

Development of an Ontario Food and Nutrition Strategy

Background Document

Prepared by the Ontario Collaborative Group on Healthy Eating and Physical Activity
(Funded by Cancer Care Ontario)

September, 2010

Acknowledgements

Funding for this paper was provided by Cancer Care Ontario.

This report was written by Lesley Macaskill, Nutrition Consultant and its development was guided by a working group of the Ontario Collaborative Group on Healthy Eating and Physical Activity. Members of this group provided valuable content and feedback and included: Macy Chan, Carol Dombrow, Lynn Roblin and Rebecca Truscott.

This report was circulated as a discussion document in June and July 2010 to a number of key individuals working in public health, health promotion, agriculture and food, food and nutrition, food security, research and surveillance, including representatives from several ministries and the Ontario Agency for Health Protection and Promotion. Their feedback is included in this revised document which will serve as a backgrounder for moving forward on a collaborative inter-ministerial food and nutrition action plan for population health.

About the Ontario Collaborative Group on Healthy Eating and Physical Activity

Important evidence links diet, physical inactivity and obesity in the population to several chronic diseases such as cardiovascular disease, some cancers and type 2 diabetes. The *Ontario Collaborative Group on Healthy Eating and Physical Activity* (the Collaborative Group or OCGHEPA) addresses the individual, cultural, social, economic and environmental determinants of healthy eating, physical activity and healthy weights. Translating this evidence to impact the health of all Ontarians requires the coordination of research, surveillance, intervention development, advocacy and healthy public policy to ensure that these components are in place.

A population-based framework guides the work of the *Ontario Collaborative Group on Healthy Eating and Physical Activity*. Population-level approaches are intended to shift the risk of entire populations by focusing on the upstream causal factors which account for the distribution of risk in society and on all people, rather than targeting only those individuals most at risk. However, the group recognizes that special consideration needs to also be given to reduce inequities in health. The *Ontario Collaborative Group on Healthy Eating and Physical Activity* is a forum to advocate for comprehensive approaches to address these issues, achieved by meeting to discuss key issues, providing advice, and supporting concerted action.

The Canadian Cancer Society, Ontario Division provides Secretariat support to the *Ontario Collaborative Group on Healthy Eating and Physical Activity*.

See Appendix A for list of member organizations

Executive Summary

The Ontario Collaborative Group on Healthy Eating and Physical Activity (OCGHEPA) is calling on the Ontario government to begin a cross-government coordinated approach in the area of food and nutrition through the development of an Ontario Food and Nutrition Strategy. A provincial strategy developed by a cross-government, multi-stakeholder group will make strides toward improving the health and productivity of Ontarians and lowering the health care and social costs to the Province. Ontario's health care costs are burdened by increasing rates of overweight, obesity and chronic diseases and these costs are on an upward trajectory to consume over half of the provincial budget by 2014 (1). The time to act is now and OCGHEPA proposes work closely with Ontario's government and other important stakeholders to play a key role in the development of a Food and Nutrition Strategy.

The purpose of this background paper is to analyze Ontario's capacities for the development of a provincial food and nutrition strategy and to identify recommendations and opportunities for action. The functional areas of capacity assessed were: planning and management, research and innovation, knowledge exchange and capacity building, goal and objective setting, advocacy and policy development, program development, communications, financial transfers, human resources, evaluation and learning, and surveillance, performance monitoring and accountability. These were taken from the Chronic Disease Prevention Alliance of Canada's "Primary Prevention of Chronic Diseases in Canada: A Framework for Action" (2), and for each one, key recommendations are identified.

The overarching message revealed through the analysis is that an Ontario Food and Nutrition Strategy needs to be a cross-governmental initiative, involving multiple ministries. Inter-ministerial planning and implementation are key features of success experienced in other jurisdictions. A business case showing the financial impact of future health costs on the Province will demonstrate the immediacy for action and an environmental scan shows that there is energy and momentum for action now. If the goals and objectives of the Ontario Food

and Nutrition Strategy are linked across Ontario Ministries, they will be measured, accountable and acted upon.

Ontario needs to ramp up its research on food and nutrition by facilitating partnerships with academic institutions, providing incentives for research on priority topics and creating a system for disseminating and sharing results among all stakeholders. Current inter-ministerial initiatives can be built upon and opportunities for more integration should be sought. Policy and program development in all Ministries should be viewed through a health and health impact lens and the re-establishment of the Ministry of Health Promotion and Sport's Inter-ministerial Healthy Living Committee could facilitate knowledge exchange, communication and capacity building. In addition, engaging agencies and organizations external to government will provide support for policy development and help to implement new programs.

An infrastructure such as the Inter-ministerial Healthy Living Committee could work on mutual goal and objective setting for the Ontario Food and Nutrition Strategy. These goals and objectives should be linked to existing priorities within each Ministry such as student success, obesity reduction, poverty reduction and economic sustainability of the agriculture sector. Policy development should include a step that assesses the impact on the most vulnerable groups, such as children, immigrants, the elderly, disabled people and Aboriginals.

Communication and leadership should begin at the highest level, with the Premier announcing the Ontario Food and Nutrition Strategy. Mechanisms and incentives to promote engagement and commitment to an intergovernmental approach should be developed and an infrastructure to coordinate and manage communications in the field could be created.

Per capita funding for population health and health promotion strategies should be increased to be on par with Quebec and British Columbia. As well the human capacity for this strategy needs to be enhanced at all levels, including sufficient positions for Registered Dietitians to support provincial initiatives.

Linkages with organizations with the capacity to conduct evaluations, such as universities, colleges and the Ontario Agency for Health Protection and Promotion need to be fostered and strengthened. Evaluation results should be used to secure growth and expansion of small initiatives to become population-based and to facilitate program and policy initiatives that have been successful in other jurisdictions are implemented province-wide. Expertise for evaluation is needs to be available and resourced for any new program or policy and more performance-monitoring targets need to be included in initiatives with nutrition as a key component, such as the Ontario Diabetes Strategy.

There are many recommendations and opportunities for action in this background paper, not without their challenges to implement. The next steps recommended to begin dialogue on this issue include individual interviews with staff-level representatives of Ontario Ministries to discuss the recommendations and challenges and identify other ideas to be incorporated. Once staff-level input is incorporated, a focus group meeting of senior Ministry representatives and external stakeholders is recommended. Ideally this could be facilitated and hosted by the Ontario Agency for Health Protection and Promotion and other partners. From these two short-term actions, a think-tank group can be formed to begin the development of goals and objectives to form an Ontario Food and Nutrition Strategy.

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Introduction

Ontario's health care costs are burdened by increasing rates of overweight, obesity and chronic disease. Currently, one in four Ontarians suffers from cardiovascular disease, diabetes, cancer, depression or another chronic condition and two-thirds of Ontarians have at least one preventable risk factor for developing these chronic diseases in the future (3). An estimated 80% of heart disease, stroke and type 2 diabetes, and 40% of cancers could be avoided if shared risk factors were eliminated (4). These grim statistics and the projection that healthcare costs will consume over half of the provincial budget by 2014 create an urgency to coordinate the Ontario government's food and nutrition planning, programs and policies to work cohesively to prevent chronic disease and improve the health of Ontarians (1) .

The Ontario Collaborative Group on Healthy Eating and Physical Activity (OCGHEPA) recognizes the need for a more comprehensive and coordinated approach in the area of food and nutrition to promote health and wellness in Ontarians. Through the development of an Ontario Food and Nutrition Strategy, OCGHEPA is calling on the Ontario government to begin a coordinated cross-government approach in the area of food and nutrition to improve the health and productivity of Ontarians and lower health care and social costs to the province. The time to act is now.

Approach

Through a review of the current landscape, key documents and the accomplishments of provincial and national health organizations, OCGHEPA exposes lessons learned and assesses Ontario's capacity for an Ontario Food and Nutrition Strategy with the focus areas of childhood nutrition, chronic disease prevention and food security.

This paper provides an assessment of Ontario's current critical capacity to take action on a comprehensive Food and Nutrition Strategy. The Chronic Disease Prevention Alliance of

Canada's (CDPAC) functional areas of capacity¹ provide the backbone for this in-depth analysis of Ontario's current food and nutrition system. (2);

1. Planning and management (of organizations, partnerships and relationships)
2. Research and innovation
3. Knowledge exchange and capacity building
4. Goal and objective setting
5. Advocacy and policy development
6. Program Development
7. Communications
8. Financial transfers
9. Human resources
10. Evaluation and learning
11. Surveillance, performance monitoring and accountability

This analysis includes recommendations for essential components of a Food and Nutrition Strategy with a focus on promoting a healthy population. These recommendations will address current gaps in critical capacities and programming. Feedback on these recommendations was received from representatives of key Ontario government ministries and stakeholders from non-governmental organizations and has been incorporated into this background document.

1. Planning and Management

Planning and management include activities to identify and engage key partners, building coalitions and establishing and maintaining a coordinating body responsible for overall planning and decision-making.

¹ In CDPAC's Primary Prevention of Chronic Diseases in Canada: A Framework for Action, *functional areas of capacity* are described as those inter-related capacities "required for implementation of a comprehensive intervention model."

According to ICES (the Institute for Clinical and Evaluative Sciences), a **guiding health imperative** must drive overall health strategies (5). Declaring the health of the population as an overriding goal for its citizens has helped several jurisdictions make gains in the prevention of chronic disease. Establishing a health imperative such as this would enable Ontario to plan across ministries for the coordinated implementation of a Food and Nutrition Strategy.

In order to realize the urgency of identifying a health imperative and focusing on chronic disease prevention, we examine Ontario's current health care spending. Based on the most recent 10-year trends in government health care spending and total available revenue (TAREV), Ontario health care expenditures will consume 50% of TAREV by 2014 and 75% of TAREV by 2038 if there are no new actions to promote health or prevent disease (1). The change that is needed immediately is not more funding for health care, but a commitment to and investment in health promotion and disease prevention. A comprehensive and coordinated Food and Nutrition Strategy would be a key component of this necessary change.

Ontarians with low incomes are particularly vulnerable to poor health and children in low-income families are one and a half times more likely to be obese (6). An important priority in a Food and Nutrition Strategy is to narrow the existing disparities in health and health behavior by employing the principle of equity to planning and management. Interventions should ensure that people in disadvantaged groups, whose health tends to be poorer, make the first and greatest gains. If this is not done, the disparities will increase (5).

