing of government budgets, performance reviews, audits, evaluation reports or the findings of other reviews or inquiries<br>- Includes 'freedom of information' legislation and related processes to enable the public access to government information on request, with minimal restrictions and exemptions<br>- Includes policies or procedures to guide the timely, online publishing of population health data captured / owned by government |
| **International examples** | - **Australia / New Zealand**: The Freedom of Information Act provides a legally enforceable right of the public to access documents of government departments and most agencies. |

**Context**

**Policy details**

**Open Government Plan**

In the ***Open Government Plan*** for 2016 to 2018, the Government of Canada has committed to improving the ***Access to Information Act***, and will undertake a full review of the Act by 2018. Near-term commitments include making more data and information easily accessible online, providing written explanations when information cannot be released, among other commitments. The full list is available here:

http://open.canada.ca/en/consultations/canadas-new-plan-open-government-2016-2018

The draft ***Open Government Plan*** for 2016-2018 also makes a commitment to increase the science performed in support of Government of Canada programs and decision making open and transparent to Canadians. The plan also suggests that starting with Budget 2017, data from Budget charts and tables will be available in near real time.

**Access to Information Act**

The ***Access to Information Act*** gives Canadian citizens and corporations the right to access information contained in federal government records, subject to certain specific and limited exceptions.[172]

The Access to Information and Privacy Operations Division is within the Planning, Integration and Management Services Directorate of Corporate Services Branch at Health Canada. A recent ***Interim Directive on the Administration of the Access to Information Act*** has waived the information fees apart from the $5 filing fee, and mandates the release of information in user-friendly formats (e.g., spreadsheets) when feasible. Lists of all previous access to information requests where data have been released are published online and other interested parties can file a request for a copy. [http://open.canada.ca/en/access-to-information]

During the 2015-2016 fiscal year, Health Canada completed the processing of 1,026 of 2,073 active requests. There were 887 exemptions invoked by Health Canada, mostly as result of three sections of the Act: section 19 (personal information), section 20 (third party information), and section 21 (operations of government)[173].

**Publication of data from Statistics Canada**

Release of data is governed by Statistics Canada and Health Canada. Additional details to be provided in the Food-EPI workshops.

**Comments/ notes**

# Policy area: Monitoring & Intelligence

Food-EPI vision statement: The government's monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans

## MONIT1 Monitoring food environments

Food-EPI good practice statement

Monitoring systems, implemented by the government, are in place to regularly monitor food environments (especially for food composition for nutrients of concern, food promotion to children, and nutritional quality of food in schools and other public sector settings), against codes / guidelines / standards / targets

| | |
|---|---|
| **Definitions and scope** | - Includes monitoring systems funded fully or in part by government that are managed by an academic institution or other organisation<br>- Includes regular monitoring and review of the impact of policies implemented by the government on food environments (as relevant to the individual State / Territory, and described in the policy domains above), in particular:<br>- Monitoring of compliance with voluntary food composition standards related to nutrients of concern in out-of-home meals (as defined in the 'Food composition' domain)<br>- Monitoring of compliance with food labelling regulations (as defined in the 'Food labelling' domain above)<br>- Monitoring of unhealthy food promoted to children via broadcast and non-broadcast media and in children's settings (as defined in the 'Food promotion' domain above)<br>- Monitoring of compliance with food provision policies in schools, early childhood services and public sector settings (as defined in the 'Food provision' domain above) |
| **International examples** | - **Many countries** have food composition databases available. For example, the New Zealand Institute for Plant & Food Research Limited and the Ministry of Health jointly own the New Zealand Food Composition Database (NZFCD) which is a comprehensive collection of nutrient data in New Zealand containing nutrient information on more than 2600 foods.<br>- **New Zealand**: A national School and Early Childhood Education Services (ECES) Food and Nutrition Environment Survey was organised in all Schools and ECES across New Zealand in 2007 and 2009 by the Ministry of Health to measure the food environments in schools and ECEs in New Zealand.<br>- **UK**: In October 2005, the School Food Trust ('the Trust'; now called the Children's Food Trust) was established to provide independent support and advice to schools, caterers, manufacturers and others on improving the standard of school meals. They perform annual surveys, including the latest information on how many children are having school meals in England, how much they cost and how they're being provided[174]. |
| **Context** | |

**Policy details**

**Canadian Nutrient File**

Health Canada periodically updates and releases the Canadian Nutrient File (CNF), a food composition database maintained by Health Canada. The database reports on up to 152 nutrients in nearly 6,000 generic Canada foods and was last updated in 2015. The database is not branded, and provides information for generic foods in each food type/category. The CNF is not currently used to monitor the nutritional quality or nutrient content of foods in Canada.

**Trans Fat Monitoring Program[175]**

The Trans Fat Monitoring Program was created to assess the industry's progress in meeting the 2% and 5% tans fat targets. Sampling occurred approximately twice per year starting in 2005 (Released in December 2007, July 2008, February 2009, December 2009). The data tables provided by Health Canada included information for total fat, saturated fat, and *trans* fat. The fourth (and final) set of monitoring data was posted in 2009. Samples for the fourth set of monitoring were collected in and around Winnipeg and Toronto from small and medium-sized family and major quick service restaurant chains. Samples were also collected from cafeterias in hospitals, college and university campuses, high schools, train stations and nursing homes from across Canada. Unlabelled foods were analyzed, while a label review was conducted for packaged foods, with a sub-sample analyzed. (See COMP1)

**Monitoring foods marketed to children**

There are no federal programs monitoring the nutritional quality of foods promoted to children.

**Monitoring sodium content in food supply**

The CNF is not used to monitor sodium content in the food supply. The CNF is not branded, and cannot be used to assess company compliance of sodium targets. There are currently government plans to monitor sodium in the food supply, but no data has been released. Health Canada conducted a pilot study early in 2016 as a "snapshot" indicator of industry's progress towards the sodium reduction targets established by Health Canada in 2012. While targets have been set for 94 food categories to be achieved by December 31, 2016, the pilot study looked at samples from 15 food categories. The interim assessment of industry's progress toward meeting the 2016 voluntary sodium targets was published online[16].

**Monitoring of the nutritional quality of foods in schools and public sector settings**

There is currently no federal monitoring of the nutritional quality of foods in schools and public sector settings, although most monitoring in this areas falls under the jurisdiction of the provincial/territorial governments.

**Joint Consortium for School Health Healthy School Planner[176]**

The Joint Consortium for School Health is a partnership of 25 ministries of health and education from across Canada that promote Comprehensive School Health. They have implemented the Healthy Eating module of the Healthy School Planner as a free tool to monitor school food environments, which collects data of school food environments nationally with regards to the availability of healthy schools in schools. Schools who complete the HSP have the option of providing permission to aggregate data for analysis.

**Comments/ notes**

There are plans underway to conduct sodium content monitoring by Health Canada using Nielsen Marketing data, and Health Canada will be developing a monitoring framework for Marketing to Children (written communication, April 2017).

The ***Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice*** Journal is planning to publish a specialized issue in 2017 that will focus on the food environment in Canada. This journal will support health by publishing articles on research relating to all aspects of food environment, including articles that focus on food composition, labelling, promotion and marketing, provision and procurement, retail, prices, and trade and investment, with emphasis on articles that:

- Characterize the current Canadian food environment
- Examine the impact of food environment policies and interventions in the Canadian context
- Synthesize evidence regarding the state of the food environment in Canada

HPCDP journal is monthly, online open access and does not charge article processing fee.

