

**REVISED AGENDA**  
**MIDDLESEX-LONDON BOARD OF HEALTH**

399 RIDOUT STREET NORTH  
SIDE ENTRANCE, (RECESSED DOOR)  
Board of Health Boardroom

Thursday, 7:00 p.m.  
2013 November 21

**MISSION - MIDDLESEX-LONDON BOARD OF HEALTH**

The mission of the Middlesex-London Health Unit is to promote wellness, prevent disease and injury, and protect the public's health through the delivery of public health programs, services and research.

**MEMBERS OF THE BOARD OF HEALTH**

Mr. David Bolton	Mr. Ian Peer
Ms. Denise Brown (Vice Chair)	Ms. Viola Poletes Montgomery
Mr. Al Edmondson	Ms. Nancy Poole
Ms. Patricia Fulton	Mr. Mark Studenny
Mr. Marcel Meyer (Chair)	Ms. Sandy White
Mr. Stephen Orser	

**SECRETARY-TREASURER**

Dr. Christopher Mackie

**DISCLOSURE OF CONFLICTS OF INTEREST**

**APPROVAL OF AGENDA**

**APPROVAL OF MINUTES**

**SCHEDULE OF APPOINTMENTS**

7:05 - 7:20 p.m.	Ms. Trish Fulton, Chair, Finance and Facilities Committee re Item # 1 Report No. 118-13 Finance and Facilities Committee Meeting – November 7
7:20 - 7:35 p.m.	Ms. Hillary Caldarelli, Epidemiologist, re Item #2 Report No. 119-13 Middlesex- London I-Track Survey of People Who Inject Drugs
7:35 - 7:50 p.m.	Family Health Services re Item #3 Report No. 126-13 Middlesex County: Impact of Social and Economic Changes on Human Services Needs

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
<b>Committee Reports</b>						
1	Finance and Facilities Committee (FFC) Report - November 7 <sup>th</sup> Meeting Report No. 118-13	Appendix A	x	x		For the Board of Health to receive information and consider recommendations from the November 7 FFC meeting
<b>Other Delegation and Recommendation Reports</b>						
2	Middlesex-London I-Track Survey of People Who Inject Drugs Report No. 119-13	Appendix A	x		x	To report the results of the I-Track survey of people who inject drugs that was conducted in London and other areas across the country
3	Middlesex County: Impact of Social and Economic Changes on Human Services Needs Report No. 126-13	Appendix A	x		x	To present findings of the <a href="#">Middlesex County: Impact of Social &amp; Economic Changes on Human Service Needs Report</a> re existing needs of Middlesex County communities, and make recommendations for further actions related to human service needs
4	Menu Labelling: Improving the Food Environment Report No. 120-13	Appendix A Appendix B		x		To request Board of Health support to advocate for provincial menu labelling legislation that includes calories and sodium content on menus
5	Criteria Weights for 2014 Budget Report No. 121-13			x		To request Board endorsement of the criteria weights that will be applied to developing proposals for resource investment and disinvestment within the Health Unit
<b>Information Reports</b>						
6	Tobacco Promotion in Tobacco Retailers Report No. 122-13				x	To update the Board of Health about the ongoing promotion and enforcement of the <a href="#">Smoke-Free Ontario Act (SFOA)</a> and surveillance of tobacco industry activities
7	Updated Board of Health E-Learning Module Report No. 123-13				x	To report that an updated <a href="#">Board of Health E-Learning Module</a> has been released by the Ministry of Health and Long-Term Care that provides valuable content for both new and experienced Board of Health members

Information Reports (continued)						
8	Health at Work 4 All! 2013 Report No. 124-13				x	To summarize the Health at Work 4 All! Program that is a collaboration of MLHU and two other health units to help employers make positive changes in their workplaces
9	tykeTALK: Thames Valley Preschool Speech And Language Program, The Infant Hearing Program - Southwest Region and The Blind Low Vision Early Intervention Program Report No. 125-13				x	To describe changes made by the Ministry of Children And Youth Services to tykeTALK: Thames Valley Preschool Speech and Language Program, the Infant Hearing Program - Southwest Region, and The Blind Low Vision Early Intervention Program
10	Medical Officer of Health Activity Report – November Report No. 127-13				x	To provide an update on the activities of the MOH for November

## CONFIDENTIAL

## OTHER BUSINESS

Next scheduled Finance and Facilities Committee Meeting: Thursday, November 28, 2013 10:00 a.m.

Next scheduled Board of Health Meeting: Thursday, December 12, 2013 6:00 p.m.

## CORRESPONDENCE

- a) Date: 2013 October 18 (Received 2013 October 28)  
Topic: Resolution to ask the MOHLTC to Enhance Access to Oral Care Services  
From: Mr. Carman Kidd, Chairperson, and Dr. Marlene Spruyt, MOH & CEO, Timiskaming Health Unit  
To: The Honourable Deb Matthews, Minister of Health and Long-Term Care
- b) Date: 2013 October 28 (Received 2013 October 31)  
Topic: Transportation and Public Health  
From: Dr. Penny Sutcliffe, Medical Officer of Health, Sudbury and District Health Unit  
To: Mayors/Reeves of Constituent Municipalities
- c) Date: 2013 October 30 (Received 2013 November 4)  
Topic: Formula industry violations of the International Code of Marketing Breastmilk Substitute and Advocate for legislation of the Code in Canada  
From: Mr. David Watton, Chair, Board of Health, Peterborough County-City Health Unit  
To: The Honourable Rona Ambrose, Minister, Health Canada
- d) Date: 2013 October 31 (Received 2013 October 31)  
Topic: Discontinuation of Sewage System Management Program (Part 8 Program)  
From: Ms. Chandra Tremblay, Manager, Communication Services, Haliburton, Kawartha, Pine Ridge District Health Unit  
To: All Health Units
- e) Date: 2013 November 13 (Received 2013 November 13)  
Topic: Minister of Health and Long-Term Care announced proposals for legislated enhancements to the Smoke-Free Ontario Act  
From: Mr. Gord Fleming, Manager, Public Health Issues, alPHa  
To: All Boards of Health

## ADJOURNMENT



## PUBLIC SESSION - MINUTES

### MIDDLESEX-LONDON BOARD OF HEALTH

2013 October 17

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**MEMBERS PRESENT:** Mr. David Bolton  
Ms. Denise Brown (Vice-Chair)  
Mr. Al Edmondson  
Ms. Trish Fulton  
Mr. Marcel Meyer (Chair)  
Mr. Stephen Orser  
Mr. Ian Peer  
Ms. Viola Poletes Montgomery  
Ms. Nancy Poole  
Ms. Sandy White

**REGRETS:** Mr. Mark Studenny

**OTHERS PRESENT:** Mr. Wally Adams, Director, Environmental Health and Chronic Disease Prevention Services  
Ms. Vanessa Bell, Manager Privacy and Workplace Safety  
Ms. Diane Bewick, Director, Family Health Services  
Mr. Dan Flaherty, Manager, Communications  
Mr. Ross Graham, Manager of Strategic Projects  
Ms. Kim Leacy, Registered Dietitian  
Ms. Sarah Maaten, Epidemiologist  
Dr. Christopher Mackie, Medical Officer of Health & CEO  
Mr. John Millson, Director, Finance and Operations  
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)  
Ms. Pat Simone, Manager, Emergency Preparedness  
Ms. Louise Tyler, Director, Human Resources and Labour Relations Services  
Mr. Alex Tysl, Online Communications Coordinator  
Dr. Bryna Warshawsky, Associate Medical Officer of Health and Director, Oral Health, Communicable Disease & Sexual Health Services

**MEDIA OUTLETS:** Mr. Craig Gilbert          London Community News

Board of Health Chair, Mr. Marcel Meyer, called the meeting to order at 7:00 p.m.

#### **DISCLOSURES OF CONFLICT(S) OF INTEREST**

Chair Meyer inquired if there were any disclosures of conflict of interest to be declared. None were declared at this time.

#### **APPROVAL OF AGENDA**

It was moved by Mr. Edmondson, seconded by Mr. Bolton that the AGENDA for the October 17, 2013 Board of Health meeting be approved.

Carried

## APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Ms. White *that the [MINUTES](#) for the September 19, 2013 Board of Health meeting be approved.*

Carried

## COMMITTEE REPORTS

### 1) Finance and Facilities Committee (FFC) Report, October Meeting ([Report No. 108-13](#))

Ms. Trish Fulton, Chair of the Finance and Facilities Committee (FFC), introduced Report No. 108-13 re the October Finance and Facilities Committee meeting.

#### Business Arising from the October 3 FFC meeting

It was moved by Ms. Fulton, seconded by Mr. Peer *that the Board of Health approve the meal allowances, identified in Policy 4-120 "Out-of-Town Travel," attached as Appendix B to Report No. 010-13C, be reduced to \$10/\$20/\$30 and the per diem rate be eliminated.*

Carried

It was moved by Ms. Fulton, seconded by Ms. White *that the Board of Health endorse the Board Chair to sign the Counterpoint Needle Exchange Program Agreement with the Regional HIV AIDs Connection as appended to Report No. 011-13C.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Orser *that the Board of Health approve the Panorama Implementation Project budget as attached to Report No. 012-13C.*

Carried

It was moved by Ms. Fulton, seconded by Ms. White *that the Board of Health direct Health Unit staff to perform a market assessment review and to bring back options regarding the Strathroy office lease to the Finance and Facilities Committee prior to the end of 2013.*

Carried

It was moved by Ms. Fulton, seconded by Mr. Orser *that Report No. 108-13, including the draft minutes of the October 3, 2013 Committee meeting, be received for information.*

Carried

## ACTION REPORTS

### 2) Proposed Criteria for 2014 Budget ([Report No. 117-13](#))

Dr. Christopher Mackie, Medical Officer of Health and CEO, assisted Board members with their understanding of this report and reported that Board members will be participating in Program Budgeting and Marginal Analysis process (PBMA) at the November 1<sup>st</sup> retreat with the help of Professor Craig Mitton and Dr. Francois Dionne, experts in PBMA.

It was moved by Mr. Edmondson, seconded by Ms. Poletes Montgomery *that the Board of Health endorse the refined criteria presented in Report No. 117-13 re Proposed Criteria for 2014 Budget Process.*

Carried

**3) Promoting A Healthy Workplace Nutrition Environment ([Report No. 109-13](#))**

It was moved by Ms. Brown, seconded by Mr. Orser:

1. *That the Board of Health endorse the Ontario Society of Nutrition Professionals in Public Health's [Call to Action: Creating a Healthy Workplace Nutrition Environment](#); and further,*
2. *That the Board of Health communicate its support by completing the Endorsement Form (attached as Appendix A) and notifying the following groups of its support: Ontario Society of Nutrition Professionals in Public Health; Council of Ontario Medical Officers of Health; Association of Local Public Health Agencies; Ontario Public Health Association; the Honourable Deb Matthews, Ontario Minister of Health and Long-term Care; and, Local MPPs.*

Carried

**4) Board of Health Self-Assessment Survey – Proposed Revisions ([Report No. 110-13](#))**

It was moved by Mr. Bolton, seconded by Ms. White:

1. *That the Board of Health Endorse the revisions to the Board of Health Self-Assessment survey, and*
2. *That the survey be completed annually in March, and*
3. *That an ad hoc committee, appointed by the Board Chair each year in February, review the survey results and propose recommendations for improvements in Board effectiveness and engagement.*

Carried

**INFORMATION REPORTS**

**5) The MLHU Workplace Violence Initiative ([Report No. 111-13](#))**

It was moved by Ms. Brown, seconded by Mr. Orser *that Report No. 111-13 re The MLHU Workplace Violence Initiative be received for information.*

Carried

In response to a question about whether or not psychological harassment is being examined, Ms. Bell reported that staff are developing policies around all types of harassment, including psychological.

Ms. Bell explained that risk assessments are conducted for job roles within the Health Unit (for example, Public Health Inspectors, Public Health Nurses, and Bylaw Enforcement Officers) to be proactive about mitigating risk to employees and clients.

**6) Southwestern Ontario Youth Unite to Celebrate “World No Tobacco Day” ([Report No. 112-13](#))**

It was moved by Mr. Bolton, seconded by Ms. Poletes Montgomery *that Report No. 112-13 re Southwestern Ontario Youth Unite to Celebrate “World No Tobacco Day” be received for information.*

Carried

**7) Summary of the Research on Local Boards of Health ([Report No. 113-13](#))**

It was moved by Mr. Peer, seconded by Ms. Fulton *that Report No. 113-13 re Summary of the Research on Local Boards of Health be received for information.*

Carried

**8) The Healthy Kids Panel – Ontario’s Action Plan for Health Care ([Report No. 114-13](#))**

It was moved by Ms. Poletes Montgomery, seconded by Ms. Brown *that Report No. 114-13 re The Healthy Kids Panel – Ontario’s Action Plan for Health Care be received for information.*

Carried

**9) Health Unit Participates in Municipal Emergency Exercises ([Report No. 115-13](#))**

It was moved by Ms. Brown, seconded by Mr. Orser *that Report No. 115-13 re Health Unit Participates in Municipal Emergency Exercises be received for information.*

Carried

**10) Medical Officer of Health Activity Report – October ([Report No. 116-13](#))**

It was moved by Ms. Poletes Montgomery, seconded by Ms. Poole *that the Board endorse the Board Chair to sign a letter commending Public Health Nurse, Ms. Joanne Dow from the Health Unit’s Infectious Disease Control team, for her contributions to the recall of Super 8 Beef Burgers and the E-Coli cases in London.*

It was moved by Ms. Poole, seconded by Mr. Edmondson *that Report No. 116-13 re Medical Officer of Health Activity Report – October be received for information.*

Carried

**CORRESPONDENCE**

There were no questions about the correspondence. Chair Meyer asked the Board to note Item b) under correspondence about the [alPHa Member Survey](#).

**OTHER BUSINESS**

Next scheduled Board of Health Meeting: **Thursday, November 21, 2013 at 7:00 p.m.**

Chair Meyer also reminded Board members that they are all invited to Staff Day on Thursday, December 5 in the Carousel Room at Western Fair District from 8:30 am to noon. They can call or email Sherri Sanders to RSVP.

**ADJOURNMENT**

At 8:15 p.m., it was moved by Ms. Brown, seconded by Mr. Peer *that the meeting be adjourned.*

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**MARCEL MEYER**  
Chair

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**CHRISTOPHER MACKIE**  
Secretary-Treasurer



TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

**FINANCE AND FACILITIES COMMITTEE REPORT – NOVEMBER 7<sup>TH</sup> MEETING**

The Finance and Facilities Committee (FFC) met at 9:00 a.m. on Thursday, November 7, 2013 (**AGENDA**). The draft minutes of this meeting are attached as **Appendix A**. The following reports were discussed at the November 7<sup>th</sup> meeting and recommendations made:

Report	Summary of Discussion	Recommendations for Board of Health's Consideration
2013 Budget Variance Report to September 30 <sup>th</sup> <a href="#">Report No. 014-13C</a>	Mr. John Millson reviewed the anticipated surplus and shortfall of the 2013 budget. Once the final amount of the shortfall is determined, the Board of Health will need to decide whether or not it wants to use reserve funds or use part of the 2013 surplus.	It was moved by Mr. Peer, seconded by Mr. Meyer <i>that the Finance and Facilities Committee recommend that the Board of Health receive Report No 014-13C "2013 Budget Variance Report to September 30th" for information.</i>
Administrative Policy 4-130 – Corporate Purchase Cards <a href="#">Report No. 015-13C</a>	Mr. Millson reported on the current use of the Health Unit's corporate Visa. He also explained that Health Unit staff are currently drafting revisions to the corporate card policy	It was moved by Mr. Bolton, seconded by Mr. Peer <i>that the Board of Health:</i> 1) <i>Endorse the Director, Finance &amp; Operations, to submit on an annual basis, a summary report on the purchases made using the corporate credit card by category; and further</i> 2) <i>Receive Appendix A to <a href="#">Report No. 015-13C</a> "Administrative Policy 4-130 Corporate Purchase Cards" for information.</i>
MLHU Insurance Review – Update <a href="#">Report No. 016-13C</a>	Mr. Millson explained that the Broker required additional information before it could fill the FFC's request. The information and will be brought to the FFC at its next meeting.	None
50 King Street Generator – Update (verbal)	An ad hoc committee of the FFC and MLHU staff met with an Engineer from Stantec before the Nov. 7 <sup>th</sup> meeting to discuss the backup generator. The Manager, Emergency Preparedness, will consult with the MLHU electrician contractor as to their recommendations and report back to the ad hoc committee.	None

Report	Summary of Discussion	Recommendations for Board of Health's Consideration
2013-2014 100% Ministry of Children and Youth Services Program Budgets <a href="#">Report No. 017-13C</a>	Mr. Millson outlined the proposed changes to the 2013-2014 preliminary grant for the Preschool Speech and Language, Infant Hearing and Blind Low Vision programs that the Health Unit administers this and other health units in the region.	It was moved by Mr. Bolton, seconded by Mr. Meyer <i>that the Report No. 017-13C be received for information and that the Finance &amp; Facilities Committee make the following recommendations to the Board of Health:</i> <ol style="list-style-type: none"> <li>1) <i>That the Board of Health approve the 100% Ontario Ministry of Children and Youth Services (MCYS) Program Budgets, attached to Report No. 17-13C as Appendix A and C respectively;</i></li> <li>2) <i>That the Board of Health approve the 100% MCYS Program Budget for the Infant Hearing Program, attached as Appendix B to Report No. 17-13C, contingent on an amendment depending on the outcome of #3, below; and</i></li> <li>3) <i>That the Director of Finance &amp; Operations draft a letter to be sent to the other participating health units as follows:</i> <ol style="list-style-type: none"> <li>a) <i>Outlining the shortfalls in the Infant Hearing program,</i></li> <li>b) <i>Reporting that the Finance and Facilities Committee recommends that MLHU will pay for its share of the shortfall, and</i></li> <li>c) <i>Encouraging the other health units to cover the costs of their shares as well.</i></li> </ol> </li> </ol>
Other Business – 50 King Street Lease	The FFC discussed that the 50 King Street lease expires in December 2016 (with the possibility of a 5 year extension). Mr. Millson reported that an internal (staff) Strategic Activities Group (SAG) was struck to look at the issue. A report will be presented to the FFC in 2014 about the work of this SAG.	None

The next scheduled meeting of the Finance and Facilities Committee is November 28, 2013 at 10:00 a.m.



Christopher Mackie, MD, MHSc, CCFP, FRCPC  
 Medical Officer of Health

**This report addresses** the Ontario Public Health Organizational Standards

**COMMITTEE**

**MEMBERS PRESENT:** Mr. David Bolton  
Ms. Trish Fulton (Chair)  
Mr. Marcel Meyer  
Mr. Ian Peer

**REGRETS:** Ms. Denise Brown

**OTHERS PRESENT:** Ms. Diane Bewick, Director, Family Health Services  
Mr. Oren Krajden, 4<sup>th</sup> Year Medical Student  
Dr. Christopher Mackie, Medical Officer of Health & CEO (Secretary-Treasurer for Board of Health)  
Mr. John Millson, Director, Finance and Operations  
Ms. Sherri Sanders, Executive Assistant to the Board of Health (Recorder)

**MEDIA OUTLETS:** none

At 9:00 a.m., Ms. Trish Fulton, Committee Chair, welcomed everyone to the Finance and Facilities Committee (FFC) meeting.

**1. DISCLOSURES OF CONFLICT(S) OF INTEREST**

Chair Fulton inquired if there were any disclosures of conflict of interest to be declared. None were declared.

**2. APPROVAL OF AGENDA**

It was moved by Mr. Peer, seconded by Mr. Bolton *that the agenda for the November 7, 2013 Finance and Facilities Committee meeting be accepted as circulated.*

Carried

**3. APPROVAL OF October 3, 2013**

It was moved by Mr. Bolton, seconded by Mr. Peer *that the minutes from the October 3, 2013 Finance and Facilities Committee meeting be approved.*

Carried

**4. BUSINESS ARISING FROM THE MINUTES**

Two items arising from the October 3, 2013 minutes were discussed:

- 1) Travel Reimbursement Policy ([Report No. 010-13C](#)) – Staff reported that more details were to be presented in [Report No. 015-13C](#), this agenda.
- 2) Strathroy Office Lease ([Report No. 013-13C](#)) – Staff will provide information about the market analysis at the November 28 FFC meeting.

5. **NEW BUSINESS**

5.1. 2013 Budget Variance Report to September 30<sup>th</sup> ([Report No. 014-13C](#))

Mr. John Millson, Director, Finance & Operations, reported that there would be an estimated \$682,500 surplus in 2013 due to the Panorama project staff funding and other staffing vacancies. He also reported there would be a \$30,000 shortfall in the dental program. Once the final amount of the shortfall is determined, the Board of Health will need to decide whether or not it wants to use reserve funds or use part of the 2013 surplus. The Ministry of Health and Long-Term Care provided the Health Unit with 75% of the costs of the Shared Services Review.

In response to a query about the amount of the surplus associated with position vacancies, Ms. Diane Bewick, Director, Family Health Services, explained that the managed gapping of staff positions was done across the Family Health Services area and not limited to one program. The Program Budgeting and Marginal Analysis (PBMA) process is looking at the most cost-effective use of Casual Nurses.

Dr. Mackie explained that the change in volunteer recognition from a banquet to group functions (e.g., Community Emergency Response Volunteers are recognized in their group) was made as the volunteer pool has changed and the recognition efforts must reflect that change.

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Finance and Facilities Committee recommend that the Board of Health receive Report No 014-13C "2013 Budget Variance Report to September 30th" for information.*

Carried

5.2 Administrative Policy 4-130 – Corporate Purchase Cards ([Report No. 015-13C](#))

Mr. Millson explained that the Health Unit corporate credit cards facilitate payment for services and materials required for Health Unit business and eliminate the need for purchase orders and additional tracking. Health Unit staff are currently drafting revisions to the corporate card policy. The Senior Leadership Team is also reviewing the frequency and reasons for card use.

It was moved by Mr. Bolton, seconded by Mr. Peer *that the Finance and Facilities Committee recommend that the Board of Health:*

- 1) *Endorse that the Director, Finance & Operations, submit on an annual basis, a summary report on the purchases made using the corporate credit card by category; and further*
- 2) *Receive Appendix A to [Report No. 015-13C](#) "Administrative Policy 4-130 Corporate Purchase Cards" for information.*

Carried

5.3 MLHU Insurance Review – Update ([Report No. 016-13C](#))

Mr. Millson explained that a 5-year claim history from the current insurance provider, as well as, submission of an insurance questionnaire were needed to receive the information that the FFC requested. A request for the claims history has been made, and the questionnaire has been submitted. It will take approximately two weeks for the Broker to prepare a response. It is expected that the resulting information and analysis will be brought to the FFC at its next meeting.

It was moved by Mr. Meyer, seconded by Mr. Bolton *that the Finance & Facilities Committee receive Report No. 016-13C "MLHU Insurance Review" for information.*

Carried

#### 5.4 50 King Street Generator – Update (verbal)

An ad hoc committee of the FFC, made up of Mr. Meyer, Mr. Bolton and Mr. Peer, met with Mr. Sergio Stevandic, Senior Electrical Engineer at Stantec, and several Health Unit staff prior to the November 7 FFC meeting to discuss a backup generator for the 50 King Street premise. After questions, the ad hoc group asked Ms. Pat Simone, Manager, Emergency Preparedness, to consult with Wilson & Associates Contracting Ltd, the company that is under contract with the Health Unit for electrical services, as to its recommendations for a generator to provide backup power for the vaccine refrigerators and computer servers (including the switches to operate telephones). Ms. Simone will report back to the ad hoc committee with her findings.

#### 5.5 2013-2014 100% Ministry of Children and Youth Services Program Budgets ([Report No. 017-13C](#))

Mr. Millson outlined the proposed changes to the 2013-2014 preliminary grants for the Preschool Speech and Language, Infant Hearing and Blind Low Vision programs. The Health Unit administers the programs for other health units in the region. The committee discussed the impacts of weekend screening being discontinued in hospitals in the infant hearing program due to no increase in funding from the Ministry of Children and Youth Services for the 100% funded programs.

It was moved by Mr. Bolton, seconded by Mr. Meyer *that the Report No. 017-13C be received for information and that the Finance & Facilities Committee make the following recommendations to the Board of Health:*

- 1) *That the Board of Health approve the 100% Ontario Ministry of Children and Youth Services (MCYS) Program Budgets, attached to Report No. 17-13C as Appendix A and C respectively; and further*
- 2) *That the Board of Health approve the 100% MCYS Program Budget for the Infant Hearing Program, attached as Appendix B to Report No. 17-13C, contingent on an amendment depending on the outcome of 3), below; and*
- 3) *That the Director of Finance & Operations draft a letter to be sent to the other participating health units as follows:*
  - a) *Outlining the shortfalls in funding for the Infant Hearing program,*
  - b) *Reporting that the Finance and Facilities Committee recommends that MLHU will pay for its share of the shortfall, and*
  - c) *Encouraging the other health units to cover the costs of their shares as well.*

Carried

## **6. OTHER BUSINESS**

The FFC discussed the fact that the 50 King Street lease expires in December 2016, with the option of a five year extension. From past experiences, the Committee suggested that investigations need to begin soon re the facilities required, consolidating the London offices in one building, and other considerations discussed at the October 3 FFC concerning the Strathroy office lease. Mr. Millson reported that an internal Strategic Activities Group (SAG) for facilities was struck to look at the issue; however, the SAG has not met recently due to the changes in the Senior Leadership Team and the focus on the PwC report. A report will be presented to the FFC in 2014 about the work to date of this SAG.

The next scheduled Finance and Facilities Committee Meeting – Thursday, November 28, 2013 10:00 a.m. Room 3A, 50 King Street, London

**7. ADJOURNMENT**

At 10:45 a.m., it was moved by Mr. Peer, seconded by Mr. Meyer *that the meeting be adjourned.*

Carried

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**TRISH FULTON**  
Chair

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**CHRISTOPHER MACKIE**  
Secretary-Treasurer

Draft



TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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## MIDDLESEX-LONDON I-TRACK SURVEY OF PEOPLE WHO INJECT DRUGS

### **Recommendation**

*It is recommended that Report No. 119-13 re Middlesex-London I-Track Survey of People Who Inject Drugs be received for information.*

### **Key Points**

- I-Track is a survey of people who inject drugs that was developed by the Public Health Agency of Canada. It has been conducted in London and in other areas across the country.
- Among the 204 people who participated in the London survey, 79.1% tested positive for hepatitis C and 5.5% tested positive for HIV.
- Opioids were the type of drug most commonly injected in the London sample.
- Sharing of needles and other injection drug equipment were also prevalent in London.

### **What is the I-Track Survey?**

I-Track is a survey of people who inject drugs that was developed by the Public Health Agency of Canada (PHAC). The survey occurs regularly in urban and semi-urban sites across Canada, and Middlesex-London participated for the first time in 2012. The Middlesex-London Health Unit and Regional HIV/AIDS Connection (RHAC) partnered with PHAC to administer this survey to local people who inject drugs. Participants were recruited via convenience sampling from the Counterpoint Needle Exchange Program at RHAC. The main goals of the I-Track survey are to provide information on injection drug use and sexual practices, and hepatitis C and HIV knowledge, testing behaviours and prevalence among people who use injection drugs. For more details on the survey methods and results, the full I-Track Report is provided in [Appendix A](#).