A quality nutrition strategy or action plan requires **investment and resources** to create the **management and organizational structures** as well as the resources to implement, monitor progress and evaluate impact and effectiveness. There is a lot of current activity in the key focus areas in nutrition in Ontario (2,7-32) but coordination and collaboration are needed to avoid confusion and duplication of efforts and to maximize resources and impact. As the Ontario Chronic Disease Prevention Alliance recommends, those involved need to "think and act, like a system" that is effective, equitable, has capacity, community partnerships and is

effectively governed and managed (8). A successful Ontario Food and Nutrition Strategy will be developed with these attributes in place. The first steps to achieving these attributes are to provide human and financial resources to govern and manage the Strategy and to bring all potential partners to the table for the planning process. In the 2004 report, “Healthy Weights, Healthy Lives”, Ontario’s Chief Medical Officer of Health called on “all levels of government, the health sector, the food industry, workplaces, schools, families and individuals to become part of a comprehensive province-wide effort to change all the factors that contribute to unhealthy weight “(33). Now is the time to make this happen.

OGHEPA proposes to take a key role by forming an inter-ministerial, multi-stakeholder committee and already has many of the key health partners required to work on a provincial food and nutrition strategy at the table. OCGHEPA is a provincial collaboration of health professionals from non-profit, health and academic organizations dedicated to addressing population-based issues relating to healthy eating, physical activity, healthy weights and the determinants of health, including food access, availability and adequacy. The Canadian Cancer Society acts as a secretariat for the group. See Appendix A for a list of OCGHEPA member organizations

Overall, a high level Inter-ministerial Healthy Living Committee as introduced in 2006 should be re-established to set broad directions for all ministries on matters related to promoting a healthy province and development of healthy public policies

The Federal/Provincial/Territorial (F/P/T) Ministers of Health and/or Health Promotion/Healthy Living have released a new Framework for Action to curb childhood obesity, which makes childhood overweight and obesity a collective priority for action (10). Furthermore, the F/P/T Ministers of Health and/or Health Promotion/Healthy Living at the same time released a declaration on prevention and promotion which states that “the promotion of health and the prevention of disease, disability and injury are a priority and necessary to the sustainability of the health system (11).” The Ministers also recognize that many factors that contribute to

health and disease prevention lie beyond the health sector and therefore, they have called for support from partners both inside and outside of government.

Intersectoral partnerships are complex and create many challenges, such as striking a balance between the individual priorities of each partner with the collective priorities of the group. British Columbia's ActNow BC is a bold intersectoral initiative that integrates the actions of the whole-of-government with those of civil society to achieve its health promotion targets (12). A key lesson learned in the Canadian experience is that to solve broad-based problems, one must seek solutions which can be applied across governments with the participation of the larger civil society (5). The ActNow BC case study highlighting its successes to date credits two important factors: 1) using diverse strategies and mechanisms to foster collaboration in government and 2) developing strong partnerships with organizations within civil society (12). British Columbia used a variety of mechanisms and strategies to enhance collaboration. For example, a business case illustrated how chronic diseases would be a financial drain on all ministries, and all ministries were required to include health promotion projects into their service plans and an incentive fund of \$15 million was provided for ministries other than Health to implement health promotion projects. (12)

BC also credits the **strong leadership of its Premier** and his commitment to the principles of an integrated health promotion initiative as a key success factor of ActNow BC (12). His continuous support enhanced the profile of the initiative and ensured that it remained high on the agendas of all Ministers, Deputies and Assistant Deputies. Another lesson learned in Canada is that the best strategies for improving population health and health-related behaviours arise during the tenure of **strong political leaders**. The best kind of leader articulates a vision, unites different government ministries and departments together around a common purpose and signals how the larger society can best engage and support government strategies (5). Ontario's Premier has demonstrated commitment and leadership in calling a meeting of stakeholders in July 2010 to discuss action on sodium within the year (34). Following this, the Provincial/Territorial Ministers of Healthy and/or Health Promotion/Healthy Living recommended to the Federal Health Minister that a regulatory mechanism be established should industry not meet voluntary

targets being established by the Sodium Working Group (35). Ontario's Premier could build upon this momentum, by focusing on the guiding health and financial imperative or the upcoming 2015 Pan Am Games to rally partners and Ministries around a provincial Food and Nutrition Strategy.

Finally, **enthusiasm and momentum** toward a strategy are crucial to its success. BC had the momentum of the 2010 Winter Olympic Games and the enthusiasm of its leader to keep it active and high profile. Timing and the ability to seize upon opportunities are important and should not be discounted. By acting now Ontario could be the first to make gains since the release of the F/P/T Ministers' declaration on prevention and promotion and framework for action on childhood obesity. Ontario has some indication that at least two key potential partners are ready to engage in the development of a Food and Nutrition Strategy with announcements made in spring 2010. The Canadian Federation of Agriculture announced its plans to develop a national Food Strategy with diverse partners and the federal Liberal party announced its plans for a comprehensive national food policy (36, 37). In 2009, the Canadian Agri-Food Policy Institute (CAPI) also demonstrated readiness with the release of its discussion paper, *Building Convergence: Toward an Integrated Health & Agri-Food Strategy for Canada* (38). While these organizations are seeking to develop a national strategy, Ontario may be able to learn from their collaborative approach and could demonstrate leadership among provinces in beginning the process first. In March 2010, the Agri-Food Institute at the Ivey School of Business at the University of Western Ontario hosted a workshop on the connections between food and health and how we could better integrate agri-food and health policies to achieve broader economic and social objectives (39). The energy and enthusiasm of these groups and their partners could be channeled into the planning of a partnership for the development of an Ontario Food and Nutrition Strategy.

Recommendations for Planning and Management

- Re-establish a Minister's Healthy Living Committee as introduced in 2006 to set broad directions for all ministries on matters related to promoting a healthy province and development of healthy public policies

- Establish an interministerial, multi-stakeholder committee to work on the development of a collaborative Ontario Food and Nutrition Action Plan. In addition to OCGHEPA, members of the committee would include ministerial representation from the ministries of: Aboriginal Affairs, Agriculture, Food and Rural Affairs, Children and Youth Services, Community and Social Services, Culture, Education, Environment, Finance, Health Promotion, Health and Long-term Care, Municipal Affairs and Housing and others as deemed appropriate.
- Develop a business case showing the financial impact of projected health costs due to obesity, chronic disease and health inequities on the province; include an analysis of the opportunities and challenges for Ontario's agri-food sector.
- Encourage the Premier to articulate a vision and a target such as becoming the healthiest province in Canada by the 2015 Pan Am Games or to be the first province to sign on to the development of a national food and nutrition strategy or the first province to make gains on common goals since the F/P/T announcements on the priorities of prevention and promotion, childhood obesity and sodium reduction in September 2010.

2. Research and Innovation

Research

A recent review and consultation with key informants of Canada's Nutrition for Health – an Agenda for Action, released in 1996, showed that all of its strategic directions: reinforcing healthy eating, supporting nutritionally vulnerable populations, continuing to advance the availability of foods that support healthy eating, and supporting nutrition research, all remained equally important priorities and should not be changed (40). **The need for nutrition research is as great today as it was in 1996.**

Obesity in Ontario is now so prevalent that individual approaches are neither feasible nor cost-effective: addressing obesity at the population level may have the best potential to reverse the trend of rising obesity rates (9). The population health approach to prevent obesity addressing a range of determinants of health is a priority for research. Research topics such as comparisons of healthy diet costs, housing and other living expenses with social assistance rates or minimum wage will support the development of policies to strengthen the social safety net (41). The Ontario Public Health Association Food Security Workgroup (OPHA/FSWG) has led collaborations across the province among public health practitioners with housing and social

assistance agencies to combine and present this type of data annually (42). In Montreal, the Public Health Unit's research on social inequalities in health contributed to the advocacy campaign leading to the adoption of Quebec's anti-poverty bill (43). Quebec is the only province addressing poverty as a health issue, recognizing the link between income and health, and implementing programs such as universal day care, to reduce the proportion of the population living in poverty. Research exploring health disparities in Ontario and how various determinants are connected to one another could inform provincial policy development to improve the population health.

An environmental scan by Health Canada has identified **many gaps and thus opportunities to makes strides in nutrition research**; there is very little information on food intake and nutrient status of **children, immigrants, older Canadians or Aboriginal populations**, when in fact, these groups are among the most vulnerable (44, 45). The increase in excess weight and mean body mass index over the last two decades has been more pronounced in children than in adults (46). This rapid increase is an alarm sounding the fact that population-wide approaches for reducing this trend are needed for children and youth. Although immigrants generally present lower all-cause mortality than the general Canadian population, mortality from stroke, diabetes and some cancers are elevated among immigrants (47). There is a "healthy immigrant effect" in Canada, due in part to the fact that a large proportion of immigrants now come from countries where rates of overweight and obesity, smoking and heavy alcohol consumption are lower (47). However, the length of time since immigration is an important risk factor for excess weight for women in Canada (48) and may be more due to factors beyond individual control, such as the food system and the built environment (49).

The 2004 Canadian Community Health Survey (CCHS) has provided the first nutrition related data in decades but the groups discussed above were not at all or not well-represented in the sample (50). More research specific to immigrant groups is needed to understand their changes to risk over time to be able to respond with appropriate policy or environmental changes. This will become increasingly important as Statistics Canada expects that by 2030, deaths will outnumber births and immigration will be the only growth factor for the Canadian population

(51). The CCHS also showed that the highest proportions of overweight and obesity were observed in the oldest age groups surveyed; those between 55 and 64 years of age (49). There are no data available for those over the age of 64, which is a concern since the proportion of the Canadian population over age 64 is growing rapidly as the baby boomer generation reaches this stage (52).

Northern remote communities in Canada, characterized by a high percentage of Aboriginal populations, exhibit the highest obesity rate of the country. 55% of First Nations children on reserve and 41% of Aboriginal children and adolescents living off-reserve are either overweight or obese (53). A key limitation of the CCHS is that it provides no data for the on-reserve Aboriginal population, shown to be at high risk for obesity (49). This is a key research gap that needs to be addressed both provincially and nationally, especially since the population reporting Aboriginal identity grew by 45% between 1996 and 2006 (52).