## MONIT2 Monitoring nutrition status and intakes

Food-EPI good practice statement

There is regular monitoring of adult and childhood nutrition status and population intakes against specified intake targets or recommended daily intake levels

**Definitions and scope**

- Includes monitoring of adult and child intake in line with Canada's Food Guide and Canadian dietary recommendations
- Includes monitoring of adult and child intake of nutrients of concern and non-core/discretionary foods including sugar-sweetened beverages (even if there are no clear intake targets for all of these)
- 'Regular' is considered to be every five years or more frequently

**International examples**

- **USA**: The National Health and Nutrition Examination Survey (NHANES) is a program of studies designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations[177]. The NHANES program began in the early 1960s and has been conducted as a series of surveys focusing on different population groups or health topics. In 1999, the survey became a continuous program that has a changing focus on a variety of health and nutrition measurements to meet emerging needs. The survey examines a nationally representative sample of about 5,000 persons each year. These persons are located in counties across the country, 15 of which are visited each year.

**Context**

**Statistics Canada** is Canada's national statistical agency. Statistics Canada collects Canada's newly re-instated Long Form Census and is primarily responsible for implementing Canada's nationally representative surveys regarding health, in association with Health Canada and the Public Health Agency of Canada.

**Canadian Community Health Survey (CCHS)**

CCHS is the nationally representative health survey most frequently conducted in Canada. The survey includes the general Canadian population over the age of 2, and does not include persons living on reserves and other Aboriginal settlements in the provinces, full time members of the Canadian Forces, institutionalized populations and persons living in the Quebec health regions of Region du Nunavik and Region des Terres-Cries-de-la-Baie-James (a total of 3% of the Canadian population).The main survey is conducted annually (annual component).

**Canadian Health Measures Survey (CHMS)**

CHMS is a biospecimen survey conducted biannually, starting in 2007. Sampling is conducted according to 11 age-gender groups, and 500-600 units per group (57000 total) to produce national estimates [178].

**Policy details**

**ONGOING SURVEYS OF DIET & POPULATION INTAKES**

***CCHS***

The **Annual Component of the CCHS** includes one 6-question food frequency screener regarding dietary intake of fruits and vegetables. This survey has a sample size of approximately 65,000 persons each year, to provide a sample of 130,000 respondents on a two year basis (120,000 ages 18 and over, and 10,000 ages 12 to 17 years).

The **Nutrition Focus component of CCHS** collects one 24-hour recall from the entire sample, and two recalls among a subset of participants. The Nutrition focus was conducted in 2004, and again in 2015[179]. Sampling in 2015 included 24,000 respondents nationally, according to 12 age-sex groups corresponding with Dietary Reference Intake (DRI) groups ages 1 year and older. Those ages 1 to 5 are collected by proxy, 6 to 11 are collected with parent assistance, and

12 and up are self-reported without assistance (non-proxy). There is currently no statement describing the time interval between the next CCHS Nutrition Focus. Also excluded from the nutrition focus surveys are the 3 Territories, though they are captured in the CCHS annual component.

Statistics Canada has adapted the Healthy Eating Index to a Canadian context (Healthy Eating Index – Canada) using CCHS 2004 data aligned with Canada's Food Guide. This has been adapted to examine the overall quality of the Canadian diet[180].

***CHMS***

Dietary information is also collected for specific aspects of diet in CHMS. The short food frequency questionnaire measures are not meant to examine total diet, but do contain measures on several aspects of diet linked to health, including meat consumption, dairy consumption, grain and fruit and vegetable consumption, drink consumption, fat consumption, and added salt behaviours[178].

**First Nations Food, Nutrition and Environment Study (FNFNES)**

The First Nations Food, Nutrition and Environment Study is exploring important aspects of health that are explored by other surveys including the CCHS nutrition focus surveys and the Total Diet Studies. The FNFNES is a ten-year study (2008-2018) providing information about food consumption (using a 24-hour food recall) and nutrient intake, consumption of country foods, household food security, and environmental contaminants exposure through water and traditional foods. Data is representative for adults living in First Nations communities throughout each province or Atlantic region[181]. The study is funded by Health Canada (FNIHB) through grants and contributions.

**PREVIOUSLY CONDUCTED SURVEYS**

**First Nations and Inuit Regional Longitudinal Health Survey**

The First Nations and Inuit Regional Longitudinal Health Survey (FNIRLHS) (2002-03, 2008-10, 2015) contains an FFQ and the 6-item subset of the USDA Household Food Security Survey Module, along with other nutrition-related questions. Sampling includes children/adolescents and adults[182]. Funding for this survey is provided by the First Nations Inuit Health Branch (FNIHB) of Health Canada.

**Inuit Health Survey[183]**

The Inuit Health Survey (IHS) was conducted in the 3 Inuit regions of: Inuvialuit Settlement Region, Nunavut, and Nunatsiavut (Labrador) in 2007-08. Sampling was undertaken in Nunavik (northern Quebec) in 2004. The adult survey was conducted among 1901 randomly selected households (68%), and included 2595 adults 18 years of age or older. The child survey was conducted in 16 communities in Nunavut among 388 children aged 3 to 5 years of age. The IHS included a 24-hour recall, to provide food and nutrient intake of adults and preschoolers, food insecurity prevalence using the 18-item module and a battery of health parameters (many of those explored through the CHMS); the survey has not been repeated. Government of Canada, INAC, and Health Canada were all part of the steering committee for the IHS.

**Maternal-Infant Research on Environmental Chemicals (MIREC)[184]**

The Maternal-Infant Research on Environmental Chemicals (MIREC) Study was established to obtain national biomonitoring data on pregnant women and their infants and to examine potential adverse health effects of prenatal exposure to environmental chemicals on pregnancy and infant health. Subsequently, studies of some of the MIREC children at birth, at 6 months, and at 2-5 years of age were carried out. MIREC also includes a data and biospecimens biobank, for future research. MIREC includes biospecimens for breast milk, urine and cord blood, and includes self-reported measures of meat intake, fish intake, and a

food frequency questionnaire which includes milk, water, juice, tea, coffee, alcohol, calcium and iron sources, species of fish, and nutrient supplements. This data has been used to evaluate mandatory trans-fat labeling regulations and product reformulations using breast milk samples[185]. MIREC is funded by Health Canada, Canadian Institutes of Health Research and the Ontario Ministry of the Environment.

**Comments/ notes**

Data from the 2015 Nutrition Component of CCHS are planned to be released by Statistics Canada in June 2017.