### **Why is This Information Important?**

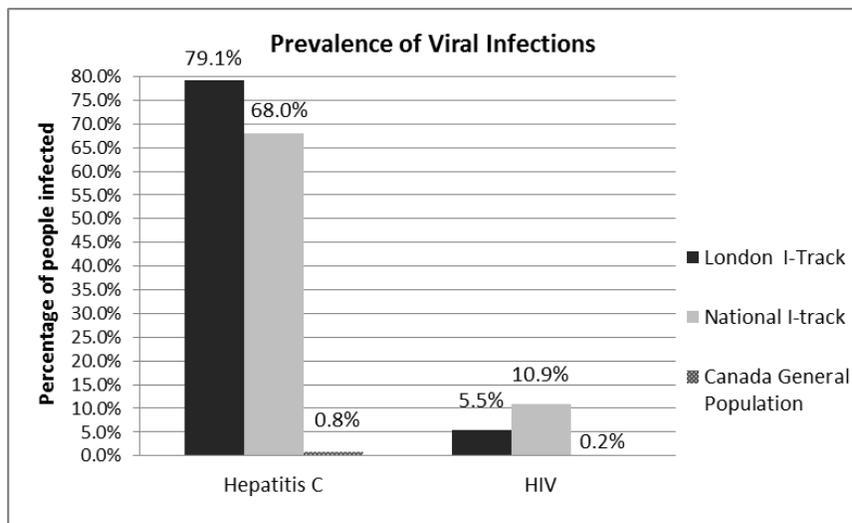
Injection drug use is a major risk factor for bloodborne infections such as hepatitis C and HIV, both of which have long-term, serious health consequences such as liver cancer and progression to AIDS respectively. These infections are much more prevalent in people who inject drugs. They represent significant public health risks since people who inject drugs may engage in high-risk activities like sharing injection equipment and having unprotected sex. Treatment for both infections is lengthy, costly and often difficult to complete, particularly for people who inject drugs. Awareness of infection is essential so that treatment can be started in order to improve health outcomes and prevent spread to others. However, many people are unaware of their infection status.

In Middlesex-London in 2010, the reported incidence rate of hepatitis C among the general population (53.4 per 100,000 population) is significantly higher than the rate in the province as a whole (33.1 cases per 100,000); while the reported incidence of HIV is lower in Middlesex-London (4.2 cases of HIV per 100,000) than the province's rate of 6.4 cases of HIV per 100,000. Additional harms associated with injection drug use include overdose and serious bacterial blood and heart infections.

## What Were the Results of the Local I-Track Survey?

In Appendix A, detailed results of the survey are presented, comparing the London sample to the collective results from all jurisdictions (including London) that have participated in I-Track (the overall national sample). There were 204 participants in the local survey; 73.5% were males and 26.5% were females. The average age of respondents was 36 years. Many (56.9%) of respondents had an unstable housing situation and 43.8% of respondents had less than \$1000 income to live on each month. Opioids were the most common type of drug injected by the London sample, but use of multiple drugs was common.

Injection risk behaviours in the six months prior to the survey were also prevalent in the London sample; 19.6% of respondents borrowed needles and 26.6% lent needles to others in this time frame. This proportion is higher compared to the national sample.



Results of dried blood sample testing showed a very high lifetime prevalence of hepatitis C. Over three-quarters (79.1%) of the London sample tested positive for hepatitis C, which is higher than the 68.0% positive rate in the overall national sample. For HIV, 5.5% of respondents tested positive in the London sample, while 10.9% of the national sample tested positive. The majority of those who tested HIV positive in London (6 of 10 people) were unaware of their status.

## Conclusion

These I-Track results demonstrate that there is an active local population of people who inject drugs with a high prevalence of hepatitis C and HIV. They inject opioid drugs most frequently. There appears to be a slightly higher prevalence of injection-associated risk behaviours, such as borrowing and lending of needles and other injection equipment, in London than compared to the national sample. Appropriate programs and services such as needle exchange and sexual health services should continue to be offered, and additional harm reduction initiatives, based on a comprehensive community drug strategy, could further reduce the health risk and improve the health of this highly vulnerable population.

## Next Steps

The Health Unit is currently undertaking a more detailed health status report on local injection drug use which will be presented at a Board of Health meeting in 2014.

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This report addresses the following requirement(s) of the Ontario Public Health Standards: Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections (including HIV); Foundational Standard - Population Health Assessment and Surveillance Protocol.

# **A Profile of People Who Inject Drugs in London, Ontario**

Report on the Public Health Agency of Canada  
I-Track Survey, Phase 3

Middlesex-London, 2012



November 2013

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In collaboration with the Regional HIV/AIDS Connection.

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## Table of Contents

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I. Introduction .....	1
II. Methods .....	3
III. Results.....	4
1. Demographics.....	4
2. Drug Use Behaviours .....	6
3. Sexual Risk Behaviours .....	10
4. Hepatitis C and HIV Laboratory Testing Results and Testing Behaviours.....	11
5. Health Services Accessed .....	14
6. Knowledge of HIV-related Risk Behaviours and Transmission .....	15
IV. Summary and Conclusion .....	16
References.....	17
Figure 1 Selected drugs injected in the past six months, National and London I-Track samples .....	8
Figure 2 Selected non-injection drugs used in the past six months, London I-Track sample .....	8
Figure 3 Knowledge of HIV and HIV transmission, National and London I-Track samples.....	15
Table 1 Demographic characteristics, National and London I-Track samples .....	5
Table 2 Injection behaviours, National and London I-Track samples.....	7
Table 3 Injection frequency in the past month, London I-Track sample .....	9
Table 4 Injection risk behaviours, National and London I-Track samples.....	9
Table 5 Sexual risk behaviours, National and London I-Track samples.....	10
Table 6 HIV and Hepatitis C laboratory testing results, National and London I-Track samples .....	12
Table 7 HIV and Hepatitis C testing behaviours, care and treatment, National and London I-Track samples.....	13
Table 8 Table 8: Health services accessed in past 12 months, National and London I-Track samples ..	14

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The Middlesex-London Health Unit gratefully acknowledges the collaborative contributions of the Regional HIV/AIDS Connection (RHAC) in London, Ontario, which were instrumental for participating in I-Track. Survey participants were recruited through RHAC's Counterpoint Needle Exchange Program. RHAC staff administered the survey to local participants and collected their finger prick blood samples, and ensured that all other aspects of the interview protocol were met.

The Health Unit also acknowledges the Public Health Agency of Canada (PHAC), who funded this survey. PHAC provided support for administering the I-Track survey by offering comprehensive training and interview tools, and their guidance and feedback were integral to the analysis of local data included in this report.

## I. Introduction

I-Track is an enhanced behavioural and biological surveillance system of people who inject drugs developed by the Public Health Agency of Canada (PHAC). Surveys are cross-sectional and cyclical, and include collection of a biological specimen, either blood or saliva. I-Track takes place in sentinel urban and semi-urban sites across Canada (PHAC, 2012a). After a pilot of five sites was conducted, the first phase of the I-Track survey occurred from 2003-2005 and included seven sentinel sites. The second phase was from 2005-2008, and involved 10 sentinel sites. London became involved for the first time in Phase 3 from 2010-2012, along with 10 other sentinel sites (PHAC, 2010). Sites that have participated in each phase have varied over time. Participants are recruited using convenience sampling methods specific to each site, in order to access this difficult to reach population. To be eligible to participate, respondents must have injected drugs in the past six months, be at least 16 years old and able to provide informed consent, be able to speak English or French, and must not have already participated in the current survey phase (PHAC, 2013). Some of the main goals of the I-Track system are to provide descriptive data on injection drug use and sexual practices, hepatitis C and Human Immunodeficiency Virus (HIV) testing behaviours, and to estimate hepatitis C and HIV prevalence at the national, regional and local levels (PHAC, 2012a).

Injection drug use is a major risk factor for bloodborne infections such as hepatitis C and HIV. In fact, injection drug use has been implicated as the predominant risk factor for hepatitis C acquisition; about 70-80% of new cases in Canada are thought to be acquired in this manner (Wong & Lee, 2006). Similarly, according to PHAC (2012b), people who inject drugs remain a key risk group in the ongoing infection and transmission of HIV: about 13.7% of new HIV infections are attributed to injection drug use. This rate of infection represents a significant public health risk, as people in this population may engage in high-risk activities such as sharing of needles/injection equipment and having unprotected sex, and therefore can transmit their infection to others (Ogunnaike-Cooke, Archibald et al., 2013; PHAC 2012a).

Both hepatitis C and HIV have significant long-term health consequences. Persons chronically infected with hepatitis C may develop cirrhosis, hepatocellular carcinoma and eventually require a liver transplant (Wong & Lee, 2006). In Ontario, hepatitis C has been found to account for more years of life lost (YLL) and morbidity than any other infectious disease, while HIV was sixth in terms of YLL and morbidity (Kwong et al., 2010). In the case of HIV, undetected infection will eventually progress to Acquired Immune Deficiency Syndrome (AIDS) with opportunistic infections and cancers (Bennett & Gilroy, 2013). Initial infection for both diseases may be mild or clinically unapparent, and therefore may go undetected. Proper treatment can help slow the disease processes and improve prognosis (Holmberg, Spradling, Moorman & Denniston, 2013; Bennett & Gilroy, 2013). The advent of highly active anti-retroviral therapy (HAART) has significantly reduced mortality in HIV-infected patients (Bennett & Gilroy, 2013). Likewise, there are now many genotype-specific hepatitis C therapies available and many new promising therapies in development (Liang & Ghany, 2013). Awareness of infection is essential so that treatment can be started to improve health outcomes and to prevent spread to others. However, many persons are unaware of their infection status. In the United States, the Centers for Disease Control and Prevention (CDC) has recommended mass hepatitis C screening for people born from 1945-1965 (Liang & Ghany, 2013). Some organizations in Canada recommend doing so as well. The Canadian Liver Foundation recently recommended hepatitis C screening for the birth cohort from 1945-1975 (Canadian Liver Foundation, 2012). In addition, hepatitis C/HIV co-infection is common given the shared parenteral mode of transmission, and management of these patients is far more difficult (Wong & Lee 2006).

Among the general Canadian population, HIV surveillance indicates that the incidence (new cases) and prevalence (existing cases) is fairly low. In Canada in 2011, the estimated number of new HIV cases was 3,175 cases. The estimated number of people in Canada living with HIV and AIDS in 2011 was 71,300. This represents an HIV prevalence rate of 208 cases per 100,000, or approximately 0.2% of the total population (PHAC, 2012b). The Middlesex-London Health Unit (MLHU) Community Health Status Resource (CHSR) presents local and Ontario health statistics, including data on HIV. While prevalence

rates are not available for comparison to provincial or national figures, the MLHU incidence rate of HIV was significantly lower than that of the province's incidence rate from 2005-2009. In 2010, while the rates of HIV in MLHU were not statistically different than the province, MLHU's rate was 4.2 cases of HIV per 100,000, compared to the province's rate of 6.4 cases of HIV per 100,000 (MLHU CHSR, 2012a).

Similarly, for Canada in 2007, the estimated prevalence of hepatitis C, including acute and chronic cases, was about 242,500 cases or 0.8% of the population (Remis, 2007). The Canadian 2009 incidence rate of acute hepatitis C infections was 33.7 per 100,000 (PHAC, 2009). The Middlesex-London rate of newly reported hepatitis C infections increased between 2006 and 2010, and has remained significantly higher than the Ontario rate. In 2010, the MLHU incidence rate was 53.4 per 100,000 population, while the Ontario rate, at just 33.1 cases per 100,000, was similar to the Canadian rate (MLHU CHSR, 2012b). However, while the MLHU and Ontario rates represent newly reported hepatitis C cases, it is important to note that although some are acute, most are likely chronic infections, and it is often not possible to differentiate them.

The prevalence of these bloodborne diseases is much higher in people who inject drugs, compared to the general Canadian population. The prevalence of HIV and hepatitis C in Canadian people who inject drugs has remained relatively stable in the past decade. The current Phase 3 of the I-Track study, conducted from 2010-2012, found that in the entire national sample (n=2,687), HIV seroprevalence was 11%, while lifetime prevalence of hepatitis C was 68% (Tarasuk, Ogunnaike-Cooke, Archibald et al., 2013). About 9% of the Phase 3 I-Track sample was co-infected with both viruses (Tarasuk, Ogunnaike-Cooke, Archibald et al., 2013). The previous Phase 2 results from 2005-2008 indicated that the overall prevalence of HIV in the sample was 14% among males and 12% among females, while lifetime hepatitis C prevalence was 69% in both males and females. Finally, the original I-Track Phase 1 results from 2003-2005 found an HIV prevalence of 13% and a hepatitis C prevalence of 66% (PHAC, 2010).

Opioids such as heroin are a class of drugs that are commonly injected by people in this population. Recently, there has been a disturbing trend of injecting prescription opioids such as morphine and hydromorphone (Dilaudid) (Fischer & Argento, 2012). In addition to bloodborne viral and bacterial infections resulting from injection practices, there are other serious sequelae associated with prescription drug misuse which include: addiction, injuries, overdose and death, irrespective of whether these drugs are legally or illegally sourced (National Advisory Committee on Prescription Drug Misuse [NACPD], 2013). Further, there appears to be an increase in criminal activity to divert prescription drugs to illegal markets (Royal Canadian Mounted Police, 2010). Prescription drugs may be illegally obtained via "double doctoring", forgery, theft/robbery, or from the Internet (Royal Canadian Mounted Police, 2010). Globally, Canada has the second highest consumption level of prescription opioids, behind only the United States. In addition, the increase in consumption over recent years has occurred more sharply than in the United States (Fischer & Argento, 2012). In Ontario over the past decade, rapid increases, by about 2.5 times, have occurred in emergency visits due to narcotics withdrawal, intoxication/overdose, psychosis and related misuse, and there has been a nearly threefold increase in opioid-related deaths in the same period (Fischer & Argento, 2012). Treatment for prescription opioid addiction and methadone maintenance has also increased rapidly over the past decade, predominantly driven by misuse of prescription opioids (Fischer & Argento, 2012).

This year, the NACPD published a comprehensive evidence-informed document with five streams of action and recommendations to address Canada's prescription drug crisis, including: prevention, education, treatment, monitoring/surveillance and enforcement (NACPD, 2013). A specialized, nationally coordinated surveillance system for the monitoring of prescription drug use has been urged, given the scope of this public health issue. The analysis of data such as the I-Track survey, particularly at the local level, contributes important surveillance intelligence, and hopefully, provides insight into the needs of people who inject drugs that can inform local prevention, education and treatment efforts.

## II. Methods

Locally, MLHU partnered with the Regional HIV/AIDS Connection (RHAC) to recruit participants and interviewers, and to interview eligible people who inject drugs. In early January 2012, representatives from PHAC delivered training to interviewers from RHAC; some members of the MLHU Oral Health Communicable Disease & Sexual Health service area also attended. Due to time constraints, survey promotion and recruitment began just one to two days before initial interviews were scheduled (RHAC, 2012). Recruitment occurred predominantly via non-random convenience sampling of people who inject drugs who came in to use the Counterpoint Needle and Syringe Exchange program (NEP) at RHAC, with word-of-mouth spread resulting in additional recruitment (sometimes referred to as “snowball sampling”). Posters were placed in the reception and NEP areas at RHAC, and reception staff and volunteers also told eligible participants about the survey. Eligibility criteria for the participants of I-Track in London were the same as described in the Introduction. Interviews were conducted between January 17 and February 28, 2012 (RHAC, 2012). Interviewers entered data on laptops provided by PHAC using an electronic data collection tool during interviews.

Respondents were asked questions about basic demographic information, injection and other drug use, sexual behaviours, health/community service use, HIV and hepatitis C testing behaviours and knowledge and attitudes regarding HIV infection. A blood sample was collected via lancet finger prick from consenting participants; the blood was smeared on a dried blood sample (DBS) card for laboratory analysis for HIV and hepatitis C infection (methodology described elsewhere in Tarasuk, Ogunnaike-Cooke, Archibald et al., [2013]). Data entered on laptops and DBS cards were stored in a locked cabinet at a secure location on RHAC premises. Data were backed up daily, and password protected; encrypted data files were sent weekly to PHAC via email. The DBS cards were dried, bundled in groups of 50, and shipped via secure courier to the National HIV & Retrovirology Laboratories (NRHL) in Ottawa for testing (PHAC, 2012a). Participants received an honorarium of \$20 in gift cards of their choice and/or bus tickets, which was advertised as part of the recruitment strategy. Counselling on safer injection and sexual practices, as well as testing for bloodborne infections, were provided as needed to participants as per usual RHAC practice (RHAC, 2012). PHAC obtained research ethics approval for the I-Track survey as a whole, and MLHU’s Research Advisory Committee (RAC) also reviewed and approved the study locally.

There are some limitations of the survey and methodology. A non-random convenience sampling method of volunteers who used the local needle exchange program was employed. This may introduce selection bias, as volunteers may be different than non-volunteers in their risk profile (PHAC 2012a). For example, they may be more motivated to protect their health or obtain the benefits of participation (the honorarium), so results may not be representative of people who inject drugs as a whole. As with any survey, self-report data are subject to recall bias. There is also potential for social desirability bias in answering questions on sensitive topics such as drug use, sexual behaviours and illegal activities. Every effort was made by survey experts at PHAC to reduce or eliminate these biases through interviewer training, using interviewers known to the population, and providing safe and private areas to conduct interviews. Careful management and coordination of recruitment and interviewing activities also occurred to reduce duplicate participation.

The data from London form the basis of this primarily local analysis. The methods and definitions used are the same those used in the overall national level data, which includes London and data from all the other sites, as presented by Tarasuk, Ogunnaike-Cooke, Archibald et al. (2013). Chi-squared and independent samples t-tests are used for significance testing of sex-based differences in the local sample. In addition, totals from the overall national sample are presented for comparison.

Not applicable responses due to skip patterns in the questionnaire are excluded from analyses of individual variables as per analytical guidelines. Similarly, “don’t know” and “refused” responses are excluded from analyses when these responses comprised less than 5% of the sample. As such, some variables have fewer than the total number of respondents. When “don’t know/refused” responses comprise more than 5% of the sample, it is noted accordingly, and they are included as a separate response category in the analysis.

### III. Results

#### 1. Demographics

The demographic differences in the overall national and London samples, and a breakdown of the London sample by sex, are outlined in Table 1. In total, there were 204 respondents in the London sample. Of these, there were 150 (73.5%) males and 54 (26.5%) females. This is a similar pattern to the national sample, where among a total of 2,687 respondents, 68.2% were male and 31.8% female. The average age of respondents in the London sample was 36 years, although males were significantly older than females. In the national sample, the average age of respondents was 39 years.

Approximately 12.3% of the London sample identified as gay, lesbian, two-spirit or bisexual, with significantly more females (25.9%) than males (7.3%) in this category. Further, 19.1% of the London sample self-identified as Aboriginal, which was lower than the national sample (36.1%). In the London sample, 52.9% of respondents had less than high school education, with more females (59.3%) than males (50.7%) in this category. This pattern is similar to the national sample, where 55.7% of all respondents who had completed less than high school. In the London sample, 43.8% of respondents had less than \$1000 income to live on each month, while 54.1% of the national sample had the same amount of income. In London, a total of 56.9% of respondents had an unstable housing situation, with significantly more males (61.3%) than females (44.4%) in unstable housing. This is much higher than the national sample, where only 38.7% of respondents reported unstable housing. Finally, in London, 20.1% of respondents had been in jail in the past six months, with significantly more males than females having been in jail in the previous six months. This proportion is higher than in the national sample, where 11.5% of the total sample had been in jail in the past six months.

**Table 1: Demographic characteristics, National and London I-Track samples <sup>a</sup>**

Characteristic	National Sample		London - Total		London - Males		London - Females		p-value – sex comp.
	N	%	N	%	N	%	N	%	
<b>Age (years)</b>									
Range	16-71		17-60		17-60		18-54		
Median	40		36		36.5		32		
Mean (±sd)	39.4 (10.5)		36.2 (10.8)		37.3 (10.6)		33.2 (11.0)		0.019
	N	%	N	%	N	%	N	%	
<b>Sex</b>	2687 100%		204 100%		-	-	-	-	
Male	1832	68.2%	150	73.5%	-	-	-	-	
Female	855	31.8%	54	26.5%	-	-	-	-	
<b>Sexual orientation</b>									
Gay/Lesbian/ Two Spirit/ Bisexual	NA	NA	25	12.3%	11	7.3%	14	25.9%	0.001
Straight	NA	NA	179	87.7%	139	92.7%	40	74.1%	
<b>Ethnicity</b>									
Aboriginal	968	36.1%	39	19.1%	28	18.7%	11	20.4%	NS
Other	1710	63.9%	165	80.9%	122	81.3%	43	79.6%	
<b>Education</b>									
Less than high school	1492	55.7%	108	52.9%	76	50.7%	32	59.3%	NS
High school	560	20.9%	49	24.0%	36	24.0%	13	24.1%	
More than high school	627	23.4%	47	23.0%	38	25.3%	9	16.7%	
<b>Monthly income</b>									
Less than \$500	379	14.4%	33	16.4%	26	17.6%	7	13.2%	NS
\$500 to \$999	1049	39.7%	55	27.4%	39	26.4%	16	30.2%	
\$1000 to \$1999	775	29.3%	74	36.8%	51	34.5%	23	43.4%	
\$2000 or more	438	16.6%	39	19.4%	32	21.6%	7	13.2%	
<b>Housing situation</b>									
Stable housing	1637	61.3%	88	43.1%	58	38.7%	30	55.6%	0.047
Unstable housing	1032	38.7%	116	56.9%	92	61.3%	24	44.4%	
<b>In jail in past six months</b>	308	11.5%	41	20.1%	~	~	~	~	0.012

<sup>a</sup> Percentages in categories may not sum to 100% due to rounding

± sd Plus or minus standard deviation

NA Not available

NS No statistically significant differences between males and females at p=0.05

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## 2. Drug Use Behaviours

Information about injection behaviours in the national and London samples is provided in Table 2. The median age at first injection was 23 years in London and 21 years for the national sample. In London, 38.2% of respondents were in methadone treatment, with more women in methadone treatment (50.0%) than men (34.0%). Among London respondents, 47.3% injected alone. There were significant sex differences however; women were more likely to shoot up with a regular sex partner (42.6%), while men were more likely to shoot up alone (52.3%). In the national sample, 40.1% of respondents shoot up alone. In the London sample, the location where injection most often occurred was one's own residence (47.8%), although more women (26.4%) than men (15.5%) shoot up at a friend's place. However, 10.4% of the London sample injects in a public place.

Prescription drugs were the predominant drugs injected by the London sample. Figure 1 shows the drugs that participants were asked about injecting in the past six months. Of all the drugs that people were asked about using, morphine (non-prescribed) and hydromorphone (Dilaudid) were tied as the drugs that the highest proportion of participants had injected in the past six months, with 75.5% of all respondents reported using each of these drugs in the past six months. This proportion is much higher than in the national sample, with 47.0% injecting non-prescribed morphine and 47.2% injecting hydromorphone. The next most frequently used drugs were oxycontin (69.1% of the London sample, compared to 37.7% of the national sample), methamphetamine (68.1%) and Ritalin (66.2%) (London only, no comparisons for these two drugs is available in the national sample). Injecting cocaine was reported by 58.3% of the London sample, and showed the greatest difference between females (50.0%) and males (61.3%). In the national sample however, cocaine was the drug injected by the highest proportion of respondents (64.3%). Another drug that was common in the London sample was crack, with 49.0% of the sample injecting crack, compared to 24.8% of the national sample. Heroin was less common in both samples; 17.2% of the London sample and 26.7% of the national sample had injected heroin in the past six months.

Figure 2 shows the non-injected drugs used by the London sample in the past six months; this information was not available for the national sample. This includes drugs that were snorted, smoked, drank, eaten or used as a patch in the previous six months. Marijuana was the most frequently used drug, reported by 73.0% of London respondents. Significantly more men (77.3%) than women (61.1%) used marijuana. Other common non-injected drugs included: alcohol (51.5% of all respondents), followed by crack/freebase (48.5%), oxycontin (42.6%) and cocaine (40.7%). More males than females used crack and cocaine, while more women than men used oxycontin.

Data on injection frequency are shown in Table 3. The majority of respondents who injected in the past month were daily injectors (52.0%). Amongst those who injected daily, the average number of injections per day was 3.9, while the median number of injections per day was three, and ranged from a low of one injection to a high of 20 injections. Amongst respondents who injected in the past month, the average number of injections per month was 71.3, with a median of 56 injections per month, and ranging from a low of one to a high of 650 injections. The upper limit of the range for both the daily number and monthly number of injections was much higher for males than for females.

Injection risk behaviours, such as borrowing and lending needles and other equipment, are outlined in Table 4. The vast majority of all London respondents (94.6%) and national respondents (94.5%) had a sterile last injection; a sterile last injection is defined as: "a brand new needle and/or syringe that had not been previously used by anyone, including yourself" (PHAC, 2012c). In the London sample, 19.6% of respondents borrowed needles in the past six months, compared to 15.5% of the national sample. A higher proportion of the London sample (26.6%) lent needles to others in the past six months than did the national sample (15.5%). London women more frequently lent needles (35.8%) than men (23.3%). Borrowing other injection equipment was more common than borrowing needles; 42.9% of London sample compared to 34.5% of the national sample borrowed other injection equipment. Borrowing other injection equipment was more common amongst London females (50.0%) than males (40.3%). Similarly, 43.6% of the London sample lent other injection equipment, while only 33.1% of the national sample did so. Again, more London females (48.1%) lent other injection equipment, compared to 41.9% of London males.

**Table 2: Injection behaviours, National and London I-Track samples <sup>a, b</sup>**

Indicator	National Sample		London – Total		London - Males		London - Females		p-value - sex comp.
	N	%	N	%	N	%	N	%	
<b>Age at first injection (years)</b>									
Range	3-60		11-49		11-45		12-49		
Median	21		23		23		23		
Mean (±sd)	23.4 (8.9)		24.8 (8.9)		24.6 (8.8)		25.4 (9.1)		NS
<b>Taken prescribed methadone in past six months</b>	NA	NA	78	38.2%	51	34.0%	27	50.0%	0.056
<b>Most frequent shooting partner</b>									0.034
Alone	1057	40.1%	96	47.3%	78	52.3%	18	33.3%	
Regular sex partner	644	24.4%	56	27.6%	33	22.1%	23	42.6%	
Friends/people you know well	673	25.5%	39	19.2%	27	18.1%	12	22.2%	
Casual sex partner(s)	37	1.4%	5	2.5%	~	~	~	~	
People you don't know well	122	4.6%	5	2.5%	~	~	~	~	
People you don't know at all	9	0.3%	~	~	~	~	~	~	
Client sex partner <sup>c</sup>	9	0.3%	0	0.0%	-	-	-	-	
Paid sex partner <sup>c</sup>	~	~	0	0.0%	-	-	-	-	
<b>Location most often injected</b>									
Own apartment / house	NA	NA	96	47.8%	71	48.0%	25	47.2%	0.044
Friend's place	NA	NA	37	18.4%	23	15.5%	14	26.4%	
Shelter / hostel	NA	NA	29	14.4%	~	~	~	~	
Public place (e.g., street, park, squats, subway, underpass, washroom, stairwell, etc.)	NA	NA	21	10.4%	16	10.8%	5	9.4%	
Rooming / boarding house	NA	NA	6	3.0%	~	~	~	~	
Hotel / motel room	NA	NA	5	2.5%	~	~	~	~	
Other places (e.g. shooting gallery, parents' place)	NA	NA	~	~					

<sup>a</sup> Percentages in categories may not sum to 100% due to rounding

<sup>b</sup> Some variables have fewer than the total number of respondents due to not applicable or non-response in sample

<sup>c</sup> Client sex partner is *one who* gave money, drugs, goods or anything else in exchange for sex with the respondent. Paid sex partner is *one to whom* the respondent gave drugs, goods or anything else in exchange for sex (Tarasuk, Ogunnaike-Cooke, Archibald et al., 2013).