Another priority area for nutrition research is the importance of mental health and its link to disordered eating which could lead to obesity or severe underweight. The CCHS data identifying 3.1 % of Ontario females at risk for an eating disorder highlights the fact that body mass index should not be the only indicator of achieving population targets for nutritional health (54).

The 2003 Ontario Nutrition and Cancer Prevention Survey was the first survey in over ten years to provide province-wide information on vegetable and fruit consumption, food insecurity, BMI, and knowledge, attitudes and behaviours for healthy eating, but only surveyed adults between the ages of 18 to 64 (55). Research on food intake and dietary status of children, immigrants, the disabled, older Canadians and Aboriginal populations may help identify the key dietary factors leading to increased risk of becoming overweight or obese. Research and innovation that improves population health through food, while providing economic opportunities and competitive advantages for Ontario's agri-food sector are also needed. Data sources that are available now cannot be linked to understand the relationships between dietary intakes, nutritional status, environmental exposures, resiliency, nutrition-related knowledge, attitudes and behaviours, health status and health determinants (44).

Finally, there is little provincial information to **better understand food insecurity** and its impacts and solutions. Community food security involves long term planning with a wide range of stakeholders working towards a healthy, just and sustainable food system (56). A population health approach addresses the root causes of individual and household food insecurity – poverty – through improvements to the social safety net (41). Research should begin by building upon what is known already; several academics, health groups and non-governmental organizations in Ontario have conducted relevant research on food and nutrition (57-64). For example, the results of the CCHS indicate that 9.2% of Canadian households experienced food insecurity in 2004 (65), but much higher prevalence rates have been documented among on-reserve Aboriginals and among homeless people, groups not included in the CCHS (62-64, 66-68). Cost-benefit analyses would underscore the economic burden that could be prevented vis-à-vis the cost of programs and policies to reduce food insecurity as well as the benefits of healthier living (57). Sharing and collaborating as partners with a common goal will help to build the knowledge base more quickly.

The Public Health Research, Education and Development (PHRED) program involves five health units in Ontario, health science programs at universities and colleges and the Ministry of Health and Long-Term Care (69). Its goal is to provide evidence to support effective, efficient and accountable public health practice; to increase capacity within the public health system and to provide leadership in research and education through strategic partnerships. The PHRED program will cease operations as of January 1, 2011 and all functions and funding will be centralized by a transfer to the Ontario Agency for Health Protection and Promotion. Although centralization of these functions may appear to increase the efficiency of the system, the transition to centralized operation poses several challenges; the connection to local public health practice will be reduced, if not lost, and the ability to develop skills such as research and evaluation among the public health nutrition workforce (both students and health professionals) across the province will be more difficult. In addition, health units will have a greater challenge meeting the 2008 Ontario Public Health Standards that require the use of health data and evidence about the effectiveness of public health interventions to inform

decision-making at the local level regarding program assessment, planning, delivery, management and evaluation (28). To identify local priorities and address local needs, health units would benefit from a blended model that includes regional hubs with specific applied research and program content expertise (70).

The OAHPP legislated functions are: To develop, disseminate and advance public health knowledge, best practices and research in the areas of population health assessment, infectious diseases, health promotion, chronic diseases, injury prevention, and environmental health; To inform and contribute to policy development processes across sectors of the health care system and within the Government of Ontario through advice and impact analysis of public health issues; To undertake, promote and co-ordinate public health research in cooperation with academic and research experts as well as the community; and To provide education and professional development for public health professionals, scientists, researchers, and policymakers across sectors (70). It is unknown if the OAHPP will be able to maintain the knowledge base currently generated by the PHRED program but the OAHPP has begun a consultative process with public health units on how it can address all of PHRED's former functions.

Innovation

In the current information laden environment, is appealing to want to wait to have as much evidence as possible on the success of a potential intervention prior to implementation. However, leading jurisdictions in health promotion act promptly, are often the first to implement **innovative interventions** and do not necessarily wait for conclusive scientific evidence (5). For example, British Columbia launched strategies to reduce tobacco consumption long before similar strategies were implemented in other provinces. Starting in 1971 with a ban on tobacco advertising, the province also increased tobacco prices, provided smoking cessation help and legislated smoke-free workplaces. These strategies were implemented before systematic evaluations of their effectiveness and before nearly all other jurisdictions world-wide took similar steps (5). Today, British Columbia boasts one of the lowest smoking rates in the world. This courage to be a leading jurisdiction and innovator has been cited as a possible

reason why widespread implementation of obesity initiatives in British Columbia and Quebec has shown improvements in health and health behaviours (5). Leading jurisdictions also skip smaller demonstration projects and introduce large programs, allowing the government and its partners to establish and maintain fully implemented strategies (5). Evidence of this is also apparent in British Columbia and Quebec, where the spending on population health programs is between three and eight dollars more per capita than it is in Ontario (5). More research is needed in practice as practice-based evidence can provide valuable insights for policy, further research or direct action (2). A balance must be struck between the urgency to implement population-based strategies to improve diet and reduce the prevalence of overweight and obesity and the need for an evidence-base to support any large-scale program. Food, nutrition, diet and obesity are complex issues to understand and spending too much time collecting information may result in too much of a lag for the well-being of the province, in terms of both finances and health.

Recommendations for Research and Innovation

- Engage the Ontario Agency for Health Protection and Promotion (OAHPP) to support research and coordination.
- Increase spending on research and practice based evidence that is directly related to food and nutrition.
- Facilitate and provide incentives for research on the food intake and nutrient status of children, older adults, immigrants and Aboriginal populations and the broad determinants of health affecting diet and healthy weights.
- Create a system to help disseminate and share research results among practitioners, academic institutions, non-governmental organizations and government.
- Ensure the functions and capacities of the PHRED program (applied, local research, workforce and student development, and knowledge exchange) are not lost, by implementing a blended regional model as stated in the Knowledge to Action (K2A) document (70).
- Implement large-scale promising and innovative programs.
- Ensure evaluation is conducted to provide evidence.

3. Knowledge exchange and capacity building

Knowledge exchange is a collaborative problem solving process involving researchers, public health practitioners, and community partners. Knowledge exchange provides information about not only what might work in different contexts, but also how and why. It also includes the facilitation and support of knowledge exchange networks and communities of practice.

Capacity building refers to the training and skills development needed to enhance the ability of partners, community members and networks to plan, implement and assess initiatives, as well as key factors within organizations such as leadership, culture and organizational learning supports required to implement chronic disease prevention innovations (2). **Infrastructure development** refers to the collective system support structure, including all of the enabling elements, such as project management supports, information technology and the development and provision of information resources and training and technical assistance supports that are critical for the planning, capacity building and knowledge exchange activities of province-wide, multi-component initiatives.

Ontario has a wealth of Knowledge products related to food and nutrition including systematic reviews, critical reviews, best advice, practice guidelines and standards of practice, through academic researchers, chronic disease prevention groups, health professionals' groups, non-governmental organizations and industry expertise (2). What is lacking however is a system to link these products together to create the infrastructure necessary for health practitioners in the field to work to the best of their ability. Much can be learned from the Program Training and Consultation Centre (PTCC), which is funded by the Smoke Free Ontario Strategy to increase the capacity of organizations and providers to deliver effective, comprehensive, tobacco use reduction interventions in Ontario. PTCC builds capacity in tobacco control at the local level through various knowledge exchange activities: training, consultation, resource development, media analysis, communities of practice, and referral services (71). The province's health providers could greatly benefit from a similar venture in the area of food and nutrition. The Nutrition Resource Centre (NRC), at the Ontario Public Health Association is well-positioned to lend to the food and nutrition knowledge exchange infrastructure. With their complement of

Registered Dietitians, NRC can offer the nutrition field the technical knowledge and expertise needed to increase capacity and support local initiatives. In recent years NRC has expanded their services to include webinars and other training activities to public health nutrition promoters. This type of expertise could be blended with a PTCC model to maximize this type of support.

Currently, through a Healthy Communities Grant from the Ministry of Health Promotion and Sport, PTCC has expanded its Media Network to provide services to practitioners working in nutrition and physical activity. The advisory group, to which NRC belongs, plays a crucial role in ensuring this service meets the needs of the food and nutrition field. This collaboration is a positive initial step towards developing a food and nutrition promotion system with a sound knowledge exchange infrastructure. Knowledge transfer, linkages, maximization of resources, minimization of duplicated efforts, and harmonization of efforts should all be centralized. However, this would require adequate resources for infrastructure development, training, and a clear understanding of who is responsible for what and how (72). Ontario's Agency for Health Protection and Promotion is ideally situated to build this infrastructure.

Recommendations for Knowledge Exchange and Capacity Building

- Using a PTCC model, develop knowledge exchange infrastructure in the food and nutrition field.
- Use best advice from critical reviews, practice guidelines, etc. to address gaps and build capacity and infrastructure.
- Encourage OAHPP to develop the infrastructure necessary to support the planning, capacity building and knowledge exchange activities for an Ontario Food and Nutrition Strategy.

4. Goal and objective setting

Goal and objective setting are critical steps for strategic and operational planning. Goals are usually broad statements providing overall direction or specifying a desired end state.

Objectives, by contrast, are measurable statements describing a specific, measurable, time-limited (short of long-term) outcome within a population or setting (i.e., how much of what happens to whom by when). At a broader level, collaborative planning is also needed to establish mission and/or vision statements that reflect the ultimate purpose of the initiative. Logic models that link goals to resource inputs, activities, outcomes and indicators, are essential for performance monitoring, evaluation and surveillance.

Ontario should be a leader in health and nutrition promotion. To make this a reality, **goal setting needs to be even more ambitious than in other Canadian jurisdictions** and the overarching goal should be proclaimed by the Premier to demonstrate strong leadership and urgency (5). In British Columbia, the goal was to be the healthiest jurisdiction ever to host the Olympic Games (12). In England, the goal for the Healthy Weight, Healthy Lives Strategy was more specific:

“to be the first major nation to reverse the rising tide of obesity and overweight in the population by ensuring that everyone is able to achieve and maintain a healthy weight. Our initial focus will be on children: by 2020, we aim to reduce the proportion of overweight and obese children to 2000 levels” (73).