## MONIT3 Monitoring Body Mass Index (BMI)

Food-EPI good practice statement

There is regular monitoring of adult and childhood overweight and obesity prevalence using anthropometric measurements

| | |
|---|---|
| **Definitions and scope** | - Anthropometric measurements include height, weight and waist circumference<br>- 'Regular' is considered to be every five years or more frequently |
| **International examples** | - **UK**: England's National Child Measurement Programme was established in 2006 and aims to measure all children in England in the first (4-5 years) and last years (10-11 years) of primary school. In 2011-2012, 565,662 children at reception and 491,118 children 10-11 years were measured[186]. |
| **Context** | See MONIT2 Policy details and context for information on sample sizes for the surveys described below. |
| **Policy details** | **ONGOING SURVEYS**<br>The **annual component of CCHS** collects self-reported height and weight, while the **Nutrition Focus** in 2004 and 2015 collected measured height and weight for most participants.<br><br>**CHMS** collects self-reported height and weight, and physical measures of standing height, sitting height, weight, waist circumference, hip circumference.<br><br>The **FNFNES** measures overweight and obesity (measured when possible, or if self-reported a bias factor is applied to the analysis).<br><br>**PREVIOUSLY CONDUCTED SURVEYS**<br>The **FNIRLHS** includes measures for self-reported height/weight.<br><br>The **IHS** included measured height and weight. |
| **Comments/ notes** | |

## MONIT4 Monitoring NCD risk factors and prevalence

Food-EPI good practice statement

There is regular monitoring of the prevalence of NCD risk factors and occurrence rates (e.g. prevalence, incidence, mortality) for the main diet-related NCDs

| | |
|---|---|
| **Definitions and scope** | - Other NCD risk factors (not already covered by 'MONIT1', 'MONIT2' and 'MONIT3') include level of physical activity, smoking, alcohol consumption.<br>- Diet-related NCDs include, amongst others, hypertension, hypercholesterolaemia, Type 2 Diabetes, cardiovascular disease (including ischaemic heart disease, cerebrovascular disease and other diseases of the vessels), diet-related cancers<br>- 'Regular' is considered to be every five years or more frequently<br>- May be collected through a variety of mechanisms such as population surveys or a notifiable diseases surveillance system |
| **International examples** | - **OECD countries:** Most OECD countries have regular and robust prevalence, incidence and mortality data for the main diet-related NCDs and NCD risk factors |

**Context**

**Policy details**

**ONGOING SURVEYS**

**CCHS** collects information on self-reported physical activity, smoking and alcohol consumption. Smoking measures assess present smoking habits, smoking in the past 30 days, and lifetime smoking as well as smoking cessation attempts and use of smoking cessation products. Alcohol use measures assess lifetime alcohol use, use in the past week, and frequency of consumption in the past 12 months. Physical activity is assessed using self-report measures of types of physical activity in the last 7 days for at least 10 continuous minutes among adults ages 18 years and older. A separate set of measures are used to assess physical activity among youth. The questionnaire also collects information regarding sedentary time in a set of self-report measures.

CCHS uses self-report to record prevalence of several diet-related NCDs including high blood pressure, high blood cholesterol, heart disease, stroke, diabetes or cancer (non-specific). Participants are asked "*Now I'd like to ask about certain long-term health conditions which you may have. We are interested in "long-term conditions" which are expected to last or have already lasted 6 months or more and that have been diagnosed by a health professional. Have you had/Do you have…*"

**CHMS** collects physical activity data using accelerometers. Participants are given a waterproof activity monitor that is worn for one week at all times except when sleeping to record all patterns of physical activity. The study also uses a mobile clinic to collect measures of cardiovascular health and fitness, including resting heart rate, blood pressure and hand grip strength.

**FNFNES** includes measures for self-reported diabetes prevalence and activity levels.

**Canadian Cancer Registry (CCR)**

The CCR is a national database of information on cancer incidence and survival data for each primary type of cancer. Cancer incidence data is collected by provincial and territorial cancer registries and is reported to the CCR. The database includes all cases of cancer among Canadian residents since 1992.

**Vital Statistics – Death Database**

This survey collects demographic and cause of death information from all provincial and territorial vital statistics registries on all deaths in Canada. Deaths are classified according to the World Health Organization *International Statistical Classification of Diseases and Related Health Problems*.

**Public Health Agency of Canada's Canadian Chronic Disease Surveillance System (CCDSS)**
The CCDSS is a collaboration between the provincial and territorial surveillance mechanisms, and supported by PHAC, with a focus on chronic conditions. Analyses include period prevalence, incidence and all-cause mortality rate and ratio. The most recent summary covers 1999 to 2010.

**PREVIOUSLY CONDUCTED SURVEYS**

**FNIRLHS** included measures of physical activity, smoking and alcohol use, as well as self-reported prevalence of health conditions including NCDs.

**IHS** included measures regarding smoking, physical activity and alcohol use, as well as chronic disease risk for diabetes and heart disease.

**Comments/ notes**

## MONIT5 Evaluation of major programmes

Food-EPI good practice statement

There is sufficient evaluation of major programs and policies to assess effectiveness and contribution to achieving the goals of the nutrition and health plans

| | |
|---|---|
| **Definitions and scope** | - Includes any policies, guidelines, frameworks or tools that are used to determine the depth and type (method and reporting) of evaluation required<br>- Includes a comprehensive evaluation framework and plan that aligns with the key preventive health or nutrition implementation plan<br>- The definition of a major programs and policies is to be defined by the relevant government department<br>- Evaluation should be in addition to routine monitoring of progress against a project plan or program logic |
| **International examples** | - **USA**: The National Institutes for Health (NIH) provide funding for rapid assessments of natural experiments. The funding establishes an accelerated review/award process to support time-sensitive research to evaluate a new policy or program expected to influence obesity related behaviours (e.g., dietary intake, physical activity, or sedentary behaviour) and/or weight outcomes in an effort to prevent or reduce obesity[187]. |

**Context**

**Policy details**

**CIHR's Institute of Population and Public Health has previously held several project competitions for funds to support research evaluating population-level policies and interventions (**Operating Grant: Population Health Intervention Research**)[188].**

The **Office of Evaluation** at Health Canada conducts evaluations that provide credible, timely, neutral evidence to support government accountability and decision-making on policy, expenditure management, and program improvements within Health Canada and the Public Health Agency of Canada[189].

The Office of Nutrition Policy and Promotion has developed **a framework for the evaluation of the use of dietary guidance**. The framework will facilitate the design and implementation of evaluation efforts related to the assessment of the use of dietary guidance products[190].

**Performance Measurement Strategies** have been developed to support on-going performance monitoring and evaluation of programs at Health Canada, as per the Government of Canada Policy of Results[191]. The performance measurement strategies includes an evaluation framework containing potential indicators, data sources, etc. Nutrition-related indicators have been identified as appropriate in these PMS[192]. An example for NNC can be see here.

**Comments/ notes**

## MONIT6 Monitoring progress on reducing health inequalities

Food-EPI good practice statement

Progress towards reducing health inequalities or health impacts in vulnerable populations and social determinants of health are regularly monitored

| | |
|---|---|
| **Definitions and scope** | - Monitoring of overweight and obesity and main diet-related NCDs includes stratification or analysis of population groups where there are the greatest health inequalities including Indigenous peoples and socio-economic strata<br>- Includes reporting against targets or key performance indicators related to health inequalities |
| **International examples** | - **New Zealand**: All annual Ministry of Health Surveys report estimates by subpopulations in particular by ethnicity (including Maori and Pacific peoples), by age, by gender, and by New Zealand area deprivation. |

**Context**

**Policy details**

Several points are relevant to reportiong and monitoring inequalities:

- Canada has reinstated the **mandatory long-form census** as of 2016. The long form census provides key information on socioeconomic inequalities.