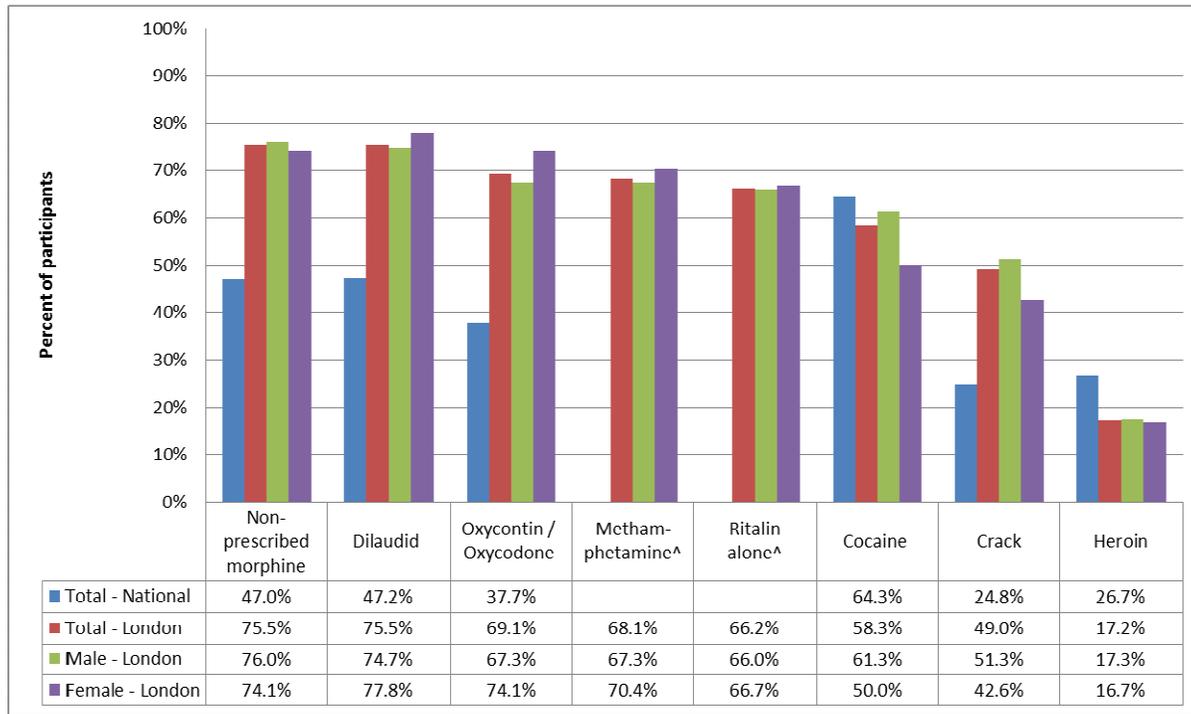
±sd Plus or minus standard deviation

NA Not available

NS No statistically significant differences between males and females at p=0.05

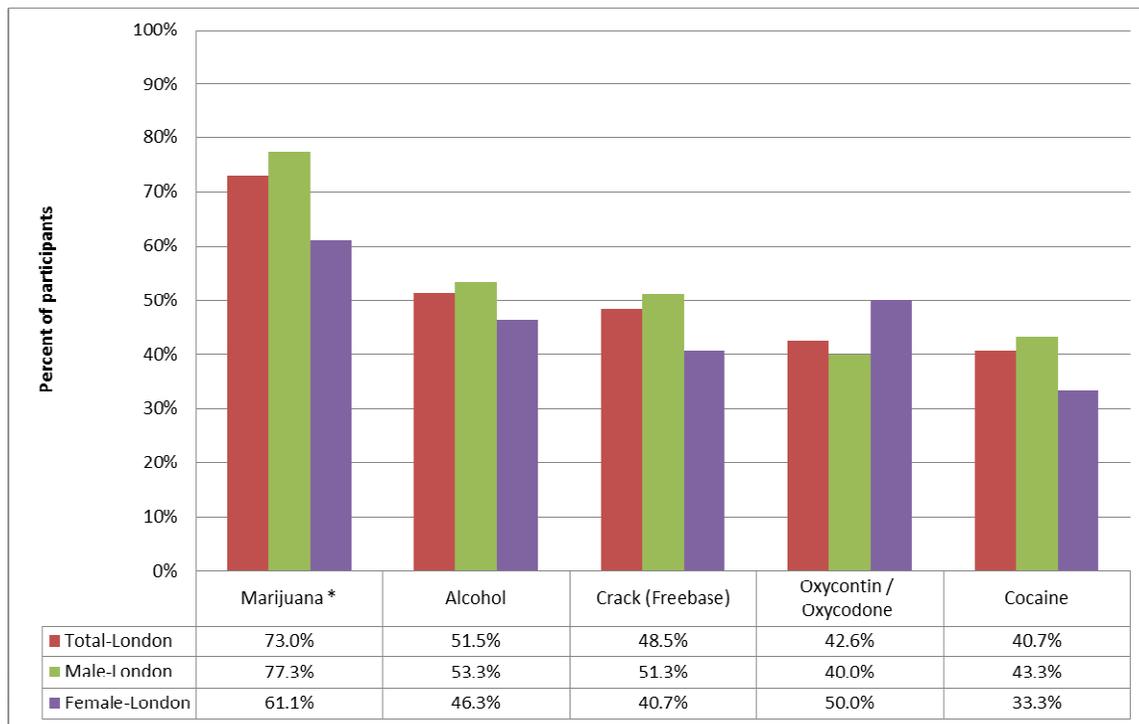
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**Figure 1: Selected drugs injected in the past six months, National and London I-Track samples**



<sup>^</sup> Information on these drugs was not available for the national sample

**Figure 2: Selected non-injected drugs used in the past six months, London I-Track sample (n=188<sup>a</sup>)**



<sup>a</sup> Not all London respondents used non-injected drugs. Data about non-injection drug use was not available from the national sample.

\* Statistically significant difference between males and females (p=0.034)

**Table 3: Injection frequency in the past month, London I-Track sample**

Indicator	London – Total		London - Males		London – Females		p-value - sex comp.
	N	%	N	%	N	%	
<b>Injection frequency in past month</b>							NS
Not at all	12	5.9%	10	6.7%	2	3.7%	
Once in a while, not every week	18	8.8%	13	8.7%	5	9.3%	
Regularly, once or twice a week	29	14.2%	23	15.3%	6	11.1%	
Regularly, three or more times per week	39	19.1%	27	18.0%	12	22.2%	
Every day	106	52.0%	77	51.3%	29	53.7%	
<b>Number of times injecting per day (amongst daily injectors, n=106)</b>							NS
Range (injections per day)	1-20		1-20		1-10		
Median (injections per day)	3		3		3		
Mean (injections per day (±sd))	3.9 (2.7)		3.9 (2.9)		4.0 (2.3)		
<b>Estimated number of times injecting per month (amongst all who injected in past month, n=190)</b>							NS
Range (injections per month)	1-650		3-650		1-280		
Median (injections per month)	56		56		56		
Mean (injections per month (±sd))	71.3 (84.6)		72.8 (90.3)		67.1 (67.3)		

NS No statistically significant differences between males and females at p=0.05

**Table 4: Injection risk behaviours, National and London I-Track samples <sup>a</sup>**

Risk Behaviour	National Sample		London – Total		London - Males		London - Females		p-value - sex comp.
	N	%	N	%	N	%	N	%	
Sterile last injection	2516	94.5%	191	94.6%	139	94.0%	52	96.3%	NS
Borrowed needles in past six months	415	15.5%	40	19.6%	28	18.7%	12	22.2%	NS
Borrowed any other equipment (e.g. water, cooker) in past six months	922	34.5%	87	42.9%	60	40.3%	27	50.0%	NS
Lent needles in past six months	409	15.5%	54	26.6%	35	23.3%	19	35.8%	NS
Lent any other equipment (e.g. water, cooker) in past six months	880	33.1%	88	43.6%	62	41.9%	26	48.1%	NS

<sup>a</sup> Some variables have fewer than the total number of respondents due to not applicable or non-response in sample  
NS No statistically significant differences between males and females at p=0.05

### 3. Sexual Risk Behaviours

Table 5 shows that in the London sample, 54.0% of participants were sexually active in the past month. Women were significantly more likely to have been sexually active in the past month (74.1%) than men (46.6%). In the London sample, 31.2% of respondents who reported sexual activity in the past month used a condom during their last sexual encounter, which is less than 36.6% of respondents in the national sample. In London, 35.6% of all respondents had multiple sex partners in the past six months, and significantly more women (46.3%) than men (31.8%) reported having multiple sex partners. Amongst the small number of female and male sex workers in the London sample (21 people), 71.4% reported condom use at the last client sexual encounter. This is less than the national sample, where 77.1% of sex workers reported condom use at their last client sexual encounter. In London, 36.8% of the sample had ever been diagnosed with a sexually transmitted/bloodborne infection (STBBI), with significantly more females (53.7%) than males (30.6%) diagnosed with an STBBI. This is consistent with 39.3% of all national respondents having ever been diagnosed with an STBBI.

**Table 5: Sexual risk behaviours, National and London I-Track samples <sup>a</sup>**

Risk Behaviour	National Sample		London – Total		London - Males		London - Females		p-value - sex comp.
	N	%	N	%	N	%	N	%	
Had sex in past month	NA	NA	109	54.0%	69	46.6%	40	74.1%	0.001
Condom use during most recent sex (among those who had sex in past month)	777	36.6%	34	31.2%	21	30.4%	13	32.5%	NS
Two or more sexual partners in past six months,	920	34.4%	72	35.6%	47	31.8%	25	46.3%	0.02
Condom use at last sex with client sex partner <sup>b</sup>	236	77.1%	15	71.4%	~	~	~	~	NS
Ever diagnosed with an STBBI	680	39.3%	74	36.8%	45	30.6%	29	53.7%	0.004

<sup>a</sup> Some variables have fewer than the total number of respondents due to not applicable or non-response in sample

<sup>b</sup> Client sex partner is one who provided money, drugs, goods or anything else in exchange for sex with the respondent Tarasuk, Ogunnaike-Cooke, Archibald et al., (2013). In London sample, sex workers n=21.

NS No statistically significant differences between males and females at p=0.05

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#### 4. Hepatitis C and HIV Results and Testing Behaviours

The results of dried blood sample (DBS) testing are provided in Table 6, and show an extremely high lifetime prevalence of hepatitis C: 79.1% of the London sample, which is much higher than 68.0% of the national sample. This test does not distinguish between acute and chronic hepatitis C infections, and the vast majority are likely chronic. Further, there is a sex difference in that 81.7% of males compared to 71.7% of females tested positive for hepatitis C. For HIV, the prevalence was lower in the London sample (5.5% of respondents) than in the national sample (10.9% of respondents). Of those in the London sample who provided an adequate DBS for both hepatitis C and HIV testing, 5.6% were HIV/hepatitis C co-infected, meaning that they had both HIV and hepatitis C infections. In the national sample, 9.2% of respondents were HIV/hepatitis C co-infected, and just 1.7% were HIV positive without having hepatitis C. The majority of the London sample (73.4%), was seropositive for hepatitis C only; 77.1% of males and 63.0% of females had hepatitis C without having HIV. The overall proportion is higher than 58.8% of the national sample that was infected with hepatitis C only without having HIV. In London, 20.9% of respondents were infected with neither hepatitis C nor HIV (18.3% of males and 28.3% of females), which is lower compared to 30.3% of the national sample with neither hepatitis C nor HIV. Although the number is very small, six of the 10 people in London with HIV (60.0%) were unaware of their HIV positive status. This proportion is much higher than the national sample, where just 21.4% were unaware of their HIV positive status.

Table 7 shows that in London, 86.1% of participants had ever been tested for HIV, which is lower than the national sample, where 92.9% of participants had ever been tested for HIV. Among those who reported being HIV negative, 80.7% of the London sample (78.5% of males and 86.7% of females) had an HIV test in the past two years. The comparable figure in national sample was 85.0%. The number of those who self-reported being HIV positive was too few to report additional information on care and treatment in the London sample. However, in the national sample, of those that self-reported being HIV positive, 95.0% were under a doctor's care, 77.0% had ever taken drugs for HIV, and 66.0% were currently still taking the drugs.

In London, 87.6% of the sample had ever been tested for hepatitis C, slightly less than 91.4% of the national sample. Further, just 32.6% of the London sample who reported being currently infected with hepatitis C was receiving a doctor's care for their infection, which is much lower than 48.4% in the national sample. Similarly, the number of participants in the London sample currently taking prescribed drugs for hepatitis C was too small to report, and only a very small proportion of the national sample (2.4%) were taking drugs for hepatitis C.

**Table 6: HIV and Hepatitis C laboratory testing results, National and London I-Track samples <sup>a</sup>**

Indicator	National Sample		London - Total		London - Males		London - Females		p-value - sex comp.
	N	%	N	%	N	%	N	%	
<b>HIV seroprevalence</b>	282	10.9%	10	5.5%	~	~	~	~	NS
<b>Lifetime hepatitis C prevalence</b>	1750	68.0%	140	79.1%	107	81.7%	33	71.7%	NS
<b>Combined HIV &amp; hepatitis C serostatus</b>									NS
Seropositive for HIV only	44	1.7%	0	0.0%	0	0.0%	0	0.0%	
Seropositive for hepatitis C only	1514	58.8%	130	73.4%	101	77.1%	29	63.0%	
Seropositive for both HIV & hepatitis C	236	9.2%	10	5.6%	~	~	~	~	
Seronegative for both HIV & hepatitis C	781	30.3%	37	20.9%	24	18.3%	13	28.3%	
<b>Unaware of HIV positive status, (among those who were HIV seropositive) <sup>b</sup></b>	60	21.4%	6	60.0%	~	~	~	~	NS

<sup>a</sup> Some variables have fewer than the total number of respondents due to not applicable or non-response in sample. As well, not all respondents consented to or were able to provide an adequate dried blood sample (DBS) specimen.

<sup>b</sup> This applied to a very small number of participants in London sample (n=10); interpret with caution.

NS No statistically significant differences between males and females at p=0.05

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**Table 7: HIV and Hepatitis C testing behaviours, care and treatment, National and London I-Track samples <sup>a</sup>**

Indicator	National Sample		London - Total		London - Males		London - Females		p-value - sex comp.
	N	%	N	%	N	%	N	%	
<b>HIV testing, care and treatment</b>									
Ever tested for HIV	2468	92.9%	174	86.1%	128	86.5%	46	85.2%	NS
Tested for HIV in past two years (among those who reported being HIV negative)	1709	85.0%	134	80.7%	95	78.5%	39	86.7%	NS
Under doctor's care for HIV (among those who reported being HIV positive)	95	95.0%	~	~	~	~	~	~	NA
Ever taken prescribed drugs for HIV (among those who reported being HIV positive)	77	77.0%	~	~	~	~	~	~	NA
Currently taking prescribed drugs for HIV (among those who reported being HIV positive)	66	66.0%	~	~	~	~	~	~	NA
<b>Hepatitis C testing, care and treatment</b>									
Ever tested for hepatitis C	2417	91.4%	176	87.6%	129	87.8%	47	87.0%	NS
Under doctor's care for hepatitis C (among those who reported being currently infected with hepatitis C)	514	48.4%	30	32.6%	23	33.8%	7	29.2%	NS
Currently taking prescribed drugs for hepatitis C (among those who reported being currently infected with hepatitis C)	25	2.4%	~	~	~	~	~	~	NA

<sup>a</sup> Some variables have fewer than the total number of respondents due to not applicable or non-response in sample.

NA Not applicable

NS No statistically significant differences between males and females at p=0.05

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## 5. Health Services Accessed

A variety of health and other services were accessed by London and national respondents in the past year. Table 8 shows that in general, in London, women tended to use each service more than men. Most services were used in similar frequency by London and national respondents overall. Almost all London respondents reported using a needle exchange or harm reduction service (96.0%). This was higher than 89.0% of respondents in the national sample as a whole, and is likely due to the local recruitment strategy through the needle exchange program. In London, 66.5% of respondents reported going to a hospital, with more females (75.5%) than males (63.3%) visiting a hospital. This is slightly more than 59.4% of national respondents going to hospital. Community drop-in and community health centres were also used in higher frequency by the London sample (66.0% and 53.0%, respectively) than in the national sample (54.5% and 44.9%, respectively). In London, 29.3% of respondents used the services of a medical/walk-in clinic, with a significantly higher proportion of women (49.1%) than men (22.1%) accessing one. This is compared to 47.1% of national respondents accessing a medical/walk-in clinic. Just over one-third of respondents (34.5%) in London reported having tried detox or drug treatment, which is comparable to the national sample (32.2%). In London, 28.5% of the sample accessed a mental health or addiction centre (37.7% of females and 25.2% of males), compared to 23.7% of the national sample. In London, 8.0% of the sample accessed a sexual health centre, with a significantly higher proportion of women (18.9%) than men (4.1%) doing so. This is slightly less than 9.6% of national respondents that accessed a sexual health centre.

In addition, respondents were asked about using over 50 individual services. Two of these were provided by MLHU: The Clinic (11 people used this service) and the MLHU site of the Counterpoint Needle and Syringe program (21 people used this service).

**Table 8: Health services accessed in past 12 months, National and London I-Track samples <sup>a</sup>**

Service	National Sample		London - Total		London - Males		London - Females		p-value - sex comp.
	N	%	N	%	N	%	N	%	
Needle exchange/harm reduction service	1541	89.0%	192	96.0%	141	95.9%	51	96.2%	NS
Hospitals	1029	59.4%	133	66.5%	93	63.3%	40	75.5%	NS
Community drop-in centres	945	54.5%	132	66.0%	94	63.9%	38	71.7%	NS
Community health centres	779	44.9%	106	53.0%	75	51.0%	31	58.5%	NS
Detox or drug treatment facility	557	32.2%	69	34.5%	51	34.7%	18	34.0%	NS
Medical/Walk-in clinics	815	47.1%	58	29.3%	32	22.1%	26	49.1%	<0.001
Mental health and addictions centre	409	23.7%	57	28.5%	37	25.2%	20	37.7%	NS
Culturally-based services	173	10.0%	21	10.5%	~	~	~	~	NS
Sexual health centre	165	9.6%	16	8.0%	6	4.1%	10	18.9%	0.002

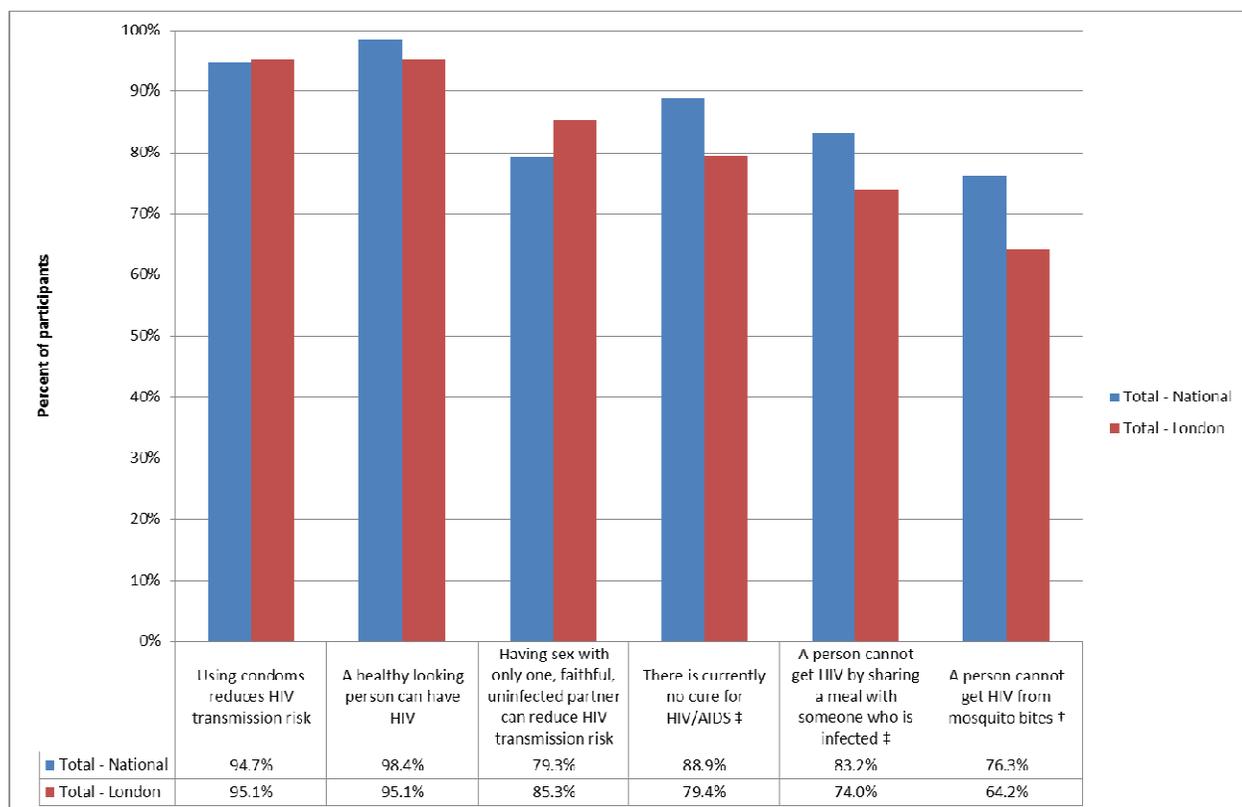
<sup>a</sup> Some variables have fewer than the total number of respondents due to not applicable or non-response in sample. NS No statistically significant differences between males and females at p=0.05

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## 6. Knowledge of HIV-related Risk Behaviours and Transmission

There was very high non-response to some items regarding HIV-related risk behaviour and transmission in the London sample, predominantly in the form of “don’t know” responses. Where non-response comprises 5% or more of the sample, it is noted. Because of the high non-response rates, results for these variables should be interpreted with caution. Figure 3 shows that in London, participants were most knowledgeable about condoms reducing HIV transmission and that a healthy looking person can have HIV (95.1% of respondents answered correctly for each question). This was similar to the national sample, where 94.7% of respondents knew that using condoms reduces the risk of HIV and 98.4% knew that a healthy looking person can have HIV. In the London sample, 85.3% of respondents knew that having sex with only one, faithful, uninfected partner could reduce the risk of transmission, which was more than 79.3% of the national sample. While 79.4% of the London sample correctly identified that there is no cure for HIV/AIDS, a higher proportion (88.9%) of the national sample did so. Seventy-four percent of the London sample correctly identified that sharing a meal with someone could not transmit HIV, although non-response for this item was high, at 9.8%. This is lower compared to 83.2% of national respondents who got correctly answered this question. Finally, respondents were less sure about whether mosquitos could transmit HIV, with just 64.2% of London respondents correctly identifying that mosquitos cannot transmit HIV. This question also had the highest proportion of “don’t know/refused” responses, about 22.1% of respondents. By contrast, 76.3% of the national sample knew that mosquitos cannot transmit HIV.

**Figure 3: Knowledge of HIV and HIV transmission, National and London I-Track samples**



‡ High proportion of “don't know/refused” responses (~10%) in London sample

† Very high proportion of “don't know/refused” responses (~20%) in London sample

## IV. Summary and Conclusion

Demographically, the national and London samples were quite similar, although there was a higher proportion of Aboriginal people and a higher proportion of people with less than \$1000 monthly income in the national sample. London had a higher proportion of people who had unstable housing and a higher proportion of people who had recently been in jail than the national sample.

A slightly higher proportion of the London sample injected drugs alone than in the national sample. In London, the most common drugs of choice to inject were non-prescribed morphine, hydromorphone, and oxycontin/ oxycodone, while for the national sample the most commonly injected drug was cocaine. Marijuana was the most common non-injected drug used in London. London participants were more likely than national participants to borrow and lend needles and other injection equipment. Slightly fewer London participants reported condom use at last sex and at last sex with a client sex partner than in the national sample.

Results of dried blood sample laboratory testing in London showed a very high prevalence of lifetime hepatitis C, which was higher than in the national sample, and a lower prevalence of HIV in London than the national sample. All London respondents infected with HIV were also co-infected with hepatitis C. While there was a high prevalence of previous HIV and hepatitis C testing both nationally and in London, the prevalence of testing for both was slightly higher in the national sample. Although the number is very small, six of the ten people in London with HIV were unaware of their HIV positive status, which was a much higher percentage than in the national sample.

In general, the London sample more frequently accessed local health and community services than the national sample, with the exception of medical/walk-in clinics, which were accessed more frequently by the national respondents overall. Needle exchange programs were the service used most widely, with nearly all participants reporting use of a NEP in both the London and national samples. However, this is somewhat biased given that recruitment was done at needle exchange program sites for many participating sites, and was done exclusively at a NEP in London. London and national participants were fairly similar on their knowledge of HIV and its transmission, though non-response was an issue for some questions in the London sample.

These local I-Track results demonstrate that there is an active local population of people who inject drugs, with a high prevalence of hepatitis C and HIV. They inject opioid drugs most frequently. There appears to be a slightly higher prevalence of risk-associated behaviours for both injection and sexual practices in London than compared to the national sample. Appropriate programs and services such as needle exchange and sexual health services should continue to be offered, and additional harm reduction initiatives, based on a comprehensive community drug strategy, could further reduce the health risk and improve the health of this highly vulnerable population.

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TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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**MIDDLESEX COUNTY: IMPACT OF SOCIAL AND ECONOMIC CHANGES  
ON HUMAN SERVICE NEEDS**

***Recommendation***

*It is recommended that Report No. 126-13 re Middlesex County: Impact of Social and Economic Changes on Human Service Needs be received for information.*

**Key Points**

- Where one lives has the potential to impact health. As such, children and their families living in county settings, such as Middlesex County, may experience both benefits and challenges that are associated with rural living.
- Residents and communities of Middlesex County are facing significant changes in demographics, economics and services.
- Barriers to relevant and reliable resources are experienced by some Middlesex County residents.
- The Health Unit is committed to identifying and responding to the emerging needs of Middlesex County residents.

**Background**

A priority of [Ontario's Action Plan for Health Care](#) is to keep Ontario healthy. However, as many reports and other notable sources have demonstrated, Ontarians live in many different economic, social and physical environments, some of which are healthier than others.

The [Middlesex County: Impact of Social & Economic Changes on Human Service Needs Report](#) (See [Appendix A](#) for the Executive Summary), prepared by United Way London & Middlesex and funded by Employment Ontario, provides insight into this. The purpose of the Report is to identify assets, needs and gaps experienced by Middlesex County communities, and to make recommendations for further actions related to human service needs. As such, a detailed overview of the outcomes of a needs assessment that was conducted within Middlesex County from May 2012 to May 2013 is included in the full report. The Health Unit participated on the planning committee which led to this report.

As a result of the various communities' abilities to gain access to and participate in the needs assessment, varying degrees of information for each geographic area within Middlesex County appear within the Report. Regardless of the level of individual regional detail, an over-arching theme is that both the physical and mental health of Middlesex County residents and their need for service are impacted by the social determinants of health. This in turn impacts the well-being of these residents and their need for services.

## Recommendations from the Report

The Report outlines four key recommendations which address aspects of service development and rural-specific issues, such as access and transportation limitations. The recommendations demonstrate a need for 'action' and 'planning' in the following areas:

- Integration & Development
  - Functional re-design of resource centres
  - Cost sharing and coordination for greater efficiencies and effectiveness
  - Advertising and communication
  - Representation and governance
  - Further exploration of Aboriginal issues
  - Priority service areas, including: addictions, mental health, violence, and unemployment
- Access
  - Addressing distance to services/transportation
  - Alternate modes of service delivery and communication considerations
  - Hours of operation and client-centredness
- Development of Social Capital
  - Community and political leadership skills development
  - Voluntarism skills and engagement
  - Training and education opportunities
- Community and Strategic Leadership
  - Leadership and coordination
  - Funding considerations
  - Technical expertise and consulting
  - Enhanced coordination of services and/or resources

## Conclusion/Next Steps

The Health Unit is committed to working with the County of Middlesex and other key stakeholders in the identification of emerging needs, opportunities, and implementation of effective strategies.

Additional considerations for the Health Unit as it moves forward may include working with the County of Middlesex and key stakeholders to:

- Identify additional opportunities to increase awareness, communication, cooperation and collaboration among service providers in order to link families to appropriate service
- Identify and reduce barriers that may interfere with the ability of county residents to access current and future resources in their communities.
- Continue to consider all relevant aspects of the Social Determinants of Health when planning, implementing and evaluating programming made available to residents who reside within Middlesex County.

This report was prepared by Ms. Deb Fenlon, Public Health Nurse, and Ms. Diane Bewick, Director, Family Health Services.



