Benchmarking New Zealand Food Environment Policies against International Best Practice

# Evidence Summary for Expert Panel

## Food-EPI

## 2017-2019





The International Network for Food and Obesity/NCDs Research, Monitoring and Action Support (INFORMAS)

The University of Auckland

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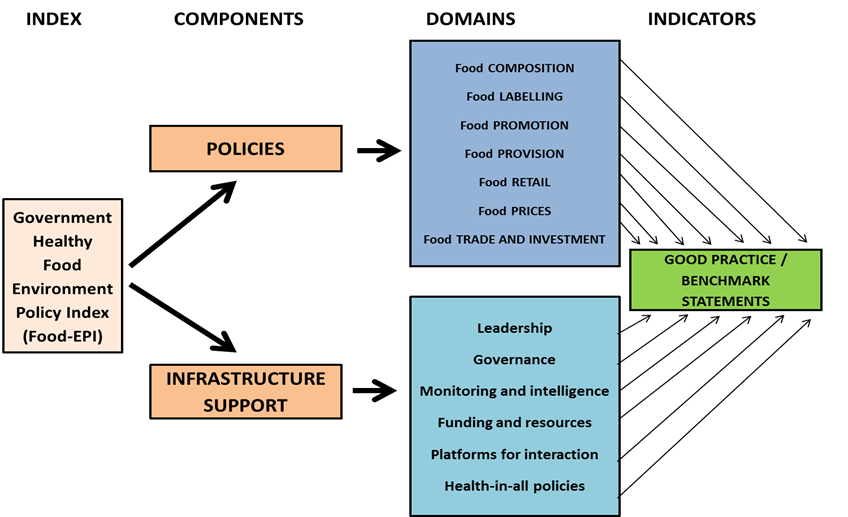
# Introduction

New Zealand has an unacceptably high prevalence of overweight and obesity. Two in three adults and one in three children are overweight or obese. Diet-related non-communicable diseases (NCDs), such as diabetes, cardiovascular diseases and cancer, are the biggest cause of death and ill-health in New Zealand and they are preventable.

Effective government policies are essential to make food environments healthier[[1]](#footnote-2) and reduce the very high levels of obesity, NCDs, and their related inequalities. It is critical that the New Zealand Government implements preventive policies and actions to match the magnitude of the burden that unhealthy diets are creating in New Zealand. Monitoring the level of implementation of the policies and actions recommended by the World Health Organisation (WHO) is an important part of ensuring progress towards healthier diets for New Zealanders.

***The Healthy Food Environment Policy Index (Food-EPI)***

The Food-EPI has been developed by the International Network for Food and Obesity/NCDs Research Monitoring and Action Support (INFORMAS). INFORMAS assesses the level of implementation and priority of government policies and actions to improve the healthiness of food environments against the international best practice (Figure 1).



**Figure 1: Components and domains of the Healthy Food Environment Policy Index (Food-EPI)**

The index consists of two components (Policies and Infrastructure Support), 13 domains and 47 good practice indicators. The current expert panel aims to rate the level of implementation of policies on food environments by the Government against international best practice.

***The New Zealand Food-EPI 2014 & 2017***

More than 50 experts participated in the first Food-EPI in May 2014 and 70 experts in May 2017. It was found that the New Zealand Government was performing well, at the level of international best practice, regarding preventing unhealthy foods carrying health claims, providing ingredient lists and nutrition information panels on packaged foods, transparency in policy development processes, providing access to information for the public and monitoring the prevalence of NCDs and their risk factors. There has also been progress since 2014 with health star ratings, systems-based approaches with communities, developing healthy food and drink policy in the public sector, and improving platforms for interaction. However, major ‘implementation gaps’ were identified with the level of implementation of about three quarters (74%) of the policy indicators and half (48%) of the infrastructure support indicators rated as ‘low’ or ‘very little, if any’ compared to international best practice. These gaps decreased slightly in 2017 with 70% of policy indicators and 29% of infrastructure support indicators rated as ‘low’ or ‘very little’ compared to best practice. For both time periods, the major implementation gaps noted were for food environment policies, especially for healthy food policies in schools, fiscal policies, food retail policies and protection of food environments from trade and investment agreements. Implementation gaps for infrastructure support were leadership to reduce obesity and improve public health nutrition, lack of a national nutrition survey and targets to reduce childhood obesity rates, inequalities and achieve WHO recommendations for average population sugar, salt and saturated fat intakes. There was no comprehensive obesity/NCD action plan in 2014, with some improvement by 2017.

The ratings were informed by extensive documented evidence of current implementation of policies by the Government, validated by government officials, and international best practice examples or benchmarks for each of the indicators. In 2014, based on the implementation gaps identified, the Expert Panel recommended 34 concrete actions to improve the healthiness of food environments, prioritising 7 for immediate action in 2014. In 2017, 53 actions were proposed with nine prioritised as shown below:

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| 2014 Priority Recommendations | 2017 Priority Recommendations |
| * *Implement a comprehensive national action plan* for obesity and NCD prevention. | * *Strengthen the Childhood Obesity Plan* including policy objectives and targets to reduce obesity prevalence and inequalities, and more and stronger policies to create healthy children’s food environments and increasing funding for the implementation and evaluation of the plan. |
| * *Set priorities in Statements of Intent and set targets for:*  1. Reducing childhood & adolescent obesity 2. Reducing salt, sugar & saturated fat intake 3. Food composition (salt & saturated fat) in key food groups. | * *Set targets for:*  1. Reducing childhood overweight and obesity by 8 percentage-points (from one-third to one-quarter) by 2025 with decreasing inequalities 2. Reducing mean population intakes of salt, sugar and saturated fat based on WHO recommendations 3. Voluntary reformulation of composition (salt, sugar and saturated fat) in key food groups |
| * *Increase funding* for population nutrition promotion, doubling it to at least $70m/year. | * *Increase funding* for population nutrition promotion to at least 10% of obesity/overweight healthcare costs |
| * *Reduce the promotion of unhealthy foods to children and adolescents by:*  1. Restricting the marketing of unhealthy foods to children & adolescents through broadcast and non-broadcast media 2. Ensuring that schools and ECE services are free of commercial promotion of unhealthy foods. | * *Regulate unhealthy food marketing, as defined by the WHO nutrient profiling model, to children up to 18 years*  1. In broadcast media, including during children’s peak viewing times (e.g. up to 9 pm) 2. In non-broadcast media, including food packaging, sports sponsorship and social media 3. In children’s settings, including ‘school food zones’ |
| * *Ensure that food provided in or sold by schools and ECE services* meets dietary guidelines. | * *Ensure healthy foods in schools and early childhood education services*using the updated Ministry of Health Food and Beverage Classification System |
| * *Implement the front-of-pack Health Star Rating* labelling system. | * *Strengthen the health star rating system* by urgently addressing anomalies in the design algorithm (especially for sugar), increasing funding for promotion and making it mandatory if there is not widespread uptake by 2019. |
| * *Introduce an excise tax* of at least 20% on sugar-sweetened beverages. | * *Introduce a substantial (e.g. 20%) tax on sugar-sweetened beverages* and explore using the revenue for programs to improve public health and wellbeing. |
|  | * *Implement the new Eating and Activity guidelines* by increasing funding for their promotion and translating them for New Zealand’s social, environmental and cultural contexts. |
|  | * *Conduct a new national nutrition survey for children* within 3 years and institute a plan for future regular adult and children nutrition surveys |

# Instructions for Rating

You are invited to participate in the 2020 Food-EPI expert panel. This will involve rating the **current** level of implementation of each of the 47 good practice indicators by the New Zealand Government, **against international best practice,** on a Likert scale from 1 to 5 using an online questionnaire.

The meaning of the Likert scale is:

**1:** *<20% implemented compared to international best practice*

**2:** *20-40% implemented compared to international best practice*

**3:** *40-60% implemented* *compared to international best practice*

**4:** *60-80% implemented compared to international best practice*

**5:** *80-100% implemented compared to international best practice*

There is also a ‘cannot rate’ option, so use if don’t feel informed to rate.

The **ratings** require expert judgement, taking **multiple considerations** into account:

1. **Quality** of government policies/actions compared to international best practice.
2. **Extent of implementation** of government policies/actions considering all aspects of the ‘policy cycle’:

* Agenda setting and initiation
* Policy development
* Implementation
* Evaluation

The ratings thus need to consider the intentions and plans of the Government, Government funding for implementation of actions undertaken by NGOs and establishment of working or advisory groups, etc., in addition to the policies and actions that have been implemented.

**This booklet** gives you the full details of the current evidence of implementation by the New Zealand Government for each good practice indicator and includes international best practice examples (benchmarks) for each good practice indicator to **support you** in the rating process and give you the confidence to make those judgements. Summaries of the evidence and the benchmarks are also available within the online questionnaire used for the rating process. You will receive a separate invitation email with a link to this questionnaire. **It is important to read the evidence of implementation and international benchmarks before putting in your rating for each good practice indicator.**

We anticipate the rating process will take **more than an hour of your time** to complete and it will be possible to save your ratings online and come back to where you left off at a later stage.

Some important **points of attention** to keep in mind during the rating process are the following:

* Please note that the Government’s level of implementation is **evaluated against international best practice** and not against any theoretical or ideal standards. In some cases, the benchmarks only cover certain aspects of the good practice indicator since no country globally is currently covering all aspects. For a few indicators (e.g. Funding) the actual benchmarks are unknown. In this case, the benchmarks are examples only and it is mentioned in the online summaries. There are a few good practice indicators for which New Zealand is listed as a benchmark.
* In the online rating tool, we provide a summary of the evidence of implementation and benchmarks for each indicator. We also highlight if there is new evidence of implementation since 2017 and if the benchmark has substantially improved since 2017. The median rating as per the results of the Food-EPI 2017 is also included. **This information is given to support you to rate but does not suggest which rating you need to choose**. It is important to keep in mind that the categories for rating are fairly broad (0-20%, 20-40%, 40-60%, 60-80% and 80-100%). Therefore, it is not necessarily the case that a higher rating should be given if there is new evidence of implementation in New Zealand, while the benchmark has not improved compared to 2017. Nor should a lower rating necessarily be given if there is no new evidence of implementation, but the benchmark has substantially improved compared to 2017. This is left up to your judgement, taking all elements into account.
* Any **comments** that you have during this exercise (including on the evidence of implementation presented in this document) are very important for us, so feel free to use the online comment boxes extensively in the rating process.

An example with explanations for the first good practice indicator (COMP1) is visible in the online rating questionnaire included on the next page.

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| **COMP1** *Food composition targets/standards have been established by the government for the content of the nutrients of concern in certain foods or food groups if they are major contributors to population intakes of these nutrients of concern (trans fats and added sugars in processed foods, salt in bread, saturated fat in commercial frying fats).* | ***This is the definition of the good practice indicator for which you will rate the extent of implementation by the NZ Government against international best practice*** |
| **EVIDENCE OF IMPLEMENTATION BY THE NZ GOVERNMENT 2019:**   * No food composition targets have been specified by the Ministry of Health (MoH) or the Ministry for Primary Industries for the nutrients of concern (sodium, saturated fat, *trans* fat, added sugar). However, the MoH funds the Heart Foundation’s Food Reformulation Programme, a national programme, that focusses on reducing sodium and total sugar levels in processed foods. * The Heart Foundation’s Food Reformulation Programme is a national programme that has set 44 targets for sodium or sugar across 35 food categories/sub-categories. It’s goal is for 80% (sales volume) products achieving the targets. It aims to align with Australian Healthy Food Partnership (which is in the process of formalising its targets). * As part of the Healthy Kids Industry Pledge, stimulated by MOH, several companies, including the retailer’s FoodStuffs and Countdown, set reformulation targets. * The Government response to the Food Industry Taskforce on addressing factors contributing to obesity, prioritised the food industry to set and review nutrient reformulation targets. * FSANZ leads work on the status of *trans* fats in NZ and decided previously based on 2015 meeting that regulatory intervention is not required and the non-regulatory approach is sufficient to further reduce levels. | ***This is a summary of the current evidence of implementation by the NZ Government for the COMP1 good practice indicator. New evidence of implementation compared to 2017 is highlighted.*** ***The detailed version of the evidence can be found in this printed booklet.*** |
| **INTERNATIONAL BEST PRACTICE EXAMPLES (BENCHMARKS) 2019:**   * *UK: Reduction programme to remove sugars by at least 20% by 2020.* * *Argentina/South Africa*: Laws on max levels of sodium in a broad range of food categories * *France*: Under a Charter of Engagement with the food industry (2008), companies can make voluntary commitments to reduce salt, sugar, total and saturated fats and increase fibre. | ***These are the international best practice examples or benchmarks (e.g. countries doing particularly well) for the COMP1 good practice indicator against which you will rate the extent of implementation by the New Zealand Government for COMP1. The detailed version of the benchmarks can be found in this printed booklet.*** |
| **SUMMARY**  **The median rating** by experts for COMP1 was **3** in 2017.  There is **new evidence of implementation** by the New Zealand Government since 2017. The benchmark has not substantially improved since 2017. | ***This is a summary including the median rating as per the Food-EPI 2017. It also mentions whether there is new evidence of implementation and whether the international benchmarks have improved since the Food-EPI 2017.*** |
| **Please enter your rating on the degree of policy implementation towards international best practice:**  1. < 20% implemented  2. 20-40% implemented  3. 40-60% implemented  4. 60-80% implemented  5. 80-100% implemented  6. cannot rate | |
| **COMMENTS** | |

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| Definitions **Benchmark**: A best practice exemplar or a standard or point of reference, against which aspects of food environments or policies can be assessed and compared.  **Civil society**: The aggregate of non-governmental organizations, institutions and individuals that manifest interests and will of citizens (academia, professional organizations, public-interest NGOs and citizens).  **Diet-related non-communicable diseases (NCDs)**: Type 2 diabetes, cardiovascular diseases and nutrition-related cancers, excluding micronutrient deficiencies, undernutrition, stunting, osteoporosis, mental health and gastrointestinal diseases.  **Food environments**: The collective physical, economic, policy and socio-cultural surroundings, opportunities and conditions that influence people’s food and beverage choices and nutritional status.  **Government**: National and local government, including Councils, District Health Boards and Public Health Units.  **Government-funded settings**: Government departments and agencies, publicly funded schools, publicly funded early childhood education services, elderly homes, hospitals and prisons.  **Government implementation:** Refers to the intentions and plans of the government, government funding for implementation of actions undertaken by non-governmental organisations, and actions and policies implemented by the government.  **Healthy foods:** Foods recommended in national food-based dietary guidelines, dietary guidelines or food-based standards.  **Healthy food environments**: Environments in which the foods, beverages and meals that contribute to a population diet meeting national dietary guideline are widely available, affordably priced and widely promoted.  **Nutrients of concern:** salt, fat, saturated fat, *trans* fat, added sugar.  **Platforms**: Formal government mechanisms (e.g. standing committees, ad hoc committees, advisory groups, task forces, boards, joint appointments) for interaction on issues.  **Population nutrition promotion:** Population promotion of healthy eating and healthy food environments for the prevention of obesity and diet-related NCDs, excluding all one-on-one promotion (primary care, antenatal services, maternal and child nursing services etc.), food safety, micronutrient deficiencies (e.g. folate fortification) and undernutrition.  **Unhealthy foods:** processed foods or non-alcoholic beverages high in saturated fats, *trans* fats, added sugars, and/or salt. Important information If ‘foods’ are mentioned, it means ‘foods and non-alcoholic beverages’. Alcohol and breastfeeding/infant formulae are excluded from the Food-EPI framework.  The time frame is the last three years (election cycle), although the monitoring domain needs to take a longer view (5 years). Abbreviations ASA: Advertising Standards Authority; DHB: District Health Board; ECE Early Childhood Education; ERO Education Review Office; FSANZ: Food Standards Australia New Zealand; GST: Goods and Services Tax; HEHA: Healthy Eating Healthy Action; HPA: Health Promotion Agency; HPS: Health Promoting Schools; HSR: Health Star Rating; INFORMAS: International Network for Food and Obesity/NCDs Research, Monitoring and Action Support; MBIE: Ministry of Business, Innovation and Employment; MoH: Ministry of Health; MPI: Ministry for Primary Industries; NAG: National Administration Guideline; NCDs: Non-communicable diseases; NHMRC: National Health and Medical Research Council; NIP: Nutrition Information Panel; NPSC: Nutrient Profiling Scoring Criterion; NZFCD: New Zealand Food Composition Database; SNAP: Supplemental Nutrition Assistance Program; SPEAR: Social Policy Evaluation and Research; SSC: State Services Commission; WIC: Special Supplemental Nutrition Program for Women, Infants, and Children; WHO: World Health Organisation; WTO: World Trade Organization Acknowledgements We would like to thank government officials who spent time answering queries and official information requests, and who checked completeness and accuracy of the evidence as presented in this document. Authors This document was written by Emily Brownie, with input from Dr Sally Mackay, Fiona Sing and Dr Sarah Gerritsen. |