- Data in the CCHS are collected on a variety of socioeconomic characteristics and include measurements of household food insecurity. Most results are published by academic researchers using the data in further analyses of CCHS datasets.

- The CCHS and other Statistics Canada surveys don't include persons living on reserves and other Aboriginal settlements in the provinces, full time members of the Canadian Forces, institutionalized populations and persons living in the Quebec health regions of Region du Nunavik and Region des Terres-Cries-de-la-Baie-James (a total of 3% of the Canadian population). Thus, comparisons among those who are the most vulnerable are not always possible. CCHS annual is inclusive of First Nations people living off-reserve and Metis people.

- In addition to the previously described surveys, the Statistics Canada administered Aboriginal Peoples Survey (2012) included the 6-item HFSSM; this survey included First Nations people living off-reserve and Metis.

**Public Health Agency of Canada Pan-Canadian Health Inequalities Reporting Initiative**

The Pan-Canadian Health Inequalities Reporting (HIR) Initiative provides a comprehensive and systematic portrait of health inequalities in Canada and a foundation for ongoing measurement and monitoring of health inequalities. The HIR initiative is collaboration among the Pan-Canadian Public Health Network (PHN), the Public Health Agency of Canada (PHAC), the Canadian Institute for Health Information (CIHI) and Statistics Canada that reports on food insecurity under its social inequities theme. The HIR initiative is a response to the 2012 World Health Assembly at which Member States (including Canada) endorsed the **Rio Political Declaration on the Social Determinants of Health**, pledging to monitor health inequities within their jurisdictions. The initiative uses 70 indicators of health status, health behaviours and structural determinants of health.

**Comments/ notes**

# Policy area: Funding & resources

## Food-EPI vision statement: Sufficient funding is invested in 'Population Nutrition' to create healthy food environments, improved population nutrition, reductions in obesity, diet-related NCDs and related inequalities

### FUND1 Population nutrition budget

Food-EPI good practice statement

The 'population nutrition' budget, as a proportion of total health spending and/or in relation to the diet-related NCD burden is sufficient to reduce diet-related NCDs

| | |
|---|---|
| **Definitions and scope** | - 'Population nutrition' includes promotion of healthy eating, and policies and programs that support healthy food environments for the prevention of obesity and diet-related NCDs<br>- The definition **excludes** all one-on-one and group-based promotion (primary care, antenatal services, maternal and child nursing services etc.), food safety, micronutrient deficiencies (e.g. folic acid fortification) and undernutrition<br>- Please provide estimates for the budget allocated to the unit within the Department of Health that has primary responsibility for population nutrition. The 'Population Nutrition' budget should include workforce costs (salaries and associated on-costs) and program budgets for the 2016-17 financial year (regardless of revenue source), reported separately.<br>- The workforce comprises anyone whose primary role relates to population nutrition and who is employed full time, part time or casually by the Department of Health or contracted by the Department of Health to perform a population nutrition-related role (including consultants or funding of a position in another government or non-government agency). The number of full time equivalent persons in the workforce will be reported in 'FUND4'<br>- Exclude budget items related to physical activity promotion. If this is not feasible (for example, a program that combines both nutrition and physical activity elements), please highlight where this is the case<br>- With regards to 'health spending', please provide the total budget of the Department of Health for the 2016-17 financial year |
| **International examples** | **NOTE THESE ARE EXAMPLES ONLY: NO BENCHMARKS ARE AVAILABLE**<br>- **New Zealand**: The total funding for population nutrition was estimated at about $67 million or 0.6% of the health budget during 2008/09 Healthy Eating Healthy Action period. Dietary risk factors account for 11.4% of health loss in New Zealand.<br>- **Thailand**: According to the most recent report on health expenditure in 2012 the government greatly increased budget spent on policies and actions related to nutrition (excluding food, hygiene and drinking water control). Total expenditure on health related to nutrition specifically from local governments was 29,434.5 million Baht (7.57% of total health expenditure from public funding agencies), which was ten times over the budget spending on nutrition in 2011. Dietary risk factors account for more than 10% of health loss in Thailand. |
| **Context** | Both the *Department of Health Act* and the *Food and Drugs Act* allow Health Canada to regulate the safety and nutritional quality of food. |

**Policy details**

The following information has been gleaned from the Health Canada 2016-2017 Report on Plans and Priorities:[193]

**Total Health Canada budget (2016-2017): $3,756,604,937 (Main estimates)**

**Program 2.2: Food Safety and Nutrition budget: $68,562,778**

The *Department of Health Act* and the *Food and Drugs Act* provide the authority for Health Canada to develop, maintain, and implement a regulatory framework associated with the safety and nutritional quality of food. Food safety standards are enforced by the Canadian Food Inspection Agency. Health Canada develops and promotes evidence-based, national healthy eating policies and standards for Canadians and key stakeholders, including non-governmental organizations, health professionals, and industry associations to enable all stakeholders to make informed decisions about food and nutrition safety as well as healthy eating. The program objectives are to manage risks to the health and safety of Canadians associated with food and its consumption, and to enable Canadians to make informed decisions about healthy eating.

**Food Safety (Sub-Program 2.2.1): $63,957,645**

The Department of Health Act and the Food and Drugs Act provide the authority for Health Canada to develop, maintain, and implement a regulatory framework associated with the safety and nutritional quality of food. Food safety standards are enforced by the Canadian Food Inspection Agency. Health Canada develops and promotes evidence-based, national healthy eating policies and standards for Canadians and key stakeholders, including non-governmental organizations, health professionals, and industry associations to enable all stakeholders to make informed decisions about food and nutrition safety as well as healthy eating. The program objectives are to manage risks to the health and safety of Canadians associated with food and its consumption, and to enable Canadians to make informed decisions about healthy eating.

The only indicators that relate to the Food Directorate are for food safety incidents, and are not relevant to this project.

**Human resources (FTEs) for relevant groups=567**

**Nutrition policy and promotion (Sub-Program 2.2.2): $4,605,133**

The *Department of Health Act* provides the authority to develop, maintain and implement **the Nutrition Policy and Promotion program. The program develops, implements, and promotes evidence-based nutrition policies and standards, and undertakes surveillance and monitoring activities.** It anticipates and responds to public health issues associated with nutrition and contributes to broader national and international strategies. The program works collaboratively with other federal departments/agencies and provincial/territorial governments, and engages stakeholders such as non-government organizations, health professionals, and industry associations to support a coordinated approach to nutrition issues. The program objective is to target both Canadian intermediaries and consumers to increase knowledge, understanding, and action on healthy eating.

**Human resources (FTEs)=35**

- Performance indicator = % of Canadians who consult Health Canada's healthy eating information to inform their decisions.

- Performance Indicator = % of targeted stakeholders who integrate Health Canada's healthy eating knowledge products, policies, and/or education materials into their own strategies, policies, programs and initiatives that reach Canadians.