Christopher Mackie, MD, MHSc, CCFP, FRCPC  
Medical Officer of Health

**This report addresses** the following requirement(s) of the Ontario Public Health Standards: Foundational Standard.

## Executive Summary

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This report summarizes an assessment of the assets, needs, gaps and opportunities for improving human services in eight municipalities in Middlesex County, Ontario, and it illustrates the direct link that exists between a community's social programs and its economic vitality. The report was commissioned by the United Way of London & Middlesex, and guided by a multi-party advisory committee over the course of 2012-2013.

Multi-methods were used to compile, assess and react to the data including: literature and document analysis; human services key informant interviews; telephone, on-line and paper surveys; focus groups with consumers and engaged citizenry; and service provider panel discussions. There was a variety of respondents to the surveys, the majority of whom were female and home owners. Service agencies were canvassed, and data from each geographic centre within Middlesex County collected and reported in both aggregate and disaggregated forms.

This needs assessment focused on Middlesex County (excluding London) with an emphasis on the communities of Lucan, Strathroy, Glencoe, Dorchester and Parkhill and their surrounding townships. The population of Middlesex County is approximately 71,000 people, and has experienced an increase of 2.3% since 2006. The main challenges are dealing with economic pressures while maintaining a sustainable environment and a healthy agricultural base. Hidden in these trends are tensions between long-time and newer residents, and their different approaches and traditions.

Rurality can negatively affect the recognition, experience and manifestation of numerous social and economic issues and subsequent service provision and access. Some of these issues are compounded by stigma, pride, lack of anonymity and isolation, such as domestic violence, poverty, economic duress and mental health and addiction problems. Access to the internet is positively correlated with income, and telephone charges pose a barrier to connection for rural residents. Transportation is a necessity, and generally privately owned and operated, but access to many government and other services is often at considerable distance.

These factors also affect the delivery and design of services. Access and reliability are affected by long distances, winter weather driving and time shortages. Sparse population distribution requires consolidated services, adaptations in service delivery, fewer locations, and challenges client trust, decreases volunteer recruitment and retention, and increases staff turnover and delivery costs.

To this end, local resource centres have historically been available to provide a valuable and safe space for struggling citizens. These centres help to connect those residents in need to the social service or government agency most suited to address their issue. However, recent changes to the resource centres' funding models and reduced operations have created great

risk, but offer great potential as well. Through collaboration, communication and coordination, there is a prospect for long-term sustainability of service delivery and capacity of non-based service providers to respond to this opportunity.

Respondents and informants report lack of services, information and/or access were key service issues in Middlesex County. Almost 40% of the respondents work in London, and hence found access to local services difficult during business hours. Two-thirds of the respondents did not know of the 211 service. The optimal system would have services available locally in order to raise awareness, serve local need and build social capital.

The physical and mental health of Middlesex county residents and their need for services is affected by the social determinants of health. Reported gaps in service include caregiver respite, youth access to sexual and reproductive health, well baby clinics, palliative care, midwifery, dental care for children and services for children with disabilities. However, the need for mental health and addictions services was most pronounced with shortages and incomplete continua of care limiting availability and level of care.

The economic recession of the past five years has resulted in a rise in unemployment, shortage of full time work, less training money and more use of temporary labour by local companies. Plant closures have eroded the tax base and increased the need for retraining. The agricultural workforce is aging with 44% needing replacement within the next 10 years, and farm consolidation and global competition are inserting stress into the sector.

Housing pressures include unaffordable housing for 40% of renters and long waiting lists for social housing. A transportation deficit, however, was an overriding theme in the consultations. Lack of adequate transport systems increased isolation for marginalized and aging groups, as well as for stay-at-home parents. Lack of transport affects mental and physical health by reducing access to social life and human and health services.

Education services are in flux, with consolidations of existing schools, expansion of full day kindergarten, lack of any post-secondary education, and the limitation of adult training to one centre in Strathroy. There is considerable unmet need for adult education and training among respondents. The most serious gap in services for children was child care, with the suggestion that the lack thereof was a serious risk to retraining and employability. Children's mental health services were under available, as are recreation programs for children, with no indoor swimming pool available in Middlesex County.

Each geographic area within Middlesex County is reported upon separately, with data sources described and data mapped against provincial data, and in some cases, peer regional data. In summary, these data reflect a County and various centres within the County affected by significant economic and social pressures, shifts in agriculture, plant closures and job loss, and an overall difficulty in accessing needed health and social services. Various forms of limits on access are described, that illustrate the impact of demographic changes and rurality on Middlesex County residents, as well as shifting social networking patterns that undermine voluntarism and the strength of social capital.

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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## MENU LABELLING: IMPROVING THE FOOD ENVIRONMENT

### Recommendations

#### *It is recommended that the Board of Health:*

1. *Endorse the recommendation that clear, prominent labelling of calorie and sodium content on menus, including reference values, be required through provincial legislation as proposed by the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) [Position Statement \(Appendix A\)](#), “[Serving Up Nutrition Information in Ontario Restaurants](#)” and [Toronto Public Health \(Appendix B\)](#).*
2. *Communicate its support for provincial menu labelling legislation by sending a letter to the Premier of Ontario, the Minister of Health and Long-Term Care, local members of parliament, the Ontario Public Health Association and the Association of Local Public Health Agencies (alPHA).*
3. *Endorse the OSNPPH [Position Paper \(Appendix A\)](#) in its entirety and forward this Report to all Boards of Health across Ontario to communicate its support for the implementation of local, evidence-based complementary menu labelling initiatives.*

### Key Points

- Addressing unhealthy diets high in calories and sodium would result in a major increase in life expectancy – likely greater than two more years for every per person in Ontario.
- Food environments, particularly restaurants, can affect people’s food choices in ways that are difficult to overcome through individual knowledge, skills, and good intentions.
- Menu labelling interventions may have a more substantial effect on higher-calorie consumers, influencing higher-risk, priority populations.
- Menu labelling legislation should emphasize clear, prominent labelling of calorie and sodium content on menus and include reference values and nutrient profiles to be optimally effective.

### The Issue

Increasingly, the food environment has been implicated in rising rates of overweight and obesity, even more than individual knowledge, skills and intentions. It has been estimated that obesity costs Ontario billions of dollars annually. Addressing unhealthy diets high in calories and sodium would result in a major increase in life expectancy – likely greater than two more years for every per person in Ontario. There is strong evidence that consuming excessive calories and sodium has long-term negative health implications.

Over 60% of Canadians eat out at least once per week, and multiple studies have associated increased consumption of restaurant meals with excessive intakes of calories, sodium and fat. It is difficult for consumers to estimate the calorie and sodium content of restaurant meals. For nearly a decade, the World Health Organization has been recommending that governments include food labelling in strategies to prevent non-communicable diseases in hopes that such interventions will enable consumers to make informed decisions. In October, the Ontario government revealed plans to re-introduce legislation to implement

mandatory menu labelling in the province through consultations with key stakeholders from the health and food industry sectors.

Nutrition labelling on menus is seen by more consumers than other methods of nutrition communication (e.g., on-premise brochures, restaurant's website). When menu labelling is provided, one study found that 34% of people used the information to make purchasing decisions, compared to as few as 0.1% of consumers when nutrition information is provided somewhere other than the menu.

Menu labelling may have a larger effect on individuals consuming higher calories compared to those consuming fewer. A study of consumers at Starbucks® locations in three American states found that overall, consumers reduced the calorie content of their orders 6% upon implementation of menu labelling. However, consumers in the Starbucks® study whose orders had been over 250 calories reduced the calorie content of their meals by 26%. This indicates potential for menu labelling interventions to target consumers at increased risk. Although small, such an effect is significant on a population level. If only 10% of customers reduced their order by 100 calories, menu labelling could prevent 40% of the average annual weight gain in consumers five years of age and older.

The type and amount of information provided at point of sale also seems to impact the effectiveness of menu labelling campaigns. Research shows that providing too much information may be counterproductive, as over 70% of consumers faced with only calorie content remembered the information whereas only 49% remembered the information when 4 nutrients were provided. As such, it is recommended that only calories and sodium content be provided on menus to prevent information overload.

### **Need for Legislation**

Voluntary menu labelling measures have proven ineffective; without strong legislation, nutrition information tends not to be provided clearly or consistently, leading to consumer confusion. As well, mandatory menu labelling has the potential to reach beyond the individuals who read and understand nutrition information to everyone who eats at restaurants. If menu labelling is implemented through legislation, provision of genuinely healthier foods may become a competitive advantage, stimulating restaurants to voluntarily lower their calorie and sodium content.

### **Conclusion and Next Steps**

Recent surveys have shown that 70-73% of Canadians feel it is important for restaurants to display calorie and sodium content in their menu items. The adoption of U.S. federal legislation for menu labelling means that US outlets of large chain restaurants, many that operate in Canada, are preparing to display nutrient content. Several public health units and organizations such as Canada's Sodium Reduction Task Force, the OSNPPH, Cancer Care Ontario, and the Healthy Kids Panel have endorsed menu labelling as an improvement strategy targeting the food environment.

The Ministry of Health and Long-Term Care (MOHLTC) hosted a series of consultations with key stakeholders from the food, beverage and advertising industries, the health sector and families. ALPHA is preparing a submission to MOHLTC to speak to the need for provincial menu labelling legislation and marketing restrictions to children and youth based on the latest evidence. Health Unit staff will support ALPHA's submission to MOHLTC by forwarding recommendations for consideration.

This report was prepared by Ms. Lisa Doerr, Dietetic Intern; Dr. Heather Thomas RD, Public Health Dietitian, and Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team.



Christopher Mackie, MD, MHSc, CCFP, FRCPC  
Medical Officer of Health

This report addresses the following requirement(s) of the Ontario Public Health Standards: Chronic Disease and Injuries Program Standards: 4, 5, 6, 7, 11, 12.
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# SERVING

# NUTRITION INFORMATION in ONTARIO RESTAURANTS:



Ontario Society of Nutrition  
Professionals in Public Health

La société ontarienne des professionnel(le)s  
de la nutrition en santé publique

A Position Paper by the Ontario Society of Nutrition Professionals in Public Health



Lunch Menu  
(all items \$8.99)

	Calories	Sodium (mg)
Grilled Cheese + salad	960	1430
Chicken Fajitas	1370	4030
Beef Stir-fry on Rice	1190	1940
Grilled Chicken Salad	530	1715
Cheese Ravioli	840	1520
Cedar Plank Salmon	595	470





## Authors

***Serving up Nutrition Information in Ontario Restaurants: A Position Paper*** was prepared by the Ontario Society of Nutrition Professionals in Public Health (OSNPPH) Menu Labelling Workgroup.

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## Acknowledgements

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## **SERVING UP NUTRITION INFORMATION IN ONTARIO RESTAURANTS:** A Position Paper by the Ontario Society of Nutrition Professionals in Public Health

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### **Introduction**

The Ontario Society of Nutrition Professionals in Public Health (OSNPPH) is the independent and official voice for Registered Dietitians working in the public health system in the province of Ontario. OSNPPH Members are public health leaders and experts in human nutrition who focus on improving health and preventing disease at the individual and population levels. OSNPPH works toward the development of healthy and supportive eating environments for all Ontarians.

This statement outlines OSNPPH's position on menu labelling. Menu labelling informs people's decision-making in complex food environments, supports information transparency and the community right to know, and makes nutrition information readily and consistently available at the point of sale when people eat out. Menu labelling can also lead to nutritionally beneficial product reformulations by restaurants.

OSNPPH has previously issued Calls to Action to challenge the provincial government, public health, and other stakeholders to acknowledge and act upon their roles in creating healthy school food environments. While some admirable progress has been made in schools, the province has not yet acted upon other important environments where people eat away from home, such as restaurants. OSNPPH thus calls upon the province to address this gap.

Menu labelling legislation has already been adopted in a number of municipalities and states in the United States (U.S.). The U.S. federal government has subsequently adopted menu labelling legislation for large chain restaurants nationwide through the 2010 *Patient Protection and Affordable Care Act*. These provisions will be implemented soon. Evidence from the U.S. and emerging work in Canada indicates that menu labelling legislation receives strong public support, is effective in making nutrition information clear and visible, and makes people more likely to use nutrition information when they eat out.

Numerous organizations have recommended menu labelling legislation as a strategy to help improve the quality of the food environment, including the U.S. Institute of Medicine, Canada's Sodium Reduction Task Force, and in Ontario, multiple public health units, the Ontario Medical Association, Cancer Care Ontario and Public Health Ontario in their 2012 report *Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario*, and the Healthy Kids Panel in their 2013 report *No Time to Wait: The Healthy Kids Strategy*.



## Position Statement

**OSNPPH supports menu labelling and calls upon the provincial government to enact menu labelling legislation requiring the prominent display of calorie and sodium content of food items at the point of sale in restaurants in Ontario, as an important step toward creating healthy and supportive food environments for Ontarians.**

OSNPPH recommends the following emerging best practices for menu labelling, based on evidence described in detail in the Position Paper accompanying this Position Statement.

**Menu labelling should be required through legislation.** A growing range of evidence suggests that voluntary approaches to menu labelling fall short of prioritizing population health goals (largely because they do not put key nutrition information right on menus). When menu labelling is voluntary, nutrient information is not provided clearly and consistently. Voluntary menu labelling also does not provide a level playing field for restaurant operators to display information about their products. Menu labelling initiatives in Canada are all voluntary at present. Larger foodservices establishments with a high degree of standardization, and whose existing practices include nutrition analysis of their food products, appear to be the most readily able to implement menu labelling in the short term. Smaller, independent restaurants have also demonstrated an interest in voluntary programs and pilots for menu labelling in Canada and the U.S., and with public health supports, could be enabled to implement menu labelling as well.

**Display clear and unbiased information about product content.** Menu labelling is not a health claim. It is the display of clear and unbiased information about product content to support food decisions in a retail environment. OSNPPH thus recommends that listing nutrient content, and not warning labels, is the most appropriate way of using menu labelling to share information.

**Calorie and sodium content information should be displayed.** There is good evidence that calorie content of foods should be displayed through menu labelling, which could have important long-term effects on population levels of obesity. In addition, based on the increasing array of evidence about the high sodium content of restaurant foods and the negative health impacts of excessive sodium intake in the Canadian diet, OSNPPH recommends the display of sodium content through menu labelling, to make sodium information more apparent and accessible to Ontarians.

**Calorie and sodium content information should be displayed clearly and prominently where people can readily see it when ordering food.** This means that the information should be displayed on menus, the menu board, drive through menus, or on individual food item tags where appropriate, such as in vending machines. Calorie and sodium information should also be displayed in a visually consistent format to match how price information is presented in a font size at least as large as the price.



## **SERVING UP NUTRITION INFORMATION IN ONTARIO RESTAURANTS:** A Position Paper by the Ontario Society of Nutrition Professionals in Public Health

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**Menus and menu boards should also include reference values for calories and sodium.** Reference values put the calorie and sodium content of menu items in the context of daily needs/limits and therefore support consumers' use of nutrition information on menus.

**OSNPPH encourages public health units in Ontario to consider developing and implementing complementary menu labelling initiatives according to emerging best practices, and in ways that are consistent with local needs, priorities, and resources.** This includes activities to complement and enhance the effectiveness of provincial menu labelling legislation, such as consumer food and nutrition literacy initiatives, and activities to increase public awareness of and demand for menu labelling. Public health units can also consider developing activities to support local food businesses in adopting menu labelling, particularly for smaller independent restaurants with fewer resources, and where appropriate, enacting compatible local menu labelling legislation to address specific local needs.

In summary, this position statement identifies the importance of supportive information environments when Ontarians eat out. Clear and accessible information about foods is needed to promote individual and population health, to mitigate the effects of unhealthy food environments, and to support prevention of dietary risk factors for obesity and non-communicable diseases. Menu labelling is a valuable step toward creating supportive environments for healthy living. It increases transparency in food environments, supports the community right to know, enables informed consumer decisions, and promotes nutrition literacy.



## Position Paper

Menu labelling is one way in which Registered Dietitians in public health in Ontario can support and lend their expertise to the development of healthy public policy initiatives, towards healthier food environments.

### What is menu labelling?

Menu labelling is a population health intervention that applies principles of food labelling to the eating out environment. Menu labelling makes clear and standardized information about the nutrient content of food available at the point of purchase in restaurants and other foodservices establishments.

Menu labelling encompasses food and beverages. The Canadian definition of ‘food’ in the *Food and Drugs Act* includes “any article manufactured, sold or represented for use as food or drink for human beings, chewing gum, and any ingredient that may be mixed with food for any purpose whatever.”<sup>1</sup>

Menu labelling has been recommended by many organizations and experts<sup>60</sup> as a valuable step toward creating healthy, supportive food environments. The United States (U.S.) Institute of Medicine,<sup>2,3</sup> Canada’s Sodium Reduction Task Force,<sup>4</sup> and in Ontario, multiple public health units, the Ontario Sodium Summit,<sup>31</sup> the Ontario Medical Association,<sup>5,6</sup> Cancer Care Ontario and Public Health Ontario in their report on Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario,<sup>7</sup> and the Ontario Healthy Kids Panel in their final report, No Time to Wait: The Healthy Kids Strategy,<sup>8</sup> have recommended menu labelling legislation as a strategy to help improve the quality of the food environment.

Menu labelling has been demonstrated to effect changes in people’s uptake of information, food purchases, and consumption behaviours when they eat out, and could have a substantial long-term impact on population health outcomes including obesity. For example, researchers in Los Angeles, California estimated that even if only 10% of restaurant patrons ordered 100 fewer calories per meal, a reasonable assumption based on emerging evaluations of the effects of menu labelling legislation, menu labelling could prevent over 40% of the average annual weight gain in children and adults aged 5 years and older in their county.<sup>9</sup>





## **SERVING UP NUTRITION INFORMATION IN ONTARIO RESTAURANTS:** A Position Paper by the Ontario Society of Nutrition Professionals in Public Health

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### **Why is menu labelling needed?**

**Today's food environments are complex, challenging, and changing rapidly. Food environments can undermine people's best efforts to eat well and live healthily.** A growing array of research indicates that food environments affect people's food choices in ways that cannot be overcome through their individual knowledge, skills or good intentions.<sup>10</sup> This is particularly true when people eat out, where they face large portion sizes, a lack of transparency about food content, and a high intensity and frequency of health claims and marketing messages.<sup>11,12</sup>

Available data suggests that Canadians are eating out more than ever before, and people of all ages and income groups eat out.<sup>13,14,15</sup> Young people under 30 years of age and people with higher income eat out more often and spend a higher share of their household expenditures on eating out.<sup>16,17</sup> A national online survey, carried out in 2010 by Ipsos Reid in partnership with Kraft Canada Inc. for the Canadian Restaurant and Foodservices Association, found that while 62.5% of respondents felt that eating out "is a luxury," over 60% reported that they purchase a meal or snack at a restaurant at least once a week, including 6.7% who eat out daily.<sup>18</sup>

It is also important to acknowledge that it is increasingly easy for people to eat away from home in a wide variety of places and settings. As noted by Statistics Canada,<sup>16</sup> what people think of as 'restaurants' can include table service (also called 'sit-down'), quick-service (also called 'fast food' or 'take-out'), cafeterias, mobile food vendors, and other venues. Eating out also includes pre-cooked ready-to-eat meals that can be purchased not only at 'take-out' locations, but from other types of businesses such as retail grocery stores. Statistics Canada has also noted that people eat away from home in their daily activities, when they travel, and for meals including breakfast, lunch, dinner, and snacks.<sup>16</sup> Eating out is thus increasingly common and presents new challenges for making healthy food choices. Moreover, Health Canada's *Eating Well With Canada's Food Guide: A Resource for Educators and Communicators* emphasizes that when Canadians increasingly rely on and consume food prepared away from home, they are often exposed to different and conflicting nutrition messages in their food environments.<sup>19</sup>



In the U.S., it has been demonstrated that increased eating away from home is associated with excessive intakes of calories, sodium, and fat among children and adults.<sup>20,21,22</sup> Researchers have also uncovered a wide variation in the nutrient content of foods, making it difficult for people to predict what is in their meal. For example, University of Toronto researchers found that in sit-down chain restaurants in Canada, the average menu item contains 97% of the Adequate Intake (AI) level for sodium,<sup>23</sup> and in a single menu category (e.g., 'rib entrees'), the highest calorie item can be up to 7.5 times higher in calories than the lowest calorie item.<sup>24</sup> Not surprisingly,



consumers are unable to estimate the levels of calories and sodium in restaurant meals.<sup>25,26,27,28,29</sup> While progress has been made in adapting some settings, such as school environments, to promote healthier eating in Ontario, other environments where people increasingly eat away from home, such as restaurants, present ongoing barriers to healthy and informed food decisions.

**We have already seen the effects of unhealthy food environments in the poor quality of our diets and growing rates of overweight, obesity, and non-communicable diseases in Ontario.**

Less than half (42%) of Ontarians over the age of 12 years report consuming fruits and vegetables five or more times per day, which has implications for cancer prevention, risk of cardiovascular disease, and



maintenance of healthy weights.<sup>30</sup> Ontarians consume, on average 2,871 mg of sodium per day.<sup>31</sup> While this is lower than the Canadian average intake of 3,400 mg per day,<sup>4</sup> it is still well above recommended targets by the World Health Organization (2003) for populations to consume less than 2,000 mg per day.<sup>32</sup> It is nearly double the Institute of Medicine recommended Adequate Intake (AI) level of 1,500 mg per day<sup>33</sup> and even above the Tolerable Upper Intake Level (UL) of 2,300 mg interim target per day identified in the Sodium Reduction Strategy for Canada.<sup>4</sup>

Over one-quarter (27%) of Ontario youth aged 12 to 17, and over half (52%) of Ontario adults over age 18 are overweight or obese.<sup>34</sup> It has been estimated that obesity costs Ontario billions of dollars per year.<sup>35</sup>

When considered against other non-communicable disease risk factors in Ontario (including smoking, excessive alcohol consumption, physical inactivity, inadequate diet, and high stress), unhealthy diets have the most harmful potential impact on life expectancy for Ontarians after smoking.<sup>36</sup>

**Nutrition information is an important factor in healthy and informed food decisions.** The Canadian federal *Guide to Food Labelling and Advertising* states that the purpose of nutrition labelling is “to provide a system for conveying information about the nutrient content of food in a standardized format, which allows for comparison among foods at the point of purchase. Clear, uniform information should support consumers in making informed food choices toward healthy eating goals. Canadians need nutrition information to permit dietary management of chronic diseases of public health significance, and to help them make food choices that may reduce the risk of developing chronic diseases.”<sup>37</sup>

The World Health Organization has recommended for nearly a decade that governments adopt food labelling interventions to enable people to make informed food decisions, as part of broader strategies to prevent non-communicable diseases and obesity.<sup>32</sup>



## **SERVING UP NUTRITION INFORMATION IN ONTARIO RESTAURANTS:** A Position Paper by the Ontario Society of Nutrition Professionals in Public Health

**Restaurant foods are exempted from existing nutrition labelling legislation in Canada, creating a gap in people’s ability to access nutrition information to support their purchasing and eating decisions.** Federal legislation, in place since 2005 in the *Food and Drugs Act* and associated regulations, has required nutrition labelling for the vast majority of prepackaged food labels. Food sold in retail environments for immediate consumption – i.e., in restaurants and foodservices – is exempted from federal food labelling requirements. Consumers eating out are thus faced with a gap in the information that is available for them to use when making food purchasing and consumption decisions.



Evidence from Canada and the U.S. indicates that in the absence of legislation, many businesses have taken the positive step to voluntarily provide nutrition information to their consumers, but voluntary menu labelling has resulted in nutrition information being inconsistently available, and sometimes even obscured.<sup>38,39,40,41</sup>

**The Ontario Public Health Standards emphasize that creating healthier food environments, including information transparency, is a provincial and public health unit responsibility.** The *Ontario Public Health Standards*<sup>42</sup> (OPHS)

offer guidance in fulfillment of the *Ontario Health Protection and Promotion Act* (HPPA) and associated regulations.<sup>43</sup> The OPHS sets out the mandate for public health nutrition professionals in Ontario to develop policies and programs that promote and protect health and prevent disease. This includes action by local boards of health to “collaborate with local food premises to provide information and support environmental changes through policy development related to healthy eating”.

A legal analysis carried out for the Public Health Agency of Canada has noted that all levels of government likely have a jurisdiction to enact menu labelling legislation.<sup>44</sup>

**Menu labelling improves food information transparency in eating out environments by making nutrient content of foods clearly and consistently visible to a majority of people.** Menu labelling makes nutrient information clearly visible to a majority of people, in contrast to the very few who see it when it is ‘available on request’. This has been repeatedly demonstrated in experimental studies as well as in real-world settings where menu labelling has been adopted.<sup>45,46,47,48</sup> In New York City, for example, the Health Department assessed the visibility of calorie information in 167 locations of 11 major fast-food chain restaurants across all boroughs in 2007 prior to menu labelling legislation taking effect. They found that only 4% of patrons reported seeing calorie information.<sup>49</sup> After the legislation, the Health Department team found that over 70% of people reported seeing nutrition information.<sup>50</sup> Another study showed that only 6 of 4311 customers (0.1%) accessed on-premises nutrition information that was not on the menu in 8 locations of 4 major chain restaurants in New York and Connecticut.<sup>51</sup>



**While not everyone who sees menu labelling uses the nutrition information immediately to adapt their food choices, menu labelling can increase the likelihood that they do.** As noted above, in New York City after menu labelling legislation took effect, the Health Department found that over 70% of people reported seeing nutrition information, and 15% reported using the information. Although no statistical difference was observed amongst the several major food chains, those consumers who used the calorie information chose 106 calories less.<sup>50</sup> Other studies and evaluations have documented a modest decrease,<sup>52,53,54</sup> or no change in average calories ordered and/or consumed per transaction.<sup>48,55</sup> A menu labelling program in full-service restaurants resulted in 34% of customers using the nutrition information to make a healthier choice - 20% chose an entrée lower in calories and 8% chose an entrée lower in sodium. Those who used the information to make a lower calorie choice were estimated to have ordered about 75 fewer calories.<sup>47</sup>

**Menu labelling seems to have a more substantial effect on higher-calorie consumers.** For example, in New York City, researchers with access to every sales transaction over 14 months at Starbucks locations in New York City, Boston, and Philadelphia, including individual cardholder data found overall there was a 6% average reduction in calories ordered per transaction and a 14% reduction for food items excluding beverages. Individuals who had been ordering more than 250 calories per transaction reduced the calorie content of their orders by 26% after menu labelling.<sup>53</sup> In King County, Washington, health department staff found that 4% fewer consumers were buying 'high calorie' meals (over 667 calories per meal) 18 months after adoption of menu labelling legislation.<sup>56</sup>

Other researchers have discovered that people are more likely to change their food purchase intentions as well as their choices when they are surprised by what they find out as a result of menu labelling. That is, when menu labelling reveals that food items are much higher in calories than people had initially predicted, then they are more likely to make a behaviour change.<sup>28,29</sup>



**The evidence base is evolving and we may not even fully understand the ways in which menu labelling might have a positive influence on people's food choices at a given meal, throughout the day, or in their routines overall.** For example, researchers at the University of Waterloo found that while people did not necessarily change the calorie content of their orders when presented with menu labelling, they did end up eating less of their food. The same researchers have also found that too much information might be counterproductive, so this is an important consideration as research and policy initiatives move forward. In their study, more than 70% of people could recall seeing nutrition information when calorie content, or calorie content and a 'traffic light' symbol, was added to a menu, but when four nutrients were added alongside the traffic light, then only 49% of people could recall seeing the information.<sup>46</sup>



## **SERVING UP NUTRITION INFORMATION IN ONTARIO RESTAURANTS:** A Position Paper by the Ontario Society of Nutrition Professionals in Public Health

**There is no evidence to date that menu labelling is harmful to health, or causes individuals to increase their calorie intake.**

**Emerging evidence also suggests that menu labelling could promote healthier food environments through restaurants being prompted to reformulate their menu items to recipes of improved nutritional quality.**<sup>53</sup> With health equity considerations in mind, this is an important way in which menu labelling could benefit the population more broadly - i.e., even people who do not read nutrition information will benefit from menu items that are reformulated to be healthier.