# EVIDENCE SUMMARY

# Healthy Food Environment Policy Index: POLICY domains

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| 1 FOOD COMPOSITION: There are government systems implemented to ensure that, where practicable, processed foods minimise the energy density and the nutrients of concern (salt, fat, saturated fat, *trans* fat, added sugar). |
| COMP 1**: Food composition targets/standards have been established for processed foods by the government for the content of the nutrients of concern in certain foods or food groups if they are major contributors to population intakes of these nutrients of concern (*trans* fats and added sugars in processed foods, salt in bread, saturated fat in commercial frying fats).** |
| **Evidence of implementation**   * There are no food composition targets specified by the Ministry of Health (MoH) or the Ministry for Primary Industries (MPI) for the nutrients of concern. * As part of the 2016 Healthy Kids Industry Pledge, companies have set reformation targets. Nestlé products for children meet Nestlé Nutritional Foundation criteria. Nestlé pledged to reduce salt, sugar and saturated fat by 10% in products that do not meet the criteria, including 2 Minute Noodles (1). Children’s cereals were reformulated to reduce sugar to 9g or less per serving. Fonterra is moving everyday products for children towards minimum quantities of added sugars, refined carbohydrates, added fats and salt along with Health Star Ratings on all everyday products (2). Retail NZ pledged, where possible, to reformulate private label products to improve nutritional value and to support and encourage the reformulation of supplier products (3). Countdown pledged to undertake a nutritional review of all private-label grocery products by December 2018 (over 1000 products) so that products are nutritionally on par, or better than, the category average for saturated fat, sugar and sodium (4). Coca-Cola has pledged to reduce sugar in some products, increase the range of low kilojoule and no-sugar varieties, and provide and promote smaller packs (5). * The Government response to the Food Industry Taskforce on addressing factors contributing to obesity prioritised the recommendation for the food industry to set and review nutrient reformulation targets (28).   Heart Foundation Food Reformulation Programme (6)   * The national food reformulation programme (a Ministry of Health funded initiative), has continued to evolve over the past 4 years  Sodium reduction has been the focus of the programme since the bread reformulation pilot was conducted in 2007; sugar reduction has been included since mid-2016. The work targets high- volume and lower-cost products. Targets for prioritised food categories/sub-categories are set on a rolling basis,  in consultation with the food industry.  The goal is for 80% of the market share meeting the targets within the timeframe (typically 3-5 years).  The programme will be aiming for alignment of their targets with those from the Australian food reformulation programme (Healthy Food Partnership) which is currently in the process of formalising their targets. (personal communication, Heart Foundation, 2020) * Forty-four nutrient targets have been set across 35 food categories/sub-categories. An updated monitoring approach has been developed with consideration to the monitoring approaches used by other reformulation programmes (e.g. Public Health England, Australian Healthy Food Partnership). The new monitoring approach aims to provide an annual,  transparent quantitative and qualitative update on company commitment and progress in reformulation initiatives. Details are reported to the Ministry of Health. (personal communication, Heart Foundation, 2020) * Full category reviews of sodium reduction in the past 4 years   + Bread - In addition to the 20% reduction by main manufacturers in 2007, an additional 4.8% reduction has been achieved across the category. 73% (by sales volume) meet the target.   + Soups - 11% sodium reduction achieved across the category through product reformulation.   + Cooking sauces - 77% (by sales volume) of pasta/Indian sauces meet the target; 11-13% reduction in mean sodium achieved across all categories.   + Savoury crackers - 77% (by sales volume) meet the targets. 10.5% reduction in category median sodium achieved.   + Savoury snacks - 10-32% reduction in the median sodium contents. The reset sodium targets represent 26-38% reductions on the previous targets. * Interim highlights of sugar reduction in the past 4 years   + Yoghurts - 40% added sugar reduction across a top selling range by 1 company   + Breakfast cereals - 12 cereals by 2 companies have had a 16-35% reduction in sugar content   + Flavoured milks - 30% added sugar reduction of top selling range by 1 company.   FSANZ *trans* fats   * The current level of TFAs in the diet is well below the at-risk level. At a meeting in 2015, ministers accepted the advice of FSANZ that, given the low level of TFAs in the foods sampled in Australia and New Zealand, mandatory labelling does not appear warranted (7). The average total *trans*-fat intakes from both ruminant and manufactured sources in New Zealand were below the WHO population goal of contributing less than 1% to total energy intake.   **International best practice examples (benchmarks)**   * **UK**: In 2016, a key commitment of the ‘Childhood obesity: a plan for action’ was to launch a broad, structured sugar reduction programme to remove sugar from everyday products. All sectors of the food and drinks industry were challenged to reduce overall sugar across a range of products that contribute most to children’s sugar intakes by at least 20% by 2020, including a 5% reduction in the first year of the programme (August 2016 to August 2017). The overall reduction between 2015 -2018 (in total sugar per 100g) was -2.9% (8). Only three food groups of the eight measured have managed at least a 5% reduction in the first year: sweet spreads and sauces, yoghurts and fromage frais, and breakfast cereals. There has been no sugar reduction in biscuits and chocolate bars (9). In contrast to this co-regulation, products where the sugar tax applies over the same period saw about a 30% reduction in sugar. * **Argentina**: In December 2013, the Government adopted a law on mandatory maximum levels of sodium permitted in meat products and their derivatives, bread and farinaceous products, soups, seasoning mixes and tinned foods (Act 26905), which entered into force in December 2014. The law is applicable to salt levels in restaurant dishes. The law includes gradual reductions (between 5% and 18% of reduction). Infringements by producers and importers may be sanctioned, the most severe penalties being fines of up to one million pesos, in case of repeat infringements, up to ten million pesos and the closing of the business for up to five years (10,11). The text of the legislation and specific reduction targets can be found on the Ministry of Health of Argentina website (12). The legislation is embedded into a wider initiative (Less Salt, More Life) which also includes the reduction of salt in processed foods through voluntary agreements with manufacturers, retailers and bakers, and public awareness of the health effects and the need to reduce discretional salt. To date, about 60 companies representing 487 processed food products and more than 9000 bakeries have signed the voluntary agreement (11). * **South-Africa**: In 2013, the South African Department of Health adopted mandatory targets for salt reduction in 13 food categories (including bread, breakfast cereals, margarines and fat spreads, savoury snacks, processed meats as well as raw-processed meat sausages, dry soup and gravy powders and stock cubes) by means of regulation (Foodstuffs, Cosmetics and Disinfectants Act). There is a stepped approach with food manufacturers given until June 2016 to meet one set of category-based targets and another three years until June 2019 to meet the next (11,13). The specific reduction targets for each of the food groups can be found in the Staatskoerant of 20 March 2013 (14). * **France**: As part of the French National Nutrition and Health Programme (PNNS), the Ministry of Health established a Charter of Engagement with the food industry (2008). One area of action is improving the nutritional composition of food products by reducing the amount of salt, sugar, total and saturated fats and increasing the amount of fibre. Any entity with an economic interest in the food industry is eligible to submit nutritional commitments. Nine principles are detailed: compliance, honesty, efficiency, retroactivity, fairness, transparency, monitoring, updating, and confidentiality. Commitments must be clear, accurate, precise, dated, and controllable. To date, over 35 companies have made voluntary commitments, which are reviewed and approved by an external committee of 24 public sector experts to ensure they are ‘significant’. There is a strict follow-up. The approved charters are signed by the food industry and monitored by the Food Quality Observatory (created in 2008) (11,15). |

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| **1 FOOD COMPOSITION:** There are government systems implemented to ensure that, where practicable, processed foods minimise the energy density and the nutrients of concern (salt, fat, saturated fat, *trans* fat, added sugar). |
| COMP 2**: Food composition targets/standards have been established for out-of-home meals in food service outlets by the government for the content of the nutrients of concern in certain foods or food groups if they are major contributors to population intakes of these nutrients of concern (*trans* fats, added sugars, salt, and saturated fat).** |
| **Evidence of implementation**   * There are no food composition targets specified by the Ministry of Health (MoH) or the Ministry for Primary Industries (MPI) for out-of-home meals for the nutrients of concern. * The Chip Group initiative aims to improve the nutrient profile of food service deep-fried chips by reducing fat (total, saturated, *trans*) and salt (16). It was funded by both food industry and the MoH, however the MoH stopped funding the Chip Group in January 2020 (personal communication, Heart Foundation, 2020). The Chip Group sets Industry Standards that are scientifically robust and achievable, including chip size, serving size, cooking time, basket drainage (shake, bang and hang), cooking oil temperature, salt addition, and oil type. The standards for a deep-frying oil are a maximum 28% saturated fat, max 3% linoleic acid and max 1% *trans*-fat. The Chip Group oil logo, for use on approved oil packaging and point-of-sale, was developed in 2010. There are currently 11 registered approved oils – including blends and new variety oils - marketed by Bakels, Integro (a division of Goodman Fielder), Cookright, Peerless, and NZ Sugar/Wilmar. The Chip Group runs the Best Chip Shop Competition every second year to find the best providers of healthier chips. There are awards presented for National Judges’ Supreme Award, People’s Choice Award and Regional finalists of People’s Choice which must be 9% or less fat. All entrants whose fat percentage is 9% or less received *Highly Commended Chips* awards (17).   **International best practice examples (benchmarks)**   * **New Zealand**: In New Zealand, The Chip group, was funded 50% by the MoH and 50% by industry, aims to improve the nutritional quality of deep-fried chips served by food service outlets by setting an industry standard for deep frying oils. The standard for deep frying oil is max. 28% of saturated fat, 3% linoleic acid and 1% of *trans*-fat. The Chip group oil logo for use on approved oil packaging was developed in 2010 (16). * **New York**: In 2009, New York City established voluntary salt guidelines for various restaurant and store-bought foods. In 2010, this city initiative evolved into the National Salt Reduction Initiative that encouraged nationwide partnerships among food manufacturers and restaurants involving more than 100 city and state health authorities to reduce excess sodium by 25% in packaged and restaurant foods. The goal is to reduce Americans’ salt intake by 20% over five years. The National Salt Reduction Initiative has worked with the food industry to establish salt reduction targets for 62 packaged foods and 25 restaurant food categories for 2012 and 2014. The commitments and achievements of companies have been published online (18). * **The Netherlands**: On January 2014, the Dutch Ministry of Health, Welfare and Sport signed an agreement with trade organizations representing food manufacturers, supermarkets, hotels, restaurants, caterers and the hospitality industry to lower the levels of salt, saturated fat and calories in food products. The agreement includes ambitions for the period up to 2020 and aims to increase the healthiness of the food supply (11,19). |

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| 2 FOOD LABELLING**:** There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to prevent misleading claims and allow consumers to make informed food choices. |
| LABEL1**:**  **Ingredient lists and nutrient declarations in line with Codex recommendations are present on the labels of all packaged foods.** |
| **Evidence of implementation**   * New Zealand meets CODEX standards and regulation is in place to ensure compliance. The MPI manages New Zealand’s participation in CODEX and sets strategic priorities which ensure that CODEX standards have the widest possible application (20). * Labelling standards are included in the Australia New Zealand Food Standards Code (21,22). The MPI is responsible for the implementation of the Food Standards Code, which has been in force since 2002. Labels must include the ingredient list. Ingredients must be declared in the statement of ingredients in descending order of ingoing weight (23). * The general format for the nutritional information panel (NIP) is shown below and is required on most packaged food products. Where average quantities or minimum/maximum quantities are given, this must be indicated in the NIP (example is shown below): * In 2009, the Council of Australian Governments (COAG) and Australia and New Zealand Food Regulation Ministerial Council (Ministerial Council) agreed to undertake a review of food labelling law and policy. An expert panel, chaired by Dr Neal Blewett, AC, was appointed and the report Labelling Logic, was released in January 2011 (24). The report contained 61 recommendations with some related to nutrition labelling and FSANZ has completed the required work on a number of these recommendations (25): * Recommendation 12: ‘*That where sugars, fats or vegetable oils are added as separate ingredients in a food, the terms ‘added sugars’ and ‘added fats’ and/or ‘added vegetable oils’ be used in the ingredient list as the generic term, followed by a bracketed list (e.g. added sugars (fructose, glucose syrup, honey), added fats (palm oil, milk fat) or added vegetable oils (sunflower oil, palm oil)*’. * FSANZ undertook work to clarify the policy issue in relation to naming sources of fats and oils, and the next steps to provide adequate information for consumers to make informed choices in support of dietary guidelines. * In April 2017 the Forum agreed to extend the scope of the project to cover all parts of the food label including the identification of fats and oils. The following activities have been completed: a literature review on consumers’ knowledge, attitudes and behaviours relating to the labelling of fats and oils, identification of international approaches to fats and oils labelling, the policy context in NZ, engagement with stakeholders. In June 2018 the Forum acknowledged consumer’s ability to identify saturated and/or mono and polyunsaturated fats in food is limited. Work currently being undertaken is for the National Health and Medical Research Council to provide advice on the guidance required to assist consumers to choose healthy fats and oil, and to seek stakeholder input on smart labelling. Public consultation on a range of policy options in relation to labelling of sugars on foods and drinks was undertaken between July and September 2018 with over 160 submissions. A ‘Policy Paper: Labelling of sugars in packaged foods and drinks’ was developed that identifies which of the policy options would best provide consumers with information to enable them to make an informed choice in relation to sugars. In August 2019 the Forum agreed to request that FSANZ review nutrition labelling for added sugars, noting that the option to quantify added sugars in the NIP best met the desired outcome and that a pictorial approach applied to sugary beverages warrants further consideration, along with other options, pending the response to the HSR five-year review (26). * Recommendation 13: ‘*That mandatory declaration of all trans fats above an agreed threshold be introduced in the NIP if manufactured trans fats have not been phased out of the food supply by January 2013’.* At a meeting in 2015 ministers accepted the advice of FSANZ that, given the low level of TFAs in the foods sampled in Australia and New Zealand, mandatory labelling does not appear warranted. The Code currently permits the voluntary declaration of *trans* fatty acids content on labels and requires the declaration of *trans* fatty acids when certain nutrition content and health claims are made (7). * Recommendation 26: ‘*That the energy content be displayed on the labels of all alcoholic beverages consistent with the requirements for other food products’*. Targeted consultation was undertaken in mid-2017. This information is being used to develop policy options for a wider public consultation (27). * The Government response to the Food Industry Taskforce on addressing factors contributing to obesity prioritised the recommendation for the food industry to take on the recommendations that might result from the developments of the Australia and New Zealand Ministerial Forum on Food Regulation ‘Labelling of Sugars on Packaged Foods and Drinks’ review (28). * In August 2019, the Australia and New Zealand Ministerial Forum on Food Regulation (the Forum) asked FSANZ to review nutrition labelling for added sugars and to consider energy labelling on alcoholic beverages (29,30).   **International best practice examples (benchmarks)**   * **Many countries**: In a wide range of countries, including New Zealand, producers and retailers are required by law to provide a comprehensive nutrient list on pre-packaged food products (with limited exceptions), even in the absence of a nutrition or health claim. The rules define which nutrients must be listed and on what basis (e.g. per 100g or per serving) (31). Most other countries follow Guideline CAC/GL 2-1985 from the Codex Alimentarius Commission in requiring nutrition labels only when a nutrition or health claim is made and/or on food with special dietary uses. (31) |