**ALSO RELEVANT TO POPULATIO NUTRITION:**

**First Nations and Inuit Health Promotion and Disease Prevention (Sub-Program 3.1.1)**
**Planned Spending: $455,785,998**

**Sub-Sub-Program 3.1.1.1: Healthy Child Development $102,803,627**

*The Healthy Child Development program administers contribution agreements and direct departmental spending to support culturally appropriate community-based programs, services, initiatives, and strategies related to maternal, infant, child, and family health. The range of services includes prevention and health promotion, outreach and home visiting, and early childhood development programming. Targeted areas in the delivery of this program include: prenatal health, nutrition, early literacy and learning, and physical and children's oral health. The program objective is to address the greater risks and lower health outcomes associated with First Nations and Inuit infants, children, and families. This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.*

- Performance Indicator: # of women in First Nations communities accessing Prenatal and Postnatal Health services and supports including Nutrition.
- Performance Indicator: % of First Nations communities with maternal and child health programming that provide group breastfeeding support activities.
- Performance Indicator: % of women in First Nations communities accessing maternal and child health program activities who breastfed for six months or more.
- Performance Indicator: Difference in % of children aged 0 to 11 who were breastfed longer than six months in First Nations communities with Maternal Child Health (MCH) programs versus those without MCH programs.
- Performance Indicator: % of First Nations communities that screen for risk factors for developmental milestones through participation in healthy child development programs and services.
- Performance Indicator: Average number of decayed teeth in the 0-7 year population in First Nations communities with access to the Children's Oral Health Initiative (COHI).
- Performance Indicator: # of children in First Nations communities accessing early literacy

*****NOTE: This program houses the CPNP and AHSOR programs.***

**Subprogram 3.1.1.3: Healthy Living $81,654,643**

*The Healthy Living program administers contribution agreements and direct departmental spending that supports culturally appropriate community-based programs, services, initiatives, and strategies related to chronic disease and injuries among First Nations and Inuit. This program aims to promote healthy behaviours and supportive environments in the areas of healthy eating, physical activity, food security, chronic disease prevention, management and screening, and injury prevention policy. Key activities supporting program-delivery include: chronic disease prevention and management, injury prevention, the Nutrition North Canada - Nutrition Education Initiative, and the First Nations and Inuit component of the Federal Tobacco Control Strategy. The program objective is to address the greater risks and lower health outcomes associated with chronic diseases and injuries among First Nations and Inuit individuals, families, and communities. This program uses funding from the following transfer payment: First Nations and Inuit Primary Health Care.*

- Performance Indicator: % of First Nations adults who reported that they eat fruit or vegetables at least once a day. (Baseline Fruit: 56.6, Vegetables: 62.9)

- Performance Indicator: % of First Nations and Inuit communities that deliver healthy eating activities under the Aboriginal Diabetes Initiatives. (Baseline 87.7)

***Note that the HL and the HCD programs/budgets are broader than nutrition.****

**Comments/ notes** A more recent budget has been established in the 2017-2018 Report on Plans and Priorities; however, this was considered outside of the time frame for this study.

## FUND2 Research funding for obesity & NCD prevention

Food-EPI good practice statement

Government funded research is targeted for improving food environments, reducing obesity, NCDs and their related inequalities

**Definitions and scope**

- Includes the clear identification of research priorities related to improving food environments, reducing obesity, NCDs and their related inequalities in health or medical research strategies or frameworks
- Includes identifying research projects conducted or commissioned by the government specifically targeting food environments, prevention of obesity or NCDs (excluding secondary or tertiary prevention)
- It is limited to research projects committed to or conducted within the last 12 months.
- Excludes research grants administered by the government (including statutory agencies) to a research group where the allocation of a pool of funding was determined by an independent review panel
- Excludes evaluation of interventions (this is explored in 'MONIT5' and should be part of an overall program budget)

**International examples**

**NOTE THESE ARE EXAMPLES ONLY: NO BENCHMARKS ARE AVAILABLE**

- **Australia**: The National Health and Medical Research Council (NHMRC) Act requires the CEO to identify major national health issues likely to arise. The National Health Priority Areas (NHPAs) articulate priorities for research and investment and have been designated by Australian governments as key targets because of their contribution to the burden of disease in Australia. For the 2015-16 Corporate Plan, obesity, diabetes and cardiovascular health are three of these NHPAs.
- **Thailand**: The National Research Council funded more research projects on obesity and diet-related chronic diseases (such as diabetes, cardiovascular diseases and hypertension) in 2014, accountable for almost six times over the research funding in 2013 (from 6,875,028 baht in 2013 to 37,872,416 baht in 2014).

**Context**

**HISTORICAL CONTEXT FOR OBESITY RESEARCH FUNDING**

Scientists at the Canadian Partnership Against Cancer conducted an audit to assess investments in obesity-related research from major Canadian funding agencies from 2006 to 2008. The results suggested that during that time period, 23 research funders were identified, and $97million was invested in obesity research, $12.9 million of which was invested in diet and nutrition research[194].**

In May 2012, the Canadian Cancer Research Alliance (CCRA) conducted an audit of funding for cancer-related research. Approximately $9.7 million was invest in obesity research related to cancer[195].**

***Note that the above mentioned research is not within the 12 month time frame, but provides historical context.*

**CURRENT CONTEXT**

The main research funding for population nutrition in Canada is the Canadian Institutes of Health Research (CIHR). CIHR has funding opportunities for food environment, obesity and NCD research, as well as inequalities, primarily through the Institute for Nutrition, Metabolism and Diabetes (INMD) and the Institution of Population and Public Health (IPPH), as well as potentially the Institute of Aboriginal Peoples Health (IAPH).

**Health Canada and the Public Health Agency of Canada**

Health Canada and PHAC have some opportunities for funding the Grants and Contributions, etc., which are provided on a case-by-case basis.

**Policy details**

**CIHR**

The **majority of funding from CIHR is investigator-initiated funding**. Only about one-quarter of CIHR's overall budget is devoted to priority-driven or strategic research. Each of the 13 institutes receives a strategic initiatives budget, which was just over $8M/yr from about 2008-2014. In 2015, half of the institute budgets were reallocated to a "common fund" as part of the institute modernization process (explained here: http://www.cihr-irsc.gc.ca/e/47677.html).

**CIHR's Institute of Population and Public Health has previously held several project competitions for funds to support research evaluating population-level policies and interventions (**Operating Grant: Population Health Intervention Research**)[188]. There were no Population Health Intervention Research competitions held in the previous 12 months. Two recent specific calls for CIHR project funding requested applications related to sugar and another related to analysis of CCHS data may include some applications with relevance to the food environment.**

**Intramural research** is conducted in the Food Directorate national and regional food labs and by the PHAC Chronic Disease Prevention groups. The amount of funding provided is not publicly available.

**Comments/ notes**

Currently, there are 2 ongoing food-related research projects in PHAC's HPCDP Branch: (1) Epidemiology of neural tube defects after folic acid food fortification in Canada; and (2) Toronto Public Health FoodReach Initiative, for which the HPCDP provided research funding to study the impact of this initiative designed to address food insecurity (written communication, April 2017).