### **What do stakeholders think about menu labelling?**

**Many stakeholders, including industry and the public, support menu labelling in principle and practice.** Public opinion is strongly in favour of menu labelling legislation. In New York City's public consultations prior to adoption of menu labelling legislation requiring display of calories in large chain restaurants, 99% of respondents supported the proposed legislation.<sup>57</sup> In Canada, a nationally representative survey carried out by Ipsos Reid for the Public Health Agency of Canada in 2011 found that 70% of respondents strongly support requiring menu labelling in fast food restaurants.<sup>58</sup> Another recent Canadian survey using a nationally representative consumer panel found that 73% of respondents felt it was important to require restaurants to display the amount of sodium in the foods they serve.<sup>59</sup>

As introduced earlier, numerous health professional groups, nongovernmental organizations, and governmental organizations also support menu labelling legislation. Individuals and groups including the Canadian Diabetes Association, the Canadian Stroke Network, the Childhood Obesity Foundation, *Coalition québécoise sur la problématique du poids*, Dietitians of Canada, the Fitness Industry Council of Canada, and Hypertension Canada recently called for menu labelling legislation through a Center for Science in the Public Interest (CSPI)-coordinated letter.<sup>60</sup>



Even the restaurant industry does not dispute that menu labelling is important and that set formats for display of nutrition information about menu items would “make it easier for [restaurant] consumers to find the information on a consistent basis”.<sup>61</sup> The experience of New York City in the U.S. with menu labelling legislation suggests that while the restaurant industry disputes the potential commercial free speech infringements related to nutrition labelling legislation, U.S. legal rulings support menu labelling and rejected the New York State trade association complaints on the basis that such labelling helps disclose accurate facts about food products in restaurants, which is a government responsibility.<sup>62</sup>



The Canadian Restaurant and Foodservices Association (CRFA) and other restaurant industry stakeholders, have emphasized, however, that they do not support the display of nutrition information directly on menus. The CRFA has formally endorsed British Columbia's voluntary Informed Dining program as their preferred nationwide approach,<sup>63</sup> which asks participating restaurants to share nutrition information for all standard menu items, including 13 core nutrients with calories and sodium highlighted, at or before the point of ordering, in a standardized format on a pamphlet or poster – not on the menu.<sup>64</sup> However, OSNPPH notes that research shows that information not

provided on the menu and nutrition information overload severely undermine consumers' use of nutrition information in choosing foods. Furthermore, OSNPPH feels that menu labelling for chain restaurants should be achieved through legislation, not through voluntary programs.

**Menu labelling has been demonstrated to be feasible for many restaurants.** The adoption of U.S. federal legislation for menu labelling, in the *Patient Protection and Affordable Care Act (ACA)* (PL111-148), Provision 4205, means that menu labelling will soon become the new reality for U.S. outlets of large chain restaurants and foodservices establishments, many of whom also operate in Canada.<sup>65</sup> Many large chain restaurants in Canada already analyze the nutrient content of their menu items and are ready to display it, as can be seen in over 30 chains' participation in the CRFA's own voluntary nutrition information program,<sup>61</sup> which the CRFA has subsequently replaced with the BC Informed Dining program. The Heart and Stroke Foundation, which also runs a voluntary menu labelling program as part of its Health Check restaurant program, has suggested that its licensing and nutrition analysis components could be cost prohibitive for some chains.<sup>66</sup> However, an analysis by the Centre for Science in the Public Interest shows that the cost of menu labelling for large restaurant chains, as determined by the U.S. Food and Drug Administration, is actually relatively low compared to commercial food equipment costs and that many U.S. states and localities that have already implemented menu labelling laws have not seen burdensome costs or negative effects on restaurant business.<sup>67</sup>

Evaluations of pilot programs with local independent restaurants in Tacoma-Pierce County, Washington and Louisville, Kentucky have indicated that with public health supports, particularly for nutrition analysis, smaller restaurants can also be enabled to implement menu labelling.<sup>68,69,70</sup>

**OSNPPH feels it's time to legislate menu labelling in Ontario.** Ontarians need clear, accurate, and accessible nutrition information about foods to help them make better food decisions. Menu labelling can make that information more readily available in restaurants and help promote nutritionally beneficial reformulation of restaurant foods, thus promoting individual and population health. This would be a valuable step toward making our complex food environments healthier and more supportive.



## **SERVING UP NUTRITION INFORMATION IN ONTARIO RESTAURANTS:** A Position Paper by the Ontario Society of Nutrition Professionals in Public Health

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# What's on the Menu?

Making Key Nutrition Information  
Readily Available in Restaurants

Technical Report  
April 2013

	<i>Calories</i>	<i>Sodium (mg)</i>	<i>Price</i>
<i>Sandwiches</i>			
<i>Deluxe Hamburger</i>	<i>860</i>	<i>740</i>	<i>\$5.99</i>
<i>Crispy Chicken Sandwich</i>	<i>680</i>	<i>1430</i>	<i>\$5.99</i>
<i>Turkey Burger</i>	<i>560</i>	<i>620</i>	<i>\$6.99</i>
<i>Veggie Burger</i>	<i>570</i>	<i>1180</i>	<i>\$4.99</i>
<i>Pulled Pork Sandwich</i>	<i>1060</i>	<i>3300</i>	<i>\$6.99</i>
<i>Chicken Wrap</i>	<i>660</i>	<i>1660</i>	<i>\$5.99</i>

**Reference:**

Toronto Public Health. What's on the Menu: Making Key Nutrition Information Readily Available in Restaurants. Toronto, Ontario. April 2013.

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**Distribution:**

Available at:

<http://www.toronto.ca/health>

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**About this Report:**

On June 1, 2010, the Toronto Board of Health endorsed the Toronto Food Strategy recommendations in [Cultivating Food Connections: Toward a Healthy and Sustainable Food System for Toronto](#), which identified menu labelling as one strategy for empowering Toronto residents with food skills and information.

Since 2010, Toronto Public Health (TPH) has reviewed the experiences of other jurisdictions and the scientific studies of the impact and effectiveness of menu labelling. Toronto Public Health also conducted survey research and consultations with key stakeholders in collaboration with the Food Policy Research Initiative at the Centre for Addiction and Mental Health and University of Toronto, to assess readiness for menu labelling in Toronto. This technical report summarizes the findings of that research. In addition, there is a TPH staff report titled, *Menu Labelling – A "Right to Know" Approach to Healthy Eating*, that summarises this technical report and identifies actions TPH is taking along with recommendations for the Board of Health to promote leadership on menu labelling in Toronto restaurants. The staff report and this technical report were presented to the Toronto Board of Health on April 29, 2013.

Copies of both reports can be found at:

<http://www.toronto.ca/health/>

# Executive Summary

The purpose of this technical report is to synthesize Toronto Public Health (TPH) research on menu labelling and the policy environment for disclosing nutrition information in Toronto restaurants. Menu labelling is a type of nutrition labelling where information about the nutrient content of foods is provided on restaurant menus/menu boards at or before the point of sale. This report provides a critical review of key evidence to inform policy, with a focus on real-world experiences with menu labelling in related jurisdictions. It also identifies municipal levers for menu labelling within the City of Toronto. It is intended as a tool to assist in coordinated action by many stakeholders in order to make optimal progress towards healthy food environments for all Toronto residents.

Food is part of our daily personal choices and, at the same time, part of the social and physical environments in which we live, work, and play. An increasing array of evidence suggests that what we choose to eat is strongly influenced by the food environments we find ourselves in, even beyond individual factors such as attitudes and knowledge. Given that people are eating out more than ever before, food environments away-from-home are an important setting in which to consider interventions to improve population health. Some of the well-documented barriers to healthy eating out include large portion sizes, excessive levels of calories and sodium, misleading health claims, wide variations in the nutrient content of foods, and nutrition information that is hard to access.

Menu labelling is an intervention that can help to address some of these barriers. Many high-level public health policy reports and research reviews, as well as professional associations and civil society organizations, have recommended menu labelling as a policy that can improve the quality of the eating out environment. Specifically, menu labelling meets Health Canada's goals for nutrition labelling in general which include helping consumers make informed dietary choices, and helping consumers easily compare foods based on consistent information. Both of these conditions support what is sometimes referred to as the 'community right-to-know'.

Currently in Canada, some nutrition information is made available by individual restaurants or chains on a voluntary basis, but the vast majority of this information is neither standardized nor readily visible at the point of purchase. Many restaurants and industry associations continue to emphasize that their principal purpose for taking steps to address health and nutrition issues is to respond to consumer demand.

Different jurisdictions have adopted varying forms of menu labelling. Legal analyses in Canada have suggested that all levels of government likely hold authority to develop mandatory menu labelling policies. However, the most prominent set of approaches in Canada to date are voluntary initiatives. For instance, the British Columbia provincial government runs Informed Dining, which has been endorsed as the preferred nationwide approach by the Canadian Restaurant and Foodservices Association. The Heart and Stroke Foundation also runs a menu labelling initiative as part of its Health Check program. In the US, mandatory menu labelling has

become the norm for large restaurant chains. New York City was the first US jurisdiction to adopt a Health Code amendment, and since then, the US federal government has enacted menu labelling legislation as part of the Patient Protection and Affordable Care Act, 2010.

While policies and programs vary, most menu labelling initiatives require, at minimum, disclosure of calorie content of food for all standard menu items. Where programs differ most is in the display of the information (on menus versus standardized brochures, for example), which is a contentious parameter. Furthermore, most menu labelling, especially when enshrined in law, is designed for larger foodservice chains rather than independently owned restaurants.

Evidence on the effects of menu labelling policies and programs continues to increase. The most detailed evidence from real-world settings comes from the New York City example. When menu labelling legislation was put in place, nutrient information became visible to a majority of restaurant patrons and increased awareness of calorie content of meals. A smaller proportion of patrons used the information to inform or change their purchasing decisions. Overall, most research has found a modest reduction or no change in average calories ordered by customers after menu labelling was put in place. When broken down by subgroups of customers who actually used the information, however, menu labelling appears to have a more substantial effect.

The other key environmental change that has been considered in existing research and evaluations of menu labelling initiatives is the phenomenon of menu reformulation, where disclosure of information leads to companies reworking their offerings for improved nutrient profiles. This change has been frequently mentioned but is not yet well evaluated in the literature.

For independent restaurants, the literature and TPH consultation findings point to some perceived operational challenges of menu labelling, such as lack of time and capacity to standardize menu items and conduct nutritional analyses. Such restaurants often benefit from dedicated public health supports.

Menu labelling is strongly supported by the public, with over 85% approval in New York City, for instance. Toronto Public Health's own background work on menu labelling reveals strong support for nutrition information disclosure. In a recent TPH survey of about 1700 residents, 78% of respondents said that they would use nutrition information 'at least sometimes' if it were to become readily available. A smaller research study done through the University of Toronto showed that 83% of Toronto consumers would like to see nutrition information when eating out.

In summary, many objective and subjective factors ultimately interact to shape personal food choices and our eating out environments. Nutrition information provided through menu labelling is one factor that does inform some individuals' food decision making. Governments have a role to play in supporting consumers' right to transparent information. Menu labelling is therefore a policy initiative that could be considered an environmental intervention to support public health and the public good.

# Table of Contents

- 1. Introduction ..... 6**
- 2. Eating Out in Canada ..... 8**
  - 2.1. Consumers Underestimate Calorie and Nutrient Levels in Restaurant Meals..... 8
- 3. Burden of Illness from Obesity and Hypertension..... 10**
  - 3.1. Obesity..... 10
  - 3.2. Hypertension ..... 10
- 4. Environmental Barriers to Healthy Eating Out.....11**
  - 4.1. Large Portion Sizes..... 11
  - 4.2. Misleading Health Claims ..... 11
  - 4.3. Wide Variation in Nutrient Content of Foods ..... 12
  - 4.4. Nutrition Information in Restaurants is Not Visible ..... 12
- 5. Menu Labelling as a Type of Nutrition Labelling ..... 14**
- 6. Menu Labelling as a Health Intervention ..... 15**
  - 6.1. Making Nutrient Information More Visible ..... 15
  - 6.2. Helping People to Factor in Nutrient Content in Food Choices ..... 15
  - 6.3. Unintended Effects of Menu Labelling ..... 17
  - 6.4. Strong Public Support for Menu Labelling ..... 18
- 7. Jurisdictional Policy Experiences ..... 19**
  - 7.1. Legislation – Canada ..... 19
  - 7.2. Voluntary Initiatives – Canada ..... 20
    - 7.2.1. Health Check (Heart and Stroke Foundation of Canada) ..... 20
    - 7.2.2. Informed Dining (British Columbia Ministry of Health) ..... 21
    - 7.2.3. Canadian Restaurant and Foodservices Association Nutrition Information Program .. 22
  - 7.3. Legislation – United States..... 23

7.3.1.	US Federal Menu Labelling .....	23
7.3.2.	New York City.....	23
7.3.3.	King County, Washington .....	25
7.4.	Voluntary Initiatives – United States .....	26
7.4.1.	SmartMenu (Tacoma-Pierce County Health Department, Washington) .....	26
7.4.2.	Healthy Hometown Restaurant Program (Louisville, Kentucky) .....	27
7.5.	Key Learning from Jurisdictional Policy Experiences .....	28
<b>8.</b>	<b>Rationale for Calories and Sodium on the Menu .....</b>	<b>29</b>
<b>9.</b>	<b>Readiness for Menu Labelling in Toronto .....</b>	<b>30</b>
9.1.	Issue History in Toronto .....	30
9.2.	Eating Out in Toronto and Resident Attitudes .....	30
9.3.	Views on Menu Labelling Among Independent Restaurants .....	31
9.4.	Views on Menu Labelling Among Chains and Franchises.....	32
<b>10.</b>	<b>Municipal Policy Levers for Menu Labelling.....</b>	<b>34</b>
10.1.	Lessons from TPH DineSafe .....	34
10.2.	Lessons from TPH ChemTRAC.....	35
<b>11.</b>	<b>Conclusion.....</b>	<b>36</b>
<b>12.</b>	<b>Legislation Cited.....</b>	<b>38</b>
<b>13.</b>	<b>Appendix: Jurisdictional Policy Experiences with Menu Labelling-Parameters and Practices .....</b>	<b>39</b>
<b>14.</b>	<b>References .....</b>	<b>42</b>

# 1. Introduction

Menu labelling refers to a type of food labelling where information about the nutrient content of foods is disclosed on restaurant menus at or before the point of sale. This report synthesizes Toronto Public Health (TPH) research and a review of studies on menu labelling as an intervention that can help to establish healthier and more supportive food environments for Toronto. Toronto Public Health also conducted a public survey and consultations with key stakeholders, including restaurant associations with a local presence, independent and chain restaurant operators, and other jurisdictions.

Past research by TPH on the state of Toronto's food outlines how policy and program interventions at many levels and scales are needed to improve food environments for all Toronto residents.<sup>1</sup> The Toronto Food Strategy has identified how TPH and the City have valuable levers at their disposal to enact positive change relating to food environments.<sup>2</sup> This discussion paper reviews menu labelling as an intervention that changes the food environment to support healthier eating.

Food is part of our daily personal choices and, at the same time, part of the social and physical environments in which we live, work, and play. An increasing array of evidence suggests that what we choose to eat is strongly influenced by the food environments we find ourselves in, so much so that food environments<sup>a</sup> affect our health over and above individual factors such as food-related knowledge, skills, and motivation.<sup>3</sup> Such environmental factors include food access, availability, cost/affordability, marketing/promotions, social and cultural norms and values, and other environmental cues.<sup>4</sup> These environmental conditions interact with our individual biology to shape our food attitudes and behaviours.

Food environments are therefore a major determinant of both individual and population health. Food is essential to our wellbeing, but unhealthy diets are a key contributor to ill health and preventable early death.<sup>5,6</sup> Rates of chronic diseases including heart disease, diabetes, chronic respiratory diseases, and cancer, as well as obesity, have soared alongside changes in our modern food environments and diets.<sup>7,8,9</sup> Ensuring healthy and supportive food environments has been identified as an important way to promote and protect health and prevent disease. Public policies that enable individuals to eat well also promote human rights and health equity.<sup>10</sup>

As the majority of the world's population now lives in cities,<sup>11,12</sup> city governments and local public health agencies have an important role to play in leading the establishment of healthy urban food environments on behalf of the public good, including enacting health-promoting local policies.<sup>13,14,15,16</sup>

Subsequent sections 2-8 of the report describe the following: 2) eating out behaviour in Canada; 3) prevalence of obesity and hypertension; 4) environmental barriers to healthy eating out; 5) menu labelling as a type of nutrition labelling; 6) the effects and effectiveness of menu labelling as a health intervention; 7) menu labelling policy experiences in other jurisdictions; 8) the

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<sup>a</sup> For a description of food environments please refer to Section 2.

rationale for putting calories and sodium on the menu; 9) readiness for menu labelling in Toronto; and 10) municipal levers for menu labelling.

## 2. Eating Out in Canada

Available national statistics suggest that Canadians are eating out more than ever before.<sup>17,18,19</sup> Overall, about 60% of Canadians are eating out one or more times per week.<sup>20</sup> Nearly 40% of Canadians eat out at least a few times per week, and about 7% eat out on a daily basis.<sup>20</sup> Restaurant foods currently make up at least one-fifth of the average Canadian's daily diet.<sup>20</sup> In 2010, households reported spending an average of \$7,443 on food, and it has been estimated that between twenty-five and thirty cents of every food dollar spent is on food eaten away from home.<sup>21,22</sup>

People of all income levels and across all age groups eat out. People in higher income groups, however, eat out more often and spend more.<sup>21</sup> Younger people also spend more on eating out.<sup>22</sup> In 2010, the National Survey of Household Spending indicated that households headed by a person under 30 years of age spent the highest share of household spending of any age group on restaurants and the lowest share on food from stores (5.4% of total household spending on restaurants; 8.6% on food from stores). In contrast, households headed by seniors spent the lowest share of any age group on restaurants, and the highest share on food from stores (3.4% of total household spending on restaurants; 12% on food from stores).<sup>22</sup>

There are many reasons why people eat away from home. Eating out can be for 'practical' reasons (e.g., availability; necessity; convenience), but also 'symbolic' ones (e.g., expressions of social relationships, cultural norms, and economic power; or for pleasure).<sup>23</sup>

The food environment when Canadians eat 'away from home' encompasses a variety of contexts.<sup>21</sup> Even eating 'at home' can include pre-cooked, ready-to-eat meals purchased 'away' at stores. People eat away from home when they travel, but also when they stay in their immediate living environments. When people eat out, it might be for breakfast, lunch, dinner, or snacks. When people eat at restaurants, this can include table-service (also referred to as 'sit-down'), quick-service (also known as 'fast food' or take-out), cafeterias, mobile food sellers, and other venues. Statistics Canada (2001) indicates that the majority of restaurant spending occurs in table-service restaurants; in 2001, nearly 60% of restaurant spending occurred in table-service establishments versus 26% on fast food. The higher cost of food in sit-down restaurants may contribute to this finding.

### 2.1. Consumers Underestimate Calorie and Nutrient Levels in Restaurant Meals

Consumers have little understanding of the nutrient content of their restaurant meals when eating out, and this is especially true for less healthy meals and/or larger meals.<sup>24,25,26,44, 73,74, 108</sup> In one study, participants underestimated calorie levels in typical quick service foods by about 30%, which translated into unknowingly consuming 900 extra calories in a week from restaurant meals,<sup>74</sup> the equivalent of 6 kg (13lbs) of body weight over the course of a year. In a survey by the Canadian Obesity Network, 67% of people underestimated the calories in a salad containing 1150 calories. Half of the participants identified this salad as a 'low-calorie' option and 31%

thought that they would be 'sure to lose weight' by eating this salad daily.<sup>24</sup> Another study tested consumers' estimates of calories, fat, saturated fat, and sodium in "more healthy" or "less healthy" restaurant menu items. A high majority of participants underestimated calories and sodium for both sets of menu items, and fat and saturated fat for "less healthy" items. About one third of participants underestimated fat and saturated fat for "more healthy" items. Overall, sodium levels were underestimated the most. Calories of "more healthy" items were underestimated by 9% and "less healthy" items by 93%. Sodium levels in "more healthy" items were underestimated by 254% and "less healthy" items by 341%. Fat levels in "more healthy" items were underestimated by 35% and "less healthy items" by 137%. The findings were quite similar for saturated fats.<sup>73</sup>

## 3. Burden of Illness from Obesity and Hypertension

Two health conditions that coincide with poor diet, and especially with food eaten in the restaurant environment, are obesity and hypertension.

### 3.1. Obesity

The rising prevalence of obesity is a significant national and local health concern. In Toronto, 46% of adults,<sup>27</sup> and about 21% of adolescents (aged 12-17 years),<sup>28</sup> are either overweight or obese, compared to 56% of adults in the rest of Ontario<sup>27</sup> and 62% in Canada.<sup>29</sup> Carrying excess weight is a risk factor for type II diabetes, cardiovascular disease, high blood pressure, osteoarthritis, some cancers, gall bladder disease as well as mental health issues, functional limitations, and disabilities.<sup>27</sup> Childhood obesity is of particular concern as it has immediate and long term health consequences. Estimates of the economic burden of obesity in Canada range from \$4.6 billion to \$7.1 billion annually.<sup>29</sup> This includes direct costs to the health care system and indirect costs from premature mortality or disability.

The rise in obesity levels is largely attributed to increases in calorie intakes.<sup>30,31</sup> Eating out frequently is associated with higher calorie intakes, overweight, and obesity.<sup>32,33,34</sup> In one study, 11- to 18-year-olds who regularly ate fast food consumed an extra 800 calories per week for boys and 660 for girls. These extra calories translate into a possible weight gain of about 4.5 kilograms (10 pounds or more) per year.<sup>35</sup> The House of Commons Standing Committee on Health concluded in their *Healthy Weights, Healthy Kids* report (2007) that if rising childhood obesity rates go unchecked, this generation of children will be the first to live shorter, sicker lives than their parents.<sup>50</sup> Reducing population level caloric intakes, which includes a focus on the restaurant environment, is an important component of addressing high obesity rates.<sup>30</sup>

### 3.2. Hypertension

High blood pressure, or hypertension, is among the leading preventable risk factors for death in Canada.<sup>38</sup> In 2006/07, the prevalence rate of (diagnosed) hypertension among adults aged 20 years and older in Canada was 22.7% and 22.6% in Ontario.<sup>36</sup> In 2007, 23.4% of Toronto residents 20 years of age and older (4.4% of 20-44 year olds and 27.7% of 45-64 year olds) had high blood pressure.<sup>37</sup> High sodium intake increases the risk of hypertension, which can lead to heart disease, stroke, and kidney disease.<sup>38</sup> Canadians consume, on average, 3400 mg of sodium per day.<sup>38</sup> This is more than twice the recommended adequate intake for adults (1500 mg per day). Reducing sodium consumption by 1800 mg per day would avert up to 23,500 fatal and non-fatal cardiovascular disease events per year. This would result in direct and indirect health care savings of \$18.47 billion per year (in 1998 dollars).<sup>38</sup> As food consumed in restaurants and foodservice establishments accounts for 18% of the average total sodium consumed per day,<sup>38</sup> action to reduce sodium intake in the restaurant environment would contribute to the goal of reducing Canadian's daily sodium intake.<sup>38,53</sup>

## 4. Environmental Barriers to Healthy Eating Out

An increasing array of evidence suggests that people's food environments can interfere with their ability to eat healthily when away from home. This also has a corresponding effect on the nutritional quality of their diets. In the United States (US), for example, eating away from home is associated with excessive intakes of calories, sodium, and fat.<sup>39,40,41</sup> As discussed above, overconsumption of calories and these nutrients increases the risk of obesity/overweight and hypertension.

### 4.1. Large Portion Sizes

Beyond what is eaten, restaurant environments affect *how much* is eaten. Researchers Pierre Chandon and Brian Wansink, experts on consumer behaviour and marketing, have documented in numerous experiments over the last decade how social and environmental cues prompt people to eat more than they need, and more than they would if they were choosing normally.<sup>42,43,44,45,46,47</sup> There is also strong evidence that portion sizes for many foods have increased substantially over time, especially in restaurants.<sup>48</sup>

Large portion sizes affect eating behaviours in multiple ways. First, large meals prompt people to eat more than usual because it appears appropriate and reasonable to consume the amount of food set before them. Second, large meals alter people's ability to make a reasoned guess about what is in their food. As indicated in Section 2.1, people routinely underestimate nutrient content in meals consumed away from home. This tendency to underestimate calories is not linked to individuals' *ability* to estimate, but rather, their environments.<sup>42,43</sup> Even professional dietitians were found to be unable to estimate calorie content accurately when presented with a larger sized meal.<sup>43</sup> The larger the meal, the more people underestimated the calories in front of them. When the same people were presented with the meals divided into smaller parts, they were able to estimate calories more accurately.

### 4.2. Misleading Health Claims

Marketing in restaurant settings can also shape individuals' behaviour. This has been noted in previous TPH work on food and beverage marketing to children.<sup>49</sup> Chandon and Wansink<sup>43</sup> have described how marketing can create a 'health halo' or bias in calorie estimation in restaurant environments. When popular foodservice establishments claim that their restaurants are 'healthy,' people tend to underestimate how many calories they are actually eating. Such 'healthy' claims have an effect on how people perceive the restaurant as a whole, as well as individual menu items and meals. For example, in a series of experiments on this 'health halo' effect, Chandon and Wansink found that people underestimate calorie content of foods based on perceptions that McDonald's is generally 'unhealthy' and Subway is 'healthy'. The researchers then demonstrated that when a specific main dish was labelled as 'healthy,' people unknowingly added beverages, side dishes, and desserts of up to 131% more calories to their meal as compared to when they thought the main dish was 'unhealthy' – even though, the main course labelled 'healthy' actually contained 50% more calories than the one labelled 'unhealthy'.

### **4.3. Wide Variation in Nutrient Content of Foods**

These environmental influences are particularly concerning given what is known about the wide range of nutrient content of foods in restaurants. Recent analyses of major chain and franchise restaurants in Canada reveal that there is a great range of calorie and sodium levels in restaurant foods as well as a vast range of variation in calorie and sodium content of food for items even in the same food category.<sup>32,50</sup>

University of Toronto researchers found that the average restaurant meal (with entrée and side dishes) contains 56% of an adult's daily calorie requirement and 98% of an adult's daily limit for sodium.<sup>51</sup> Within a single food category, the calorie content of entrees in sit-down restaurants can differ as much as 7.5-fold across restaurants. For example, rib entrées varied from 330 calories to nearly 2500 calories.<sup>32</sup> This wide variation makes it virtually impossible to guess the calorie content of restaurant menu items based on healthy eating recommendations alone. For example, over half of salads contained more calories compared to lower-calorie hamburgers in Canadian restaurant chains.<sup>32</sup>

The sodium content in Canadian restaurant foods was even more concerning. The highest average sodium content for single entrées (not meals) was in the stir-fry category. The sodium content for a single entrée in the sandwiches/wraps category, however, was found to be as high as 6523mg.<sup>53</sup> This vastly exceeds both the daily recommended Adequate Intake (AI) level (1500 mg) as well as the maximum Tolerable Upper Intake Level (UL) (2300 mg) for Canadians, as originally set out by the U.S. Institute of Medicine.<sup>38,52</sup> The range of sodium can also vary from a two-fold difference among stir fry entrées to a 78-fold difference among sandwiches/wraps.<sup>53</sup> For Caesar salad, sodium levels varied five-fold across restaurants, from 300 mg to about 1500 mg.<sup>50</sup>

### **4.4. Nutrition Information in Restaurants is Not Visible**

Even when nutrition information is available for restaurant foods, it is difficult for people to access. Although current voluntary programs in restaurants often note that nutrition information will be 'made available upon request', researchers have revealed that such information, in reality, is hard to find or absent.