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| **2 FOOD LABELLING:** There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to enable consumers to easily make informed food choices and to prevent misleading claims |
| LABEL2**: Robust, evidence-based regulatory systems are in place for approving/reviewing claims on foods so that consumers are protected against unsubstantiated and misleading nutrition and health claims** |
| **Evidence of implementation**   * Food Standard 1.2.7 Nutrition Health and Related Claims (32). This standard regulates nutrition content claims and health claims on food labels and in advertisements. It became law on 18 January 2013 and businesses had to comply from 18 January 2016 (33), and with requirements for nutrition content claims about dietary fibre from Jan 2017. Food businesses wanting to make general level health claims can base their claims on one of the more than 200 pre-approved food-health relationships in the Standard or self-substantiate a food-health relationship in accordance with detailed requirements set out in the Standard. The Standard sets out the claims that can be made on labels or in advertisements about the nutritional content of food (including nutrient comparative claims) or the relationship between a food or property of food (such as a vitamin or mineral), and a health effect (general or high-level health claims). The Standard establishes the conditions under which claims can be made. It provides exemptions for the use of ‘endorsements’ on labels or in advertisements if certain requirements set out in the Standard are met. Division 3 section 1.2.7-4 directly discusses that “Nutrition content claims or health claims not to be made about certain foods” and Division 4 is entirely related to the requirements for nutrition content claims. Health claims cannot refer to the prevention, diagnosis, cure or alleviation of a disease, disorder or condition; or compare a portion of food with a good that is represented in any way to be for therapeutic use (personal communication, FSANZ, 2020). * A new Food Standard (1.2.7) was fully implemented in January 2016 to address claims on food labels. MPI conducted a survey of nutrition content claims and health claims of 680 randomly selected products in 2014/15 (baseline) and 2016/17 (post-implementation). The number of claims meeting the requirements of the Code increased from 57% to 86%. There was a similar number of general level health claims for both MPI surveys. At baseline, none of these claims met the requirements but by 2016/17 over half did. There were no high-level health claims in the survey (personal communication, MPI, 2020). * With respect to self-substantiating a food-health relationship for the purposes of making a general level health claim, Standard 1.2.7 requires a person to notify FSANZ of a relationship between a food or property of food and a health effect (food-health relationship) which has been established by a process of systematic review before making a general level health claim. The notified food-health relationship is published on the FSANZ [website](http://www.foodstandards.gov.au/industry/labelling/fhr/Pages/default.aspx) (34), but publication by FSANZ does not indicate acceptance, approval or validation of the food-health relationship. The Ministry for Primary Industries is responsible for enforcing requirements in the Code including evaluating the evidence supplied in support of self-substantiated claims. High-level health claims (referring to a serious disease or a biomarker of a serious disease) must be based on a food-health relationship pre-approved by FSANZ. There are currently 13 pre-approved food-health relationships for high-level health claims listed in the Standard. * The Standard requires that to use a general or high-level health claim, the food to which the claim relates must meet the Nutrient Profiling Scoring Criterion (NPSC). The final score = baseline points (based on average energy, saturated fat, total sugar and sodium content per 100 g or 100ml) – (fruit and vegetable points) – (protein points) – (fibre points). An online calculator is available to help food businesses determine a food’s nutrient profiling score (35). New Zealand is one of a few countries with a nutrient profiling scheme in place for health claims (personal communication, FSANZ, 2020). * A Health Claims Scientific Advisory Group was established to provide scientific and technical advice to FSANZ (36), when requested, in relation to health claims; and matters relevant to Standard 1.2.7- Nutrition, Health and Related Claims. The role of the High-Level Health Claims Committee is to consider and provide recommendations to FSANZ in relation to draft high-level health claim variations and/or the application or proposals that resulted in that draft variation (personal communication, FSANZ, 2020). * Sections S4-4 and S4-5 of Schedule 4 in the Code outline the specific conditions required for pre-approved high level and general level health claims, respectively (e.g. ‘calcium reduces the risk of osteoporosis’: food must contain no less than 290mg of calcium per serving). * Nutrition content and comparative nutrition content claims: A nutrition content claim (including a comparative claim) can be made in accordance with the requirements set out in the Standard. Comparative claims must meet minimum standards relating to the difference between the nutrient content of that food and a comparative food (e.g. at least 25% less energy than the same quantity of reference food). Section S4-3 of Schedule 4 outlines the specific conditions required for a nutrition content claim (e.g. to claim ‘low fat’ the food contains no more fat than 1.5g/ 100 mL for liquid food; or 3g/ 100 g for solid food). For claims about properties of food not listed in section S4-3 of Schedule 4, the claim can only state that the food contains or does not contain the property of food, or contains a specified amount (personal communication, FSANZ, 2017). Where a nutrition content claim is made about any food component, it triggers the need for that component to be included in the nutrition information panel, so that the average amount in the food is known (personal communication, MPI, 2017). The NPSC does not apply for nutrition content claims. * Recommendation 3 from Labelling Logic: Complete. A Food Labelling Monitoring and Enforcement Framework has been developed (25). MPI manage non-compliant health claims and nutrition content claims using a graduated and proportionate approach: assess the non-compliant claim, determine the associated risk and use the appropriate tool in response. This ranges from education and advice, through to direct enforcement action which could include directing business to stop selling the non-complying product. A prosecution is also an option (personal communication, MPI, 2020). * Regarding self-substantiated claims, MPI continues to evaluate all dossiers associated with notifications from New Zealand food businesses. These are evaluated against the requirements of Schedule 6 of Australia and New Zealand Food Standards Code (FSC). To date, there have been ten formal notifications. Two have been removed from the Notifications Register due to not meeting the requirements of Schedule 1.2.7, and three were notified directly to MPI (not FSANZ) because they related to Supplemented Foods. Some of these are still in the process of evaluation. Dossiers contain commercially sensitive information and therefore are not available in the public domain. The industry holds these dossiers, though are obliged under Standard 1.2.7 to provide them to the regulator (MPI in NZ) for evaluation when requested (personal communication, MPI, 2020). * In 2019 one of MPI’s key strategic deliverables has been to “Work with industry to substantiate new health claims for export markets, including work on selected products”. As part of this strategic deliverable, MPI is currently exploring options for increasing resources and proactive communications with stakeholders (including industry and research groups), to facilitate a better understanding of the strict regulatory requirements for making health claims (personal communication, MPI 2020). * Other MPI work programme activities associated with Standard 1.2.7 include the provision of consumer and industry information on the standard, liaison with industry on the development of dossiers and the development of internal procedures to assess dossiers (personal communication, MPI, 2017). A resource is available from MPI explaining the detailed steps required to complete a systematic review to the requirements of the Food Standards Code. MPI also works actively with researchers and manufacturers to advise on appropriate research design and systematic review strategies prior to a notification to FSANZ (personal communication, MPI, 2017). * MPI engages with health claims regulators in other countries to better align global regulatory understanding of health claim requirements for foods (personal communication, MPI, 2017). * Laws that protect the consumer in NZ include the Fair Trading Act and the Consumer Guarantees Act (37). It is stated that ‘goods must meet the guarantees of acceptable quality, and matching description’. Consumer Protection NZ prepared a consumer guide to understand consumer rights related to the guarantees act (38). * FSANZ Food Standards Development Workplan as of 10 January 2020 with Nutrition-related work included these applications (39). 1. P1030 – composition and Labelling of Electrolyte Drinks: Assessment of compositional and labelling requirements for electrolyte drinks. The first round of submissions has been undertaken with a delay in further assessment due to the complexity of issues raised in submissions. 2. P1049 – carbohydrate and sugar claims on alcoholic beverages. This commenced in late August 2018 with 1 call for submissions.   **International best practice examples (benchmarks)**   * **Australia/New Zealand**: A law (Standard 1.2.7) (40), approved in 2013, regulates the use of nutrition content and health claims on food labels in Australia and New Zealand. Health claims must be based on pre-approved food-health relationships or self-substantiated according to government requirements and they are only permitted on foods that meet nutritional criteria, as defined by a nutrient profiling model (Nutrient Profiling Scoring Criterion (NPSC)) considering energy, sodium, saturated fat and total sugar content of foods, as well as protein, fibre, fruit, vegetable, nut and legume content of foods. Although nutrition content claims also need to meet certain criteria set out in the Standard, there are no generalized nutritional criteria that restrict their use on ‘unhealthy’ foods *per se*. The industry needed to comply with this new legislation by January 2016. Food Standards Australia New Zealand has developed an online calculator to help food businesses to calculate a food’s nutrient profiling score (41). * **Indonesia:** Regulation HK.03.1.23.11.11.09909 (2011) (42) on ‘The Control of Claims on Processed Food Labelling and Advertisements’ establishes rules on the use of specified nutrient content claims (i.e. levels of fat for a low-fat claim). The Regulation applies to any food product or beverage which has been processed. Generally, any nutrition or health claim may only be used on processed foods or beverages if they do not exceed a certain level of fat, saturated fat and sodium per serving (13g total fat, 4g saturated fat, 60mg cholesterol and 480mg sodium). The Regulation sets out certain exceptions from this rule, whereby products exceeding these limits may still contain certain nutrient or health claims (‘low in [name of nutrient]’ and ‘free from [name of nutrient]’ claims; claims related to fibre, phytosterol and phytostanol; certain disease risk reduction claims) (31). * **US**: Nutrient-content claims are generally limited to a list of nutrients authorized by the Food and Drug Administration (Food Labelling Guide 1994, as last revised in January 2013). Packages containing a nutrient-content claim must include a disclosure statement if a serving of food contains more than 13g of fat, 4g of saturated fat, 60mg of cholesterol, or 480mg of sodium. Health claims are generally not permitted if a food contains more than 13g of fat, 4g of saturated fat, 60mg of cholesterol, or 480mg of sodium. Sugar and whole-grain content are not considered (31,43). |

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| **2 FOOD LABELLING:** There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to enable consumers to easily make informed food choices and to prevent misleading claims |
| LABEL3**: A single, consistent, interpretive, evidence-informed front-of-pack supplementary nutrition information system, which readily allows consumers to assess a product’s healthiness, is applied to all packaged foods** |
| **Evidence of implementation**   * The Health Star Rating (HSR) was introduced in 2014 as a voluntary front of pack labelling system (44). It is designed to help consumers choose between similar packaged foods at the point of purchase, based on the overall nutritional value of those foods. It is a Trans-Tasman system, implemented both in Australia and New Zealand (45). The Ministry for Primary Industries administers the HSR system in NZ. The nutrient profiling system used in the HSR is aligned with the Australian and NZ dietary guidelines. The system allocates stars to foods based on their nutrition content (energy, risk nutrients: saturated fat, sodium, total sugars, and beneficial components: dietary fibre, protein, fruits, vegetables, nuts, legumes). There are tools and resources including the HSR calculator to help industry adopt the HSR. There is a process to address anomalies and a dispute resolution process (46) * http://www.foodsafety.govt.nz/industry/general/labelling-composition/health-star-rating/health-star-rating-long.jpgAn example of the health star rating label is printed below: * The committees that guide implementation are A) The Australian and NZ Ministerial Forum on Food Regulation, this includes ministers responsible for food, including the NZ Minister for Food Safety; B) Front-of-Pack labelling steering committee which was responsible for leading the process for developing the system; C) The trans-Tasman Health Star Rating Advisory Committee oversees implementation and evaluation of HSR including monitoring. NZ holds one of ten seats. It includes industry, government, consumer and public health representatives; D) The NZ HSR Advisory Group has members from food industry, academia, public health chaired by MPI to consider the latest evidence, global developments, identify areas of common ground shared by stakeholder groups, provide advice on evaluation (45). * By September 2019 almost 5,150 products displayed the HSR (personal communication, MPI, 2020). Major supermarket retailers Foodstuffs NZ (47) and Countdown (48) have committed to having HSR on 100% of their private label products. * HPA commissioned Colmar Brunton to conduct a baseline survey of grocery shoppers in 2015 to monitor awareness, recognition and correct use of HSR (49). * The Health Promotion Agency/Te Hiringa Hauora (HPA) worked with the Ministry for Primary Industries and the Ministry of Health to roll out a consumer awareness campaign, which began in March, 2016. The campaign ran until June 2018 and focused on raising consumer awareness, recognition and ease of HSR. It also included some messages to assist consumer understanding of HSR. The campaign was part of a wider programme of work and communication to establish the HSR in New Zealand. Priority groups for the campaign were grocery shoppers in households with at least one child under the age of 14 years, with an emphasis on Māori, Pacific and low income families. (personal communication, HPA, 2020). HPA involvement in HSR ended in June 2018 following the publication of the monitoring and evaluation report * Follow-up surveys occurred in 2017 and 2018. 73% of shoppers considered the advertisements were easy to understand and it was found that the awareness of HSR doubled from 38% to 76% (50). HPA has worked with the food industry and relevant government agencies on the campaign (51). * A two-year progress report on implementation was considered by the forum in 2017 (personal communication, FSANZ, 2020). * A five-year review was undertaken with public consultation in 2019. The report had ten recommendations for enhancing the HSR system (52). The Forum Ministers agreed it should continue with some amendments. Forum ministers supported many of the recommendations, noting that some require funding support and will need to be considered further in the context of an implementation plan. Forum Ministers noted that the intent of the system is for processed, packaged multi-ingredient foods and discussed the role of the system in relation to fresh fruit and vegetables. It was noted and agreed that for some minimally processed foods such as canned and frozen fruits and vegetables having a 5-star rating may be beneficial to consumers. The Food Regulation Standing Committee (FRSC) will provide advice on the implementation of this recommendation including definitions for minimally processed fruits and vegetables. Forum Ministers support changes to the algorithm identified in recommendation 4b, c, and d subject to a peer review of the modelling of these changes by FSANZ and further advice from FRSC on sugars and sodium levels in the calculator. The review recommended that the HSR system continues as a voluntary system but with clear update targets set. If the HSR is not displayed on 70% of target products within five years, the HSR system should be mandated. The Ministerial Forum on Food Regulation agreed with this recommendation in principle. They also requested that FRSC consider the way edible oils are treated under the Health Star Rating system and provide technical advice on oils to the Forum in early 2020. Consideration of outstanding issues and an implementation plan for agreed changes to the Health Star Rating system will be considered by the Forum in early 2020 (53). * The Government response to the Food Industry Taskforce on addressing factors contributing to obesity prioritised the recommendation for the food industry to encourage adoption of the outcomes of the Australia NZ Ministerial Forum on Food Regulation (28).   **International best practice examples (benchmarks)**   * **Australia/New Zealand**: The government approved a 'Health Star Rating' (HSR) system as a voluntary scheme for industry adoption. The system considers four aspects of food associated with increased risk for chronic diseases; energy, saturated fat, sodium and total sugars content along with certain 'positive' aspects of food such as fruit and vegetable content, and in some instances, dietary fibre and protein content. Star ratings range from ½ star (least healthy) to 5 stars (most healthy). Implementation of the HSR system began in June 2014 and is overseen by the Australia and New Zealand Ministerial Forum on Food Regulation, the Front-of-Pack Labelling Steering Committee, the Trans-Tasman Health Star Rating Advisory Committee, the New Zealand Health Star Rating Advisory Group and a Technical Advisory Group (54). * **France/ Belgium/Germany/Spain:** Since October 2017, the five-colour NutriScore, the official voluntary label for France has been implemented as the official, voluntary FOP scheme in four European countries. It aims to limit the consumption of foods high in energy, saturated fats, sugar or salt, in the context of an overall improvement in the nutritional quality of diets. Based on a scientific algorithm, each product is given a score based on the content of the nutrients of concern (energy value and the number of sugars, saturated fats and salt) and positive ones (the amount of fibre, protein, fruit, vegetables and nuts) (55–57). The system was developed by the Nutritional Epidemiology Research Team at the University of Paris as shown below:   **Table 1: The Nutri-Score** (56)     * **Chile:** In 2012, the Chilean Government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606) (58). In June 2015, the Chilean authority approved the regulatory norms required for the law’s implementation (Diario Official No 41.193). The regulatory norms define limits for calories (275 calories/100g or 70 calories/100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered ‘high’ in foods and beverages. All foods that exceed these limits need to have a front-of-package black and white warning message inside a stop sign that reads ‘HIGH IN’ followed by CALORIES, SATURATED FAT, SUGAR or SODIUM. A warning message needs to be added to products per nutrient of concern exceeding the limit (e.g. a product high in fat and sugar will have 2 stop signs). The regulatory norms provide specifications for the size, font, and placement of the warning message on products. The limits for calories, saturated fat, sugar and sodium are being implemented using an incremental approach, reaching the defined limits by 1 July 2018 (31). |