## FUND3 Health promotion agency

Food-EPI good practice statement

There is a statutory health promotion agency in place, with a secure funding stream, that includes an objective to improve population nutrition

| | |
|---|---|
| **Definitions and scope** | - Agency was established through legislation<br>- Includes objective to improve population nutrition in relevant legislation, strategic plans or on agency website<br>- Secure funding stream involves the use of a hypothecated tax or other secure source |
| **International examples** | - **Australia**: The Victorian Health Promotion Foundation (VicHealth) was the world's first health promotion foundation, established by the Victorian Parliament as part of the Tobacco Act of 1987 (for the first 10 years through a hypothecated tobacco tax) through which the objectives of VicHealth are stipulated. VicHealth continues to maintain bipartisan support. |

**Context**

**FEDERAL NUTRITION DEPARTMENTS**

Health Canada is Canada's federal department responsible for health promotion and protection. Health Canada has objectives relating to health promotion, including objectives to promote healthier life styles and prevent and reduce risks to individual health and the overall environment, but there are no objectives specifically relating to population nutrition.

Health Canada's Health Products and Food Branch includes the Food Directorate's **Bureau of Nutritional Sciences** and the **Office of Nutrition Policy and Promotion** which are specifically responsible for nutrition.

The **Office of Nutrition Policy and Promotion** is primarily responsible for health promotion relating to population nutrition, and serves as a focal point and authoritative source for nutrition and healthy eating policy and promotion in Health Canada. ONPP supports the nutritional health and well-being of Canadians by collaboratively defining, promoting and implementing evidence-based nutrition policies. The Office integrates science, policy and intervention activities as well as promotion and protection activities related to nutrition.

Also involved in some health promotion strategies is the **Food Directorate** which is the federal health authority responsible for establishing policies, setting standards and providing advice and information on the safety and nutritional value of food, and therefore may influence population nutrition; however, promotion is not specifically mentioned in their mandate.

Health Canada's **First Nations Inuit Health Branch has personnel specific to nutrition** at the national office, and at each regional office. Personnel are involved in policy and programming efforts.

**Policy details**

Canada has the **Public Health Agency of Canada** as a statutory public health agency, as identified in its mandate. PHAC was developed in 2004 via the *Public Health Agency of Canada Act* under the Health Portfolio. PHAC's mandate does not include public health nutrition specifically, but this would also fall within their domain of work. There are links to 'healthy living' programs on the PHAC website.

There are several centres within PHAC that conduct relevant work, including the Centre for Chronic Disease Prevention (CCDP). In 2013-2014, the agency allocated $46 million to activities of the CCDP.

**PHAC main budget estimates for 2016-2017 were: $589,737,802**[196]

**Health Promotion and Disease Prevention budget Main Estimates: $ 300,679,998**

*The Health Promotion and Disease Prevention Program aims to improve the overall health of the population—with additional focus on those that are most vulnerable—by promoting healthy development among children, adults and seniors, reducing health inequalities, and preventing and mitigating the impact of chronic disease and injury, as well as infectious diseases. Working in collaboration with provinces, territories, and stakeholders, the Program develops and implements federal aspects of frameworks and strategies (e.g., Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights, national approaches to addressing immunization, HIV/AIDS) geared toward promoting health and preventing disease. The Program carries out primary public health functions of health promotion, surveillance, science and research on diseases and associated risk and protective factors to inform evidenced-based frameworks, strategies, and interventions.*

849 full time staff (FTEs)

- Performance indicator: Rate of key chronic disease risk factors (percent of adults aged 20 and over that report being physically active) Target=52%
- Performance indicator: Rate of key chronic disease risk factors (percent of children and youth aged 5 to 17 who are overweight or obese) Target=32%

**Sub-Program 1.2.3: Chronic (non-communicable) Disease and Injury Prevention $ 59,448,823**

*The Chronic (non-communicable) Disease and Injury Prevention Sub-Program works across sectors to design, deliver and expand innovative solutions for prevention in collaboration with the not-for-profit and private sectors to address complex public health problems. The Sub-Program emphasizes population health approaches that address common risk and protective factors for chronic diseases. The Sub-Program's premise is that no one sector alone can meaningfully address the causes of chronic disease and injury, and that the combined resources and expertise of a wide range of partners are required to identify and generate sustainable solutions to improve the health of the population. Also within this Sub-Program, work is undertaken to conduct public health research and surveillance, with an emphasis on tracking and understanding the common risk and protective factors for chronic diseases and injuries across the life course, and utilizing emerging sources of surveillance information and methods of collection where possible. The Program uses funding from the following transfer payments: Integrated Strategy for Healthy Living and Chronic Disease (Cancer, Diabetes, Cardiovascular Disease, Surveillance for Chronic Disease, Healthy Living, and Observatory of Best Practices), Canadian Breast Cancer Initiative, Federal Tobacco Control Strategy, and Promoting Access to Automated External Defibrillators in Recreational Hockey Arenas Initiative.*

- Performance indicator: Percent of key stakeholders and partners using evidence
- Performance indicator: Percentage of returning users to the Chronic Disease Infobase Web Platform
- *Average daily number of minutes*
- *spent in moderate to vigorous*
- *physical activity (Ages 18+)*

This Sub-program has several highlights relevant to obesity, nutrition and NCDs including an investment in building the evidence base for childhood obesity via policy analysis, research and international collaboration with WHO, USA and Canada.

**Comments/ notes**

**WHO Collaborating Centre on Non-Communicable Disease Policy**

The Public Health Agency of Canada's Centre for Chronic Disease Prevention is designated as a WHO Collaborating Centre. For this designation, the Centre carries out a number of policy research and collaborative activities with international partners including WHO and PAHO. The 2016-2019 work plan includes a number of specific activities that address childhood obesity and the food environment. These include:

1) a peer-reviewed publication on the economic impact of childhood obesity;

2) technical support to a PAHO Non-Communicable Disease economic expert working group (e.g. research on the effectiveness of fiscal policies for unhealthy and/or potentially addictive products; and

3) research report/case study on Salt Smart Consortium – a partnership between governments and food producers in Latin America and Caribbean to reduce population-level dietary salt intake.

# Policy area: Platforms for Interaction

## Food-EPI vision statement: There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities

### PLATF1 Coordination mechanisms (national, state and local government)

Food-EPI good practice statement

There are robust coordination mechanisms across departments and levels of government (national, state and local) to ensure policy coherence, alignment, and integration of food, obesity and diet-related NCD prevention policies across governments

| | |
|---|---|
| **Definitions and scope** | - Includes cross-government or cross-departmental governance structures, committees or working groups (at multiple levels of seniority), agreements, memoranda of understanding, etc.<br>- Includes cross-government or cross-departmental shared priorities, targets or objectives<br>- Includes strategic plans or frameworks that map the integration and alignment of multiple policies or programs across governments and across departments<br>- Includes cross-government or cross-departmental collaborative planning, implementation or reporting processes, consultation processes for the development of new policy or review of existing policy |
| **International examples** | - **Finland**: The Finnish National Nutrition Council is an inter-governmental expert body under the Ministry of Agriculture and Forestry with advisory, coordinating and monitoring functions. It is composed of representatives elected for three-year terms from government authorities dealing with nutrition, food safety, health promotion, catering, food industry, trade and agriculture[82].<br>- **Malta**: Based on the Healthy Lifestyle Promotion and Care of NCDs Act (2016), Malta established an inter-ministerial Advisory Council on Healthy Lifestyles in August 2016 to advise the Minister of Health on any matter related to healthy lifestyles. In particular, the Advisory Council advises on a life course approach to physical activity and nutrition, and on policies, action plans and regulations intended to reduce the occurrence of NCDs. The prime minister appoints the chair and the secretary of the Advisory Council, while the ministers of education, health, finance, social policy, sports, local government, and home affairs appoint one member each[82].<br>- **Australia**: There are several forums and committees for the purpose of strengthening food regulation with representation from New Zealand and Health Ministers from Australian States and Territories, the Australian Government, as well as other Ministers from related portfolios (e.g. Primary Industries). Where relevant, there is also representation from the Australian Local Government Association. |
| **Context** | |