A 1994 survey of 68 of the largest foodservice corporations in the US found that only one-third of respondents were providing nutrition information to their customers.<sup>54</sup> Nearly a decade later, Wootan and Osborn<sup>55</sup> surveyed 287 of the largest chain restaurants in the US and found that 54% had made some nutrition information available, but 86% provided it only on the company website. Wootan's research team also visited 29 (88%) of the McDonald's outlets in Washington, DC, to investigate on-site availability of nutrition information. They found that 72% of outlets provided some in-store information, but in 62% of restaurants, the researchers had to consult with two or more employees in order to obtain a copy of the information.<sup>56</sup>

In January 2008, the Centre for Science in the Public Interest (CSPI) in Canada released the results of its 2007 survey of 136 outlets of 27 large chain restaurants across Canada that had committed to making nutrition information available through the Canadian Restaurant and

Foodservices Association (CRFA) Nutrition Information Program (described in section 7 - Jurisdictional Policy Experiences). The CSPI survey found that 18 (66%) of the chains provided some nutrition information at some of their outlets, including brochures and wall posters. Only one chain, McDonald's, had information available at all outlets surveyed, but the information was available on the tray liner which is provided after the purchase is made.<sup>57</sup>

In 2007, prior to their calorie labelling legislation coming into effect, the New York City Health Department assessed the visibility of calorie information to patrons in 167 locations of chain restaurants across all five boroughs, representing 11 major fast-food chains, (see also section 7.3.2 on New York City evaluations). Apart from Subway, where 32% of patrons reported seeing calorie information, only 4% of patrons at other restaurants reported seeing the calorie information that was available.<sup>58</sup>

It is clear that there is an overall lack of transparency of the nutrient content of restaurant meals and a variety of environmental cues are present that can promote unhealthy eating in restaurant settings.

## 5. Menu Labelling as a Type of Nutrition Labelling

Menu labelling is a type of nutrition labelling where information is disclosed to the public about the nutrient content of foods (including beverages) on restaurant menus or menu boards before or at the point of sale. Successive government agency reports and syntheses have recommended menu labelling as a policy option that can improve the quality of the eating out environment,<sup>14,35,38,59,60</sup> and therefore can be a tool for addressing rising rates of obesity and hypertension. Various professional associations and civil society organizations in Canada have also expressed their support for menu labelling.<sup>61</sup>

A decade ago, the World Health Organization (WHO) advised that adopting food labelling interventions could be an important part of broader strategies to prevent the growing burden of non-communicable, or chronic, diseases.<sup>5</sup> The WHO noted that such labelling should be “accurate, standardized, and comprehensible.” Food labelling would not only enable people to make informed choices but would also support a right and the means to access food rich in nutrients (as compared to foods that are high in calories but poor in nutrients) through ensuring appropriate and accurate industry use of health and nutrition claims.<sup>5,6</sup>

In Canada, prepackaged food products are required to carry a variety of information about the nutrition content of their products under federal legislation in place since 2003, but food served in restaurants is not. Following amendments to the *Food and Drugs Act* and *Regulations* which came into effect in 2005, nutritional labelling has been required on most prepackaged food labels. Nutrition labels are one of the primary means by which consumers differentiate between individual foods and brands to make informed purchasing choices.<sup>62</sup> There is a consistent link between the use of nutrition labels and healthier diets.<sup>63</sup>

Before nutrition labelling on pre-packaged foods became mandatory, food manufacturers did not provide any or adequate information to consumers. Other problems of the voluntary approach included unreliable and inconsistent information. Also, the format of the nutrition facts table was not standardized and consumers often had trouble understanding the information.<sup>64,65</sup> Mandatory nutrition labelling laws addressed most of these issues by forcing manufacturers to provide information in a standardized format.<sup>64,65</sup>

## 6. Menu Labelling as a Health Intervention

Menu labelling is an environmental intervention that is proposed to influence individual behaviour when it comes to food purchasing and eating, which, in the long run, could have a substantial impact on population health outcomes including obesity<sup>66</sup> or hypertension.<sup>38</sup> What we currently know about the effects of menu labelling as a health intervention is based on academic research (including various types of intervention studies and experiments) and analyses of real-world experiences (including evaluations of existing policies and programs). This section will review some of the academic research on menu labelling to illustrate how it is intended to work as a health intervention. It also focuses on research in restaurant environments, although, particularly in Canada, our knowledge base on consumer understanding and use of nutrition information comes from work on prepackaged foods.<sup>67</sup> Section 7 of the report reviews what has been learned from different jurisdictions that have adopted menu labelling initiatives across North America.

Overall, there is a growing range of evidence that menu labelling can be a useful intervention in moving towards healthier food environments.

### 6.1. Making Nutrient Information More Visible

Menu labelling makes nutrition information more available and visible, addressing one of the key barriers to healthy eating out, and thereby increases the likelihood that it will be used to make a menu choice. Experimental research has shown that when nutrition information is available at the point of purchase, at least 50% -70% of customers notice it.<sup>68,80</sup> Evidence of the improved availability and visibility of nutrition information following the adoption of menu labelling is presented in Section 7.

To increase visibility of nutrition information on the menu, it is recommended that font size, format, colour, and location of the label be given careful consideration.<sup>69,84</sup> Also, studies have shown that displaying a contextual statement explaining an adult's daily intake requirements for the nutrient in question increases understanding and use of the nutrition information.<sup>69,76,84,70</sup> Finally, education campaigns can be used to increase consumer awareness and understanding about menu labelling information.<sup>50</sup> Many jurisdictions in the US, such as New York City and Tacoma-Pierce County in Washington, incorporated these elements into their menu labelling strategies.

### 6.2. Helping People to Factor in Nutrient Content in Food Choices

As noted above, most consumers find it difficult to estimate the nutrition content of restaurant foods on a commonsense basis, and menu labelling helps many people to factor in objective nutrient content when making their food decisions. Even if the effects on food choices are sometimes small<sup>71</sup> or absent,<sup>72</sup> it is valuable to consider that menu labelling has been shown to have an effect and inform decisions in multiple contexts, including survey-based experiments,<sup>73,74</sup> clinic-based or psychology lab-style experiments,<sup>75,76,77</sup> as well as in quasi-experiments in real-world institutional settings such as university cafeterias.<sup>78,79,80</sup>

It is important to acknowledge that while menu labelling can help inform people's eating decisions, it does not have a major effect on everyone who sees it. In a set of statewide surveys carried out in Arkansas before menu labelling was implemented anywhere in the US, for example, researchers discovered that consumers underestimated fat and calorie content of restaurant menu items by as much as half. Then the researchers tested whether nutrition information would alter consumer attitudes, purchase intentions, and food choices (that is, ordering higher or lower calorie meals). They found that when nutrition information revealed that food items were much 'worse' than participants had expected (for example, higher in calories), people were more likely to change their purchase intentions as well as their food choices as compared to when their expectations more closely matched the actual nutrient content of the food items.<sup>73</sup> Burton and colleagues later carried out experiments that suggested that the most important factor determining the effect of menu labelling on purchase intentions and food choices was the extent to which disclosed objective nutrient information confirmed initial expectations or surprised individuals.<sup>74</sup>

In Canada, researchers at the University of Waterloo carried out an experiment to test the effects of different ways of displaying nutrition information on menus.<sup>80</sup> In this recent study, 635 adult participants, who did not know that they were part of a menu labelling study, were divided into four groups and asked to order real menu items from a Subway restaurant menu. Each group was presented with one of four types of mock menus: Group 1, no nutrition information; Group 2, calorie content listed; Group 3, calorie content alongside a 'traffic light' (green = low, yellow = medium, and red = high) signal; and Group 4, calories, fat, sodium, and sugar content with traffic lights for each. The researchers found that menu labelling clearly made nutrition information more visible. Seventy-two per cent (72%) of participants in Group 2 (calorie content) and 71% in Group 3 (calorie content + traffic light) reported seeing calories on the menu, compared to 3% in Group 1 (no information). Only 49% of people in Group 4 (four nutrients + traffic lights) reported seeing calorie information, suggesting that too much information may interfere with people's ability to process it. When asked if the nutrition information influenced their order, a statistically significant proportion of people in Groups 2 (42%), 3 (37%), and 4 (38%) said that it had. The researchers then tested the food that had actually been ordered and eaten, and while there was no significant difference between groups in the amount of calories people had ordered, people in each of the groups who had been presented with nutrition information had eaten less of their food.

A recent experimental study conducted by University of Toronto researchers also tested the effect of menu labelling on food purchase intentions.<sup>81</sup> A panel of 3,081 Canadians participated in the survey that was administered in April 2012. They found that providing calorie and sodium values on menus can change purchase intentions. About one quarter (26%) of participants chose to change their orders after seeing calories and sodium values on the menu. As well, compared to nutrients ordered before seeing menus with nutrition labelling, there was a significant overall decrease of 99 calories, 225 milligrams of sodium and 6 grams of dietary fat ordered after seeing menu labelling. Among the subset of people who changed their orders after seeing menu labelling, they chose meals with 209 fewer calories, 523 milligrams less sodium and 11 fewer grams of dietary fat.<sup>81</sup>

Toronto Public Health commissioned an analysis of the Toronto results of this study. The Toronto findings are based on a small subset of the national panel (n=199) and not necessarily representative of Toronto residents, but nonetheless provided some valuable insights into how people might use nutrition information in restaurants. The results were consistent with the findings from the larger nationally representative sample. After seeing menu labelling, 30% of respondents chose to change their order, resulting in a significant overall decrease of 188 calories, 277 milligrams of sodium and 6 grams of dietary fat. Those who changed their orders chose meals with 399 fewer calories, 939 milligrams less sodium and 21 fewer grams of dietary fat. The effects on food choices were more prominent among consumers who reported they were trying to lose weight, as well as those who had initially selected meals with significantly more calories, sodium, and dietary fat.<sup>81</sup>

### **6.3. Unintended Effects of Menu Labelling**

In addition to enabling consumers to choose a healthier menu option, there are two other potential effects of menu labelling that may have a positive impact on population health. Menu labelling enables people to balance their eating and physical activity throughout the day or week. So although knowing that a menu option contains a high amount of calories and sodium may not change one's choice to consume it, having that information may lead an individual to compensate in other ways, such as eating less at the next meal or doing more physical activity that day. There is preliminary evidence that this is more likely to happen when menu labelling includes a statement about nutrient daily intake requirements.<sup>76</sup> This area requires focused study.

Menu labelling can also alter social norms and increase consumer demand for healthier products, just as nutrition labelling on packaged foods created a demand for healthier options.<sup>50,84,117</sup> Food reformulation improves diet for everyone, even for those who do not make use of nutrition information. There is some preliminary evidence that restaurant menu reformulation has occurred, but this beneficial effect of menu labelling still needs greater study.<sup>82</sup>

An analysis of 245 U.S. chain restaurant menus found that restaurants that made nutrition information accessible on websites had significantly lower calorie, fat and sodium levels across menu items than those providing information only upon request.<sup>83</sup> Requiring nutrition information to be made more visible by putting it on the menu/menu board could increase this effect. A study in King County, Washington, assessed menu entrees after menu labelling was legislated. They found that the average amount of calories in entrées had been reduced by 73 calories in sit down restaurants 18 months after the legislation was put into place, and sodium and saturated fat levels also decreased significantly.<sup>82</sup>

In summary, menu labelling is believed to work along the following 'logic', or expected pattern of effects and outcomes.<sup>84</sup> First, people see nutrition information, then read it, develop an understanding of it, then can use it as a factor in food purchasing and consumption decisions. Of course, in planning public health policy, these steps represent 'intermediate' effects of menu labelling, because they are only part of the pathway to overall health outcomes. Whether better health is ultimately achieved (such as a reduction in population obesity levels), is also mediated by additional factors such as social context, competing factors such as taste, price, and

convenience of foods, unintended effects, and differential effects among population subgroups; moreover, it depends on whether policies are successfully implemented.<sup>84</sup>

## **6.4. Strong Public Support for Menu Labelling**

Menu labelling has been generally well supported by the public in terms of their interest in having nutrition information made available.<sup>17,24,25,34,81,85,86</sup> This has been the case when surveys have been completed as part of consultations related to specific policy initiatives (see section 7) as well as in surveys carried out for research purposes in Canada and the US. Two recent Canadian surveys found that over 90% of Canadians and Ontarians support menu labelling in fast food restaurants,<sup>85</sup> and that 86% of Canadians want nutrition information, including calories, readily available and clearly visible at the point of purchase at all restaurants.<sup>24</sup> Another recent Canadian survey using a nationally representative consumer panel found that 73% of respondents felt it was important to require restaurants to display the amount of sodium in the foods they serve.<sup>87</sup> Canadians most strongly support disclosure of calories and sodium values. Of a panel of about 3000 Canadians, 75% would like to see calories on the menu, 71% sodium, 49% fat, 47% sugar, 43% saturated fat.<sup>81</sup>

In the US, where menu labelling has largely focused on posting calories, a 2009 telephone survey on menu labelling was carried out by researchers from the Johns Hopkins Bloomberg School of Public Health with a nationally representative sample of adults aged 18 and older. They found that 68% of respondents favoured having government require chain restaurants to post calorie information on menus; 76% indicated that having calorie content of foods at the point of purchase in a chain restaurant would be ‘very or somewhat useful’; and 60% reported that calorie posting would encourage them to select a food of lower calorie content. Women, Black and Hispanic respondents, adults older than 45 years, and adults with more than a high school education were significantly more likely to report that they would use calorie posting to choose a lower calorie food.<sup>88</sup> Another American study using national-level health survey data on self-reported health status and eating behaviours found that there are two population ‘clusters’ or subgroups that are more interested than average in menu labelling: 1) generally active, healthy females with an average age of 41 years, who already watch what they eat; and 2) less-educated, less active, middle-income females with an average age of 48 years, who have poor diets and eat out more frequently.<sup>89</sup>

Toronto Public Health's survey of Toronto residents, discussed in Section 9, confirms high support for menu labelling as does the University of Toronto research on menu labelling which included a small sample of Toronto residents.<sup>81</sup>

# 7. Jurisdictional Policy Experiences

This section provides examples of menu labelling initiatives from across North America to outline real-world experiences of how menu labelling can be adopted, implemented, and used. Different types of menu labelling interventions have been adopted in various jurisdictions, and, where available, findings from evaluations of these initiatives are described as well. A summary table of common parameters and practices for existing menu labelling initiatives in Canada and the US is included in the Appendix (Section 12).

## 7.1. Legislation – Canada

A legal analysis prepared for the Public Health Agency of Canada (PHAC) has suggested that all three levels of government in Canada would likely have jurisdiction to enact mandatory menu labelling legislation.<sup>90,91</sup> Some localities in Canada have advocated for provincial or federal legislation on menu labelling, for example in Ontario, Ottawa,<sup>92</sup> Peel,<sup>93</sup> Simcoe-Muskoka District,<sup>94</sup> and Durham Region,<sup>95</sup> but none have enacted local legislation.

At the provincial level in Ontario, New Democratic Party (NDP) Member of Provincial Parliament (MPP) France Gélinas has introduced a proposal for menu labelling legislation on three occasions. The most recent version of the bill<sup>96</sup> proposed an amendment to the *Health Protection and Promotion Act* to require chain restaurants with five or more locations and gross annual revenue over \$5 million to display the calorie content of all menu items, via a menu, menu board, or food item tag where there are no menus, as well as a warning for high sodium content. The bill did not proceed to second reading due to the prorogation of Parliament in October 2012.

In March 2013, the Ontario Government released their Healthy Kids Panel report with recommendations to address childhood obesity. The three-part Healthy Kids Strategy recommends building healthier environments for children at the pre- and post-prenatal period, in the community, and in the food environment. Recommendations focused on changing the food environment include requiring menu labelling in all restaurants, including fast food outlets, and in retail grocery stores.<sup>97</sup> On April 4, 2013, the Province released *Make No Little Plans: Ontario's Public Health Sector Strategic Plan* which includes achieving the goals of the Healthy Kids Panel report among its strategic goals and collective areas of focus.<sup>98</sup>

At the federal level, Liberal Member of Parliament Tom Wappel introduced a series of private member's bills nearly a decade ago<sup>99</sup> to amend the *Food and Drugs Act* to require a number of food labelling provisions for 'foods sold for immediate consumption' by operators with over \$10 million in gross annual revenues, including display of calorie, sodium, and fat content. This bill was ultimately defeated at second reading in 2006.

NDP Member of Parliament Libby Davies has also introduced a private member's bill that may have menu labelling implications (Bill C-460, introduced November 5, 2012). While the text of the bill does not specifically mention menu labelling, apart from 'high sodium' warnings on standardized items at large chain restaurants, it sets in place parameters to implement the Sodium

Reduction Strategy for Canada.<sup>100</sup> Recommendation 1-8 in the Sodium Reduction Strategy advises that provincial menu labelling legislation be enacted for standardized menu items “prepared and assembled on site at restaurants and food services establishments ... in establishments with a high degree of standardization.”<sup>38</sup>

In 2011, a Federal-Provincial-Territorial Task Group on Provision of Nutrition Information in Restaurants and Foodservices was struck to develop a national framework for nutrition information disclosure in restaurants for Health Canada. Membership includes representatives from Health Canada, PHAC, and Ministries of Health for Ontario, British Columbia, Alberta, and Newfoundland. Both voluntary and mandatory options are being considered. There are no details on the format this will take, but there are plans underway to develop an approach to focus test next year. The timeline for delivery of a Health Canada framework has been projected at mid-2015 at the earliest.<sup>101</sup>

## **7.2. Voluntary Initiatives – Canada**

Menu labelling initiatives are often viewed as encompassing two approaches: voluntary guidance (led by various governmental and nongovernmental agencies, including industry) and requirements embedded in law (‘mandatory’ menu labelling legislation). A review of the examples below suggests that voluntary programs can vary substantially, and can be administered and funded through different public and private sources. This section outlines three examples of voluntary menu labelling initiatives: Health Check, administered by the Heart and Stroke Foundation of Canada, a nongovernmental organization; Informed Dining, run by the British Columbia provincial government; and industry-led action by the Canadian Restaurant and Foodservices Association (CRFA).

### **7.2.1. Health Check (Heart and Stroke Foundation of Canada)**

The Heart and Stroke Foundation of Canada (HSF) and its provincial offices run the Health Check labelling program. Health Check was launched for prepackaged food items in 1999 and for restaurant menu items in 2006.

The Health Check restaurant program currently works with 14 chain restaurant 'licensees' in Ontario. Individual food products or menu items are submitted by licensees who bear the costs of laboratory nutrition analysis (subsidized by the Ontario Ministry of Health and Long Term Care) and then request evaluation by HSF for compliance with program-defined nutrition standards and to receive a Health Check designation for that menu item. In many cases, restaurants develop new menu items to adhere to Health Check requirements. A licensing fee is charged for each Health Check menu item. This allows the program to operate on a cost recovery basis. Successfully evaluated items are labelled with a Health Check logo on the menu, the same logo that is used on the front-of-pack for Health Check prepackaged foods. In restaurants, in addition to the logo, Health Check menu items are required to have an explanatory message and nutrition facts brochure available prior to the point of sale.

In February 2012, a menu labelling component was added to the Health Check restaurant program. Nutrition information for Health Check menu items including calories, sodium, fat, and

other ‘Health Check nutrients’ must be displayed on menus and menu boards or in some other format available prior to the point of sale. By definition, the focus is only on "healthy" items and not all menu options.

The Heart and Stroke Foundation has highlighted key lessons from the Health Check restaurant experience, three of which are especially relevant here: a) some operators find the licensing and nutrition analysis costs prohibitive (and only chains are currently engaged); b) implementation time for restaurants to meet standards was from months to years; and c) random annual audits done by HSF have indicated ‘strong’ compliance.

#### Sources

- Health Check website (<http://www.healthcheck.org/>)
- Toronto Public Health menu labelling workgroup consultations in 2011, 2012 and 2013 with the Business Development Manager of Foodservice and the Program Manager of the Health Check Ontario Dining Program
- Presentation by Terry Dean, Director, Health Check at Ontario Sodium Summit, Toronto, February 16, 2012<sup>102</sup>

### **7.2.2. Informed Dining (British Columbia Ministry of Health)**

The British Columbia (BC) Ministry of Health identified nutrition information disclosure in restaurants as a priority initiative in April 2010. Following early consultations, a political endorsement for a voluntary “provincial restaurant recognition program” was gained in November 2010. The program evolved from then and had its official launch as “Informed Dining” in August 2011. A Restaurant Working Group was convened in December 2010 to discuss program development and design, which included representatives of the Ministry of Health, the CRFA, the BC Restaurant and Foodservices Association, and key industry leaders. Additional consultations were held with public health and industry stakeholders in early 2011. The Heart and Stroke Foundation BC joined Informed Dining as a formal partner in March 2011 for program implementation and evaluation support. The tagline for Informed Dining is “Stop Guessing. Start Asking”.

Participating restaurants in Informed Dining are not required to provide nutrition information directly on menus or menu boards. Rather, they are expected to offer nutrition information in any of several standardized formats such as via menu insert, brochure, or poster. Restaurants are asked to share nutrition information for all standard menu items, including calories and 13 core nutrients, with calories and sodium highlighted, and information on daily calorie and sodium intake requirements. They must make this information available, upon request by patrons, at or before the point of ordering, but as noted, not necessarily on the menu itself. Restaurants must display the program logo and a statement on the menu/menu board advising patrons that nutrition information is available.

At the launch of the program, the province offered free nutrition analysis aided by provincial dietetic staff as an incentive to early adopters and to promote participation among smaller/independent operators. This was popular but resource intensive for the province. A new Small Business Support Program has since been developed including nutrient analysis, recipe

reformulation, graphic design, and printing supports for operators with fewer than five locations and fewer than 50 employees per location. All other operators are responsible for obtaining their own nutrient analysis, which can be obtained independently through laboratory or computer software methods. Provincial public health inspectors are responsible for monitoring and quality assurance, not including nutrient accuracy.

To date, Informed Dining has recruited 18 restaurants (including two national chains) to voluntarily participate. Additional restaurants have signed on and are at various stages of program implementation. Informed Dining has been mandated for foodservice operators in publicly-funded provincial healthcare institutions, but it has not yet come into effect. The cost of Informed Dining to the BC provincial government has been estimated at more than \$2 million, with approximately \$1 million for a promotional campaign. An internal evaluation of Informed Dining is underway, with results anticipated in spring 2013.

#### Sources

- Informed Dining website (<http://www.healthyfamiliesbc.ca/home/informed-dining>)
- Toronto Public Health menu labelling workgroup consultations from 2011-2013 with the Provincial Nutritionist and the Senior Manager/Acting Provincial Nutritionist of BC Ministry of Health, and shared internal documents

### **7.2.3. Canadian Restaurant and Foodservices Association Nutrition Information Program**

In 2005, the Canadian Restaurant and Foodservices Association (CRFA) launched a voluntary nutrition information program with guidelines to support their members to provide nutrition information to their customers. Participating restaurants are asked to provide information on calories and the 13 nutrients found on the Nutrition Facts Table required for pre-packaged foods, and on allergens, for all core/standard menu items. They are asked to provide this information through in-store pamphlets, brochures, or posters, and on their websites.<sup>103</sup> Over 30 large chains are participating in this program, although compliance with program recommendations has been found to be inconsistent.<sup>50</sup>

The CRFA has continually emphasized that it supports the development of a nationally consistent framework for menu labelling for all restaurants. The CRFA has participated in consultations held by the Federal-Provincial-Territorial Task Group noted above. The CRFA publicly announced in December 2012 that it is endorsing a transition from the CRFA voluntary guidance program to the Informed Dining program and will support BC restaurants that also have outlets across Canada to participate.<sup>104</sup> The CRFA is also seeking partnerships with provincial governments to support the implementation of Informed Dining in non-BC chains.

#### Sources

- CRFA website (<http://www.crfa.ca/>)
- Toronto Public Health menu labelling workgroup consultations in 2012 with the Vice President of Ontario & Sustainability and the Executive Vice President of Government Affairs of CRFA; and the Chair of CRFA Board of Directors

## 7.3. Legislation – United States

A number of jurisdictions in the US, at the municipal, county, and state levels, have introduced or enacted menu labelling legislation that focuses on posting calories.<sup>105</sup> These policy initiatives will largely be superseded in 2013 by a federal menu labelling provision embedded in the *Patient Protection and Affordable Care Act (ACA)* (PL111-148), Provision 4205. Only three US jurisdictions (California, Seattle/King County, and Philadelphia) have mandated menu labelling that requires posting calories plus additional nutrient values (sodium, fats, carbohydrates) on the menu or, in some other format, at the point of purchase. In all three jurisdictions, only calories are required on menu boards. All state and local menu labelling legislation will be pre-empted by the federal legislation once it comes into force. Philadelphia, however, has applied for an exemption based on the grounds that the city has a very high prevalence of adult obesity, cardiovascular disease and hypertension, and diabetes. As California's menu labelling law has not been evaluated,<sup>106</sup> and the results of Philadelphia's evaluation are not yet available, these jurisdictions are not included in this section.

### 7.3.1. US Federal Menu Labelling

The ACA became law in March 2010 and was upheld in a Supreme Court ruling in 2012. It establishes calorie labelling requirements for large chain restaurants and related retail foodservice operators with 20 outlets or more nationwide. The legislation requires calorie content of standard menu items to be posted prominently on menus, menu boards, or drive-through menus, with contextual information on daily requirements. Calorie posting is also required on vending machines near the selection button where consumers cannot inspect the prepackaged Nutrition Facts Panel prior to purchase. This legislation is expected to come into force in April 2013.

#### Sources

- Legislation cited
- US Federal Register Volume 75, Number 129 (Wednesday, July 7, 2010), Docket No. FDA-2010-N-0298, <http://www.gpo.gov/fdsys/pkg/FR-2010-07-07/html/2010-16303.htm>; Volume 75, Number 164 (Wednesday, August 25, 2010), Docket No. FDA-2010-D-0370 and FDA-2010-D-354 <http://edocket.access.gpo.gov/2010/pdf/2010-21067.pdf>

### 7.3.2. New York City

New York City was the first jurisdiction in the US to adopt menu labelling legislation, and provides important information on implementation and effectiveness. In December 2006, the New York City Board of Health agreed to adopt a municipal Health Code amendment, Article 81.50, requiring foodservice establishments who already make calorie information publicly available to post this information on menu boards. After legal challenges by the New York State Restaurant Association, the New York City Health Department went on to repeal, rewrite, and reenact the amendment to require posting of calorie information for all foodservice establishments of a particular size in the city, and the Board of Health adopted this in January 2008.

New York City's menu labelling requirement took effect in April 2008 with enforcement beginning in July 2008. It requires foodservice establishments with 15 or more locations nationwide to post calorie information for all menu items on menus, menu boards, drive through menus, and food item tags, with provisions for elements such as format/font size, flavours/varieties, and food item combinations.

New York City is one of a few jurisdictions that has undertaken a formal evaluation of their menu labelling program. An analysis of the New York City experience by City officials emphasized three lessons for other jurisdictions considering menu labelling legislation: 1) voluntary initiatives were highly unlikely to succeed; 2) a combination of public health disciplines and city staff was needed to ensure success; and 3) local authorities have a high degree of expertise and capacity in terms of public health authority over food distribution and retail, particularly restaurants.<sup>107</sup>

Evaluative evidence from New York City offers modest but compelling empirical evidence that mandatory menu labelling has several important effects. Two are undisputed: menu labelling changes the food information environment in restaurants by rendering calorie content of foods visible; and this information is readily noticed after implementation by a majority of patrons.<sup>108,109,110</sup>

Three key pieces of research break down the effects of the legislation further. The Health Department team and collaborators carried out baseline, and 3 month pre- and post-enforcement exit surveys across 11 chains (not including coffee chains), collecting information from over seven thousand customers each time (baseline n=7,318; pre n=7,309; post n=8,489). They found high baseline calorie intakes, with over one-third of customers ordering over 1,000 calories for a lunchtime meal prior to the legislation.<sup>58,111</sup> The pre-post evaluation found that after the legislation, 72% of respondents reported seeing the calorie information; 15% reported using it; and overall, there was no significant difference in overall calories purchased.<sup>112</sup> Yet significant reductions were observed for particular chains (McDonald's, Au Bon Pain, and KFC), and among those who reported using the information, there was an average reduction of 106 calories purchased per transaction.