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| **2 FOOD LABELLING:** There is a regulatory system implemented by the government for consumer-oriented labelling on food packaging and menu boards in restaurants to enable consumers to easily make informed food choices and to prevent misleading claims |
| LABEL4**: A consistent, single, simple, clearly visible system of labelling the menu boards of all quick-service restaurants (i.e. fast food chains) is applied by the government, which allows consumers to interpret the nutrient quality and energy content of foods and meals on sale** |
| **Evidence of implementation**   * There is no government-initiated mandatory or voluntary labelling of foods and meals in any restaurants or outlets across New Zealand. In some chains, voluntary information is available. * Relevant recommendations from the Labelling logic report (24), commissioned by Australian food minister are 18: *‘That the declaration of energy content of standardised food items on the menu/menu boards or in close proximity to the food display or menu should be mandatory in chain food service outlets and on vending machines. Further, information equivalent to that provided by the Nutrition Information Panel (NIP) should be available in a readily accessible form in chain food service outlets*’. The Forum agreed that no further action is required on this recommendation. The Australia and New Zealand Food Regulation Ministerial Council has agreed that jurisdictions that have implemented point of sale nutrition schemes should work together informally to aggregate their data. 54: ‘*That chain food service outlets across Australia and New Zealand should be encouraged to display the multiple traffic lights system on menus/menu boards. Such a system should be mandatory where general or high-level health claims are made, or equivalent endorsements/trade names/marks are used*’. The Forum agreed that no further action is required on this recommendation recognizing that progress has been made on point-of-sale nutrition schemes (59). * The Government response to the Food Industry Taskforce on addressing factors contributing to obesity prioritised the recommendation for the food industry on voluntary menu labelling in fast food outlets (28).   **International best practice examples (benchmarks)**   * **Australia**: Legislation in Australian Capital Territory (Food Regulation 2002) and the States of New South Wales (Food Regulation 2010) and South Australia (Food Regulation 2002) requires restaurant chains (e.g. fast-food chains, ice cream bars) with ≥20 outlets in the state (or seven in the case of ACT), or 50 or more across Australia, to display the kJ content of food products on their menu boards. Average adult daily energy intake of 8700 kJ must also be prominently featured. Other chains/food outlets are allowed to provide this information on a voluntary basis but must follow the provisions of the legislation (31). * **South Korea**: Since 2010, the Special Act on Safety Control of Children’s Dietary Life has required all chain restaurants with 100 or more establishments to display nutrient information on menus including energy, total sugars, protein, saturated fat and sodium (31). * **Canada:** In effect since 1 January 2017, Ontario’s Healthy Menu Choices Act 2015, requires food service premises that are part of a chain of 20 or more food service premises in Ontario (as well as certain cafeteria-style food service premises) to display calories for “standard food items” on menus, labels and display tags. The Act’s regulations specify where caloric information is to be displayed on the menus, as well as the size, format and prominence of the display (60). Food service premises must also display information on daily caloric requirements: “*Adults and youth (ages 13 and older) need an average of 2,000 calories a day, and children (ages 4 to 12) need an average of 1,500 calories a day. However, individual needs vary.”* Ontario’s 36 public health units are responsible for the implementation of the Act (60). * **Saudi Arabia**: In 2018, the Saudi Food and Drug Authority (SFDA) introduced mandatory measures on calorie labels on menus. These measures apply to all food facilities including restaurants, ice cream parlours, juice and fresh fruit vendors, bakeries, sweets shops, cafeterias, supermarkets, recreation facilities, colleges, universities and government agencies. Calories will be displayed at cashier desks, menu boards, table menus, drive-through menus, phone and web applications (61). |

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| 3 FOOD PROMOTION**:** There is a comprehensive policy implemented by the government to reduce the impact (exposure and power) of the promotion of unhealthy foods to children (<16years) across all media |
| PROMO1: **Effective policies are implemented by the government to restrict exposure and power of promotion of unhealthy foods to children through broadcast media (TV, radio)** |
| **Evidence of implementation**   * There are no government regulations in place to restrict unhealthy food marketing to children through broadcast media. * The ASA (Advertising Standards Authority) governs the Children and Young Peoples Advertising Code, published in 2017. The Code includes specific food and beverage advertisements rules for children (up to 14 years) and young people (up to 18 years). The advertising of occasional food, as defined by the Ministry of Health Food and Beverage Classification system is unable to be ‘targeted at children’ as defined by the Code (62). Public health academics have criticised the definition used by the ASA as it is too narrow in scope and does not accurately capture the advertising to which children are actually exposed, which is the definition the WHO endorses. (63). * Sixteen complaints were made regarding advertising of occasional food to children and young people between 2017 and 2019. Eight were brought under the CYPA Code solely, six under both the CYPA Code and the Advertising Standards Code and two under the CYPA Code and other Codes (Advertising Code of Ethics and Code for Advertising Food). The advertising mediums included a mix of television advertisements, online advertisements (Facebook, websites, Instagram), outdoor advertisements (outside shops, street signage, bus shelters) or print advertisements. The marketing techniques used include using famous sports stars, children, digital techniques such as emojis or characters like Santa Claus, and advertising limited edition offers, major food and beverage industry sponsored events or advertising the ‘healthful’ nature of the products (i.e. a healthy burger or pizza options). Other advertisements suggested ways children could consume products, like, cookies for breakfast cereal, chocolate eggs ‘made for kids’, or biscuit packets in lunch boxes. Public health experts, who were testing how the various ASA Codes would be interpreted and enforced, made the complaints. * Two complaints were upheld under the CYPA Code; however, one was appealed, and the decision reversed, and four complaints were upheld under the ASC. Two further complaints were settled, and one complaint was partially settled therefore no decision was given. Therefore, of the sixteen complaints, twelve were not upheld, and only one was upheld under the CYPA Code. * Principle 1: Advertisements targeted at children or young people must not contain anything that is likely to result in their physical, mental or moral harm and must observe a high standard of social responsibility**.**   + *Rule 1(i)* Advertisements (including sponsorship advertisements) for occasional food or beverage products must not target children or be placed in any media where children are likely to be a significant proportion of the expected average audience (25% or more of expected audience will be children).   + *Rule 1(j)* a special duty of care must be applied to occasional food and beverage product advertising to young people*.*   + *Rule 1(k)* the quantity of the food in the advertisement should not exceed portion sizes that would be appropriate for consumption on one occasion by a person or persons of the age depicted.   + *Rule 1(l)* Advertisements featuring a promotional offer of interest to children or young people which is linked to food and beverage products must avoid creating a sense of urgency or encouraging the purchase of an excessive quantity for irresponsible consumption. Guidance note: no promotional offers for occasional food and beverage products to children. * Principle 2: Advertisements must not by implication, omission, ambiguity or exaggerated claim mislead or deceive or be likely to mislead or deceive children or young people, abuse their trust or exploit their lack of knowledge.   + *Rule 2(f)* Advertisements must not mislead as to the potential physical, social or mental health benefits from consumption of the product. * Principle 3: A special duty of care must be exercised for Occasional Food and Beverage Product sponsorship advertising targeted to young people.   + *Rule 3(a)* Sponsorship advertisements must not show an occasional food or beverage product, or such product’s packaging, or depict the consumption of an occasional food or beverage product.   + *Rule 3(b)* Sponsorship advertisements must not imitate or use any parts of product advertisements for occasional food or beverage products from any media.   Healthy Auckland Together partners, co-ordinated by Auckland Regional Public Health Services, have an advocacy focus on protecting children from junk food marketing. HAT regularly make complaints to the ASA about specific ads that market unhealthy food to test the interpretation of the code. A ‘How to Guide’ to simplify the process of making a complaint is available. HAT partners have developed a set of recommendations and changes for the Government to strengthen the ASA code to prevent unhealthy food marketing to children (64).   * The Government response to the Food Industry Taskforce on addressing factors contributing to obesity prioritised the recommendation for the food industry to limit advertising, marketing and sponsorship related to energy-dense, nutrient-poor food and beverages (28).   **International best practice examples (benchmarks)**   * **Quebec (Canada)**: Quebec is the only province in Canada where children below 13 years old are protected under the Consumer Protection Act since 1980 (65). In Quebec, the Consumer Protection Act prohibits commercial advertising (including food and non-food) directed at children less than 13 years of age through television, radio and other media. To determine whether an advertisement is directed at persons under thirteen years of age, account must be taken of the context of its presentation, and of a) the nature and intended purpose of the goods advertised; b) the manner of presenting such advertisement; and c) the time and place it is shown. A cut-off of 15% share of children audience is used to protect children from TV advertising (66). Any stakeholder involved in a commercial process (from the request to create an advertisement to its distribution, including its design) may be accused of not complying with the legislation in force. Per the indictment, that person is liable to: a fine ranging from $600 to $15,000 (in the case of a natural person); a fine ranging from $2,000 to $100,000 (in the case of a legal person). Notably, for the rest of Canada, child-directed food marketing is self-regulated using the Canadian Children’s Food and Beverage Advertising Initiative (CAI) by Advertising Standards Canada (ASC) through The Broadcast Code for Advertising to Children. * **Chile:** In 2012, the Chilean government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606) (58). In June 2015, the Chilean authority approved the regulatory norms required for the law’s implementation (Diario Official No 41.193). The regulatory norms define limits for calories, saturated fat, sugar and sodium content considered ‘high’ in foods and beverages. The regulatory norms define limits for calories (275 calories/100g or 70 calories/100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered ‘high’ in foods and beverages. The law restricts advertising directed to children under the age of 14 years of foods in the ‘high in’ category. The regulatory norms define advertising targeted to children as programmes directed to children or with an audience of greater than 20% of children, and according to the design of the advertisement. Promotional strategies and incentives, such as cartoons, animations, and toys that could attract the attention of children are included in the ban. The regulation is scheduled to take effect 1 July 2016 (67). Chile outlaws Kinder Surprise eggs and prohibits toys in McDonald’s ‘Happy Meals’ as part of this law (68). Exposure to unhealthy food advertising after implementation of the television advertisement restriction fell by 44% for pre-schoolers and by 58% for adolescents but was not fully eliminated. The percentage of food and beverage products that targeted children decreased from 36% before implementation of the law to 21% after implementation. The percentage of “high-in” packages that used at least one child-directed marketing strategy decreased from 43% before implementation to 15% after implementation (69,70). |

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| **3 FOOD PROMOTION:** There is a comprehensive policy implemented by the government to reduce the impact (exposure and power) of the promotion of unhealthy foods to children (<16years) across all media |
| PROMO2: **Effective policies are implemented by the government to restrict exposure and power of promotion of unhealthy foods to children through non-broadcast media (e.g. Internet, social media, food packaging, sponsorship, outdoor advertising including around schools)** |
| **Evidence of implementation**   * There are no government regulations in place to restrict unhealthy food marketing to children through non-broadcast media. * The Advertising Standards Authority Codes outlined above include non-broadcast media in their scope. The code does not apply to food packaging and commercial sponsorship. However, as outlined above, to date only one complaint against the Codes has been upheld by the self-regulated Complaints Board (Coca Cola outdoor advertising using Santa Claus) and no other mediums – such as internet, social media etc have been upheld as the advert has not been deemed be ‘targeting children’ as the audience was not made up of over 25% children. * The Government response to the Food Industry Taskforce on addressing factors contributing to obesity prioritised the recommendation for the food industry to limit advertising, marketing and sponsorship related to energy-dense, nutrient-poor food and beverages (28).   **International best practice examples (benchmarks)**   * **Chile**: In 2012, the government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606) (58). In June 2015, the authorities approved the regulatory norms required for the law’s implementation (Diario Official No 41.193). The regulatory norms define limits for calories, saturated fat, sugar and sodium content considered ‘high’ in foods and beverages. The regulatory norms define limits for calories (275 calories/100g or 70 calories/100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered ‘high’ in foods and beverages. The law restricts advertising directed to children under the age of 14 for foods in the ‘high in’ category. The regulatory norms define advertising targeted to children as websites directed to or with an audience of greater than 20% children, and according to the design of the advertisement. Promotional strategies and incentives, such as cartoons, animations, and toys that could attract the attention of children are included in the ban. The regulation took effect on 1 July 2016 and applies to all advertising media (67). Chile outlaws Kinder Surprise eggs and prohibits toys in McDonald’s ‘Happy Meals’ as part of this law (68). The percentage of food and beverage products that targeted children decreased from 36% before implementation of the law to 21% after implementation. The percentage of “high-in” packages that used at least one child-directed marketing strategy decreased from 43% before implementation to 15% after implementation (69). * **Quebec (Canada)**: Quebec is the only province in Canada where children below 13 years old are protected under the Consumer Protection Act since 1980 {Office de la protection du consommateur, 2013 #443}. In Quebec, the Consumer Protection Act prohibits commercial advertising directed at children less than 13 years through all media. To determine whether or not an advertisement is directed at persons under 13, account must be taken of the context, and in particular of a) nature and intended purpose of the goods advertised; b) the manner of presenting advertisement; c) the time and place it is shown (66). Any stakeholder involved in a commercial process (from the request to create an advertisement to its distribution, including its design) may be accused of not complying with the legislation in force. Per indictment, that person is liable to: a fine ranging from; $600 to 15,000 (for natural person); $2,000 to 100,000 (for a legal person). For the rest of Canada, child-directed food marketing is self-regulated using the Canadian Children’s Food and Beverage Advertising Initiative by Advertising Standards Canada through The Broadcast Code for Advertising to Children. * **UK:** UK CAP rules have been reviewed so that online marketing targeted at under-16s is prohibited. This means that HFSS product ads are not permitted to appear in media that is specifically targeted at under-16s (for example, a children’s magazine or on a website aimed at children); or where under-16s make up a significant proportion (more than 25%) of the audience (for example, advertorial content with an influencer that might have broad appeal but also a significant child audience). (71) * **London UK:** On 25 February 2019, the Mayor of London, introduced restrictions on the advertising of unhealthy food across the entire Transport for London (TfL) public transport network, as part of his work to help tackle childhood obesity in London. The policy specifies that food and non-alcoholic drinks high in fat, salt and sugar (according to the UK Nutrient Profiling Model, are not permitted to be advertised on TfL-controlled buses, underground and over ground train networks, taxis, river services, trams and other transport systems. Food and drink brands, restaurants, takeaways and ordering services are required to promote their healthier food and drink instead of just advertising their brand. Advertisements for food and non-alcoholic drink products that are high in fat, salt, sugar may be considered for an exception by TfL if the advertiser can demonstrate, with appropriate evidence, that the product does not contribute to child obesity. |