**Policy details** Health Canada works closely with partners from across Canada in various jurisdictions.

With respect to public health nutrition, the Office of Nutrition Policy and Promotion and the Food Directorate regularly engage the following Federal/Provincial/Territorial tables:

- **Pan-Canadian Public Health Network (PHN)**: The PHN is a network of individuals across Canada from many sectors and levels of government, who effectively work together to strengthen public health in Canada. The PHN includes academics, researchers, public servants, members of non-governmental organizations, and health professionals. The PHN has strong links to senior government decision-makers and other key players in the public health system, which supports horizontal linkages across public health policy issues in a sustainable and integrated manner. This includes an objective to work collaboratively across sectors to advance new partnerships for promoting health and expand effective initiatives under **Curbing Childhood Obesity: A F/P/T Framework to Promote Healthy Weights**.

- **Federal, Provincial Territorial Group on Nutrition (FPTGN)**: The FPTGN provides leadership in stimulating and accelerating actions towards achieving nutritional well-being for all Canadians. Membership includes representation from each province and territory health department (or department responsible for health) with responsibility for nutrition planning, programs and policies and from Health Canada (Health Products and Food Branch and the First Nations and Inuit Health Branch).

  According to Health Canada's website, The Federal/Provincial/Territorial Group on Nutrition is committed to:

  - *Communications and actions that are timely, effective and strategic;*
  - *Minimizing duplication; and*
  - *Alliances and collaboration with other agencies.*

**Trilateral Cooperation on Childhood Obesity**

In 2014, the Minister and Secretaries of Health from Canada, Mexico and the U.S. committed to work together to address childhood obesity, which is a top public health priority in all three countries. Since then, a working group of technical officials has actively exchanged information, best practices and lessons learned on respective national approaches including multi-sectorial partnerships, the U.S. Let's Move initiative, and public awareness campaigns in Mexico targeting food portion sizes and physical activity.

**Comments/ notes** There is also a Provincial/Territorial Group on Nutrition that meets monthly. Details of this are described in provincial documents.

## PLATF2 Platforms for government and food sector interaction

Food-EPI good practice statement

There are formal platforms between government and the commercial food sector to implement healthy food policies

| | |
|---|---|
| **Definitions and scope** | - The commercial food sector includes food production, food technology, manufacturing and processing, marketing, distribution, retail and food service, etc. For the purpose of this indicator, this extends to commercial non-food sectors (e.g. advertising and media, sports organisations, land/housing developers, private childcare, education and training institutes) that are indirectly related to food<br>- Includes established groups, forums or committees active within the last 12 months for the purpose of information sharing, collaboration, seeking advice on healthy food policies<br>- Includes platforms to support, manage or monitor private sector pledges, commitments or agreements<br>- Includes platforms for open consultation<br>- Includes platforms for the government to provide resources or expert support to the commercial food sector to implement policy<br>- Excludes joint partnerships on projects or co-funding schemes<br>- Excludes initiatives covered by 'RETAIL3' and 'RETAIL4' |
| **International examples** | - **UK**: The UK 'Responsibility Deal' was a UK government initiative to bring together food companies and NGOs to take steps (through voluntary pledges) to address NCDs. It was chaired by the Secretary of State for Health and included senior representatives from the business community (as well as NGOs, public health organisations and local government). A number of other subgroups were responsible for driving specific programs relevant to the commercial food sector. |

**Context**

The *Canada Gazette* is the Government of Canada's official newspaper, and publishes new statutes and regulations, proposed regulations, decisions of administrative boards and other various government publications.

The *Canada Gazette* is published in three parts, two of which are relevant to the policy consultation process. The first, *Canada Gazette Part I* is for proposed regulations from the government, whereby all stakeholders can submit comments on the proposed regulations to the relevant government agency or department. Finalized regulations are then published as official regulations in *Canada Gazette Part II*.

Prior to the *Canada Gazette* process, policy documents, white papers and background documents are frequently published and widely circulated for comment.

**Policy details**

***Canada Gazette*** is a platform for providing all stakeholders with information on proposed policies.

**Food Expert Advisory Committee (previously known as the Food Regulator Advisory Committee)**

According to the Health Canada website:

> "The Food Expert Advisory Committee (FEAC) was established to provide Health Canada's Food Directorate with broad expert advice on its regulatory and administrative oversight of foods. It also provides advice on matters relating to strategic planning, priority-setting and environmental scanning of issues related to food safety, nutritional quality or other issues related to the Food Directorate's mandate"[197].

Biographies for all members are available online. As a condition of appointment to the committee, all members must publicly disclose a summary of their affiliations and interests, including direct and indirect financial interests, intellectual interests, and other interests. Expertise, affiliations and interests for all ad-hoc members are also publicly available online. http://www.hc-sc.gc.ca/fn-an/consult/frac-ccra/memb-eng.php.

For details on **Health Canada's policies relating to consultation and engagement** with industry with respect to the Healthy Eating Strategy, see GOVER3.

**Comments/ notes**

## PLATF3 Platforms for government and civil society interaction

Food-EPI good practice statement

There are formal platforms for regular interactions between government and civil society on food policies and other strategies to improve population nutrition

| | |
|---|---|
| **Definitions and scope** | - Civil society includes community groups and consumer representatives, NGOs, academia, professional associations, etc.<br>- Includes established groups, forums or committees active within the last 12 months for the purpose of information sharing, collaboration, seeking advice<br>- Includes platforms for consultation on proposed plans, policy or public inquiries<br>- Excludes policies or procedures that guide consultation in the development of food policy (see 'GOVER3') |
| **International examples** | - **Brazil**: The National Council of Food and Nutrition Security (CONSEA) is a body made up of civil society and government representatives, which advises the President's office on matters involving food and nutrition security[198]. CONSEA is made up from one-third government and two-thirds non-government executives and workers. It has special powers. It is housed in and reports to the office of the president of the republic. It is responsible for formulating and proposing public policies whose purpose is to guarantee the human right to healthy and adequate food. There are also CONSEAs at state and municipal levels that deal with specific issues, also responsible for organising CONSEA conferences at their levels. CONSEAs are charged to represent Brazilian social, regional, racial and cultural diversity at municipal, state or national level. The elected politicians in Brazil's parliament formally have the power to challenge and even overturn proposals made by CONSEA. In practice it is most unlikely that any Brazilian government whether of the left or right would wish to do so, partly because of the constitutional status of the CONSEA system, and also because, being so carefully representative of all sectors and levels of society, it remains strong and popular. |

**Context**

See details of Health Canada's transparency process in GOVER3, which also applies to civil society.

Health Canada previously worked with the **Network on Healthy Eating**. Membership included representation from national organisations and associations, advocacy groups, industry, marketing boards, health charitable organisations with a focus on nutrition and healthy eating and Health Canada, via the Office of Nutrition Policy and Promotion.