Now is the time for Ontario to step up and meet the challenge to become a leader in Canada by **setting health targets for 2015 in time for the Pan Am Games**. A review of leading jurisdictions around the world in terms of population health (5), suggested benchmarks for Ontario to achieve by 2015 in order not to lag behind other provinces:

- Reduce the proportion of Ontarians who use tobacco from 20% to less than 15%.
- Increase the proportion of Ontarians who are physically active, that is, they take part in more than 30 minutes of moderate physical activity each day from 55% to 73% or more,
- Reduce the proportion of Ontarians who are either overweight or obese, according to body mass index (BMI) calculations, from 59% to less than 32%.

It is also prudent to consider targets set by provincial agencies. For instance, Cancer Care Ontario has a target for 90% of the population to be consuming five or more servings of

vegetables and fruit each day (74). Recent estimates based on Canadian Community Health Survey data from 2007 and 2008 show that only 40% of Ontarians are meeting this target (75).

Opportunity to make advances in the area of food and nutrition can also be found by setting objectives that **go beyond traditional health related risk factors and outcomes**. For instance, including innovation objectives for environmental changes in areas like urban design, transportation, food pricing and advertising will lead to increased action in these areas (15). Priority should be given to objectives that will lead to reduced disparities in health and health behaviour and increased resilience among those most at-risk (5). Goal and objective development should be a facilitated process done in collaboration with all Ministries and relevant partners, such as the Ontario Collaborative Group on Healthy Eating and Physical Activity and all of its member organizations. Food industry representatives should include the Canadian Restaurant and Foodservice Association, Alliance of Ontario Food Processors, Canadian Federation of Independent Grocers, Canadian Council of Grocery Distributors, Food and Consumer Products of Canada and relevant Ontario commodity and farmers' groups such as Ontario Fruit and Vegetable Growers Association and Ontario Federation of Agriculture. All objectives developed by the partnership should have measurable outcomes. This collaborative approach will ensure multiple interests are met and that the partnership is united in its commitment to achieving them.

The use of agencies external to government to provide support for program and policy development is an approach common to leading jurisdictions (5). Giving all partners a sense of ownership and empowerment can leverage commitment and action toward the common goal. Several organizations already have nutrition objectives that they are working toward and would provide a good starting point for discussion. For example, Dietitians of Canada, the Canadian Diabetes Association, the Heart and Stroke Foundation, the Ontario Chronic Disease Prevention Alliance and the Food Security Workgroup of the Ontario Public Health Association have emphasized access to and availability of nutritious foods as a key health determinant that must be addressed to promote and protect health (8, 56, 60, 61, 76).

Goals and objectives should be clear and require access to resources to achieve them (15). They need to address both societal and individual level factors in the environment, both immediate and distant causes, have multiple focal points and levels of intervention (i.e. at provincial, regional, community and individual levels) (77). The 2008 Ontario Public Health Standards (28) have broad societal outcomes for which the province is accountable and there are dozens of Board of Health outcomes for which each health unit is responsible. The performance management system of the Ministry of Health and Long-term Care and Ministry of Health Promotion and Sport is in the process of developing assessment measures to align with these outcomes.

Recommendations for Goal and Objective Setting

- Develop an infrastructure involving senior staff from relevant Ministries to work on mutual goal and objective setting for a food and nutrition strategy (e.g. inter-ministerial, multi-stakeholder committee recommended under planning and management). Ensure agreed-upon objectives are included in each Ministry's service plans and link some objectives to relevant cross-ministry initiatives, i.e., Ontario's Poverty Reduction Strategy was linked with the Childhood Obesity Strategy/Ontario's After-school Initiative in 2009 (14).
- The process for goal and objective setting should be facilitated by the Ontario Agency for Health Protection and Promotion and include scientific and practitioner input into program logic models developed with goals and objectives, short, medium and long term outcomes with corresponding indicators and evaluation plans attached.
- Involve expertise from relevant partners (e.g. OCGHEPA and its members, food industry and agriculture sector groups, etc.)
- Goals and objectives should go beyond traditional health outcomes such as BMI, since other food-related areas including nutritious food intake, sustainable local agriculture and food insecurity are also critical to address.
- Set targets (e.g. 2015) and goals that are achievable, attract energy and momentum and build upon the strength of the vision and goals of the Ontario Ministry of Health Promotion and Sport's Healthy Communities Framework (26).

5. Advocacy and policy development

Policy development at local, provincial and federal levels is a key strategy for the achievement of project objectives. Policies can range in scope from formal written rules addressing specific settings such as schools or workplaces to legislation affecting entire communities or

populations. Policies can make the healthy choices easier, the less healthy choices more difficult and can contribute to healthier environments. They can be applied at the local, provincial or federal level and can provide access to the key determinants of health such as education, housing and employment.

It is well recognized that due to the prevalence and extent of obesity that policy interventions focusing on the population as a whole have the potential to make much bigger contributions to tackling obesity than those targeting individuals. It is also well understood that **factors beyond health contribute** to health promoting or health compromising environments and as such, **these should be given priority in policy development** (15, 78). Healthy eating has importance beyond obesity too, and should be emphasized above and beyond weights (79). The case of dietary sodium is a timely example. Community food security provides another example, as it can impact social equity and human health, environmental health, economic vitality and sustainability. Food insecurity is associated with several negative health outcomes including obesity, nutritionally inadequate diets due to limited food access and affects vulnerable isolated communities to a greater extent (56).

Integrating sustainability, public health and economic goals into a policy framework is one approach to consider and would be a prerequisite to community food security. This would encourage community self-reliance and support community economic development. Canadian farmers are primary producers of many Canadian foods, and yet they have seen their incomes decline steadily over the past several decades. Policies to promote innovative direct marketing, local food processing and adequate wages for those who earn their livelihoods from the food system will help to protect and sustain Ontario's local food supply (56). Foodland Ontario is one example of a government program that has successfully promoted awareness and consumption of fresh Ontario produce for over thirty years, and integrating it into a policy framework could further improve sustainability of the local food supply. By beginning to redesign the food system for sustainability, Ontario will see benefits in achieving economic, agricultural, environmental and health goals.

Citizen engagement, mobilization and participation in nutrition issues are critical to advance healthy public policy at all levels and to influence policy development in other sectors such as school boards and the private sector (15). Societal attitudes about health affect whether new policies and/or programs are instituted and, if they are, whether they will yield positive results (5). For example, altering societal attitudes and the denormalization of smoking created a demand to ban smoking in public spaces in many municipal jurisdictions long before provincial policy to create a “Smoke-free Ontario” was introduced. Engaging other sectors of government, such as the Ministries of Transportation, Municipal Planning, Agriculture, Food and Rural Affairs, Aboriginal Affairs, and Children and Youth Services, along with health-related NGOs could help identify environmental barriers to healthy eating experienced by vulnerable populations and address these ahead of time. OCGHEPA, its members and other health professional groups are skilled at advocacy and at engaging the public in their issues.

Ontario has already made progress in establishing food and nutrition policies that are recommended in the literature. The new Health and Physical Education Curriculum is a Ministry of Education policy that covers a broad range of topics including healthy eating (80). According to Ontario’s Physical Health and Education Association, this new curriculum, “will be the most significant advancement in health promotion the province has ever seen” (29). With the exception of reproductive health, which is under review, it is being implemented in the fall of 2010 (80). The new Food and Beverage Policy (P/PM150) is another exciting new advancement in Ontario’s policy landscape. It is to be implemented in all schools by September 2011 and ensures that all foods sold in schools are nutrient-dense and trans-fat free (17). Ontario also benefits from the food industry’s voluntary compliance with the recommendations of the Trans Fat Task Force in reducing or eliminating artificial *trans* fat from processed food sold in retail outlets (18).

The Sodium Reduction Strategy for Canada, released in July 2010, is a multi-stage, three-pronged approach that includes structured voluntary reduction of sodium levels in processed food products and foods sold in restaurants (81). A second report to be released in December 2010 will include actual sodium reduction target values (34). Although not official policies,

strategies such as these can encourage industry to reformulate food products to result in healthier choices for Canadians. For example, in British Columbia the food industry is changing food products offered to meet the Guidelines for Food and Beverage Sales in BC Schools. The food industry is “reducing portion sizes, cutting back on salt, sugar and fat, switching to whole grains and adding fruits and vegetables” (78.)

Labeling the nutritional content of foods (i.e., calories, fat, sodium, etc.) in restaurants and take-out establishments, a policy recommended in the literature (15), is not yet required in Ontario, but will be implemented in the United States as part of its health-care reform (82). The Ontario Healthy Decisions for Healthy Eating Act, (Bill 90 in 2010 introduced as Bill 156 in 2009), would require restaurants with more than 5 units and \$5 million in revenue to post calorie counts for all menu items if it is passed. It received second reading in the Ontario Legislature on April 9, 2009 but was dropped when government prorogued and was reintroduced on June 2, 2010 by France Gelinas, NDP Health Critic, and the first reading carried (83, 84).

Regulating television commercials in children’s programming occurs in Quebec and the United Kingdom, but is not done in Ontario. Bill 53, an Act to amend the Consumer Protection Act, to ban advertising food or drink to children under the age of 13, received first reading in the Ontario legislature and was carried on April 7, 2008, but has not progressed any further (85). A similar private member’s bill at the federal level (C-324) received first reading in the House of Commons in February 2009 but has not progressed further (86). Other policy options for Ontario to consider include price supports to promote or discourage consumption of certain foods or taxes on certain foods and using the revenues to support other health promotion activities (15, 78).

Successful advocacy and policy development includes a key role for municipalities as demonstrated by the many innovative and important health policies that originated in progressive cities and towns (5). For example, Ottawa and Vancouver spearheaded smoke-free public spaces initiatives, which were eventually implemented across Canada. Similarly, the City of Toronto is taking the lead in the province by proposing that only nutritious beverages (milk, soy beverage and 100% fruit and vegetable juices) be available in city-operated community

centres and arenas. The changes, which are expected to go into effect starting in 2012 as food-service contracts come up for renewal, create momentum and set the bar for other municipalities and the province as a whole (87). Local bans on the use of *trans* fats in restaurants has proven to be more difficult in Canada, with Calgary reversing its ban after just one year of implementation due to restructuring of its health services (88). However, British Columbia has implemented a province-wide ban in foodservice operations as of September 30, 2009 after consultation with the food industry, government and the health sector (89). New York City was the first of several municipalities in the United States that has maintained such a ban, and has inspired several jurisdictions to follow suit, including Philadelphia, Boston and the State of California (90). A report of evidence-based guidelines for public health in Ontario recommends partnering with municipalities, industry, other levels of government and voluntary organizations to create public policies to increase the supply of and access to healthier foods (91). It could start with municipalities leading by example, with healthy eating policies being implemented in public buildings as is being proposed with vending machine and concession stand changes in Toronto, as well as within programs delivered in the community. Broader-based municipal food strategies and policies are also emerging across the province, such as Toronto's Food Strategy, food charters in Thunder Bay and Greater Sudbury, and Halton Region's adoption of local sustainable food procurement practices for its municipal food services (92-95). On a provincial level, British Columbia has led the country with its restriction of foods in vending machines in public buildings to healthier choices (96).