This study's baseline findings from the Subway chain are also worthy of note. Subway had posted calorie values on the menu board before the legislation went into effect. At baseline, Subway patrons who reported having seen the calorie information purchased 52 fewer calories and fewer higher-calorie meals than Subway patrons who did not see it. Of Subway patrons who reported seeing calorie information, 37% reported that this information had an effect on their purchases. Those who reported seeing and using calorie information purchased 99 fewer calories compared to those who reported seeing the information, but stated that it had no effect.<sup>58</sup>

A smaller study consisting of lunchtime surveys of 1156 customers leaving a restaurant at selected low-income neighbourhood locations of four large fast food chains (McDonald's, Burger King, Wendy's, KFC) in New York City and Newark, New Jersey, found that there was no significant difference in overall calories purchased two weeks pre and four weeks post enforcement, and no difference in calories purchased between the two cities.<sup>110</sup>

Finally, an intensive study by Bollinger et al. (2010), with access to every sales transaction (n=over 100 million) at Starbucks locations in New York City, Boston, and Philadelphia from January 2008 through February 2009, including individual-level data from store cardholders, found that calorie posting did have significant effects on calories purchased. Overall, there was a 6% average reduction in calories ordered per transaction; a 14% reduction for food items, excluding beverages; and among individuals who ordered more than 250 calories per transaction prior to the labelling rule, a 26% reduction. The reduction effect was also seen for commuters (i.e., individual cardholders who purchased at Starbucks inside and outside New York City), leading the authors to suggest that there was a learning effect of display of information. They also discovered that there was no change in revenue for Starbucks, with a 3% increase in revenue for Starbucks located close to Dunkin Donuts establishments. An untested hypothesis that was put forward by the researchers was that the availability of calorie information at Starbucks may have attracted some Dunkin Donuts patrons.

In terms of lessons for policy development and implementation, three points should be made. First, the New York City experience indicates that public support for menu labelling is very high. Ninety-nine percent (99%) of respondents to the City's public consultation supported the legislation prior to adoption and 86% of respondents to an August 2008 survey after implementation noted it was a 'positive move'.<sup>113</sup> Second, evidence demonstrates that nutrition labelling works in the way it is intended: through improved information transparency, people are influenced to make healthier food choices.<sup>114</sup> Third, the legal analyses have concluded that local governments have the clearest authority over labelling when it is about information transparency, in contrast to regulation of health/nutrition claims, which are largely seen to be the responsibilities of the federal government and private companies.<sup>114</sup>

#### Sources

- Toronto Public Health menu labelling workgroup consultations with the Director of Built Environment and Active Design, New York City Department of Health and Mental Hygiene
- Peer-reviewed literature cited

### **7.3.3. King County, Washington**

King County is a large county in Washington State encompassing the City of Seattle, with a population of over 1.9 million people. Seattle & King County Public Health is the metropolitan health department and administers both local (Board of Health) and state policies and programs. On July 19, 2007, the King County Board of Health adopted Rule and Regulation (R&R) 07-01, which requires chain restaurants with fifteen or more locations nationwide, with at least \$1 million USD in gross annual sales, to label calories, saturated fat, carbohydrates, and sodium content for all standard menu items on menus, menu boards, and as of 2009, drive-through menus. This requirement came into effect August 1, 2008 and was enforced as of January 1, 2009. In light of the pending US federal menu labelling legislation, King County initiated a process to revise its regulation and align it with the national statute, which was approved at a public hearing at the Board of Health on May 20, 2010, effective June 19, 2010.

Finkelstein et al. carried out an assessment of the effects of the original King County regulation using data from Taco Time Northwest, a chain restaurant that provided transaction data for all menu items sold one year before and after the legislation was enforced.<sup>115</sup> Based on transaction analysis, the researchers did not find any substantial difference in calories per transaction before and after the legislation came into effect. A year and a half after the regulation, however, health department staff found that consumers were less likely to be making ‘high calorie’ meal purchases (defined as over 667 calories per meal), with an approximately 4% reduction in customers buying ‘high calorie’ items.<sup>116</sup>

Other researchers carrying out an audit of King County restaurants affected by the legislation, including sit-down and quick-service chains with four or more locations in King County, found some evidence that menu reformulation also took place. They found a modest decrease in calories, fat, and sodium in entrées and combination meals after the legislation, with the exception of pizza chains.<sup>117</sup>

Another group of researchers compared King County to San Diego County (where there was no regulation). While they found no significant difference between the two counties in terms of calories ordered, they did note that in King County, the proportion of people who reported seeing nutrition information increased significantly post-regulation, from 44% to 87%, whereas there was no change in San Diego County.<sup>118</sup>

#### Sources

- King County government website (<http://www.kingcounty.gov/healthservices/health/nutrition/healthyeating.aspx>)
- Peer-reviewed literature cited

## 7.4. Voluntary Initiatives – United States

### 7.4.1. SmartMenu (Tacoma-Pierce County Health Department, Washington)

Tacoma Pierce County is a mid-sized public health jurisdiction in Washington State, home to 800,000 people, including ~200,000 people in the City of Tacoma, and 3,200 food establishments of which 600 are independently locally owned and operated. The SmartMenu pilot recruited 24 independent establishments from mid-June 2007 to Sept 2008. The program did not do any further recruitment. These establishments were seen as “early adopters.” The program included software nutrition analysis supported through the Health Department and contracted Registered Dietitians; restaurant recognition and promotions; and menu labelling for calories, fat, carbohydrate, and sodium content in a standardized but optional format for all regular menu items. The total cost of the program was estimated at over \$350,000 USD.

Evaluations of the program process<sup>119</sup> and effects on consumer behaviour<sup>120</sup> have provided evidence to assist other local health authorities in thinking through their own initiatives. Consumer behaviour findings echoed those of other initiatives. They found that 34% of customers reported using the nutrition information to make a healthier choice (for example, 20% chose an entrée lower in calories and 8% chose an entrée lower in sodium). Those who used the

information to make a lower calorie choice were estimated to have ordered about 75 fewer calories.<sup>120</sup> Britt et al. detail how this pilot-scale, voluntary program was time and resource intensive; Health Department staff supported menu item standardization and carried out the software nutrition analysis.<sup>119</sup>

From a broader perspective, the experience from the SmartMenu pilot cannot really be seen as a ‘lead up’ to legislation or even reasonably compared with a potential health agency burden following implementation of legislation for major chain restaurants; rather, it should serve as a source of implementation lessons for a voluntary independent restaurant program model.

#### Sources

- Tacoma-Pierce County Health Department website (<http://www.tpchd.org/index.php>)
- Peer-reviewed literature cited
- Toronto Public Health menu labelling workgroup consultations in 2012 with an Evaluator and a Prevention Specialist of the Tacoma-Pierce County Health Department

### **7.4.2. Healthy Hometown Restaurant Program (Louisville, Kentucky)**

Using part of a major federal grant for obesity prevention in 2010, Louisville, Kentucky initiated a program of support for smaller restaurants to implement US federal requirements for menu labelling (local restaurants with fewer than 20 locations nationwide; budget allotted was approximately \$600,000 USD for development and implementation of the program). Initial public consultations indicated that there was strong public support for menu labelling. The health department offered the following supports to participants: software nutrition analysis by dietitians; access to contracted local chefs who helped with recipe standardization and menu reformulation; free healthy cooking workshops; free printing of menus; and restaurant promotion.

Forty restaurants out of 1300 eligible were participating as of May 2012. An outcome evaluation of the menu labelling initiative was undertaken but the findings have not as yet been released. Project staff noted anecdotally that very few restaurants changed their menu upon seeing the nutrition analysis; those who did change their menu item adjusted the portion size rather than adjusting the recipe. Although there was interest in an implementation evaluation, the funding timelines did not allow for this undertaking. One of the objectives of this initiative was to improve access to healthy food in lower income areas. It was noted that restaurants in lower income areas were reluctant to participate because they thought that changing their menu to make it healthier could negatively affect their sales.

#### Sources

- City of Louisville government website (<http://www.louisvilleky.gov/Health/PuttingPreventiontoWork/RestMenuLabel.htm>)
- Toronto Public Health Menu Labelling Work Group consultation with the Coordinator of the Louisville's Healthy Hometown Restaurant Program, May 30, 2012
- Toronto Public Health Menu Labelling Work Group consultation with Lead Evaluator, Healthy Hometown Restaurant Program, January 22, 2013.

## 7.5. Key Learning from Jurisdictional Policy Experiences

In summary, the review of jurisdictional policy experiences has highlighted several key points.

- Public support for menu labelling is high. Menu labelling clearly makes nutrition information more visible in eating out environments and it can influence ordering behaviour, including calorie reductions, for a subset of customers.
- There is a growing range of evidence on menu labelling process and outcomes, including specific ‘lessons learned’ from jurisdictions on how to do menu labelling initiatives well. Program design depends on the policy context in each jurisdiction. It is necessary to engage industry in the development phase.
- Specific adoption and implementation barriers exist for both voluntary and mandatory menu labelling initiatives. These barriers are not insubstantial, particularly for smaller/independent restaurants. The New York City example suggests that beyond acceptability of the legislation in the first place, fewer implementation challenges may exist for mandatory menu labelling among large chains. Menu labelling is unlikely to be widely supported or adopted by the restaurant and foodservice industry on a voluntary basis.
- For voluntary menu labelling initiatives:
  - multiple recruitment strategies have to be used and attrition should be expected;
  - dedicated health staff and financial resources have to be allocated to ensure sustainability; and
  - one of the most challenging components is nutrient analysis because, although using computerized nutrient analysis can be lower in absolute cost, it can be resource intensive in terms of public health staff resources required to support restaurants to complete the process.

## 8. Rationale for Calories and Sodium on the Menu

In order to prioritize which nutrients to include on the menu, the following criteria were considered: a) nutrition information that is associated with critical population health concerns because of the high levels found in restaurant foods and the overconsumption of these nutrients; b) nutrients that consumers have difficulty estimating in their restaurant meals; c) nutrients that consumers most want to know about; and d) the amount of the nutrition information which consumers have the capacity to easily see, understand and use at the point of purchase.

Calories and sodium values are recommended as the key nutrients to include on chain restaurant menus/menu boards since they meet all of the above criteria. The evidence linking excess calorie consumption to weight gain and excess sodium intake to high blood pressure is strong, with implications for population level obesity reduction and chronic disease prevention efforts. Previous sections of this report showed that restaurant meals are generally very high in calories and sodium, and that consumers highly underestimate calorie and sodium levels.

A small number of US jurisdictions have included fat (either total fat or saturated fat) and carbohydrates (either total carbohydrates or sugars) in menu labelling initiatives. Although both low-fat and low-carbohydrate diets can lead to weight loss, the most important determinant of maintaining weight loss is the ability to sustain a lower-calorie diet regardless the source of the calories.<sup>121,122</sup>

The evidence linking dietary fat and carbohydrate intakes to chronic diseases is not straightforward.<sup>123</sup> While there is strong evidence linking diets high in saturated and trans fat with cardiovascular diseases, other types of fatty acids (i.e. unsaturated) are considered an important part of a healthy diet. Similarly, there are "good" carbohydrates derived from whole grains, vegetables, fruit and legumes which are health promoting, in contrast to carbohydrates derived from added sugars that are associated with poor health effects such as dental caries and obesity. Therefore, a total fat or total carbohydrate value is not a useful indicator of the healthfulness of a menu item beyond being a proxy for calorie content. Furthermore, adding information on a larger number of nutrients can make it challenging for people to process. As in other jurisdictions, large chain restaurants (both sit-down and quick-service) should also be required to provide customers with comprehensive nutrition information, upon request, so that individuals with particular health or dietary concerns can access the information they need to make an informed choice.

Finally, according to a survey of about 3000 Canadians, the strongest public support is for calorie and sodium values on the menu (75% wanted calories, 71% sodium, 49% fat, 47% sugar, and 43% saturated fat).<sup>81</sup>

# 9. Readiness for Menu Labelling in Toronto

## 9.1. Issue History in Toronto

Toronto Public Health has studied the issue of menu labelling since 2008. The Toronto Food Strategy's May 2010 Board of Health report, *Cultivating Food Connections: Toward a Healthy and Sustainable Food System for Toronto*,<sup>2</sup> identified menu labelling as a direction that TPH would explore to help achieve one of the priority areas on 'empowering people with food skills and information.'

In June 2010, TPH first expressed its official support for menu labelling legislation at the provincial level as one of the signatories to a letter coordinated by the Centre for Science in the Public Interest (Canada), in support of Ontario MPP Gélinas' private member's bill on menu labelling.

Since late 2010, TPH has carried out in-depth background research to assess the policy environment and stakeholder readiness for menu labelling, including:

- Consultations with representatives of local, provincial, and national groups and organizations in Canada and the US involved in menu labelling initiatives (outlined above);
- Consultations with restaurant associations and operators;
- A telephone survey of Toronto residents;
- An online survey of independent restaurant operators; and
- In-depth key informant interviews with executives and decision makers at chain and franchise restaurants.

The following sections report on TPH research on readiness for menu labelling with Toronto residents and independently owned/operated and chain/franchise restaurants in Toronto.

## 9.2. Eating Out in Toronto and Resident Attitudes

A consumer eating out module was incorporated into the 2011 Toronto Health Survey, a population health surveillance telephone survey of Toronto residents (n=1,699) commissioned by TPH and carried out by a market research firm between October 2011 and March 2012.<sup>124</sup> The survey found that eating out is very common among Toronto residents. Over 7 in 10 (71%) Torontonians reported having eaten out at a restaurant or fast food outlet (or both) at least once in the past week. Over half (54%) reported having eaten at a restaurant and nearly half (47%) reported having eaten fast food. Eating out is more common among men and younger age groups, for both restaurants and fast food. Torontonians who have postsecondary education or a higher household income are significantly more likely to have eaten out at a restaurant than those with less education or lower income.

Most respondents also noted that they believed getting "nutritious food" was important, with over half (54%) agreeing that it was "very important" and another third (36%) "somewhat important" to them. When asked about their current and intended use of nutrition information

(self defined), people responded positively. Nearly 70% of respondents indicated that they already consider nutrition information when eating out ‘at least sometimes’ and 78% suggested that they would use nutrition information ‘at least sometimes’ if it were readily available. Females, those in younger age groups, and those with higher levels of education were significantly more likely to report that they would use nutrition information if it were readily available.

A smaller study mentioned above, requested by TPH and carried out through the University of Toronto, revealed that 83% of Toronto consumers would like to see nutrition information when eating out.<sup>81</sup> The nutrients of greatest interest to consumers are calories and sodium, with 79% and 74% of consumers, respectively, saying they want to see these nutrients. Fifty-eight percent (58%) of consumers said they want to see information about dietary fat. About half of consumers are interested in seeing values for trans fat, saturated fat and sugar. Only one in six consumers were interested in seeing vitamin content and one in eight want to see mineral content.

### **9.3. Views on Menu Labelling Among Independent Restaurants**

Toronto Public Health contracted a market research firm to administer an online survey of independent restaurant operators across Toronto from December 2011 to January 2012 (n=256 completed surveys). The survey suggested that the majority of these independent restaurants at present are not interested (72%) in providing nutrition information to their customers. Underpinning this view appears to be an idea that people already have a good idea of what is healthy or not (91%) and that restaurants’ ability to provide nutrition information would not affect consumers’ decisions to eat at their establishment (62%).

There are worries about what menu labelling would mean in practical implementation terms. Three quarters (76%) of independent operators agreed that adjusting menus to provide nutrition information would be an expensive undertaking. 64% felt that they were too busy to “figure out” how to provide nutrition information and 62% of respondents said that they would not provide it unless they absolutely had to.

Yet over half (57%) of respondents to the survey reported feeling some responsibility to provide nutrition information. Half of respondents thought that nutrition information could be good for business in terms of attracting customers. As well, 80 restaurants (42%) expressed interest in working with TPH on a pilot project focused on providing nutrition information to their customers.

In the summer of 2012, follow-up consultations were conducted with a sample of this group of restaurant operators to further explore their interest in a proposed TPH menu labelling pilot project. The stated purpose of the pilot was to test the feasibility of menu labelling among independently owned/operated and small chain restaurants in Toronto. The proposed parameters of the pilot were that operators would analyze all standard items on their menu (using computerized software or laboratory analysis) and post calories, sodium, and fat values on the menu/menu board. Similar to models in other jurisdictions described in Section 7, TPH would provide some support in conducting the nutrition analysis and recognition to participating restaurants in a number of ways.

Of the 13 independent restaurant operators that were consulted, 11 confirmed their interest in participating in a pilot. Two others would consider it further once the parameters of the pilot project were finalized. Overall, these operators indicated that they want to be leaders and see menu labelling as an opportunity to take advantage of a current trend and create a competitive advantage against chains. They hoped that they could boost their business by providing this service to their customers, promoting their menu, and receiving recognition for participating in the pilot. Restaurant operators indicated needing some support from TPH, primarily with the cost and time requirements of nutritional analysis.

#### **9.4. Views on Menu Labelling Among Chains and Franchises**

Toronto Public Health commissioned in-depth interviews with executives of 9 chains/franchises operating in Toronto, conducted in February 2012. Consultations were also conducted in 2011-2012 with the CRFA, the Ontario Restaurant, Hotel & Motel Association, and the Ontario Chinese Restaurant Association. Similar to the independent restaurant operators, the executives of chains and franchises interviewed by TPH noted that restaurants are responsive to consumer demand, including health concerns, which are seen to be a topical industry issue. (This is consistent with industry perspectives elsewhere in Canada and the US.)<sup>125,126</sup>

‘Health’ is also broadly defined in the restaurant sector. The range of health concerns discussed by chain/franchise executives went well beyond calorie or even nutrient-specific information. With little prompting, interviewees raised topics such as general health and health conditions (e.g., diabetes), health concerns among particular population groups (e.g., aging population), foods or preparations that are perceived to be “healthy” (e.g., fish or grilled items), allergies, diets (e.g., gluten free), quality of products or standards of production (e.g., agricultural origin), and broader environmental issues (e.g., biodegradable packaging), in addition to traditional nutrient categories (e.g., calories, portion sizes, sodium).

The largest chains already see themselves as industry leaders in providing nutrition information, but smaller chains interviewed also reported taking active steps to provide this service. Nearly all interviewees noted that they had taken health concerns into account to reformulate their menu offerings in some way, including sodium reduction or clearer food handling policies to minimize risk of allergies. One small chain recounted how carrying out nutritional analysis had prompted them to reduce sodium, lower fat, and even switch to brown rice in their menu items. The same small chain suggested that smaller companies, in contrast to large ones, could more readily and feasibly adapt menus since they were less embedded in complex food supply chains.

Overall large chain restaurants, and some smaller chains, both indicated that they were already providing some type of nutrition or health information to consumers. Several interviewees questioned the evidence on effectiveness of menu labelling interventions to shape consumer behaviour.

There was not strong support for menu labelling amongst chain restaurants in Canada. Rather, there is a preference for the current model of voluntary nutrition information disclosure as set out

by the CRFA. The views presented by the consulted restaurant associations were consistent with these findings.

An additional six local chains were consulted by TPH staff in the fall of 2012 about the proposed TPH menu labelling pilot project which yielded consistent findings. Most chain representatives indicated that they already provide comprehensive nutrition information on their website and make it available in their restaurants, upon request. One chain was providing calorie and fat values for some menu items and another US-based chain had begun posting calories on the menu/menu board in their Canadian locations. Overall, there was recognition that menu labelling is on the horizon, but most were hesitant to undertake it voluntarily. Unlike the view of independent operators, they did not see any benefit for their chain, only for their customers. They feared it could negatively affect their revenue from lower sales of 'less-healthy' items. Another challenge was the issue of cluttering the menu board; three operators said it would be easier to do menu labelling with LED screens. There were mixed views about menu labelling with calories, sodium, and fat values, and reluctance to participate in the pilot project.

The cost of putting nutrition information on the menu has been identified as a concern by the restaurant industry, as well as those consulted by TPH. The U.S. Federal Department of Agriculture conducted a cost-benefit analysis of their federal menu labelling legislation.<sup>127</sup> They estimate the cost per large restaurant chain for nutritional analysis, replacing menus/menu boards and staff training to be on average USD \$45,720 per year. This may not be a substantial cost for larger chains, and the potential health benefits of menu labelling have to be considered.<sup>127,128</sup> Menu labelling may also offer opportunities to recover some of these costs through increased sales, as more health conscious consumers indicate that they will eat out more often if easily accessible nutrient and calorie information is available.<sup>74</sup>

# 10. Municipal Policy Levers for Menu Labelling

Although there is agreement among diverse stakeholders that a provincial and/or federal menu labelling legislation is preferable, every level of government has a role to play in creating environments that protect and promote health.

Toronto Public Health's mandate comes from two principal sources. It fulfills the requirements of the provincial Ontario Health Protection and Promotion Act (HPPA) and associated regulations, including the Ontario Public Health Standards (2008). R.R.O. 1990, Regulation 562 deals specifically with Food Premises. Toronto Public Health also holds a role within the City of Toronto municipal government, reporting to the municipal Board of Health, defined by the City of Toronto Act (COTA).

Part III of the HPPA, Community Health Protection, permits the medical officer of health to investigate and take action to eliminate potential health hazards, including food premises. The Act makes it incumbent upon food premise operators to provide the medical officer of health with information regarding the food at or distributed from the food premise. Section 96(3) (b) through (e) and (h) through (j) provide the province with powers to enact regulations regarding food premises including food vending machines. A “food premise” includes those premises “where food or milk is manufactured, processed, prepared, stored, handled, displayed, distributed, transported, sold or offered for sale, but does not include a private residence.”

The Ontario Public Health Standards include several sections that refer to healthy eating and food premises. Beyond the detailed descriptions of food premise requirements for safe food and food handling, the section on chronic disease prevention notes that local boards of health “shall collaborate with local food premises to provide information and support environmental changes through policy development related to healthy eating”. Menu labelling could be one such policy initiative.

The Toronto Food Strategy identified how the City of Toronto already has many roles, responsibilities, and levers to help make food systems more health promoting.<sup>2, 129</sup> Moreover, one major dimension of a supportive food environment that was identified by Torontonians as important to them is food system transparency. Residents want to know more about their food, in a way that is accessible and easy to understand, and they want City government to champion that kind of food system transparency.<sup>129</sup>

## 10.1. Lessons from TPH DineSafe

Promoting food system transparency is not a new role for the City. Toronto has already demonstrated that it is a leader in food system transparency through the Toronto Food Premises Inspection and Disclosure (DineSafe) program. Federal, provincial, and local authorities all hold responsibilities for overseeing food safety in Canada. Based on its provincial and local (Board of Health) authority over environmental public health hazards, TPH initiated DineSafe in 2001. DineSafe combines food safety inspection and public disclosure for foodservice businesses, food handler training and certification, a quality assurance component, and data management. It was

the first program of its kind in Canada and has become a model for similar programs in localities worldwide.<sup>130</sup> DineSafe makes information about the safety of food establishments freely and readily available to the public, through Inspection Notice postings at restaurants and in detail on the web. The program has also benefited local businesses by providing their customers with a third-party guarantee of the safety standards to which they adhere. A multidimensional evaluation of DineSafe in 2003 and a series of legal rulings since the adoption of DineSafe have demonstrated continued improvements in food safety practices and compliance by operators, fair inspection practices, improved public confidence, and a legally valid role for the City in public disclosure of inspection notices.<sup>130</sup>

## **10.2. Lessons from TPH ChemTRAC**

The City of Toronto has also been a leader in establishing legislation that enables community access to information about other types of environmental risks through Toronto's Environmental Reporting and Disclosure Bylaw (Municipal Code Chapter 423) and the Environmental Reporting Disclosure and Innovation (ChemTRAC) program, developed in 2005 and adopted in 2008.<sup>131,132</sup> This program collects information to support healthy environments while promoting the city's green economy through: requiring businesses and other facilities to report annually on their manufacture, use, and release of 25 toxic chemicals into the air, surface water, or land that are of priority as public health risks; increasing public awareness about toxic substances; and offering support to facilities on how to prevent pollution, especially smaller enterprises.

In the case of both DineSafe and ChemTRAC, public health programming to inform and support Toronto residents as well as operators/facilities is accompanied by legislation requiring information disclosure. In addition, both programs offer dedicated public health supports to businesses in terms of improving the healthfulness of their practices.

# 11. Conclusion

The overarching objective of and rationale for a menu labelling policy for Toronto would be to help make Toronto a more transparent and supportive environment for residents to eat healthily when dining out.

Through provision of readily available nutrition information at the point of sale, menu labelling can help to fill gaps in the availability of facts and inputs that people use towards optimal purchasing and consumption decisions. This is a key part of food literacy and the government's role in championing food system transparency, both of which Toronto Public Health has previously identified as being essential to building a healthy, sustainable, and equitable food system.<sup>2,129</sup>

While it is clear that many objective and subjective factors interact to ultimately shape personal food choices, it does not take away from the clear and increasing evidence that nutrition information is a logical and valid variable that increases awareness and enters into people's food decision making. There is certainly no compelling reason why nutrition information should be hidden or obscured from consumers who wish to use it to inform what food items they order. Accordingly, policy for a more supportive food environment should include interventions to make nutrition information more readily available to support purchasing and consumption decisions.

Menu labelling can serve to link public health and local foodservice businesses to engage with consumer demand in ways that are more health promoting. Certainly, business owners, and especially small entrepreneurs, need government to promote economic growth and to enable them to comply with rules and regulations. They want a fair and consistent approach that will help them to serve their customers well and enable successful operation.

Voluntary guidance for food businesses (i.e., informal standards) and mandatory measures (i.e., formal regulation) are often viewed as mutually exclusive policy options along a continuum of intervention; i.e., voluntary nutrition information disclosure is sometimes offered as an option that should be tried first, and if unsuccessful, could be a reason for moving on to mandatory menu labelling. This reasoning is ostensibly based on the principle of least restrictive intervention that is common in public health.<sup>133</sup> Yet as a public health intervention, the restriction in this case would be to place requirements for information disclosure on private sector food businesses, which, as a policy instrument, is less intrusive than requiring changes to food content.<sup>91</sup> There is no evidence that menu labelling restricts choices of individuals and populations.

In essence, menu labelling can be interpreted as an intervention that represents the role of the state in ensuring that markets operate in a way that promotes the public good. Thus, menu labelling is supportive of Health Canada's two aims for nutrition labelling: to help consumers to make informed dietary choices and to help consumers easily compare foods based on consistent information.