According to Health Canada's website, the objectives of the Network were

- Provide a forum to share information and learning related to initiatives on nutrition and healthy eating;
- Foster partnerships and opportunities for collaboration; and
- Encourage/enhance consistent communication and integrated message platforms on key issues in nutrition and healthy eating[199].

This has recently been updated (see Policy Details below).

**Policy details**

**Consultation and Stakeholder Information Management System (CSIMS)**

CSIMS is a web-based, centralized information management system for all Health Canada (HC) and Public Health Agency of Canada (PHAC) stakeholders and public engagement activities. CSIMS was created to improve the openness and transparency of stakeholder engagement and consultations at Health Canada and the Public Health Agency of Canada and allow Canadians to have a stronger say in departmental/agency priorities and policies. Both individuals and organizations can register with CSIMS.

Using the **CSIMS**, Health Canada expanded the Network on Health Eating across the country, through the creation of a virtual network for information sharing, in order to allow healthy eating stakeholders more broadly to participate. This ensures that Health Canada is operating in a fair and transparent way by increasing the reach of information and opportunities to a greater number of stakeholders.

Examples of other working groups that include(d) civil society include:

- ***Sodium Working Group*** membership included representatives from the federal and provincial governments scientific and health professional community, health-focused and consumer non-governmental organizations, the food manufacturing and food-service industry.
- ***Trans fat Task Force*** membership included the same representatives as the Sodium Working Group.

The government commonly holds round tables regarding food environment policy decisions. For example, Health Canada recently held a round table with experts on the health impacts of marketing to children. The Department also held a two day Symposium on Sodium Reduction in Foods, which took place in Ottawa in October 2016. The Symposium included participants from local, national and international organizations in discussions about the successes and challenges of reducing sodium levels in foods.

***Canada Gazette*** is a platform for providing all stakeholders with information on proposed policies.

**Comments/ notes**

Public consultations (including the *Canada Gazette* process) are open to all interested stakeholders, including industry.

## PLATF4 Systems-based approach to improve food environments nationally

Food-EPI good practice statement

The government leads a broad, coherent, effective, integrated and sustainable systems-based approach with local organisations to improve the healthiness of food environments at a national level

| | |
|---|---|
| **Definitions and scope** | - Systems-based approaches may include policies within other domains of health<br>- May include a social-determinants of health approach<br>- May bring together multiple departments or ministries to approach health<br>- Includes multiple levels of government |
| **International examples** | - **Australia**: Healthy together Victoria in Australia aims to improve people's health where they live, learn, work and play. It focuses on addressing the underlying causes of poor health in children's settings, workplaces and communities by encouraging healthy eating and physical activity, and reducing smoking and harmful alcohol use. Healthy Together Victoria incorporates policies and strategies to support good health across Victoria, as well as locally-led Healthy Together Communities. The initiative was originally jointly funded by the State Government of Victoria and the Australian Government through the National Partnership Agreement on Preventive Health[200]. It is unclear at this stage whether funding for Healthy Together Victoria will continue or not.<br>- **New Zealand**: Healthy Families NZ is a large-scale initiative that brings community leadership together in a united effort for better health. It aims to improve people's health where they live, learn, work and play, in order to prevent chronic disease. Led by the Ministry of Health, the initiative will focus on ten locations in New Zealand in the first instance. It has the potential to impact the lives of over a million New Zealanders. The Government has allocated $40 million over four years to support Healthy Families NZ[201]. |
| **Context** | |
| **Policy details** | No policy documents were identified. |
| **Comments/ notes** | |

# Policy area: Health-in-all-policies

## Food-EPI vision statement: Processes are in place to ensure policy coherence and alignment, and that population health impacts are explicitly considered in the development of government policies

### HIAP1 Assessing the health impacts of food policies

Food-EPI good practice statement

There are processes in place to ensure that population nutrition, health outcomes and reducing health inequalities or health impacts in vulnerable populations are considered and prioritised in the development of all government policies relating to food

| | | |
|---|---|---|
| **Definitions and scope** | - | Includes policies, procedures, guidelines, tools and other resources that guide the consideration and assessment of nutrition, health outcomes and reducing health inequalities or health impacts in vulnerable populations prior to, during and following implementation of food-related policies |
| | - | Includes the establishment of cross-department governance and coordination structures while developing food-related policies |
| **International examples** | - | **Slovenia**: Undertook a HIA in relation to agricultural policy at a national level. The HIA followed a six-stage process: policy analysis; rapid appraisal workshops with stakeholders from a range of backgrounds; review of research evidence relevant to the agricultural policy; analysis of Slovenian data for key health-related indicators; a report on the findings to a key cross-government group; and evaluation.[202] |
| **Context** | | |
| **Policy details** | | The Canadian Environmental Assessment Act, 2012 (CEAA 2012) provides the basis for Health Canada's legislated role in environmental assessments (EA) as a federal authority. Health Canada participates in Environmental Assessments (EAs) in terms of whether or not there may be risks associated with proposed projects on contamination of country foods or drinking water. There are no assessments related to population health.<br><br>No health impact assessment approach exists at the federal level, and population nutrition, health and inequities are not required to be considered in the development and implementation of food policies in other sectors; however, this does sometimes occur. Nutrition North Canada, administered by INAC, is an example of this. |
| **Comments/ notes** | | |

## HIAP2 Assessing the health impacts of non-food policies

Food-EPI good practice statement

There are processes (e.g. HIAs) to assess and consider health impacts during the development of other non-food policies

| | |
|---|---|
| **Definitions and scope** | - Includes a government-wide HiAP strategy or plan with clear actions for non-health sectors<br>- Includes policies, guidelines, tools and other resources that guide the consideration and assessment of health impacts prior to, during and following implementation of non-food-related policies (e.g. HIAs or health lens analysis)<br>- Includes the establishment of cross-department or cross-sector governance and coordination structures to implement a HiAP approach<br>- Includes workforce training and other capacity building activities in healthy public policy for non-health departments (e.g. agriculture, education, communications, trade)<br>- Includes monitoring or reporting requirements related to health impacts for non-health departments |
| **International examples** | - **Australia**: Established in 2007, the successful implementation of Health in All Policies (HiAP) in South Australia has been supported by a high level mandate from central government, an overarching framework which is supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process. The government has established a dedicated HiAP team within South Australia Health to build workforce capacity and support Health lens Analysis projects[203]. Since 2007, the South Australian HiAP approach has evolved to remain relevant in a changing context. However, the purpose and core principles of the approach remain unchanged. There have been five phases to the work of HiAP in South Australia between 2007 and 2016: 1) Prove concept and practice emerges (2007-2008), 2) Establish and apply methodology (2008-2009), 3) Consolidate and grow (2009-2013), 4) Adapt and review (2014) and 5) Strengthen and systematise (2015-2016).<br>- **Finland**: Finland worked towards a Health in All Policies (HiAP) approach over the past four decades[204]. In the early 1970s, improving public health became a political priority, and the need to influence key determinants of health through sectors beyond the health sector became evident. The work began with policy on nutrition, smoking and accident prevention. Finland adopted HiAP as the health theme for its EU Presidency in 2006. |
| **Context** | |
| **Policy details** | There is no health-in-all-policies approach at the federal level in Canada. |
| **Comments/ notes** | |

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