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| **3 FOOD PROMOTION:** There is a comprehensive policy implemented by the government to reduce the impact (exposure and power) of the promotion of unhealthy foods to children (<16years) across all media |
| PROMO3: **Effective policies are implemented by the government to ensure that unhealthy foods are not commercially promoted to children in settings where children gather (e.g. preschools, schools, sport and cultural events)** |
| **Evidence of implementation:**   * There are no government regulations in place to restrict unhealthy food marketing to children in children’s settings. The Government stimulated a review of the Advertising Standards Authority Code on Advertising to Children and Children’s Code for Advertising Food as described in PROMO1. Changes to Children and Young People’s Advertising Code in 2017 now restrict advertising of occasional food in locations where children gather, including schools and early childhood education services (72). * The Government response to the Food Industry Taskforce on addressing factors contributing to obesity prioritised the recommendation that industries reduce unhealthy food and beverage outdoor advertising within 300m of primary and intermediate school gates (28). The time-frame and implementation have not yet been determined (73).   **International best practice examples (benchmarks)**   * **Chile**: In 2012, the Chilean government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606) (58). In June 2015, the Chilean authority approved the regulatory norms required for the law’s implementation (Diario Official No 41.193). The regulatory norms define limits for calories, saturated fat, sugar and sodium content considered ‘high’ in foods and beverages. The regulatory norms define limits for calories (275 cal. /100g or 70 cal. /100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered ‘high’ in foods and beverages. The law restricts advertising directed to children under the age of 14 of foods in the ‘high in’ category on school grounds, including preschools, primary and secondary schools. Promotional strategies and incentives, such as cartoons, animations, and toys that could attract the attention of children are included in the ban. The regulation took effect 1 July 2016 (67). The percentage of food and beverage products that targeted children decreased from 36% before implementation of the law to 21% after implementation. The percentage of “high-in” packages that used at least one child-directed marketing strategy decreased from 43% before implementation to 15% after implementation (69,70). * **Spain**: In 2011 the Spanish Parliament approved a Law on Nutrition and Food Safety (Ley 17/2011), which stated that kindergartens and schools should be free from all advertising. Criteria for the authorisation of food promotion campaigns, nutritional education and promotion of sports or physical activity campaigns were developed jointly by the Spanish Agency for Consumer Affairs, Food Safety and Nutrition (AECOSAN) and the Regional Health Authorities and implemented in July 2015. AECOSAN and the Spanish Regional Education and Health Administrations monitor the enforcement of the law (67). * **Hungary**: Based on Section 8 of Act XLVIII on Basic Requirements and Certain Restrictions of Commercial Advertising Activities (2008), Hungary prohibits all advertising directed at children under 18 in child welfare and child protection institutes, kindergartens, elementary schools and their dormitories. Health promotion and prevention activities in schools may only involve external organizations and consultants who are recommended by the National Institute for Health Development according to Section 128 (7) of the Ministerial Decree 20/2012 (VIII.31.) on the Operation of Public Education Institutions and the Use of Names of Public Education Institutions (74). |

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| 4 FOOD PRICES**:** Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices |
| PRICES1**: Taxes on healthy foods are minimised to encourage healthy food choices where possible (e.g. low or no sales tax, excise, value-added or import duties on fruit and vegetables)** |
| **Evidence of implementation**   * Goods and services tax (GST) applies equally to all foods inNZ**.** There isno reduction of taxes on healthy foods in NZ, and it was never actively considered by the government due to complexity and potential revenue shortfall. The current government policy is not in favour of introducing exemptions. There has been no change since 2013.   **International best practice examples (benchmarks)**   * **Australia**: Goods and services tax (GST) exemption exists for basic foods (including fresh fruits and vegetables) (75). * **Tonga**: In 2013, as part of a broader package of fiscal measures, import duties were lowered from 20% to 5% for imported fresh, tinned or frozen fish in order to increase affordability and promote healthier diets (76). * **Fiji**: To promote fruit and vegetable consumption, Fiji has removed the excise duty on imported fruits, vegetables and legumes. It has also decreased the import tax for most varieties from the original 32% to 5% (exceptions: 32% remains on tomatoes, cucumbers, potatoes, squash, pumpkin and 15% remains on coconuts, pineapples, guavas, mangosteens) and removed it for garlic and onions (76). * **Poland**: In Poland, the basic rate of tax on goods and services is 22%, while the rate is lower (7%) for goods related to farming and forestry and even lower (3%) for unprocessed and minimally processed food products (77). |

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| **4 FOOD PRICES:** Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices |
| PRICES2**: Taxes on unhealthy foods (e.g. sugar-sweetened beverages, foods high in nutrients of concern) are in place to discourage unhealthy food choices where possible, and these taxes are reinvested to improve population health** |
| **Evidence of implementation**   * There is no increase in taxes on unhealthy foods in NZ. The current government policy is not in favour of introducing taxes on specific foods. This situation has not changed since 2014. The possibility of a sugar tax was ruled out by the government in 2019 (78). However, in Oct 2019 the Associate Minister of Health stated that sugar taxes and warning labels should be considered to turn the tide on diabetes (79). * In August 2017 the New Zealand Beverage Guidance Panel (NZBGP) presented a sugary drink tax policy brief for New Zealand including a 10,000-strong petition, however, this was declined by the 2017 government (80). * A review report of sugar taxes in New Zealand was completed by the New Zealand Institute of Economic Research for the Ministry of Health in 2017. After reviewing 47 peer-reviewed studies and working papers it found that the evidence of sugar taxes improving health was considered weak and the evidence remains inconclusive. These conclusions were then passed onto the MoH (81).   **International best practice examples (benchmarks)**   * **Mexico**: In December 2013, the Mexican legislature passed two new taxes as part of the national strategy for the prevention of overweight, obesity and diabetes. An excise duty of 1 peso ($0.80) per litre applies to sugary drinks. Sugary drinks are defined under the new law as all drinks with added sugar, excluding kinds of milk or yoghurts. This is expected to increase the price of sugary drinks by around 10%. An ad valorem excise duty of 8% applies to foods with high caloric density, defined as equal to or more than 275 calories per 100 grams. The food product categories that are affected by the tax include chips and snacks; confectionary; chocolate and cacao-based products; puddings; peanut and hazelnut butters. The taxes entered into force on 1 January 2014. The aim is for the revenue of taxes to be reinvested in population health, namely providing safe drinking water in schools, but there is no evidence (yet) that this is the case as the taxes are not earmarked (76,82). * **Hungary**: A ‘public health tax’ adopted in 2012 is applied on the salt, sugar and caffeine content of various categories of ready-to-eat foods, including soft drinks (both sugar- and artificially sweetened), energy drinks and pre-packaged sugar-sweetened products. The tax is applied at varying rates. Soft drinks, for example, are taxed at $0.24 per litre and other sweetened products at $0.47/litre. The tax also applies to products high in salt, including salty snacks with >1g salt/100g, condiments with >5g salt/100g and flavourings >15g salt/100g (71,77). * **French Polynesia**: Various food and beverage taxes have been in place since 2002 to discourage consumption and raise revenue (e.g. domestic excise duty on sweetened drinks and beer; import tax on sweetened drinks, beer and confectionery; tax on ice cream). Between 2002 and 2006, tax revenues went to a preventive health fund; from 2006, 80% has been allocated to the general budget and earmarked for health. The tax is 40 CFP (around $0.44) per litre on domestically-produced sweet drinks, and 60 CFP (around $0.68) per litre on imported sweet drinks (76). * **UK**: In April 2018 the UK government’s Soft Drinks Industry Levy (SDIL) came into force (as outlined in the Finance Act 2017). The Soft Drink Industry Levy applies to any pre-packaged soft drink with added sugar, containing at least 5g of total sugars per 100mL of prepared drink. Soft drinks that have a total sugar content of more than 5g and less than 8g per 100mL are taxed 0.18 British pounds ($0.25) per litre and drinks that have a total sugar content of 8g or more per 100mL are taxed 0.24 British pounds ($0.34) per litre. Milk-based drinks, milk substitute drinks, pure fruit juices, or any other drinks with no added sugar, alcohol substitute drinks, and soft drinks of a specified description which are for use for medicinal or other specified purposes are exempt from the levy (76). The levy applies to soft drinks produced and packaged in the UK and soft drinks imported into the UK. Manufacturers had two years to prepare ahead of this tax coming into effect and over 50% of them acted to cut sugar in their products during that period. It was forecasted that, the tax would bring in £520 million in its first year of operation, but this was revised down to £275 million as a result of company efforts to remove sugar from their products (84,85). Data from the first full year of the tax is not yet available, but receipts from April to October 2018 totalled £154 million. It was confirmed that the Department for Education would receive the full £1 billion funding that had originally been expected from the sugar tax in this Parliament. For drinks subject to the SDIL, the average sugar content decreased by 28.8% between 2015 and 2018. The sugar sold in soft drinks subject to SDIL has decreased by 21.6% (8). * **Qatar:** In 2018, the Government of Qatar introduced Law No. (25) the ‘Qatar Excise Tax Law’ that came into effect on 1 January 2019. The Qatar Excise Tax Law introduced a 50% ad valorem tax on carbonated waters with added sugar, sweeteners or flavours, as well as concentrates, powders, gels or extracts intended to be made into a carbonated beverage. A tax rate of 100% is applied to beverages sold as energy drinks that contain stimulant substances (e.g. caffeine, taurine, ginseng, guarana). Carbonated non-flavoured waters, coffee and tea are excluded from the excise tax. The excise tax applies to all imported, produced or stockpiled aerated beverages (except unflavoured aerated water) and energy drinks (31). * **South Africa:** In December 2017, the South African government passed the Rates and Monetary Amounts and Amendment of Revenue Laws Act 2017 - Act No. 14 which introduced a Sugary Beverages Levy. The Levy is fixed at 2.1 cents ($0.17) per gram of sugar content in a sugary beverage that exceeds 4g per 100mL. The first 4g of sugar content in sugary beverages are not subject to Levy. Sugary beverages include mineral waters and aerated waters, containing added sugar or other sweeteners or flavours, and other non-alcoholic beverages (excluding fruit or vegetable juices) (31). |

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| **4 FOOD PRICES:** Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices |
| PRICES3**: The intent of existing subsidies on foods, including infrastructure funding support (e.g. research and development, supporting markets or transport systems), is to favour healthy rather than unhealthy foods** |
| **Evidence of implementation**   * Subsidies on foods in New Zealand are quite small compared to other countries (e.g. agricultural subsidies in the US). * Councils can approve and encourage applications for farmers markets on Council owned land, remove any stall fees and charges at farmers markets, regional councils can ensure appropriate transport links are available to markets and other fruit and vegetable outlets, cycle pathways, lighting etc. for night markets (personal communication, Public Health Service Tauranga, 2017). Councils usually support farmers markets by land allocation and bus routes. Support for farmers markets is quite common by NZ Councils.     **International best practice examples (benchmarks)**   * **Singapore**: The government, through the Health Promotion Board (HPB) increases the availability and use of healthier ingredients through the ‘Healthier Ingredient Scheme’ (formerly part of the ‘Healthier Hawker’ programme, launched in 2011), which provides in the first instance transitional support to oil manufacturers and importers to help them increase the sale of healthier oils to the food service industry (86). The Healthier Ingredient Subsidy Scheme offers a subsidy to suppliers stocking healthier items. Cooking oil is the first ingredient under the scheme, which subsidises oils with a saturated fat level of 35 % or lower. |

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| **4 FOOD PRICES:** Food pricing policies (e.g., taxes and subsidies) are aligned with health outcomes by helping to make the healthy eating choices the easier, cheaper choices |
| PRICES4**: The government ensures that food-related income support programs are for healthy foods** |
| **Evidence of implementation**   * The Ministry of Social Development, through Work and Income, can provide recoverable or non-recoverable financial assistance to people to meet an immediate need for essential items such as food, health costs, power and other costs. These payments are available to any person provided they meet the income and asset test, and they are unable to meet the cost from any other source. A Disability Allowance may be available for someone on a limited income for additional, on-going costs of therapeutic value. This can include special foods which are beyond the normal costs of healthy eating, for example, lactose-free diet, coeliac disease etc. (87). * In 2019 a trial was held with My Food Bag and the Ministry of Social Development to supply bargain box meals to households requiring emergency food grants instead of monies and providing up to 1000 kits to those families who choose this option over the grants. Results are expected by the end of 2020 (88). * The NZ Government joined Kick-start breakfast as a supporter in May 2013, allowing the programme to extend from two to five days and committing $9.5 million over 5 years to fund half the cost of the programme, as part of Government's commitment to optimal outcomes for children and young people (89). From term 1 in 2014, all schools were eligible to join. Fonterra and Sanitarium provide the product. The school community provides plates etc., location, food storage facilities and volunteers. Statistics are published every term on the website. Currently, over 30,000 children participate throughout New Zealand in over 1,000 schools (90). * The Government funds the Fruit in Schools programme, which all decile one and two primary and intermediate schools can opt into. At the end of term 4 2019, 551 schools and 121,870 students and staff were receiving produce, (either fruit or vegetables) each day during the school term starting the second week of each term. The programme is funded by MoH and managed by United Fresh. The annual cost of FIS is approximately $8,124,000 million which covers both the management of the initiative and the supply of produce. An independent evaluation, July 2018, found FIS highly was valued by principals and aligned with international evidence on how to improve nutrition and reduce obesity in children (personal communication, MoH, 2020). * On the 29th August 2019, the Prime Minister announced the free Healthy School Lunches programme for year 1 to 8 students in up to 30 schools in Bay of Plenty/Waiariki and Hawkes Bay/Tairawhiti to begin in Term 1, 2020 (91). Up to 21,000 students in around 120 schools will eventually benefit by 2021. Minimum standards, including around health, nutrition, dietary and religious requirements, will be set by Government as the principal sponsor. Lunches will be required to be healthy and nutritious, based on the Ministry of Health’s “Healthy Food and Drink Guidance – Schools”(92). This includes offering foods from the four main food groups (vegetables and fruit, breads and cereals, milk and milk products, and lean meat, chicken, seafood, eggs, legumes, nuts and seeds. District Health Boards (DHBs) have offered their support and some schools have also taken guidance from nutritionists. The evaluation framework is currently being finalised and will commence with the start of the implementation. The evaluation will include gathering feedback from schools and suppliers on the operation and delivery of the programme (personal communication, MoE, 2020).   **International best practice examples (benchmarks)**   * **UK**: The British Healthy Start programme provides pregnant women and/or families with children under the age of four with weekly vouchers to spend on foods including milk, plain yoghurt, and fresh and frozen fruit and vegetables. Participants or their family must be receiving income support/jobseekers’ allowance or child tax credits. Pregnant women under the age of 18 can also apply. Full national implementation of the programme began in 2006 (76). * **US**: In 2012, the USDA piloted a ‘Healthy Incentives Pilot’ as part of the Supplemental Nutrition Assistance Program (SNAP, formerly ‘food stamps’). Participants received an incentive of 30 cents per US$ spent on targeted fruit and vegetables (transferred back onto their SNAP card). The Pilot included 7500 individuals (76). In New York City and Philadelphia, ‘Health Bucks’ are distributed to farmers markets. When customers use income support (e.g. Food Stamps) to purchase food at farmers markets, they receive one Health Buck worth 2USD for each 5USD spent, which can then be sued to purchase fresh fruit and vegetable products at a farmers market (76). In Philadelphia, the programme has been expanded to other retail settings like supermarkets and corner stores. * **US**: In 2009, the U.S. Department of Agriculture's implemented revisions to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to improve the composition and quantities of WIC-provided foods from a health perspective. The revisions include: Increase the dollar amount for purchases of fruits and vegetables, expand whole-grain options, allow for yoghurt as a partial milk substitute, allow parents of older infants to buy fresh produce instead of jarred infant food and give states and local WIC agencies more flexibility in meeting the nutritional and cultural needs of WIC participants (76). |