In the US, where menu labelling for major chain restaurants has already been adopted through federal legislation, it has been highlighted that “consumers’ right to truthful information” is the basis for regulations governing the disclosure of nutritional information, both on pre-packaged food and in restaurant settings.<sup>134</sup>

In summary, nutrition information provided through menu labelling is one factor that does inform some individuals’ food decision making when eating away from home. Menu labelling is therefore a policy initiative that should be considered as an environmental intervention that could be used to support public health and the public good. In doing so, it will be important to build in a rigorous and substantive evaluation process to monitor intended and unintended outcomes that can be used to facilitate effective future adaptations of policy interventions in a complex and ever-changing food environment. No single food-related policy will be able to create the complex changes that are needed to improve the overall quality of the eating out environment. Beyond menu labelling, therefore, it will continue to be important to study, test, and evaluate a wide range of environmental interventions to improve public health in the long term.<sup>135</sup>

## 12. Legislation Cited

City of Toronto Act (S.O. 2006, c. 11, Sched. A)

Consumer Packaging and Labelling Act (R.S.C., 1985, c. C-38)

Consumer Packaging and Labelling Regulations (C.R.C., c. 417)

Food and Drugs Act (R.S.C., 1985, c. F-27)

Food and Drug Regulations (C.R.C., c. 870)

Health Protection and Promotion Act (HPPA) (R.S.O. 1990, c. 17)

Ontario Public Health Standards (2008)

United States, Patient Protection and Affordable Care Act (Public Law 111-148, 111th Congress, 2010)

## 13. Appendix: Jurisdictional Policy Experiences with Menu Labelling- Parameters and Practices

Policy/Program	Type	Jurisdiction	Nutrients	Menu items	Information Location	Type of Foodservices	Impact/Evaluation
MPP Gelinas– most recent (Bill 126 omnibus)	Legislation (private members’ bill)	Provincial	Calories; High and very high sodium warnings	All items “sold or served for immediate consumption”	Menus, menu boards, or item label	Chain foodservice premises with 5 or more locations provincially and > \$5 million gross annual revenue	Unknown; draft legislation did not proceed as parliament prorogued Oct.2012
Sodium Reduction Strategy for Canada (see p. 27)	Strategy (working group, now disbanded) recommended a mandatory (or structured voluntary) approach	Federal strategy, but advises provincial legislation	“Nutrition information” (presumably including sodium values)	Standardized menu items, prepared and assembled on-site, “where feasible”	On-site	Establishments “with a high degree of standardization”	Unknown; draft legislation to implement strategy introduced in Nov. 2012 as a federal private member’s bill
Health Check (Heart and Stroke Foundation (HSF))	Voluntary, NGO-led logo-based food product program	National program but provincial implementation	Calories, sodium, fat, and ‘positive’ ‘Health Check nutrients’	Only Health Check menu items	Can be included on menus or other format (e.g., brochure)	Chain restaurant operators	Some consumer awareness data available; no outcome evaluation yet – planned research with University of Waterloo in 2013
BC Informed Dining	Voluntary, provincial government-led; endorsed by HSF and CRFA (Canadian Restaurant and	Provincial; ‘national’ component for chain restaurants involved in BC program	13 core nutrients; calories and sodium highlighted	All standard menu items	Logo on menu; nutrition information via standardized brochure,	Any foodservice operator; Small Business Support Program for operators with <5 locations and <50 employees per	Evaluation currently underway

Policy/Program	Type	Jurisdiction	Nutrients	Menu items	Information Location	Type of Foodservices	Impact/Evaluation
	Foodservices Association)	supported by CRFA			poster, or menu insert	location; mandatory component for provincial publicly funded healthcare institutions to be implemented	
US Federal legislation in Patient Protection and Affordable Care Act	Legislation	National	Calories and contextual information on daily recs Additional nutrients to be disclosed in a brochure	All standard menu items	Menus, menu boards, drive-throughs, vending machines	Chains and related foodservice with 20 or more outlets nationwide	Survived Supreme Court challenge (the Act as a whole); implementation pending
NYC Health Code amendment	Legislation	Municipal	Calories Additional nutrients to be disclosed in a brochure	All standardized menu items; standard refers to all menu items that are served in 'standard' portion sizes and content	Menus, menu boards, drive through menus, food item tags	Foodservice establishments with 15 or more locations nationwide	Overall, no change in calories ordered (large scale evaluation + two independent studies), <b>but after:</b> information was visible to 60-70% of customers; 15-20% of customers report using info and of those, up to ~100kcal (NYC study) / 6% cal (Bollinger study) reduction per order
King County, WA, Health Code provision	Legislation	County	Calories, saturated fat, carbohydrates, sodium	All standard menu items	Menus, menu boards, drive through menus	Chain restaurants with 15 or more locations nationwide	Overall, no change in calories ordered, although later evaluation suggested a reduction in 'high-

Policy/Program	Type	Jurisdiction	Nutrients	Menu items	Information Location	Type of Foodservices	Impact/Evaluation
							calorie' meal orders and some indication of reformulation; subsequently updated to align with US federal legislation
SmartMenu, Tacoma-Pierce County, WA	Voluntary pilot program led by public health department	County	Calories, fat, carbohydrates, sodium	All regular menu items	On menu, in a standardized but optional format	Independently owned and operated foodservice establishments	Nutrition information became more visible to most patrons but was only used by a subset who were estimated to have ordered 75 fewer calories; operational challenges/issues documented in process evaluation
Louisville, KY	Voluntary program led by public health department for smaller restaurants to adhere to US federal menu labelling standards	Municipal (funded via federal grant)	Consistent with US federal requirements	Consistent with US federal requirements	Consistent with US federal requirements	Local restaurants with fewer than 20 locations nationwide	Not yet evaluated

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TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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## CRITERIA WEIGHTS FOR 2014 BUDGET

### ***Recommendation***

*It is recommended that the Board of Health endorse the criteria presented in Report No.121-13 re Criteria Weights for 2014 Budget.*

### **Key Points**

- Following approval of the 12 criteria to guide the 2014 budget process, the next step is to assign weight to each criterion that reflects its relative importance.
- Criteria weights developed based on input from all members of the Board of Health and the Senior Leadership Team at the retreat on November 1 2013 are being used to guide the PBMA process.
- While these weights will be reviewed for the next budget year and all budget decisions are subject to the final approval of the Board of Health, it is important that the Board of Health has the opportunity to fully discuss them and consider whether they are acceptable for guiding the 2014 process.

### **Background**

At the October 2013 meeting, Board of Health members will recall approving 12 criteria to guide investments and dis-investments as part of the 2014 budget development process ([Report No. 117-13](#)). These criteria are an essential part of the Program Budgeting and Marginal Analysis (PBMA) process, which transparently uses pre-defined criteria to facilitate the reallocation of resources based on maximizing the value of services. The use of PBMA was approved by the Board at the September 2013 meeting ([Report No. 094-13](#)).

### **Criteria Weights**

The next step in the PBMA process was to establish weightings for each of the 12 criterion. These weightings reflect the relative importance of each criterion in budgetary decision-making. The criteria weights reported below were developed based on the input of all members of the Board of Health and the Senior Leadership Team at the retreat on November 1 2013. The total weight of all the criteria must add up to 100%.

<u>Criteria</u>	<u>Weight</u>
1. Legislative Requirements – Legal Mandate	15%
2. Legislative Requirements – Strategic Directions	6%
3. Need – Health	7%
4. Need – Health Equity and Social Determinants	8%
5. Impact – Health	14%
6. Impact – Health Equity and Social Determinants	14%
7. Impact – Client Experience	11%
8. Capacity – Other Organizations	4%
9. Partnerships/Collaboration – Achieving Shared Goals	6%
10. Organizational Risks – Litigation, Reputation	8%
11. Organizational Risks – Implementation Challenges	3%
12. Organizational Risks – Impact on Culture	<u>4%</u>
<b>Total</b>	<b>100%</b>

### Next Steps

The criteria will be applied to developing proposals for additional resource investment and disinvestment within the Health Unit. Each resource investment/disinvestment proposal is rated against these criteria and given a score that reflects the extent to which it maximizes value of those resources to the community. The areas for potential investment/disinvestment will be presented to the Board at a future meeting, and appropriate proposals will be incorporated into the 2014 budget for Board of Health approval.

This report was prepared by Mr. Ross Graham, Manager of Strategic Projects.



Christopher Mackie, MD, MHSc, CCFP, FRCPC  
Medical Officer of Health



TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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## TOBACCO PROMOTION AT TOBACCO RETAILERS

### **Recommendation**

*It is recommended that Report No. 122-13 re Tobacco Promotion in Tobacco Retailers be received for information.*

### **Key Points**

- Tobacco use remains the leading cause of preventable disease and premature death in Ontario, costing the Canadian economy \$17 billion annually for tobacco-related illness, including \$4.4 billion in direct healthcare costs.
- Restrictions on marketing and promotion are widely recognized as a means to prevent and reduce tobacco use; ongoing promotion and enforcement of the [Smoke-Free Ontario Act \(SFOA\)](#) and surveillance of tobacco industry activities are important components of the local tobacco program.
- *SFOA* prohibits the promotion of the sale of tobacco products through product association, product enhancement or any type of promotional material at point-of-sale; it also restricts the sale or distribution of cigarettes in packages of less than 20 and requires tobacco to be packaged in accordance with the federal [Tobacco Act](#) including appropriate health warnings.
- Recently, tobacco industry sales representatives were encouraging tobacco retailers to give away single cigarettes with the purchase of tobacco products. The Health Unit has determined that this is a violation of the relevant legislation and will treat it as such if it is observed in Middlesex-London.

### **Background**

The substantial decline in smoking prevalence among Canadians over the past forty-five years represents one of the most important public health achievements of our time; however, tobacco use remains a serious challenge to the population's health. Tobacco use remains the leading cause of preventable disease and death in Canada; it is estimated that 37,000 die each year and 100 die every day from a tobacco-related illness. Tobacco use is responsible for 80% of lung cancers, 80% of chronic obstructive pulmonary disorder (COPD) and has been linked with breast cancer and cancer in 18 other locations in the human body, as well as surgical complications, heart attacks and strokes.

Ontario's Action Plan for Health Care set a target that Ontario would achieve the lowest smoking rate in Canada. This commitment is expressed throughout the Ministry of Health and Long-Term Care's Smoke-Free Ontario Strategy and is an area of focus under Ontario's Public Health Sector Strategic Plan "[Make No Little Plans](#)". To achieve the target, Ontario requires approximately 490,000 fewer smokers, doubling the current quit rate; however, this is a moving target because the tobacco industry continues to creatively recruit new tobacco users to replace those who quit smoking or succumb to tobacco-related illness. To achieve the target, we need smoking rates to decrease and we need to ensure that no new users start using tobacco industry products.

## Smoke-Free Ontario Act and Prohibitions on Tobacco Product Promotion

The [Smoke-Free Ontario Act \(SFOA\)](#) came into effect May 31, 2006, prohibiting smoking in enclosed public places and workplaces, on elementary and secondary school property, within common areas of multi-unit dwellings and within nine meters of entrances and exits to health and long-term care facilities. The SFOA restricts the sale and supply of tobacco to persons under the age of 19 and requires retailers to request identification from any person who appears to be less than 25 years of age. In addition to the sales restrictions, the Act restricts how tobacco products are packaged, handled, displayed and promoted.

The retail point-of-sale environment is an important opportunity for the tobacco industry to communicate with current, former and potential tobacco users. Research shows that displaying and promoting the sale of tobacco at point-of-sale can boost the sale of cigarettes through impulse buying and can influence young people to start smoking. It also makes it more difficult for smokers to quit, and for those who have quit smoking to stay smoke-free.

It is for these reasons that the SFOA provides clear restrictions on the promotion of tobacco products. Effective May 31, 2008, the retail display of tobacco products became illegal. Further, section 3.1 (3) of the SFOA prohibits the promotion of the sale of tobacco products at point-of-sale through product association, product enhancement or any type of promotional material. Section 7 of the Regulations limits signage in or at a tobacco retailer that refers to tobacco products, tobacco product accessories or both. Lastly, section 5 of the SFOA restricts the sale of cigarettes in packages that contain less than 20 cigarettes to limit access to single or 'discount packs' of cigarettes, which would be more affordable than standard packages or cartons; Section 5 also requires tobacco to be packaged in accordance with the federal Tobacco Act including appropriate health warnings to limit tobacco brand promotion on the individual packages or cartons. Point-of-sale marketing is one of the few remaining communication vehicles available to the tobacco industry in Ontario and it is for this reason that ongoing promotion and enforcement of the SFOA and surveillance of tobacco industry activities in Middlesex-London by the Tobacco Enforcement Officers (TEOs) are so important.

### Recent Tobacco Product Promotion in the Retail Environment

Over the last few weeks, the TEOs received reports that tobacco industry sales representatives were encouraging tobacco retailers to give away single cigarettes with the purchase of tobacco products, as a means to promote one brand of tobacco over an alternative. This practice is in clear violation of Section 3.1(3) and Section 5 of the SFOA. The TEOs have employed a progressive enforcement approach, providing education to the retailers that the practice is in violation of the law and, if found to be engaging in the promotion, retailers will be issued a written warning along with corrective actions to be taken. The TEOs will return for re-inspection and if at the time of re-inspection there is evidence that the promotion is continuing, charges will be laid.

### Ongoing Monitoring and Education of Tobacco Retailers

The tobacco industry has conducted a 40 year public relations campaign to deceive the public about the known health effects of tobacco use, providing misinformation about health risks and the addictiveness of nicotine. The industry continues to engage in predatory and aggressive marketing tactics to recruit new tobacco users and to maintain brand loyalty with those already addicted. To achieve the lowest smoking rate in Canada, tobacco control efforts must be innovative and our presence within the community must be sustained.

This report was prepared by Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control Team.



Christopher Mackie, MD, MHSc, CCFP, FRCPC  
Medical Officer of Health

**This report addresses** the following requirement(s) of the Ontario Public Health Standards:  
Foundations: Principles 1, 2; Comprehensive Tobacco Control: 1, 5, 7, 11, and 13.

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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## UPDATED BOARD OF HEALTH E-LEARNING MODULE

### **Recommendation**

*It is recommended that Report No. 123-13 re Board of Health E-Learning Module be received for information.*

### **Key Points**

- An updated Board of Health E-Learning Module has been released by the Ministry of Health and Long-Term Care. This online resource provides comprehensive orientation information for both new and experienced Board of Health members on Ontario's public health system, its functions and the governance roles and responsibilities of Board of Health members.

### **Background**

On November 4, 2013, the Ministry of Health and Long Term Care released an updated [Board of Health E-Learning Module](#). Similar to the first E-Learning Module, released in 2011, this online tool is a resource for both new and experienced Board of Health members. It provides information on the public health sector, specific governance roles and responsibilities under the [Health Protection and Promotion Act](#), [Ontario Public Health Standards \(OPHS\)](#), and [Ontario Public Health Organizational Standards \(OS\)](#) that relate to the oversight and delivery of public health programs and services.

The E-Learning Module complements existing orientation resources from the Association of Local Public Health Agencies (alPHA) and health units, and can be found in the Public Health section of eHealth Ontario's website at: [www.ehealthontario.ca](http://www.ehealthontario.ca)

### **Contents**

The E-Learning Module has five sections: (1) Introduction and Instructions, (2) Public Health: The Basics, (3) Public Health Legislation, (4) An Overview of the Ontario Public Health Standards and (5) An Overview of the Organizational Standards.

The Module also provides an aggregated list of additional resources, including (a) reports on a variety of public health sector topic (e.g., public health renewal, information and privacy, public health stakeholders, public health governance), (b) hyperlinks to associated Ontario acts and regulations, (c) an overview of key terms, and (d) further description of the Ontario Public Health Standards.

This report was prepared by Mr. Ross Graham, Manager of Strategic Projects.



Christopher Mackie, MD, MHSc, CCFP, FRCPC  
Medical Officer of Health



TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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## HEALTH AT WORK 4 ALL! 2013

### **Recommendation**

*It is recommended that the Report No. 124-13 re Health at Work 4 All! 2013 be received for information.*

### **Key Points**

- Evidence has shown that workplace wellness programs positively impact healthy employee behaviours.
- Middlesex-London Health Unit, Elgin-St. Thomas Public Health and Oxford County Public Health collaborate to deliver workplace health through the Health at Work 4 All! program.
- In 2013, the *Psychological Health and Safety in the Workplace* standard was released by the Canadian Standards Association to support mental and physical health in the workplace.

### **Background**

There is evidence that a comprehensive workplace health program can provide numerous positive results including improved productivity, decreased absenteeism, reduced costs of health benefit, improved retention and recruitment, improved health and wellness, and many others. The cost of unhealthy workplaces in Canada is estimated at \$6 to \$10 billion per year in direct costs associated with absenteeism due to conflict between work and personal life and stress-related absences. Employers and society pay a heavy price in the form of healthcare costs and lost productivity due to four key lifestyle risk factors associated with workplace stress: obesity, smoking, alcohol abuse and sedentary lifestyle or lack of physical activity.

Healthy employees are assets that can be developed through a healthy work-life balance. Healthy work-life balance means that neither the demands of work nor the demands of personal/family life overwhelm the other. Healthy work-life balance is essential to improving workplace morale and productivity as well as employees' job satisfaction and physical/mental health and wellness. Public health plays an important role in assisting workplaces in achieving a healthier workplace and thus healthier employees.

In 2011, this Health Unit together with Elgin-St. Thomas Public Health, developed the Health at Work 4 All! program. In June 2013, Oxford County Public Health also adopted the program.

### **Health at Work 4 All! 2013 Highlights**

In 2013, a new voluntary safety standard entitled *Psychological Health and Safety in the Workplace* was released by the Canadian Standards Association. It was developed in response to the emerging realization in Canada and around the world that workplace psychological health and safety is as important as physical health and safety. This Standard is significant to the work of public health because:

- Safe and secure employment is a key social determinant of health which in turn impacts income, food security, quality of housing, and the other basic prerequisites of health;

- There is a direct link between dissatisfaction and stress at work, and heart disease, accidents and some types of cancer; and
- The 2008 *Canadian Community Health Survey* noted that thirty percent of the working population report experiencing work as ‘quite a bit stressful’ or ‘extremely stressful’ most days.

To introduce the new Standard to local employers, Chatham-Kent, Elgin-St Thomas, Middlesex-London, Oxford and Perth health units partnered to host a full day workshop on June 13, 2013. The Chair of the Technical Committee that created the Standard, Mary Ann Baynton (Consultant to the Mental Health Commission of Canada), and committee member Andrew Harkness (Consultant from Workplace Safety and Prevention Services), presented an overview of the standard to 160 workplace representatives. Following the workshop, a partnership was formed between the above-mentioned health units, the Elgin Middlesex Oxford Workforce Planning and Development Board, and three other Workforce Planning and Development Boards in southwestern Ontario. It was agreed that this partnership could provide mutual benefit of funding and program expertise.

A workshop will be held on April 10<sup>th</sup> 2014 with Dr. Linda Duxbury. Dr. Duxbury will be presenting “A Changing Workforce, Engaging, Building, and Managing” based on her recent research findings (2012) regarding the aging workforce and the changes, challenges and rewards this is posing for workplaces. This workshop is one of the outcomes of the partnership process.

The Health at Work for All! Program has been recognized by the lead staff person being invited to:

- Sit on an advisory committee for Excellence Canada to redesign and refocus the online resources for the annual Healthy Workplace Month initiative
- Attend the launch to the Prince's Seeing is Believing program at the London Chamber of Commerce
- Participate on a committee to advise the United Way's Mental Health Impact Council how to best promote the use of the new CSA Standard
- Present the new Standard and “what a healthy workplace is” to the United Way Advisory Committee
- Plan a workshop in partnership with CTV London and the London and District Distress Centre to highlight mental health in the workplace
- Present to the Human Resource Professionals of London and District, The London Health Providers Network and the London and District Occupational Health Nursing Network

## Conclusion

2013 has been a year of changing directions for the workplace program that has led to the creation of new partnerships and connections. Through these opportunities the Health at Work 4 All! Program is being recognized as a resource that can lead employers who are interested in health and wellness, as well as leaders and managers, to make positive changes in their workplaces.

This report was prepared by Ms. Marylou Albanese, Manager, and Ms. Sandy Richardson, Public Health Nurse, Healthy Communities and Injury Prevention Team



Christopher Mackie, MD, MHSc, CCFP, FRCPC  
Medical Officer of Health

<p><b>This report addresses</b> the following requirement(s) of the Ontario Public Health Standards: Chronic Diseases and Injuries Program Standards of Chronic Disease Prevention and Injury Program Standards Health Promotion and Policy Development requirements.</p>
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TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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**tykeTALK: THAMES VALLEY PRESCHOOL SPEECH AND LANGUAGE PROGRAM,  
THE INFANT HEARING PROGRAM - SOUTHWEST REGION  
AND THE BLIND LOW VISION EARLY INTERVENTION PROGRAM**

***Recommendation***

*It is recommended that Report No. 125-13 re tykeTALK: Thames Valley Preschool Speech and Language Program, the Infant Hearing Program Southwest Region and the Blind Low Vision Early Intervention Program be received for information.*

**Key Points**

- tykeTALK launched a re-designed website developed by resIM which includes an online referral form.
- MCYS replaced all the hearing screening equipment for the Infant Hearing Program with newer and more advanced versions. A new evidence based screening protocol as well as and a continuous quality improvement initiative were introduced.

**tykeTALK**

tykeTALK is one of 32 provincial preschool speech and language initiatives across the province of Ontario. The program focuses on the prevention, early identification and treatment of speech and language problems in children from birth to school entry age. The preschool speech and language initiatives, which commenced in November 1998, are 100% funded through the Ministry of Children and Youth Services (MCYS). In April 2000, the Health Unit became the Lead Agency for the Thames Valley (Elgin, London, Middlesex, and Oxford) program. MLHU administers the program and contracts with partner agencies for direct service delivery. The provincial funding received is \$1,482,315. This has not increased in the past seven years.

For the period April 1, 2012 to March 31, 2013 the preschool speech and language program obtained the following deliverables as outlined in the contract between MLHU and MCYS:

- 5730 children who are currently between the ages of birth and 70 months have been identified with speech and language problems. This is approximately 12% of the preschool population in Thames Valley.
- 633 (55%) of referrals were made by parents/guardians.
- 1161 new referrals were received this year.
- 3,184 children received assessment and/or intervention this fiscal year.
- The average age of children at identification was 31 months.
- The average wait between date of referral and date of first intervention was 14 weeks.

In August 2013 the new tykeTALK website [tyketalk.com](http://tyketalk.com) was launched, and is connected with [healthunit.com](http://healthunit.com), the new website for MLHU. The tykeTALK website features an online referral form improving access to the intake process.

### **The Infant Hearing Program – South West Region**

The provincial Infant Hearing Program (IHP) was announced in December 2000. This program consists of universal hearing screening for all babies, follow-up audiological assessment to confirm hearing loss in babies who failed the initial screening and communication development and supports for infants and their families where there is a confirmed hearing loss. MLHU hosts one of 12 Infant Hearing Programs across the province, covering the regions of Middlesex-London, Huron, Perth, Oxford, Elgin-St. Thomas, Sarnia-Lambton and Grey Bruce-Owen Sound. This program is 100% funded by MCYS. The base provincial funding received is \$835,886 and has not increased in the past five years.

For the period April 1, 2012 to March 31, 2013 the Infant Hearing Program obtained the following deliverables:

- 10,723 infants (99%) were screened.
- 110 infants progressed to an Audiology Assessment; 76% were seen by 4 months of age.
- 33 infants were identified with permanent hearing loss of any degree.
- 23 infants were fit with amplification.
- 19 infants began services to support communication development.
- 124 children between the ages of birth to 75 months received supports and services.

In the summer of 2013, MCYS replaced all the hearing screening equipment with newer and more advanced versions. One time funding was received to cover the costs of purchasing this. MCYS has introduced new evidence based screening protocols as well as and a continuous quality improvement initiative.

### **The Blind Low Vision Early Intervention Program – South West Region**

The provincial Blind Low Vision Early Intervention Program (BLV) was announced in January 2007 and began providing service in our region in November 2007. It provides supports and services to families and children from birth to school entry that have been diagnosed as blind or having low vision. Services include specialized intervention for the family and child as well as consultation and support services to any early learning environment that the child attends. Family Support Workers are also available to provide short-term counseling and support to families following the diagnosis and during key transitional times. This program covers the regions of Middlesex-London, Huron, Perth, Oxford, Elgin-St. Thomas, Sarnia-Lambton and Grey Bruce-Owen Sound. As the lead agency, MLHU administers the program and contracts with partner agencies for direct service delivery. This program is 100% funded by MCYS. The provincial funding received is \$158,702 and has not increased since the program began in 2007.

For the period April 1, 2012 to March 31, 2013 the BLV Program obtained the following deliverables:

- 35 new referrals were received and children began intervention within 5 weeks of referral
- Average age of referral was 19 months
- 123 children received service this fiscal year

All three early identification programs ensure a timely response to families experiencing speech, hearing and vision challenges. They integrate with health unit programs aimed at family-centred care.

This report was prepared by Ms. Diane Bewick, Director, Family Health Services.



Christopher Mackie, MD, MHSc, CCFP, FRCPC  
Medical Officer of Health

**This report addresses** the following requirement(s) of the Mandatory Health Programs and Services Guidelines: Child Health Program Goal: To promote the health of children and youth.



TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health

DATE: 2013 November 21

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## **MEDICAL OFFICER OF HEALTH ACTIVITY REPORT – NOVEMBER**

### ***Recommendation***

***It is recommended that Report No. 127-13 re Medical Officer of Health Activity Report – November be received for information.***

The following report highlights activities of the Medical Officer of Health (MOH) from the October Medical Officer of Health Activity Report to November 7, 2013.

On October 8, the Medical Officer of Health, along with Ms. Mary Lou Albanese, Manager, Environmental Health and Ms. Emily Hill, Public Health Nurse, attended Middlesex County Council meeting to present a report on healthy eating and physical activity. The MOH highlighted on priority areas of the Toronto Charter for Physical Activity including: Active Living – increase opportunities for active living; Road Safety – decrease the number of injuries and deaths by providing a safer system; Food Systems and Healthy Eating – increase the intake of healthy foods by increasing accessibility, affordability and sustainability of local food systems and; Social Capital and Mental Well-Being – increase social interaction, enhance social capital and promote mental well-being through well designed built environments. The MOH asked the County to consider endorsing of the Charter as it aligns with the County's Official Plan and many of their stated objectives.

The MOH, the Senior Leadership Team and Mr. Ross Graham, Manager, Strategic Priorities continued to meet and work on fine tuning the 2014 Budget Process. Included in this process was developing the criteria for the program budgeting and marginal analysis (PBMA) process.

The MOH delivered opening remarks October 15 at the Youth Empowerment Conference hosted by the Health Unit. This youth-led conference engaged youth and experts from the community to create short videos that will educate their peers on subjects such as media and violence, sexuality, gender, substance use and cyber safety.

On October 23, the Medical Officer of Health and Senior Leaders held an All Staff meeting to talk about improvements in the budget process and other financial measures such as the creation of the Finance and Facilities Committee, the review of finance policies, and improvements to the budget variance process.

The MOH attended and coordinated a Board of Health Retreat on November 1 that was held at the new Middlesex Centre Community Wellness & Recreation Centre. This all day event was divided into 2 parts. The morning was facilitated by Ms. Gayle Valeriote who presented on working together, being open and receptive to new ideas, and creating an updated Vision for the Health Unit. The afternoon was spent with Mr. Craig Mitton and Mr. Francois Dionne of Prioritize Consulting Inc. via Skype to further hone the weighting of program budgeting and marginal analysis criteria. The Honourable Deb Matthews, Minister of Health and Long-Term Care, attended the meeting to have an open dialogue and provide her insights into the status of Public Health in Ontario.

The Medical Officer of Health and CEO also attended the following teleconferences and events:

- October 8 Teleconference with Kate Manson-Smith to discuss Public Health and Education working together.
- October 10 Interview with LFP reporter to discuss expenses
- October 10 Attended grand opening of St. Joseph's Central out Patient facility
- October 15 Interview with CJBK reporter in regards to safe injection sites
- October 16 Had an introductory meeting with City Councillor Matt Brown
- October 16 Attended "Boss's Day" lunch with staff
- October 17 Teleconference call re Healthy Kids – Consultations on Menu Labelling and Marketing of Unhealthy Food to Children
- October 24 Teleconference with Caroline Butler to discuss Early Childhood Interventions  
Documentary
- October 25 Introductory meeting with Ms. Irene Mathysen, MP London-Fanshawe
- October 28 Introductory meeting with Michael Robbins in regards to Healthline.ca
- October 28 Welcomed 4<sup>th</sup> year Medical student Oren Krajden to the Health Unit for a 2 week rotation
- October 29 Attended Fanshawe College Board of Governors event at Saffron's Restaurant at the College
- October 31 Met with Dr. Amardeep Thind, MD, PhD in regards to the MPH Program at Western
- November 1 Attended the Shine the Light lighting of the purple tree in Victoria Park
- November 6 Introductory meeting with Professor Robert Solomon from Western University
- November 7 Attended meeting of the Board's Finance and Facilities Committee



Christopher Mackie, MD, MHSc, CCFP, FRCPC  
Medical Officer of Health

**This report addresses** Ontario Public Health Organizational Standard 2.9 Reporting relationship of the medical officer of health to the board of health