Ontario's Ministry of Health and Long Term Care is currently exploring the incorporation of **health in all policies as a means of reducing health inequity** (97). The social determinants of health are impacted by policies outside of the health sector. Therefore the only means of ensuring that policies from other sectors do not mitigate the health status of high risk population groups is to work cross-governmentally. An important first step is to re-establish an Inter-ministerial Healthy Living Committee as was done in 2006 to address this gap.

Sweden provides an example of how to take a broad government approach to policy writing. They have done so by creating social conditions for change and focusing on broad-based

solutions, rather than focusing on individual responsibility and this has resulted in its citizens enjoying the greatest life expectancy in the world (5). Policy-makers in all government ministries are guided by 11 objective domains that reflect the most important determinants of the Swedish population's health, such as participation and influence in society, conditions during childhood and adolescence, health in working life and eating habits and food (98). In Canada, Quebec's action plan for preventing obesity, *Investing for the Future*, is the only provincial strategy that specifically identifies "**promoting favourable social standards**", as one of its five priority activities (99). Since 2002, all public policies across all government ministries in Quebec must be evaluated for their impact on population health. The results of these health impact assessments must be reported to the Minister of Health (5). Similarly, in British Columbia, all ministries must have a "healthy-living lens" when proposing something to Cabinet or the Treasury Board (12). Social equity and the broad determinants of health are priorities in policy development in Sweden, Quebec and British Columbia, and a similar approach should be implemented in Ontario.

Recommendations for Advocacy and Policy Development

- Establish a **high level** Inter-ministerial Healthy Living Committee to communicate on policy development across Ministries.
- Integrate a social equity evaluation or population health impact assessment into the policy development stage across all government ministries, i.e., a "health in all policies approach"
- Include a step in policy development that assesses impact on the most vulnerable groups, such as children, immigrants, the elderly and Aboriginals
- Re-tool programs to ensure they are in alignment with the dominant social and political environment to help shift unhealthy attitudes before a policy change (5)
- Make good use of agencies and organizations external to government to provide support for policy and program development and also help with implementing new programs (5).

6. Program development

A program refers to a group of related activities carried out to achieve a specific outcome or result. For example, a program to promote healthier food choices among low income people could encompass a range of complementary initiatives, including education, food preparation

classes, field to table programs, community gardens, and public education for low income supports and other measures aimed at increasing access to affordable, nutritious food.

Program development, the creation of new and innovative approaches to public health issues, is a critical strategy for building healthier communities.

In recent years, there has been an increase in the development and implementation of food and nutrition related programs in Ontario. The Northern Vegetable and Fruit Project, which was launched in the 2006-2007 school year is one success story of a project that combines education and food access. The project has been expanded to other communities and now provides approximately 12,000 children in 60 elementary schools with three servings of vegetables and fruit each week (21). Although the expansion of the project allows more children to reap its benefits, children in other parts of the province do not have the same access. A lesson that can be learned from examining leading health jurisdictions is that these jurisdictions often skip smaller-scale demonstration projects and are the first to adopt and fully implement programs which have been proven effective elsewhere (5).

EatRight Ontario (ERO) is another example of a current provincial nutrition program. The educational website and dietitian advisory service are excellent resources for the Ontario public. However, unfortunately many Ontarians do not know that these services exist. A large-scale promotional campaign as discussed in the Communications section would heighten public awareness and profile of ERO and in turn increase uptake of its services. In addition to increasing the prominence of ERO, the program needs to be tailored to reach those who need the services most. Improvements in population health cannot be achieved until the needs of disadvantaged populations are addressed (5). Groups such as those living on low-incomes, and First Nations populations require focused attention and programming.

The Ministry of Health Promotion and Sport also funds four provincial nutrition programs (Eat Smart!, Colour It Up, Community Food Advisor, and NutriSTEP) through a transfer payment to the Nutrition Resource Centre. These programs range in scope and address areas such availability of nutritious foods in food service outlets, increasing vegetable and fruit intake, lay-

health nutrition education and preschool nutrition screening. Although they are considered provincial in scope, implementation is not mandatory. Programs are administered locally by public health practitioners. Integrating these programs more formally into the system may prove to be more efficient and effective.

In addition to the Ministry of Health Promotion and Sport, many sectors of the Ontario government are already implementing food and nutrition related programs and policies (Appendix B). Capacity should be built through vertical (local, regional and provincial) and horizontal (across Ministries) integration and comprehensive institutional organization. As a starting point, the current government initiatives related to nutrition could be integrated rather than stand as distinct programs within separate Ministries. Some examples of existing collaborative efforts are noted in the table, and more opportunities to partner should be identified and encouraged. For example, in the Northern Vegetable and Fruit Program, the Ontario Fruit and Vegetable Growers Association manage the buying and distribution of the produce in the northern and isolated communities. More economies of scale, synergistic linkages and reduced duplication of services would improve the efficiency and effectiveness of future province-wide initiatives.

Recommendations for Program Development

- Adopt and fully implement programs that have been proven successful in other jurisdictions.
- Tailor interventions to disadvantaged populations.
- Integrate existing programs across ministries to become part of a coordinated food and nutrition strategy to be lead by an inter-ministerial healthy living committee.

7. Communications

Effective communication is a key mechanism to change public awareness, knowledge, attitudes, intentions and sometimes behavior related to project priorities (2). Social marketing tactics include both earned media (e.g., media advocacy, social networking sites) as well as paid media

(e.g., print and radio public service announcements) and are integrated with programmatic interventions as part of a comprehensive strategy. Within the context of a coalition or intersectoral partnership, communications also refers to the formation and maintenance of effective networks and procedures for coordinated strategic communications.

The potential for widespread effective communication of nutrition messages among the network of public health units, community health centres, family health teams and NGOs is tremendous. An effective communication network can provide rapid response for knowledge exchange, issues management, crisis communication and strategic communication (2). What is needed is an umbrella organization or infrastructure to coordinate and manage the process and messages. As mentioned earlier, through Healthy Communities funding from the Ministry of Health Promotion and Sport, the Program Training and Consultation Centre is currently piloting a Media Network for Healthy Eating and Active Living (MN-HEAL). This initiative is an excellent first step as it has tremendous potential to develop earned media and change social attitudes. For instance, public health food and nutrition issues can be profiled in the media to increase understanding by the public about the need for a food and nutrition strategy. Additionally, the MN-HEAL supports and builds capacity among public health intermediaries to become spokespeople for the issue.

Population health communications and community-wide interventions to promote healthy eating should be tailored to people's preferences and circumstances and should aim to improve people's belief in their ability to change (91). The 2004 CMOH report, *Healthy Weights, Healthy Lives* called for a "targeted, strategic, well-resourced mass media campaign" to increase awareness of the health benefits of healthy weights, promote healthy eating and physical activity and promote energy balance within the context of a comprehensive province-wide effort to tackle unhealthy weights (33). To date this has not been addressed.

In addition to strategic communication of health messages and public awareness, communication efforts within the Ontario government need to be more effective and efficient. Improved inter- and intra-ministerial communications would strengthen government's ability to

create a healthy province. Effective communications are necessary to respond to a guiding health imperative that transcends traditional ministerial divisions. In British Columbia, the Premier set the tone that ActNow BC was a high priority across the government, by announcing it in the Throne Speech, the highest level of communication within the province (12). When an initiative is promoted by the Premier and by the Cabinet, “then you have that political drive, you start to be able to move forward and commit to things that were not always possible before.” (12). BC also credits **four key mechanisms that helped to secure partnerships** from different ministries and keep them committed and engaged:

- 1) setting goals and targets that implicated more than just the Ministry of Health,
- 2) creating a \$15 million incentive fund in the Ministry of Health, to which all ministries could submit proposals for pilot projects showing a link with the ActNow BC goals,
- 3) establishing an interdepartmental committee with an Assistant Deputy Minister from every Ministry, and
- 4) developing an accountability framework.

The United Kingdom also demonstrated leadership and collaboration in government by establishing a new **Cabinet Committee on Health and Wellbeing** to which a new cross-government obesity unit reports (73). The obesity unit includes staff and resources from across government and is supported by an expert panel of academics and a delivery reference group (of the food and health systems) from across the country.

Establishing formal communication structures is also integral to creating functional coalitions, networks and alliances composed of multiple member organizations. For example, the importance of collaboration and communication can be found in the **Nunavut Framework for Nutrition** (100). Its first goal is “to broaden the nutrition program leadership, vision, coordination and engagement of partners and stakeholders”, recognizing this as a necessary first step before achieving its population nutrition and health goals.

An additional example of recent collaboration and communication across sectors occurred in March 2010 at the **2010 Food and Health Workshop: Advancing the Policy Agenda**, organized

by Dr. David Sparling, Chair of Agri-food Innovation and Regulation at the Richard Ivey School of Business at the University of Western Ontario (39). This workshop brought together 80 policy makers, researchers, media, industry leaders and students to discuss and advise on strategies for developing and implementing effective policies to improve the health of Canadians through better food and food choices.

It is clear that **intersectoral partnerships are critical for success** but it has been recognized that they are complex and create many challenges; for example, communicating and sharing information and defining clear roles and responsibilities, especially when partners include those traditionally viewed as independent, such as the food industry (15). In the 2004 report “Healthy Weights, Healthy Lives”, Ontario’s Chief Medical Officer of Health stressed the importance of new and innovative partnerships, such as with the food industry, to enable the promotion of successful private sector initiatives to promote healthy eating (33). The Ministry of Health Promotion and Sport made a commendable effort to do just this when it conducted roundtable discussions with community representatives and stakeholders in ten communities across the province to inform the development of the Healthy Eating Active Living Strategy (24). A similar approach should be taken with multi-level and cross-government representatives; NGOs, the food industry and other provincial-level stakeholders coming together in a multi-stakeholder committee to work on identified priorities for an Ontario Food and Nutrition Strategy.