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| 5 FOOD PROVISION**:** The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies |
| PROV1**: The government ensures that there are clear, consistent policies (including nutrition standards) implemented in schools and early childhood education services for food service activities (canteens, food at events, fundraising, promotions, vending machines etc.) to provide and promote healthy food choices** |
| **Evidence of implementation**   * The National Administration Guidelines (NAG) for school administration set out statements of desirable principles of conduct or administration for specified personnel or bodies. The NAG 5 (93) states that each board of trustees is required to promote healthy food and nutrition for all students. There is no minimum nutritional standard for school canteens in New Zealand. The responsibility for complying with that requirement rests with the board of trustees, not with ERO or the Ministry of Education. ERO does not have any powers other than its ability to publish reports, and any powers of ‘enforcement’ would be through the Ministry. * From June 2008 to February 2009 there was an additional clause that schools should only sell healthy food on their premises, removed by the National Government. * The Food and Beverage Classification System was updated in March 2016 (94). It is more stringent than the initial system with the only subcategories of beverages being plain water and milk. It includes a recommendation that ‘The MoH and Ministry of Education recommend schools be plain water and reduced-fat milk only, and early learning services be plain water and plain milk only as part of the national Childhood Obesity Plan (95) with information being provided to all schools by the Ministry of Education. The Ministry of Education promoting health lifestyles web page has resources for schools including a template for formulating a ‘water-only’ policy, link to healthy confident kids guidelines and the food and beverage classification system (96). A resource tool kit surrounding the Food and Beverage Classification system is set to replace the Healthy Confident Kids resource in 2020 (personal communication, MoH, 2020). There are guidelines on the Ministry of Education’s website for schools to develop policies related to the food environment in their school (97). * A survey by the University of Auckland (School-FERST) in 2016 found that of the 819 participating schools (33% response rate), 38.5% of primary and 44.8% of secondary schools reported having a written school food and nutrition policy. Policies received from 145 schools were analysed. Overall scores for the strength and comprehensiveness of the policies were very low across all school types. Two-thirds of primary and intermediate schools and 23% of secondary and composite schools reported being ‘milk and water only’ (98). * The Early Childhood Education (ECE) Services Regulations 2008 mention: Regulation 46 Health and safety practices standard: general is the standard that requires every licensed service provider to whom this regulation applies to take all reasonable steps to promote the good health and safety of children enrolled in the service (99). * The Children’s Commissioner published Guidelines for School Food Programmes: Best Practice Guidance For Your School (February 2014) (100). Principles: school food programmes should be child-centred, inclusive, and nutritionally sound, take a whole-school approach, and be sustainable and evidence-based. The guidelines include examples of successful school food programmes in appendix 1 of that document. * The Health Promotion Agency has supporting resources specifically designed for schools promoting water as the best drink option. The Ministry of Education worked in partnership with the Ministry of Health, Health Promoting Schools and subject associations to explore, update and socialise the guidelines. Project Energize supports schools and ECEs with polices and the provision of healthy food (personal communication, MoE, 2017).     **International best practice examples (benchmarks)**   * **Australia**: There are no national mandatory standards. However, six states and territories have implemented mandatory standards, which are either based on the national voluntary guidelines or nutrient and food criteria defined by the state: Australian Capital Territory (2015), New South Wales (2011), Northern Territory (2009), Queensland (2007), South Australia (2008), and Western Australia (2014). All of these states and territories identify 'red category' foods, which are either completely banned in schools or heavily restricted (e.g. offered no more than one or two times per term) (101). The New South Wales (NSW) policy for school canteens prohibits availability of red foods, high in saturated fats, sugars, or sodium. Foods provided in school canteens should be at least 50% green foods to ensure that canteens do not increase the number of ‘amber’ foods. Green foods include low-fat carbohydrates, fruits and vegetables, and lean meat as well as small portions of pure fruit juice. Also, Queensland’s Smart Choices school nutrition standards ensure that ‘red’ foods and drinks are eliminated across the whole school environment. * **Chile**: In 2012, the Chilean government approved a Law of Nutritional Composition of Food and Advertising (Ley 20, 606) (58). In June 2015, the Chilean authority approved the regulatory norms required for the law’s implementation (Diario Official No 41.193). The regulatory norms define limits for calories, saturated fat, sugar and sodium content considered ‘high’ in foods and beverages. The regulatory norms define limits for calories (275 calories/100g or 70 calories/100mL), saturated fat (4g/100g or 3g/100mL), sugar (10g/100g or 5g/100mL) and sodium (400mg/100g or 100mg/100mL) content considered ‘high’ in foods and beverages. The law prohibits the sale of foods in the ‘high in’ category in schools. These were scheduled to take effect 1 July 2016 (101). * **Jamaica:** In November 2018, the Ministry of Health published mandatory nutrient guidelines for beverages sold/served within all public educational institutions for children (i.e. early childhood, primary level and secondary level). The guidelines prohibit sweetened beverages that exceed a maximum sugar concentration of: 6g/100ml (effective 1 January 2019); 5g/100ml (effective 1 January 2020); 4g/100ml (effective 1 January 2021); and 2.5g/100ml (effective 1 January 2023). All unsweetened beverages are permitted. The guidelines also caution against beverages containing >10mg/serve of caffeine, discourage the use of artificial sweeteners and recommend beverage portions sold/served of <12 ounces (not including water) (31). * **Brazil**: The national school feeding programme (102) places great emphasis on the availability of fresh, traditional and minimally processed foods. It mandates a weekly minimum of fruits and vegetables regulates sodium content and restricts the availability of sweets in school meals. A school food procurement law (103), approved in 2001, limits the number of processed foods purchased by schools to 30% and bans the procurement of drinks with low nutritional value, such as sugary drinks. The law requires schools to buy locally grown or manufactured products, supporting small farmers and stimulating the local economy. Resolution no 38 (16 July 2009) sets food- and nutrition-based standards for the foods available in the national school meal programme (Law 11.947/2009).   Article 17 prohibits drinks of low nutritional value (e.g. soda), canned meats, confectionary and processed foods with a sodium and saturated fat content higher than a specified threshold. |

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| **5 FOOD PROVISION:** The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies |
| PROV2**: The government ensures that there are clear, consistent policies in other public sector settings for food service activities (canteens, food at events, fundraising, promotions, vending machines, public procurement standards etc.) to provide and promote healthy food choices** |
| **Evidence of implementation**   * A ‘NationalHealthy Food and Drink Policy’ was developed in 2016 by the DHB Healthy Food and Drink Environment Network.  The policy was reviewed in 2018/19 resulting in a second edition to make the policy more practical and easier to follow while maintaining its alignment to the Ministry of Health Eating and Activity Guidelines (104). The resulting changes were relatively small and mostly specific to the nutrient criteria. By the end of 2019, six DHBs had adopted the national policy for DHB, one had adopted the national policy for organisations, six had their own policy, supported by or aligning with the national policy and seven were working towards national policy with plans to adopt in early 2020. (personal communication. A similar policy appropriate for adoption by other organisations and workplaces has also been developed – Healthy Food and Drink Policy for Organisations (105). * As of 2018, the Heart Foundation has supported the Ministry of Health with the implementation of the Food and Drink Policy across government agencies. A toolbox of fourteen supporting resources has been developed in partnership with other members of the national working group. There has also been engagement with seven government agencies. Six agencies have taken steps to implement the Food and Drink policy within their organisation (personal communication, Heart Foundation, 2020) * Childhood Obesity Plan: DHB Healthy food policies. All DHBs made a commitment to remove sugar-sweetened beverages from their campuses by Jan 2016 (106). * Healthy Families South and ARPHS have worked with AC leisure centres South to make Bronze guidelines in their cafeterias considered a minimum standard. This results in an increase in healthy food options, limits the amounts of deep-fried foods and offer only low – no sugar sweetened beverages (personal communication, HAT, 2020). * Many of the DHBs commented that they had an implementation group, and some were undertaking audits of the food environment within DHB food outlets, including vending machines. Some DHBs were jointly implementing the policy across several DHBs. * The Department of Corrections states that meals provided to prisoners are in line with the Eating and Activity Guidelines set by the MoH. The Department’s prison operations manual sets out performance standards surrounding catering, menus and responsibilities relating to prisoners with health issues, such as diabetes (personal communication, Department of Corrections, 2017). Prison Operations Manual (107): F.01.Res.01 Catering. Performance standard 1: Each prisoner is provided with a diet based on Ministry of Health (MoH) Food and Nutrition Guidelines. * All rest homes and aged residential care facilities are certified and audited to ensure they provide safe, appropriate care for their residents and meet the standards set out in the Health and Disability Services (Safety) Act 2001 (108). Health and Disability Services Standards 2008. NZS 8134.1.3.13 (109) A consumer’s individual food, fluids and nutritional needs are met where this service is a component of service delivery. Overall, there are 50 standards and 101 criteria within the standards that can be used for the audits. It is stated that food, fluid and nutritional needs of consumers are provided in line with recognized nutritional guidelines appropriate for the consumer group. * There are a few websites that provide information on healthy eating for the public. The Health Promotion Agency launched the MyFamily platform in 2014/15 to support and assist families to make healthy food choices, supports sector with tools and resources to promote water (110). HPA launched Healthykids.org.nz in 2018. The website was developed following the publication of the Active Play Guidelines in 2017, which also included advice on sleep. This purpose of this website is to provide fun, free and low cost ideas to help families eat well, move more and sleep well. * Toi Te Ora has a website: ([www.hapuhauora.health.nz](http://www.hapuhauora.health.nz)) (111) to provide ideas for making the healthy choice the easy choice at the marae and in the home.   **International best practice examples (benchmarks)**.   * **Brazil:** In July 2016, the Brazilian Ministry of Health implemented procurement guidelines for any food served or sold within the Ministry’s facilities and in its entities (Ordinance No 1.274 of 7 July 2016). The guidelines also apply to independent companies contracted to provide food services on the premises of the Ministry and its entities. The Ordinance aims to address overweight, obesity and non-communicable diseases and is based on the right to adequate food. The guidelines are based on the Food Guide for the Brazilian Population, and state that only unprocessed and minimally processed food may be procured. The purchase of processed food should be minimised, and food from organic and agroecological production preferred whenever possible. Ultra-processed food may only be used in exceptional cases if it is used in meals which are prepared from mostly unprocessed or minimally processed food. Ultra-processed food and beverages that are not used for meal preparation may not be purchased (e.g. soft drinks, sugar-sweetened fruit juices, industrialised sweets). Ultra-processed food is defined by the Ordinance as food which is mainly produced from substances extracted from whole food and/or food components derived from materials synthesised from organic matter, and which contains ≥1mg of sodium per 1kcal, ≥10% of total energy from free sugars, ≥30% of total energy from total fat, ≥10% of total energy from saturated fat and ≥1% of total energy from trans-fat (in alignment with PAHO’s Nutrient Profile Model). The Ordinance also prohibits the advertisement and sales promotions of ultra-processed food in the Ministry of Health and its entities (31). * **Bermuda**: In 2008, the Government Vending Machine Policy was implemented in government offices and facilities to ensure access to healthy snacks and beverages for staff. The policy requires that all food and beverages in vending machines on government premises meet specific criteria based on levels of total fat, saturated fat, *trans* fat, sodium and sugar. Criteria exclude nuts & 100% fruit juices (101). * **Ireland:** The HSE Vending Policy 2019 replaces the 2014 Healthier Vending Policy and applies to all vending machines that stock cold soft drinks, confectionery and snacks on HSE premises & premises funded by the HSE. Sugar-sweetened beverages will not be stocked in vending machines, 50% of beverages stocked will be still water and the remaining beverages stocked will include non-sugar sweetened beverages e.g. diet drinks, juices, flavoured and sparkling water. Snacks containing more than 200 calories per packet will not be stocked in machines. An exception to this is 3 packets of dried fruits, nuts or seeds (plain and unsalted). Products will be clearly labelled with the number of calories per product related fields. * **UK**: The UK Government Buying Standard for Food and Catering Services (GBSF of 2014, updated March 2015) by the Department of Environment, Food and Rural Affairs, sets out standards for the public sector when buying food and catering services. It is supported by the Plan for Public Procurement: Food and Catering Services (2014), which includes a toolkit consistent of the mandatory GBSF, a balanced scorecard, an e-marketplace, case studies and access to centralised framework contacts to improve and facilitate procurement in the public sector. The nutrition requirements must be followed by schools, hospitals, care homes, communities and the armed forces. To improve diets, the GBSF sets maximum levels for sugar in cereals and generally for saturated fat and salt, in addition to the minimum content of fibre in cereals and fruit in desserts. Meal deals have to include vegetables and fruit as dessert and menus fish on a regular basis (74). |

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| **5 FOOD PROVISION:** The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies |
| PROV3**: The government ensures that there are good support and training systems to help schools and other public sector organisations and their caterers meet the healthy food service policies and guidelines** |
| **Evidence of implementation**  Support and training systems for schools and early childhood education (ECE) services   * The Ministry of Education has developed resources (112) in consultation with the MoH to assist schools and ECE services in their focus on this area: 'Food and Nutrition for Healthy Confident Kids’ guidelines (2007) (113) and ‘Food and Nutrition for Healthy Confident Kids’ toolkit containing some resources to support the guidelines. These guidelines are supported by the MoH’s food and beverage classification system. These will be replaced with resources as part of Healthy Active Learning (personal communication, MoH, 2020). * Fuelled4Life is the voluntary Food and Beverage Classification System managed by the Heart Foundation on contract from MoH and is a collaborative initiative that involves the education, health and food industry sectors working together to make it easier to have healthier food in schools and early childhood education (ECE) services in NZ (114,115). It was retired on 27 January 2020 and the Heart Foundation will continue to support food suppliers, schools and ECEs with Fresh Made, a website featuring resources, recipes, menus and blogs. The Fresh Made team can support food suppliers, school canteens or boarding school caterers with a menu assessment service (116). FBCS has been used as criteria for menu and recipe assessment. A total of eleven companies met the criteria and signed up with Fresh Made by the end of 2019, supplying food into 188 schools, early learning services, residential halls and out-of-school care centres across the country (personal communication, Heart Foundation, 2020). * Along with tools and resources, the nutrient criteria continue to underpin the FBCS to identify healthier choices according to nutrient profile (‘everyday’ and ‘sometimes’), when selecting foods and drinks for catered meals, tuck shops and canteens, vending machines, sponsorship deals, fundraisers and other special events. Customised support for canteens is provided by the Heart Foundation regional staff who works directly with schools. Fuelled4life focused efforts on schools while continuing to support early learning services. Parents of children aged 0-5 have support for healthier eating through existing communication channels already developed for Fuelled4life such as the website and the Facebook page. 1792 schools and 2676 early learning services are currently signed up to Fuelled4life, which is 67.7% of schools and 56.9% of early learning services. Stronger emphasis has been placed on freshly made foods nutritional support provided to external school food suppliers and boarding school caterers. Ordering school lunches online is increasingly common with many schools now using online lunch programmes provided by external food suppliers. Fuelled4life supports food suppliers to make these fresh-made foods healthier by providing individualized nutritional support and advice. FBCS has been used as criteria for menu and recipe assessment. A total of six companies met the criteria and signed up with Fuelled4life by the end of 2016, supplying food into 210 schools in Auckland, Wellington, Christchurch, Waikato, Hawke’s Bay and Taumarunui (personal communication, Heart Foundation, 2017). * There are guidelines on the Ministry of Education’s website for schools to develop policies relating to the food environment in their school (117). * The Healthy Heart Award is an established, free programme coordinated by the Heart Foundation and partially funded by the MoH. It assists ECE services to create an environment promoting healthy eating and physical activity to under 5s and their families. There are three award levels (118). The Heart Foundation has several other resources available for schools and ECE services related to ECE menu development and school canteen menu development (119). At the end of 2019, there were 818 early learning services participating in the Healthy Heart Award programme (personal communication, Heart Foundation, 2020). * HEART START Toitoi Manawa is a free curriculum-linked programme, that was partially funded by the MoH and offered by the Heart Foundation until 2017. It was offered to all schools across New Zealand. The programme fits with schools existing work and helps build a heart-healthy environment (120). * Food for Thought uses an inquiry-based learning approach to help students (years 5-6) learn how to make healthy food choices (121). Food for Thought is owned by Foodstuffs delivered by Heart Foundation regional staff to low decile schools throughout the country. It is a free nutrition education programme that assists Year 5 and 6 primary school students make healthier food and lifestyle choices. There are nutrition resources, teaching activities and supermarket visits (122). From June to December 2019, the programme reached 2313 children in 94 classrooms (year 5-6) of 40 schools, of which 93% of schools (n=52) were decile 1-4 (personal communication, Heart Foundation, 2020). * HEAT (Healthy Eating Action and Training) is a nutrition training course, a level 3-unit standard qualification in nutrition available for food preparers offered by the Heart Foundation. The programme morphed into a Service IQ delivered nutrition course in which the Heart Foundation completed the teachings until it ended in November 2019 (personal communication, Heart Foundation, 2020). * ARPHS has delivered a Kai culture workshop to AUT ECE students about the importance of healthy kai in the ECE setting and how to achieve implementing a food policy in the settings. ARPHS consider educating the new generation of teachers to be of high importance. Education sessions were held with the Afterschool care programs (Kauri Kids and ECES that are attached to South Auckland leisure centres to review their menus and give guidance on healthy food choices to offer their tamariki and rangatahi (personal communication, ARPHS, 2020). * Health Promoting Schools (HPS) was an approach where the whole school community works together to address the health and wellbeing of students, staff and their community. The initiative was broader than nutrition only (e.g. sun-safe and smoke-free schools, kiwi sport, fruit in schools, 5+ A Day School Competition) and was funded by the MoH. The inquiry-based approach was outcomes-focused and sustainable as it built on what schools already did and integrated the actions and outcomes into schools’ planning and reporting mechanisms. Schools were supported by advisors from public health units, district health boards or local government, who were contracted by the MoH to support HPS. Late last year, the Ministry of Health considered various perspectives on the future of the HPS funding.  This included ways to maximise the impact of the investment and support the Government priorities in child wellbeing. Consequently, the Ministry stopped contracting HPS on 31 December 2019 and reinvested the funding into two main areas: The Healthy Active Learning initiative (Budget 2019), increasing the total funding made available under Budget 2019 and a new integrated co-designed service model(s) for wellbeing in schools that covers the range of health/health promotion services and achieves the best outcomes for children (personal communication, HPS, 2020). Healthy Active Learning (HAL) is a new $47.6 million initiative from the 2019 Wellbeing budget to be delivered in early 2020 with the support of the Ministry of Health and Sport New Zealand; (123). It has three components including new curriculum resources, a health promotion workforce and toolkit and a physical activity workforce (124). * Project Energize delivers the Heart Foundation programme throughout schools and preschools aiming to get kids active and educate them about healthy foods (125). * The Heart Foundation offers flexible support to schools delivering nutrition and physical activity based on the schools identified need. These activities could include policy development, support with food provision, in-class education or professional development for teachers. From June to December 2019, 87 schools were supported by a Heart Foundation Nutrition Advisor (personal communication, Heart Foundation, 2020). * Food Curriculum is a project that supports home economics/food technology teachers to support students with the skills of cooking a meal within their budget, cultural and time constraints. Since 2017, the Heart Foundation and Vegetables.co.nz have worked with teachers to develop resources and tools that are aligned to the New Zealand Curriculum. Following teacher consultation, the Year 8 resources were published in July 2018, followed by the Year 7 resources in September 2019. Teachers throughout New Zealand and from a range of school deciles have been trialling the Year 7 and 8 resources and providing feedback. The project is strongly supported through key education associations – HETTANZ (Home Economics & Technology Teachers Ass), NZAIMS (Assoc Intermediate and Middle Schools) and TENZ (Technology Education). Professional development workshops have been held around the country in 2018 and 2019 to support this work (personal communication, Heart Foundation, 2020).   Support and training systems for other settings   * There are three key workplace health and well-being tools available in New Zealand. WorkWell, Good4work and Wellplace.nz. [WorkWell](https://www.workwell.health.nz/workwell_home) is a free workplace wellbeing initiative available in various regions throughout New Zealand. It is aimed at medium to large workplaces and those wanting to do a more comprehensive wellbeing programme. WorkWell provides advisor support, easy-to-use resources, networking opportunities and recognition through accreditation (126). [Good4Work](https://www.good4work.nz/) is an online workplace wellbeing tool designed for small to medium-sized workplaces and those that are just getting started with workplace wellbeing. It was developed by a partnership of Auckland Regional Public Health Services (ARPHS), Toi Te Ora Public Health Unit, Health Promotion Agency and Ministry of Health Healthy Families New Zealand. Good4Work takes you through a step-by-step process to help you complete actions to change your work environment and culture (127). Finally, [Wellplace.nz](http://www.wellplace.nz/) is a gateway for practical workplace information, ideas and resources to help implement a workplace wellbeing programme. HPA has a Wellplace.nz website (128) with a range of healthy eating resources and links. * In 2019 HPA introduced healthy kai guidelines to support the health and wellbeing of people at work. A range of practical resources have been developed to support organisations in providing healthy kai at work. * ARPHS provides a set of nationally agreed best practice tools for workplace wellbeing with their partners, they plan to have a monitoring and response process for public policies, legislation and workplace issues, a core group of national and regional agencies supporting shared visions and mutual goals, tools and systems to collect data and champions to promote workplace wellbeing (129). * The Ministry of Health has developed a Healthy Food and Drink Policy for Organisations (105) which aligns with the National Healthy Food and Drink Policy for DHBs (DHB Healthy Food and Drink Network). ARPHS are planning to develop some tools and supporting resources to help organisations implement the Healthy Food and Drink Policy for Organisations. * The Heart Foundation has ‘Guidelines for preparing healthier cafeteria food’ and a Hospitality Hub with a lot of information about healthy food service. The Hospitality Hub was funded by the MoH (130). It has been reoriented to support food and nutrition services by the Heart Foundation. * The ANA website has a number of Workplace Health guides produced by District Health Boards (131). Sport Northland has Active Workplace programme which supports workplaces to create healthier environments (132). The focus is on activity and workplaces can choose additional key focus areas like nutrition. * Pacific Heartbeat offers a variety of nutrition courses which caterers could attend. The Pacific community nutrition course is a short course that teaches participants to plan cheap and tasty meals. The Pacific workforce nutrition course is for health professionals and those that support Pacific communities to learn about the benefits of good nutrition. The AUT Certificate in Proficiency in Pacific Nutrition focuses on the relationship between the types of food consumed and the health impact (133). * Tairawhiti DHB - contributes towards a Midland School/Kura Milk and Water only policy survey and assists Schools/Kura with policy development; provides support to Maori Women’s Welfare League to promote ‘ Kapata Kai’ ( Healthy Kai in the homes ); Promotes ‘ Ae to wai ‘ water only and Healthy Kai at our  annual ‘Pa Wars’; works in collaboration with Toi Tangata to promote  ‘He Pi Karere ‘ (Healthy Eating) in Kohanga reo; and promotes community and whanau ‘maara Kai ‘( vegetable gardens)  among rural coastal communities and schools/kura. * Southern Canterbury District Health Board: The WAVE (Wellbeing and Vitality in Education) team enabled ECE, schools and tertiary settings who identified nutrition as a health priority to work in areas such as policy development, promotion of water-only events and policy, ECE and school gardens, ECE and school lunch ideas and curriculum links. The WAVE magazine produced and distributed to all South Canterbury ECE, schools and tertiary providers x4/year included nutrition information amongst other health issues.   **International best practice examples (benchmarks)**   * **Australia**: The Healthy Eating Advisory Service supports settings such as childcare centres, schools, workplaces, health services, food outlets, parks and sporting centres to provide healthy foods and drinks to the public in line with Victorian Government policies and guidelines. The Healthy Eating Advisory Service is delivered by experienced nutritionists and dieticians at Nutrition Australia Victorian Division. The support includes training cooks, chefs, foods service and other key staff, discovering healthier recipes, food ideas and other helpful resources to provide healthier menus and products (134). * **Japan**: In 2005, Basic Law on Shokuiku (‘Shoku’ means diet, ‘iku’ means growth and education) was enacted and it was the first law that regulates one’s diets and eating habits. It involved Cabinet Office as the leading office to plan, formulate and coordinate Shokuiku policy and strategy, in collaboration with other Ministries. The laws included several concepts, which are the promotion of Shokuiku at home, schools or nursery schools and promotion of interaction between farm producers and consumers (135). Dietitians play an important role to implement Shokuiku programs by providing guidance in various settings. In Japan, dietitians are assigned to facilities with mass food service. In a specific setting, such as a school, a Diet and Nutrition Teacher System was established in 2007. The teachers are responsible to supervise school lunch programs, formulate menus and ensure hygiene standards in public elementary schools and junior high schools in accordance with the needs of local communities. They also deal with dietary education issues in collaboration with nutrition experts such as registered dietitians (136). The revised School Lunch Act 2008, included a School Lunch Practice Standard which including reference intake values of energy and nutrients (137). Moreover, it outlined the costs of facilities and manpower (e.g. cooks) to be covered by municipalities so guardians only cover the cost of ingredients (138). |

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| **5 FOOD PROVISION:** The government ensures that there are healthy food service policies implemented in government-funded settings to ensure that food provision encourages healthy food choices, and the government actively encourages and supports private companies to implement similar policies |
| PROV4**: Government actively encourages and supports private companies to provide and promote healthy foods and meals in their workplaces** |
| **Evidence of implementation**   * The Health Promotion Agency (HPA) guide to providing healthier beverage options for workplaces (139) explained how to improve the range of beverages supplied in vending machines, cafeterias and at staff functions in workplaces. They are designed to help gain the support of management and staff to improve the quality of available beverages as part of workplace health, safety and wellness responsibilities. This is not currently available but will be updated in the near future. * The Ministry of Health developed a ‘Healthy Food and Drink Policy for Organisations’ for use by non-DHB, non-health sector organisations which aligns with the National Healthy Food and Drink Policy for DHBs (DHB Healthy Food and Drink Network). The Policy has recently been updated and will be published in 2020 along with a toolkit of supporting resources to help with implementation (personal communication, MoH, 2020) (105). * In New Zealand, some local public health service units promote the workplace health programmes described in PROV3: WorkWell, Good4work and Wellplace.nz. * The Taranaki District Health Board provides support to organisations with DHB contracts to implement the National Healthy Food & Drink Policy through the development of a toolkit, workshops and ongoing support in policy development (when requested from the organisations).   **International best practice examples (benchmarks)**   * **Victoria (Australia**): ‘Healthy choices: healthy eating policy and catering guide for workplaces’ is a guideline for workplaces to support them in providing and promoting healthier foods options to their staff. The guideline is supported by the Healthy Eating Advisory Service that helps private-sector settings to implement such policies. Menu assessments and cook/caterer training are available free of charge to some eligible workplaces (140). * **Singapore**: The National Workplace Health Promotion Programme, launched in Singapore in 2000, is run by the Health Promotion Board. Both private and public institutions are encouraged to improve the w0rkplace environment by providing tools and grants. Grants are awarded to help companies start and sustain health promotion programmes. Tools include a sample Healthy Workplace Nutrition Policy, a sample Healthy Workplace Catering Policy, and a detailed Essential Guide to Workplace Health, setting out ways to transform the workplace into a health-supporting work environment (101). |

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| 6 FOOD RETAIL**:** The government has the power to implement policies and programs to support the availability of healthy foods and limit the availability of unhealthy foods in communities (outlet density and locations) and in-store (product placement) |
| RETAIL1**: Zoning laws and policies are robust enough and used, where needed, by local governments to place limits on the density or placement of quick-serve restaurants or other outlets selling mainly unhealthy foods in communities** |
| **Evidence of implementation**   * Permitted activities for each zone are set by the District Council through the District plans. Council does not regulate the type of commercial activity unless it is impacted by other regulations such as the Hazardous Substances legislation. Council does have the ability to regulate other activities using bylaws/policies such as the Trading in Public Places Bylaw. This is primarily to regulate temporary mobile vendors. Historically, the public health role of the Councils focused on sanitation and food safety and the control of infectious diseases by having a healthy physical environment. However, the Health Act 1956 imposes on Councils a general duty to improve, promote and protect public health. Councils’ bylaw making power is covered in the Local Government Act 2002. A territorial authority may make bylaws for its district for 1 or more of the following purposes: (b) protecting, promoting, and maintaining public health and safety. * No NZ Council has specific rules for regulating the number and location of food outlets. If a Council was to develop a policy on this, it would need to undertake a process using the Special Consultative Procedure under the Local Government Act 2002. Alternatively, there could be new ‘takeaway’ rules developed to be given effect through the District Plan which would require a Plan Change Process under the Resource Management Act 1991. Both involve considerable research and consultation. The real difference between the 2 processes is that the Council’s decisions on Plan Changes can be appealed to the Environment Court which can drag the process out considerably. Policy decisions developed under the Local Government Act can’t be appealed but the process can be challenged to a Judicial Review to see if the process followed was sufficiently robust. * An ANA Evidence Snapshot ‘Promoting Healthy Eating at the Local Government Level’ was published in March 2016 (141).   **International best practice examples (benchmarks)**   * **South Korea**: In 2010 the Special Act on Children’s Dietary Life Safety Management established the creation of ‘Green Food Zones’ around schools, banning the sale of foods (fast food and soda) deemed unhealthy by the Food and Drug Administration of Korea within 200 metres of schools (142,143) In 2016, Green Food Zones existed at over 10000 schools. * **Dublin (Ireland):** Fast-food takeaways will be banned from opening within 250 metres of schools, Dublin city councillors have ruled. The measure to enforce ‘no-fry zones’ will be included in a draft version of the council’s six-year development plan. City planners will be obliged to refuse planning permission to fast food businesses if the move is formally adopted after public consultation (144). * **US**: In Detroit, the zoning code prohibits the building of fast-food restaurants within 500 ft. of all elementary, junior and senior high schools (67). * **UK**: Around 15 local authorities have developed ‘supplementary planning documents’ on the development of hot food takeaways. The policies typically exclude hot food takeaways from a 400m zone around the target location (e.g. primary schools). For example, Barking and Dagenham’s Local Borough Council, London, adopted a policy in 2010 restricting the clustering of hot food takeaways and banning them entirely from 400m exclusion zones around schools. In 2009, the Local Borough Council of Waltham Forest, London developed a planning policy in 2009 restricting the development of hot food takeaways in local centres and excluding them completely from areas within 10min walks from schools, parks or other youth centres. St Helens Council adopted a planning document in 2011 and Halton in 2012 (67). |

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| **6 FOOD RETAIL:** The government has the power to implement policies and programs to support the availability of healthy foods and limit the availability of unhealthy foods in communities (outlet density and locations) and in-store (product placement). |
| RETAIL2**: Zoning laws and policies are robust enough and are being used, where needed, by local governments to encourage the availability of outlets selling fresh fruit and vegetables.** |
| **Evidence of implementation**   * There are no zoning laws in existence to encourage the availability of outlets selling fresh fruit and vegetables in NZ.   **International best practice examples (benchmarks)**   * **US**: In February 2014 the US Congress formally established the Healthy Food Financing Initiative (following a three-year pilot) which provides grants to states to provide financial and/or other types of assistance to attract healthier retail outlets to underserved areas. The pilot distributed over 140 million USD in grants to states to provide financial and other types of assistance to attract healthier retail outlets in underserved areas. To date, 23 US states have implemented financing initiatives (67). For example, the New Jersey Food Access Initiative provides affordable loans and grants for costs associated with building new supermarkets, expanding existing facilities, and purchasing and installing new equipment for supermarkets offering a full selection of unprepared, unprocessed, healthy foods in under-served areas; the initiative targets both for-profit and not-for-profit organisations and food cooperatives. * **New York**: The ‘Green Cart Permit’ was developed with reduced restrictions on zoning requirements to increase the availability of fresh fruits and vegetables in designated, underserved neighbourhoods (67). In 2008 New York City made 1000 licences for green carts available to street vendors who exclusively sell fresh fruit and vegetables in neighbourhoods with limited access to healthy foods (67). In addition, in 2009, New York City established the food retail expansion to support health program of New York City (FRESH). Under the programme, financial and zoning incentives are offered to promote neighbourhood grocery stores offering fresh meat, fruit and vegetables in under-served communities. The financial benefits consist of an exemption or reduction of certain taxes. The zoning incentives consist of providing additional floor area in mixed buildings, reducing the amount of required parking, and permitting larger grocery stores in light manufacturing districts * **Scotland**: In 2004, a small group of suppliers and retailers in Scotland established a pilot project called Healthy Living Neighbourhood Shops to increase the availability of healthier food options throughout Scotland, in both deprived and affluent areas, where little or no option existed to buy. The programme received funding from the Scottish Executive and worked closely with the Scottish Grocers’ Federation, which represents convenience stores throughout Scotland. Through several different trials, the programme established clear criteria for increasing sales and developed bespoke equipment/point of sale (POS) materials which were given to participating retailers free of charge. This has led to around 600 convenience stores across Scotland improving their range, quality and stock of fresh fruit and vegetables and other healthier eating products (145). |