Recommendations for Communications

- Develop infrastructure to coordinate and manage communications in Ontario’s food and nutrition field.
- Engage the MN-HEAL to profile food and nutrition issues to create a demand for an Ontario Food and Nutrition Strategy. Encourage public health practitioners to take advantage of the services offered, i.e., media training by the MN-HEAL to increase capacity.
- Develop a targeted, well-resourced social marketing campaign as part of a comprehensive approach to reduce unhealthy weights and promote healthy eating.
- Re-establish a Minister’s Healthy Living Committee as introduced in 2006 to create a formal communication channel for health issues across Ministries.

- Clearly communicate the urgency and importance of the Ontario Food and Nutrition Strategy by having the Premier make the announcement about its launch.
- Support a new inter-ministerial, multi-stakeholder committee to work on identified priorities in food and nutrition. Take advantage of experience and expertise of already established alliances such as OCGHEPA and the Ontario Chronic Disease Prevention Alliance.

7. Financial transfers

Financial transfers refer to the administration of grants, contributions and contractual commitments for specific scopes of program and service delivery. These funding arrangements are linked to accountability mechanisms, such as a commitment to produce specific deliverables or a requirements to participate in evaluation.

Much of what is recommended in this report cannot be accomplished without **adequate financial resources**. Even when political and bureaucratic support helps to move things along, this support does not always bring with it additional resources. Often, the expectation is that the work is to be done with existing resources, which creates pressure and stress for those involved and limits what can be achieved (15). Provincial dollars allocated to health are increasingly needed for the health care sector, leaving a smaller portion for health promotion and disease prevention. Less than 2% of the 2008/09 Ontario Ministry of Health and Long-term Care budget was allocated to public health, and of that amount, only a small fraction is devoted to population health promotion strategies (101). Although examples of significant and recent investments can be found, such as the Diabetes Strategy, more resources are devoted to managing the disease than to its prevention. In 2010/11, the Ontario government committed \$8.5 million to create up to 14 Regional Coordination Centres to help organize and manage local

diabetes programs and also created 51 new diabetes education teams across the Province (25). Since as many as 9 in 10 cases of diabetes are Type 2 diabetes (102), which is largely preventable by maintaining a healthy lifestyle, the greatest long-term payback lies in investing more in prevention initiatives. The trend towards spending a greater proportion of health dollars in treatment and management of chronic diseases is likely to continue as the proportion of older adults in Ontario grows from 13% to 22% in the next twenty years. The health spending on this group per capita is higher than any other group (43).

It cannot be stated with certainty that **additional resources bring better population health outcomes**, but evidence in British Columbia and Quebec point toward this conclusion (5).

Currently, on a per capita basis, British Columbia spends \$21.00 on population health and health behaviour strategies and Quebec spends \$16.80. Both appear to be spending much more than Ontario, which spends only \$7.40 per capita (5). To reach British Columbia's level of spending, Ontario would need to increase its spending in population health and health behaviour strategies by about \$170 million per year (5).

There are several examples of recent provincial investments in population health strategies related to food, nutrition and obesity prevention. The Ministry of Education has committed \$1.7 million to support the local implementation of the healthy food for healthy schools policy and school boards are encouraged to consult and collaborate with public health units (17). The **After-School Program** is a combined poverty reduction and obesity reduction strategy implemented in 2009/10 with a commitment of \$10 million per year (14). The program is

expected to reach 15,500 children and youth in 270 sites and has been prioritized to be accessible to communities most at-risk. While this is a great start and demonstrates intersectoral collaboration, much more funding would be required for this to be a population-wide initiative accessible to all children and youth across the province. Ontario needs more intersectoral collaboration to address poverty and health at the population level.

The **Northern Vegetable and Fruit program has been evaluated and expanded** as a result of its initial success (21). **Sufficient funding** from the Ministry of Health Promotion and Sport was identified as a key facilitator to the program, enabling delivery of a variety of vegetables and fruit of good quality. This program allows children from northern communities, who have had limited exposure to vegetables and fruit, to enhance their intake through consumption at school. Key recommendations in the evaluation included ensuring **sufficient ongoing funding** to assist schools with the preparation, storage and accessibility of fresh produce and to assess the lasting impact on the population over time. The evaluation also recommended **liaising with other Ministries** to enhance the accessibility of reasonably-priced quality fruit and vegetables for communities where barriers exist. A similar program in British Columbia operates with funding and collaboration among three provincial ministries (Healthy Living and Sport, Education and Agriculture and Lands), and serves students in over 1,000 public elementary schools (103). The Ontario program is a perfect example of one that would benefit from intersectoral collaboration to improve quality, efficiency, effectiveness and reach.

The Ministry of Health Promotion and Sport includes nutrition and healthy eating as one of its stated priorities yet does not reflect this in its operating budget. Of the \$382,558,400 listed as

total estimated operating expenses for 2009/10, only \$3,673,100 (1%) is allocated to nutrition and healthy eating (104). While an increase in intersectoral initiatives and shared funding will help to offset this budget constraint, a priority program would seem to require more than 1% of operating funds.

The Ministry of Health Promotion has been developing a new approach, called Ontario Healthy Communities, to help achieve its vision of *Healthy Communities working together and Ontarians leading healthy and active lives* (26). This approach is intended to encourage community collaboration to address factors for good health, in support of the ministry's priorities. These priorities include: physical activity; healthy eating; mental health; reducing tobacco use and exposure; preventing alcohol/substance misuse; and preventing injuries. Funds can be directed to grants, planning partnerships or resource centres, focused on training and support for community capacity building (26). This approach to building healthy communities is intended to:

- Improve health and well-being, reduce risks to good health and save health care costs;
- Promote partnerships between health promotion organizations and networks;
- Promote coordinated action at the local, regional and provincial level
- Create policies, plans and programs that make it easier for Ontarians to be healthier where they live, work, study or play.

Although there is \$14 - \$16 million available to communities from this Fund, the amount that may be dedicated to nutrition programs cannot be clearly identified (34). Nutrition and food skills programs may be underfunded due to the requirement that two or more priority areas be included in grant applications.

Recommendations for Financial Transfers

Double or triple per capita spending on population health and health promotion strategies to be on par with Quebec or British Columbia. This can be achieved by:

- Doubling the budget for public health in Ontario from 1.6% to 3.2% to enhance population-based strategies, targeted to priority populations in local regions

- Increasing the proportion of the Ontario Diabetes Strategy that is directed toward prevention programs.
- Expanding existing programs such as the After-school Initiative and the Northern Vegetable and Fruit Program to reach more at-risk communities each year.
- Doubling or tripling the funding devoted to nutrition and healthy eating in the Ministry of Health Promotion and Sport's Operating Budget to demonstrate its priority status.
- Amend the Healthy Communities funding requirements so that initiatives that focus solely on nutrition and food skills can be included.

8. Human resources

Human resources refer to the professionals and volunteers involved in the planning, implementation and assessment of primary prevention initiatives. Each of the components listed above have associated skills and competencies. As is the case in most human resource planning, there should be a system to **assess, develop and sustain the human resources** capacity of an initiative.

In BC, a special **Minister of State** was designated to coordinate and oversee the entire ActNow BC strategy and was accountable to the government for achieving the program goals (12). This Minister provided strategic facilitation and cross-government coordination, encouraged the investment of seed money across government to galvanize action and ensured expert advice and support in developing ActNow BC initiatives and policy (12). The United Kingdom's investment in food and nutrition was even greater, with the development of a **Food Standard Agency**, an independent government department, set up by an Act of Parliament in 2000 (105). The Ministry of Health Promotion and Sport could have a similar capacity if it enhanced its staff dedicated to nutrition and healthy eating.

The Ministry of Health Promotion and Sport does provide funding to the Ontario Public Health Association for the **Nutrition Resource Centre** (NRC), developed in 1999 to support local nutrition practitioners (106). The NRC employs 6 Registered Dietitians (equivalent of less than 5.0 full-time equivalents) who develop, promote, disseminate and support the implementation of provincial nutrition programs and resources. This Centre provides much needed provincial-

level service, but could be enhanced by acting as a key partner in intersectoral planning for future policy and programs.

In the Healthy Eating and Family Health division of the Ministry of Health Promotion and Sport, only one full-time position is a mapped Registered Dietitian position (107). Due to this limited capacity in nutrition expertise, the Ministry of Education is capitalizing on the current partnership between the Ministry of Health Promotion and Sport and Dietitians of Canada (DC) for EatRight Ontario (ERO). To support the Ministry of Education with the planning or implementation of the School Food and Beverage Act, DC is presently recruiting a full time Registered Dietitian. The Registered Dietitian will provide consultation to the Ministry of Education and guidance to stakeholders in the implementation of the P/PM 150. Dietetic expertise is essential to better assist stakeholders involved in the policy implementation and to enhance the capacity of the Ministry staff, ERO contact centre, and local public health units to support school stakeholders.

The Ministry of Health and Long-term Care published its plans for restructuring in 2009 to include professional practice positions for nursing, epidemiology, and health inspection, but none for nutrition (108). There is a lack of positions for Registered Dietitians at both the provincial and local levels of government. There are no dietitians at the Ministry level and few at the local level (only through public health or in kind contributions) to support development of proposals or review grant applications for the Healthy Communities Fund, which may result in fewer nutrition programs being funded or projects being funded that are not the most effective for developing food skills and increasing access to healthier foods. At the local level, public health nutritionists are few in number and have limited time to help plan, develop, implement and evaluate projects. Many healthy living and wellness projects do not use registered dietitians for planning or implementing their projects and as a result, the content and effectiveness of these projects may be of concern. Funding for dietitians to provide program planning and implementation services for community projects should be covered by the Healthy Communities Fund.

Ontario's Community Health Centres (CHCs), funded by the provincial government through the province's 14 Local Health Integration Networks (LHINs), offer a balance of primary health care, illness prevention and health promotion programs (32). Expected to serve 110 Ontario communities by 2010, each CHC's budget ranges from \$1.8 million to \$12 million with a range of 12 to 130 full-time staff equivalents (32). Each CHC determines its own local priority population, which may include Aboriginals, children and youth, immigrant and ethnocultural communities or low-income/unemployed. Dietitians are on staff at many CHCs and clients had 14,879 encounters with a dietitian in 2006/07. However, **CHCs face ongoing recruitment and retention problems for dietitians** as the funding envelope does not provide enough for benefits and pension packages to be competitive with other institutions such as hospitals. For example, when the Ministry of Health and Long-term Care and one LHIN wanted to transfer a hospital-run diabetes education program to a local CHC, a major stumbling block was a \$20,000 differential in the dietitian's salary, added to the fact that the CHC could not provide a pension to staff (32). Family health teams (FHT) have faced the same recruitment and retention challenges for Registered Dietitians with compensation packages that don't compete with dietetic positions in other settings (109). **Insufficient funding is an important barrier** to the capacity of CHCs and FHTs to provide important services, including those related to food and nutrition.

A search of the College of Dietitians of Ontario website of members who work in "public health" listed 144 Registered Dietitians across the province, approximately half of which are located in Toronto (110). This is not an accurate reflection of the services in the community related to food and nutrition as some of these dietitians work in administrative roles; positions that are gapped or unfilled in remote regions are not reflected. Even if all were counted as working toward community-based nutrition promotion, this number represents only 3.5% of all Registered Dietitians in Ontario (111). A similar number (approximately 140) of Registered

Dietitians are employed by Family Health Teams across the province, but their primary roles are to provide therapeutic nutrition care and nutrition screening as part of primary health care (112). It is not clear how much time or resources are allocated to nutrition promotion by Family Health Teams. Community nutrition will also be losing Registered Dietitians engaged in research in 2011 with the transfer of the PHRED programs to OAHPP (109). EatRight Ontario (ERO) employs dietitians to provide free advice to individuals on nutrition or healthy eating via phone or email. Although this service has increased access to dietitians for Ontarians, and is available in over 100 languages, as previously noted, there is still much to accomplish in terms of program enhancements to ensure that disadvantaged groups who need the services the most, are able to access them. ERO is a good example of a partnership between the Ministry of Health Promotion, which provides the funding and Dietitians of Canada, which manages the call centre, email service and web site.

It is evident that there is room for significant improvements to the public health nutrition workforce. Developing and implementing a public health workforce capacity assessment for dietitians and other allied health professionals will provide further detail on what specific areas require immediate attention and investment.

Recommendations for Human Resources

- Create human capacity at all levels: including sufficient positions for Registered Dietitians to support provincial initiatives.
- Ensure Ministries with nutrition-related policy or programs have in-house expertise for planning, implementation and evaluation.
- Develop recruitment and retention incentives for Registered Dietitians to go to under-served communities, which are often those most at-risk
- Create more community-based internship or training opportunities for graduates of accredited nutrition university programs to develop the workforce.
- Provide sufficient funding to Community Health Centres and Family Health Teams to allow equitable employment opportunities to health professionals such as Registered Dietitians
- Explore more partnerships when government human resources don't have the capacity to deliver on goals (such as with DC to deliver EatRight Ontario).
- Encourage OAHPP to develop and implement a public health workforce capacity survey to examine current capacity and inform knowledge exchange and capacity building initiatives to improve knowledge, skills and abilities within the existing nutrition workforce

9. Evaluation and learning

Evaluation is the systematic gathering, analysis and reporting of information to assist in decision making. In addition to assessing the effectiveness of a program or policy in meeting longer term outcomes, evaluation can also focus on continuous quality improvement (the collection of shorter-term information about what does/does not work to guide planning and decision making). Evaluation can be a costly and time consuming process and with the exception of tobacco use reduction, health promotion initiatives in Ontario are not well supported by evaluation infrastructure (31). It involves the systematic gathering, analysis and reporting of information to assist in decision-making. Many successful health promotion initiatives are not subject to any type of impact evaluation, or rely only on short-term, post-test only, self report data subject to social desirability bias and other threats to validity (31). This may be a result of lack of financial or human resources, but **evaluation should be encouraged, funded and expected**. Greater cooperation and sharing of evaluation information is necessary to promote the adoption of best practices addressing nutrition and healthy eating.

Traditional outcome evaluations can be challenging in health programs since the **benefits of intersectoral action and length of time for change in health outcome (i.e., obesity prevalence rates) may take several years to materialize** (31). In the United Kingdom, the government demanded very early evidence of impact, so the intersectoral partnership placed an early emphasis on recording outputs for individual projects (112).

Successful **evaluations can bring more political support and funding for programs** and interventions as was shown in the Northern Vegetable and Fruit Pilot Program (21). After evaluating the impact of the pilot on 5,000 children's vegetable and fruit consumption in 24 elementary schools in Northern Ontario, it was expanded to 60 schools across the North, serving 12,000 children. Similarly, other large scale policies and programs such as the school food and beverage policy, the projects via the Healthy Communities Fund and the After-school Program (14) should be evaluated to assess impact. A natural experiment occurring in the

Ontario right now is the provincial roll-out of mandated school nutrition standards with no plan for evaluating their efficacy. Instead, building evaluation into initial planning phases guarantees that resources are available to complete it, ensure baseline data is collected and expedites information needed to provide support for expansion.

Strengthening linkages with academic institutions, such as was done with the PHRED program, can also enhance capacity for evaluation and learning, especially as resources for these components are often limited or lacking. Evaluation specialists are few and epidemiologists average only 1 full-time equivalent per health unit with a 9% vacancy rate (7). The services and expertise of both are in great demand, which severely limits what can be accomplished at the local level. The OAHPP will compensate for some of these capacity issues with expert scientific and technical support, epidemiology and surveillance at the provincial level, but meeting local data needs may be more of a challenge.

Recommendations for Evaluation and Learning

- Strengthen linkages with organizations with capacity to conduct evaluations, such as universities, colleges and OAHPP (PHRED).
- Use evaluation results to secure growth and expansion of small initiatives to become population-wide.
- Fund evaluation as a necessary component of any new program or policy and ensure the expertise is on staff or contracted with a partner as necessary.
- Emphasize early outcome evaluation of any new intersectoral partnership initiatives.
- Identify specific indicators to be collected but allow local autonomy to conduct evaluation.

10. Surveillance, performance monitoring and accountability

Surveillance is population-based, involves the collection of data (i.e., health event or determinant of health) at regular intervals and includes the production of surveillance products that add value to the data through integration, analysis, interpretation and dissemination (13).

Surveillance products must be made available in a timely fashion and the systems must be able to respond quickly to changes, including new health events. Surveillance is a key function of the new **Ontario Agency for Health Protection and Promotion**. As such, OAHPP employs experts in surveillance, epidemiology, biostatistics, geospatial analysis and mathematical modeling (22). It is currently collaborating with the Association for Local Public Health Agencies and other public health partners to develop Childhood Healthy Weights Surveillance in Ontario. The OAHPP is also developing a Burden of Illness Report in late 2010 on overweight and obesity (77). Data generated from this surveillance activity and report can be used to assess impacts of future obesity prevention and nutrition policy initiatives.

The OAHPP is also involved in strengthening and enhancing the former **Ontario Rapid Risk Factor Surveillance System** (RRFSS) into the Ontario Risk and Behaviour Surveillance System Project (ORBSS) (23, 113). RRFSS began in 1999 as a pilot telephone survey of adults in Durham Region. A random sample of approximately 200 residents was surveyed each month on various lifestyle behaviours associated with chronic diseases and injuries. Since 2007, 21 health units have participated in RRFSS. It provided timely data relevant to local public health needs to support program planning and evaluation, to advocate for public policy development and to improve community awareness regarding the risks for chronic diseases and injuries (23). The ORBSS Project Advisory Committee has published an environmental scan and options paper which outline possibilities for a province-wide risk and behaviour surveillance system (113).

The Canadian Community Health Survey and the Ontario Health Study can be built upon by committing further resources for data analysis, interpretation, and reporting so that the contribution of diet to obesity can be better understood and acted upon (78, 114). Surveillance mechanisms to monitor social trends such as television viewing, food purchasing patterns, food supply (including environmental exposures and food contaminants/risks), and marketing strategies related to food could contribute to the understanding of environmental determinants of obesity (78).

Aboriginal peoples experience a high incidence of nutrition-related health problems so information through surveillance and monitoring of this group is a priority. There are some unique considerations and issues with respect to surveillance initiatives for Aboriginal populations. Surveillance must be culturally appropriate to meet community needs and realities and ensure extensive community involvement at all stages (13).

In 2004, Ontario's Chief Medical Officer of Health recommended that the Ontario government conduct ongoing, province-wide monitoring for chronic disease risk factors and use this information to inform policy and programs (33). Ontario's Action Plan for Healthy Eating and Active Living (HEAL) states that **the government will "invest in results"** and that it will **"monitor our programs to measure and evaluate the impacts of our strategy"** (24). According to an independent review of this Action Plan, it includes specific targets and dates for active living and smoking but none for diet or obesity reduction (2). It could be that there is a willingness but a lack of resources to implement these commitments more fully, influencing development of health public policy. Performance monitoring includes the assessment of some activities, outputs and immediate outcomes, measured relative to baseline levels, targets or benchmarks. To date, an evaluation of the Northern Vegetable and Fruit Pilot Project is the only piece of evaluation of the HEAL Action Plan that has been released on the PHRED website (115).

Performance monitoring and accountability operate on at least two levels. At the level of performance, some activities, outputs and immediate outcomes can be measured and assessed relative to baseline levels, targets or benchmarks. At a higher level, accountability can contribute to resource allocation decisions to improve the effectiveness of primary prevention strategies.

An example of a provincial program that has performance monitoring in place is the Ontario Diabetes Strategy (25). It is "tracking progress in its fight against diabetes" and has set specific measurable targets to achieve by 2012, such as "ensuring that 80 percent of people with diabetes, aged 18 and older have all three diabetes tests within the recommended guideline period for optimal diabetes management." Unfortunately, all of the stated targets address

people already living with diabetes, rather than prevention. The Diabetes Strategy does have provincial coordination in place, with 14 regional coordination centres across the province to help ensure access and continuum of care (25). Ontario's Public Health Units would also be able to assist in coordination, determining local population needs and service gaps as part of an overall monitoring system for the province, however financial investment would be necessary to make this happen.

With respect to accountability, Sweden includes municipalities in accountability for the nation's public health goals (5). Accountability can contribute to resource allocation decisions to improve the effectiveness of primary prevention strategies. Mechanisms that involve vertical and horizontal accountability in a provincial food and nutrition strategy may help ensure goals and objectives are met.

Recommendations for Surveillance, Performance Monitoring and Accountability

- Encourage the OAHPP develop a surveillance, performance monitoring and accountability system for the Ontario Food and Nutrition Strategy, with specific outcomes and health determinant indicators
- Participate in strengthening and enhancing the Ontario Risk and Behaviour Surveillance System to provide local surveillance data and ensure food and nutrition indicators are included (i.e., knowledge, attitudes and behaviours for supports and barriers to healthy eating, cost of a nutritious food basket, macro and micronutrient intake, etc.)
- Develop specific targets for the province with respect to diet and obesity reduction.
- Use surveillance trends to inform food (including behaviour, intentions, resiliency), nutrition and obesity policy development.
- Prioritize development of surveillance tools for groups most at-risk and missed in traditional surveillance, such as Aboriginals and immigrants with language barriers.
- Include more performance monitoring targets in initiatives with nutrition as a key component, as was done in the Ontario Diabetes Strategy.

Conclusions and Next Steps

Ontario is ready for a comprehensive food and nutrition strategy. Ever-increasing health care costs and rates of nutrition-related chronic diseases, disparities in health among certain groups, municipal and regional action to develop food policies around the province, and advocacy and

programming by many organizations have built a momentum and energy that should be seized now. Childhood obesity has been described as “the new tobacco”, an epidemic that will require changes on the scale of a social movement similar to the shift in attitudes and regulation toward smoking and tobacco (116). Ontario simply cannot afford to wait any longer.

The analysis of the current provincial capacities in this paper offers a springboard for action in the development of a provincial Food and Nutrition Strategy or Action Plan. The menu of recommendations can be used as a framework for dialogue among cross-government representatives and partnership organizations. By engaging the whole government, we can ensure mutual priorities become part of the Strategy’s priorities: such as ensuring student success, increasing the demand for and supply of Ontario fresh food and processed food products, reducing poverty and minimizing the economic burden of health care costs on the rest of the province.

Next Steps:

In the short-term, the Ontario Collaborative Group on Healthy Eating and Physical Activity proposes to:

- **Establish an inter-ministerial, multi-stakeholder committee to begin work on an Ontario Food and Nutrition Action Plan.** This will be done by:
 - Conducting one-on-one meetings with staff level representatives of stakeholder ministries and stakeholders external to government to assess these ideas and gain more direction.
 - Meeting with and engaging new partners such as those already advancing an integrated health and food policy framework: Dr. David Sparling of the Richard Ivey School of Business who hosted the 2010 Food and Health Workshop, Food and Health: Advancing the Policy Agenda (39).
 - This group could be formed out of the fall 2010 “Think Tank” as detailed below.
- **Request the Ontario Agency for Health Protection and Promotion to host a “think-tank” focus group meeting in the fall of 2010 of senior level representatives of ministries and stakeholders consulted.** The purpose of the “Think Tank” would be to:
 - Identify specific goals, outcomes and health indicators that will be monitored and evaluated between now and 2015

OCGHEPA encourages the Ontario Government to take the following longer-term steps:

- **Establish a high level inter-ministerial Healthy Living Committee as introduced in 2006 to set broad direction for all ministries on matters related to promoting a healthy province.**

This committee will spearhead discussions on healthy population goals and objectives related to healthy eating and physical activity. The committee would aim to:

- Improve the process of collaborating among ministries on policy development for the Food and Nutrition Action Plan, especially for policies at the population level; assessing each policy option for social equity and for any potential impact on nutritional health.
 - Develop an infrastructure or mechanism to ensure clear, effective, timely communication occurs at all levels and among all players: within and between ministries, within the Healthy Living Committee, with non-governmental partners and the public.
- **Increase investments in population health initiatives aimed at achieving expected outcomes identified in the Ontario Food and Nutrition Action Plan and offset increased investments with an increase in inter-ministerial initiatives that are jointly funded.**
 - **Roll out the Strategy goals as a whole government initiative with specific measurable short-term targets identified.**

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Appendix A

Ontario Collaborative Group on Healthy Eating and Physical Activity Organizations with Member Representatives

- Canadian Cancer Society (Ontario Division)
- Cancer Care Ontario
- Canadian Diabetes Association
- Dietitians of Canada
- Heart and Stroke Foundation of Ontario
- Ontario Chronic Disease Prevention Management in Public Health
- Ontario Ministry of Agriculture, Food and Rural Affairs
- Ontario Ministry of Health Promotion and Sport
- Ontario Public Health Association – Nutrition Resource Centre & Food Security Workgroup
- Ontario Society of Nutrition Professionals in Public Health
- Ontario Society of Physical Activity Promoters in Public Health
- Ontario Physical and Health Education Association
- Parks and Recreation Ontario
- University of Guelph, Human Health and Nutritional Sciences
- University of Waterloo, Health Studies and Gerontology

Appendix B

Table 1
Examples of Ontario Ministry Programs and Key Policies Related to Food or Nutrition

| Ontario Ministry | Programs/Key Policies Relating to Food or Nutrition | | | | |
|---|--|---|---|---|---|
| Aboriginal Affairs ² | Aboriginal Health Policy (1994) ³ | Aboriginal Healing and Wellness Strategy ⁴ (partnership of several Ministries: Aboriginal Affairs, Comm. & Social Services, Health and Long-term Care, Ont. Women’s Directorate) | | | Student Nutrition Program Grants ⁵ (funding also provided by Ministry of Children and Youth Services) |
| Agriculture, Food and Rural Affairs ^{6, 7} | Foodland Ontario (contributes recipes to EatRight Ontario, resources include availability guide, nutrition guide, calendar books, recipe books), Pick Ontario Freshness ^{5,6} | Savour Ontario (restaurants) ⁵ | Ontario Farmers’ Market Strategy ⁵ | Food for Health Research Theme ⁶ | Contributed technical expertise to development of Northern Fruit and Vegetable Program, School Food and Beverage Policy, Student Nutrition Program, and After-School Program ⁶ |
| Children and Youth Services ⁸ | Student Nutrition Program ⁹ (guidelines developed with other Ministries and external partners) | Revision of Day Nurseries Act ¹⁰ | | | New (2008-09) Standards to improve food and nutrition in licensed residential settings for children and youth ¹¹ |
| Culture ¹² | Ontario Trillium Foundation ¹³ (grants to community groups) | | | | |

² Ontario Ministry of Aboriginal Affairs: available at <http://www.aboriginalaffairs.gov.on.ca/english/default.asp>

³ Aboriginal Health Policy (1994): available at <http://www.ahwsontario.ca/about/healthpolicy.html>

⁴ Aboriginal Healing and Wellness Strategy: available at <http://www.ahwsontario.ca/index.html>

⁵ Student Nutrition Program Grants for Aboriginal communities: available at http://www.aboriginalaffairs.gov.on.ca/english/about/moving_forward_together/improving_social_conditions.asp

⁶ Ontario Ministry of Agriculture, Food and Rural Affairs: available at <http://www.omafr.gov.on.ca/english/index.html>

⁷ Jeff O'Donnell, Team Lead, Healthy Eating, Ontario Ministry of Agriculture, Food and Rural Affairs. Personal communication, May 18, 2010.

⁸ Ontario Ministry of Children and Youth Services: available at <http://www.children.gov.on.ca/>

⁹ Student Nutrition Program Grants: available at <http://www.children.gov.on.ca/htdocs/English/topics/schoolsnacks/index.aspx>

¹⁰ Day Nurseries Act: available at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90d02_e.htm

¹¹ 2008-09 Standards to improve food and nutrition in licensed residential settings: http://www.children.gov.on.ca/htdocs/English/about/Results_2009-2010.aspx

¹² Ontario Ministry of Culture: available at <http://www.culture.gov.on.ca/english/index.html>

¹³ Ontario Trillium Foundation: available at <http://www.trilliumfoundation.org/cms/en/index.aspx>

| Ontario Ministry | Programs/Key Policies Relating to Food or Nutrition | | | | |
|---|---|--|--|--|--|
| Education ¹⁴ | Trans fat (2008) and School Food and Beverage Policy – guidelines developed with other Ministries and external partners (Jan 2010 to be implemented by Sept. 2011) | | Foundations for a Healthy School (encourages healthy school nutrition environment, school gardens, etc.) | Healthy Schools Recognition Program | Health and Physical Education Curriculum |
| Health and Long-term Care | Family Health Teams – now 150 (with 140 Registered Dietitians) ¹⁵ Mental health promotion: Eating disorder outreach ¹⁶ Community Health Centres (43 in urban and 11 in rural Ontario, many with dietitians) ¹⁷ | | | | |
| Health Promotion ¹⁸ | Ontario Healthy Communities ¹⁸ | Ontario Stroke Strategy ¹⁸ , Diabetes Strategy ¹⁸ | Northern Vegetable and Fruit Project ¹⁷ | After-school Initiative ¹⁸ | EatRight Ontario ¹⁸ Nutrition Resource Centre ¹⁸ |
| Municipal Affairs and Housing ¹⁹ | Greenbelt Act (to protect valuable agricultural land and green space in the Greater Toronto Area) ²⁰ | | | Planning Act/Community Improvement Plans (gives municipalities tools to provide incentives for community improvements such as locating grocery stores near affordable housing) ²¹ | Rent Increase Guideline (maximum allowable annual rent increases tied to inflation to help ensure more money for food) ²² |

¹⁴ Ontario Ministry of Education: available at <http://www.ontario.ca/healthyschools>

¹⁵ Family Health Teams: http://www.health.gov.on.ca/transformation/fht/fht_mn.html

¹⁶ http://www.health.gov.on.ca/english/media/news_releases/archives/nr_06/may/nr_052306.html

¹⁷ Community Health Centres: http://www.health.gov.on.ca/english/public/contact/chc/chc_mn.html

¹⁸ Ontario Ministry of Health Promotion: available at <http://www.mhp.gov.on.ca/en/default.asp>

¹⁹ Ontario Ministry of Municipal Affairs and Housing

²⁰ Greenbelt Protection: available at <http://www.mah.gov.on.ca/Page187.aspx>

²¹ Community Improvement Plans: available at <http://www.mah.gov.on.ca/Page223.aspx>

²² 2010 Rent Increase Guidelines FAQ: available at <http://www.mah.gov.on.ca/Page6537.aspx>