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| **6 FOOD RETAIL:** The government has the power to implement policies and programs to support the availability of healthy foods and limit the availability of unhealthy foods in communities (outlet density and locations) and in-store (product placement) |
| RETAIL3**: The Government ensures existing support systems are in place to encourage food stores to promote the in-store availability of healthy foods and to limit the in-store availability of unhealthy foods** |
| **Evidence of implementation**   * ANA Evidence snapshot case studies March 2016 (141): Establishing a food policy council, Toi Te Ora, Nelson CC sugar-sweetened beverage policy. Some public health units support sport and recreation centres to reduce the availability of unhealthy food and beverages as described in PROV2.   **International best practice examples (benchmarks)**   * **US:** The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) require WIC authorised stores to stock certain healthier products (e.g. wholegrain bread) (76). * **The Netherlands:** The National Action plan for vegetables and Fruit is a cooperation of government, industry and civil society organisations. The goal is to increase the consumption of vegetables and fruits in 3 years (2018-2020) by linking and strengthening existing initiatives**.** The National Action Plan vegetables and fruit stimulates consumers to eat more vegetables and fruit using the motto ‘Go for Colour’. As part of ‘Go for Colour,’ an in-store experiment has taken place promoting the in-store availability of vegetables and fruit. |

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| **6 FOOD RETAIL:** The government has the power to implement policies and programs to support the availability of healthy foods and limit the availability of unhealthy foods in communities (outlet density and locations) and in-store (product placement) |
| RETAIL4**: The government ensures existing support systems are in place to encourage food service outlets to increase the promotion and availability of healthy foods and to decrease the promotion and availability of unhealthy foods** |
| **Evidence of implementation**   * The Heart Foundation Hospitality initiatives were supported through funding by the Ministry of Health and provided information for food preparers: creating healthy recipes, writing a healthy menu (130). This initiative is now reoriented to focus on food and nutrition Heart Foundation services introduced. * The Government response to the Food Industry Taskforce on addressing factors contributing to obesity noted that the Government wishes to progress focused action in creating healthier retail environments, (e.g. limiting product placement and price promotions of energy-dense, nutrient-poor food and beverages in supermarkets) (28).   **International best practice examples (benchmarks)**   * **Singapore**: The Healthier Dining Programme (formally the ‘Healthier Hawker’ program) involved the government working in partnership with the Hawker’s Association to support food vendors to offer healthier options such as reduced saturated fat cooking oil and wholegrain noodles and rice, reduced salt soy sauce and increased vegetable content without compromising taste and accessibility. To participate, food and beverage companies must complete an application form and implement nutrition guidelines set by the Health Promotion Board (HPB) in all outlets for a period of two years. Following HPB’s approval the ‘Healthier Choice Symbol Identifiers’ can be used next to the healthier dishes in all menu and marketing materials (e.g. ‘We serve lower-calorie options’, ‘We use healthier oil’). To date, the HPB has partnered with 45 widely known food service providers (food courts, coffee shops, restaurants) to offer lower-calorie and healthier meals across 1500 outlets and stalls. Between the launch of the programme and September 2015, the number of healthier meals sold more than doubled, from 525000 in June 2014 to 1.1 million in September 2015. * **US**: In December 2011, San Francisco implemented the Health Food Incentives Ordinance which bans restaurants, including takeaway restaurants, to give away toys and other free incentive items with children’s meals unless the meals meet nutritional standards as set out in the Ordinance: meals must not contain > 600 calories, 640mg sodium, 0.5g *trans*-fat, 35% total calories from fat and 10% calories from saturated fat and include a minimum amount of fruits and vegetables, while single food items and beverages must have <35% total calories from fat and <10% of calories from added caloric sweeteners. Incentives are defined as physical and digital items that appeal to children and teenagers as well as coupons, vouchers or similar which allow access to these items. In 2010 Santa Clara County, California banned restaurants from providing toys or other incentives with menu items high in calories, sodium, fat or sugars. The law (Ordinance No NS300-820) sets nutrition standards prohibiting restaurants from linking toys or other incentives with single food items or meals with excessive calories (more than 200 for single food items and more than 485 calories for meals), excessive sodium (> 480mg for single food item and > 600mg for a meal), excessive fat (> 35% for total fat), excessive saturated fat (>10%) and sugar ( > 10% total calories from caloric sweeteners) or > 0.5g of *trans* fats. It also applies to drinks with excessive calories (> 120 calories), fat ( > 35% from fat) and excessive sugars (> 10% from caloric sweeteners) involving added non-nutritive sweeteners or caffeine (74). * **France**: Since January 2017 France has banned unlimited offers of sweetened beverages for free or at a fixed price in public restaurants and other facilities accommodating or receiving children under the age of 18. Sweetened beverages are defined as any drink sweetened with sugar or artificial (caloric and non-caloric ) sweeteners, including flavoured carbonated and still beverages, fruit syrups, sport and energy drinks, fruit and vegetable nectars, fruit- and vegetable-based drinks, as well as water- milk- or cereal-based beverages (67). |

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| 7 FOOD TRADE AND INVESTMENT**:** The government ensures that trade and investment agreements protect food sovereignty, favour healthy food environments, are linked with domestic health and agricultural policies in ways that are consistent with health objectives, and do not promote unhealthy food environments. |
| TRADE1**: The direct and indirect impacts of international trade and investment agreements on food environments and population nutrition and health are assessed and considered** |
| **Evidence of implementation**   * A list of all New Zealand’s trade agreements (both in force and under negotiation) can be found online (146). Trade agreements between two or more countries can be known as either a Free Trade Agreement (FTA), Closer Economic Partnership (CEP), or Strategic Economic Partnership (SEP). International trade accounts for around two-thirds of New Zealand’s total economic activity. The site includes useful information on each of the agreements, including a form of the agreement, countries involved and time since entry into force. Trade agreements often cover Trade in Goods (Market Access, Rules of Origin, Customs Procedures, Chapters on institutional and legal matters, Trade Remedies, Sanitary and Phytosanitary Measures, Technical Barriers to Trade), Trade in Services (Market Access, Movement of Natural Persons), Investment, Intellectual Property, Government Procurement, Competition and Consumer Policy, Cooperation, [Trade and Labour](http://www.mfat.govt.nz/Trade-and-Economic-Relations/NZ-and-the-WTO/Trade-Issues/0-labour-framework.php) and [Trade and Environment](http://www.mfat.govt.nz/Trade-and-Economic-Relations/NZ-and-the-WTO/Trade-Issues/0-environment-framework.php). On the site, the full text of each concluded agreement can be found, as well as the National Interest Analysis for each agreement (146). Both the strategic intentions 2018-2019 (147) and the annual report (148) of the Ministry of Trade and Foreign Affairs do not include any assessment of the impact of trade agreements on food environments, population nutrition or national nutrition and health policies. For the trade agreements in force, a search for the keywords ‘nutrition’, and ‘food’ in the text of the agreement as well as any national interest analysis for the agreement did not deliver any relevant results. We found no evidence available from public sources from the Ministry of Foreign Affairs and Trade or MoH or MPI, the Ministry of Business, Innovation and Employment (MBIE), treasury or other relevant government agencies that potential impacts on nutrition and health are assessed in the negotiation of agreements (other than relying on the standard WTO clauses which have a very high bar for evidence of negative impacts on health). * Information on stated purposes of legislative proposals relating to food was sought from examining the Food Bill, introduced in 2010. This states among other things that the purpose of the act is to achieve the safety and suitability of food for sale and provide for risk-based measures that minimise and manage risks to public health; and protect and promote public health’s (clause 4). While a reference to protecting and promoting public health is positive, there is little in the act that would implement this aspect of the Act’s purpose in a broad way going beyond traditional food safety concerns. For instance, the Bill states the primary duty of persons who trade in food is to ‘ensure that it is safe and suitable’. Concepts of safe and suitable are defined in the Bill but in rather limited ways. There was a report on submissions to the Food Bill in May 2014 (149).   **International best practice examples (benchmarks)**   * **US/EU**: It is mandatory in the US and countries of the EU to undertake Environmental Impact Assessments for all new trade agreements. These assessments sometimes incorporate Health Impact Assessments (150). |

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| **7 FOOD TRADE AND INVESTMENT:** The government ensures that trade and investment agreements protect food sovereignty, favour healthy food environments, are linked with domestic health and agricultural policies in ways that are consistent with health objectives, and do not promote unhealthy food environments |
| TRADE2**: The government adopts measures to manage investment and protect their regulatory capacity with respect to public health nutrition** |
| **Evidence of implementation**   * International investment agreements have the potential to restrict a country’s regulatory capacity with respect to public health nutrition. A range of proactive measures has been proposed to manage investment and protect public health nutrition regulatory capacity. For NZ it is uncertain whether trade negotiations include evaluation on whether granting incentives that lower production costs may jeopardize public health by making unhealthy products more affordable, no assurance that investment contracts do not tie the hands of regulators in ways likely to undermine health. Also there is no clarification that a foreign investor cannot legitimately expect the host country not to issue nutrition measures and the terms, general exceptions, and the meaning of indirect expropriation and of fair and equitable treatment.   **International best practice examples (benchmarks)**   * **Many countries**: Sanitary and phytosanitary (SPS) clauses in the World Trade Organization (WTO) agreements. However, this usually does not apply to public health nutrition. * **Ghana**: Ghana has set standards to limit the level of fats in beef, pork, mutton and poultry in response to rising imports of low-quality meat following the liberalization of trade. The relevant standards establish maximum percentage fat content for de-boned carcasses/cuts for beef (<25%), pork (<25%) and mutton (<25% or <30% where back fat is not removed), and maximum percentage fat content for dressed poultry and/or poultry parts (<15%) (151). |

# Food Environment Policy Index: INFRASTRUCTURE SUPPORT domains

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| 8 LEADERSHIP**:** The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities |
| LEAD1**: There is strong, visible, political support (at the Head of State / Cabinet-level) for improving food environments, population nutrition, diet-related NCDs and their related inequalities** |
| **Evidence of implementation**   * The New Zealand government adopted the voluntary global NCD action plan from the World Health Organization (152), including 9 targets and 25 indicators for reducing premature mortality due to non-communicable diseases by 25% by 2025 (personal communication, Ministry of Health, 2017).   Strategic Plans, Ministry of Health   * The Statements of Intent of the Ministry of Health are available online and provided on a yearly basis. In the publications between 2017 and 2021, nutrition was not mentioned (153) and nutrition/obesity was not part of the 2017/2018 health targets (154). In the 2017-2021 Statement of Intent, the only item mentioned is under the third strategic priority ‘Improve outcomes for New Zealanders with long-term conditions, with a focus on obesity and diabetes’ however there is no mention of nutrition throughout the publication (153). * The Health and Independence Report (the Director-General of Health’s Annual Report on the State of Public Health) provides an overview of the current state of public health in three main sections: health status, factors that influence New Zealanders' health and health system performance. The 2017 Health and Independence Report (155) recognised that work such as green prescriptions, health-promoting schools and active families greatly supports nutrition and reduces obesity. The association of poor nutrition with negative mental health conditions was identified. * One of the actions in the NZ Health Strategy Roadmap 2016-2021 (156) under ‘Tackle long-term conditions and obesity’ is related to prevention ‘Implement and monitor a package of initiatives to prevent and manage obesity in children and young people up to 18 years of age’.  Another related action under ‘A great start for children, families and whanau’ is ‘Promote healthy nutrition and activity for pregnant women and children to reduce the prevalence of childhood and adult obesity’. * The NZ Health Strategy 2016 (157) has five-year signposts including ‘8h Obesity reduction initiative’. * The NZ Healthy Ageing Strategy 2016 (158) has two priorities that focus on prevention and NCDs. Under the priority ‘Ageing well’: ‘Older people are physically, mentally and socially active, have healthy lifestyles and greater resilience with good nutrition provided as an example of healthy behaviours’. One of the actions is to encourage services and providers to promote healthy eating, physical activity and healthy lifestyles which is to be implemented in the first two years of the strategy. Lead partners listed included DHBs, health organisations, NGOs, and the Nutrition Foundation. Under the priority ‘Living well with long-term conditions’ (diabetes, obesity, CVD etc.) there is a need to provide information on the importance of healthy lifestyles. After reviewing the progress of the 2016 Healthy Ageing strategy in 2018, new priority actions were determined for 2019-2022 with only one possibly relevant to nutrition; ‘Maintain and enhance older people's capacity through supportive environments, health promotion and disease minimisation and prevention’ (159).   Strategic Plans, Health Promotion Agency   * The Health Promotion Agency (HPA) has an overall function to lead and support activities to: promote health and wellbeing and encourage healthy lifestyles, prevent disease, illness and injury, enable environments which support health, wellbeing and healthy lifestyles, and reduce personal, social and economic harm. The HPA undertakes work on a wide range of health issues, including alcohol, gambling harm, health education, immunisation, mental health, nutrition and physical activity, sun safety and tobacco (147). In the Statement of Intent for 2017-2021 ‘nutrition and physical activity’ is considered as one of the seven core areas of focus (160) with outcomes for 2021 to motivate and support communities to eat well, move more, and sit less as well as support the nutrition and physical activity sector with quality advice, evidence and resources to support New Zealanders to eat healthy foods and be active. * In the HPA Statement of Performance Expectations 2018/19 (161) nutrition and physical activity is a major work domain for the HPA. Activities include: HPA supports Sit Less, Move More, Sleep Well guidelines and the Sport New Zealand Play principles launched in 2017 as guiders for nutrition and activity. Also, through the use of the Healthy Kids website and Facebook page (162), HPA encourages healthy meal preparation and activity especially targeted at low income, Māori and Pacific families. HPA promotes the MOH 2018 updated Eating and Activity Guidelines to the public and health professionals. Performance indicators are related to supporting the dissemination of guidelines and aligning with government priorities including prevention of childhood obesity and Healthy Families NZ.   Media releases   * Media releases (163) and news items from the MoH were investigated between 2017 to 2019. Of the many media releases from the MoH during this time there was a total of 10 relevant media releases to nutrition, healthy eating, and non-communicable diseases. The common topics were the Health survey and its results regarding obesity and food insecurity and the childhood obesity plan. Also discussed were the National food and drink policy and healthy food and drink guidance, the Food Industry Taskforce Report and Healthy Families. This was through a search of keywords including ‘food’ and ‘obesity’ and all releases dated 2017-2019. * On the government website [www.beehive.govt.nz](http://www.beehive.govt.nz), a search for the media releases between 2017-2020 keyword ‘nutrition’ had 14 items with 4 relevant from 2017-2020 relating to the wellbeing budget, improving child well-being, grants for nutrition-related research and Active Families programme. A search for the keyword ‘obesity’ had 10 items with 2 relevant relating to health benefits of reducing our carbon footprint and one on improving child well-being. The final search was using the keyword ‘food’ which gave 263 results with 6 potentially relevant including food rescue expansion in Northland, regional economic development awards for healthy food produce, school lunch programmes, child poverty results and improving child well-being in New Zealand. * On the website of Health Minister Hon Dr David Clark (164) speeches, releases, features and newsletters were searched for the Labour-led Government time between 2017-2020. There were 31 items for ‘obesity’ ‘food’ and ‘nutrition’ with 5 relevant: food industry being asked to step up the fight against obesity, improving child well-being, a commitment to reducing carbon footprint, grants for children and families research and the Active Families programme.   **International best practice examples (benchmarks)**   * **New York**: As Mayor of New York City, Michael Bloomberg prioritised food policy and introduced several ground-breaking policy initiatives including ‘Health Bucks’, a restriction on *trans* fats, the establishment of an obesity taskforce, a portion size restriction on sugar-sweetened beverages, public awareness campaigns, etc. He showed strong and consistent leadership and a commitment to innovative approaches and cross-sectorial collaboration (165). * **Brazil**: The Minister of Health showed leadership in developing new dietary guidelines that are drastically different from the majority of dietary guidelines created by any nation to date, and align with some of the most commonly cited recommendations for healthy eating (166). * **CARICOM Countries**: Active NCD commissions exist in six of the 20 CARICOM member states (Bahamas, Barbados, Bermuda, British Virgin Islands, Dominica, Grenada) which are all housed in their Ministries of Health, with members recommended by the Minister of Health and appointed by the Cabinet of Government for a fixed duration; all include government agencies and to a varying degree, civil society and the private sector. |

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| **8 LEADERSHIP:** The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities. |
| LEAD2**: Clear population intake targets have been established by the government for the nutrients of concern to meet WHO and national recommended dietary intake levels.** |
| **Evidence of implementation**   * There are no intake targets specified by the Ministry of Health (MoH) or the Ministry for Primary Industries (MPI) for the nutrients of concern. * New Zealand adopted the voluntary non-communicable diseases (NCD) action plan and global monitoring framework of the World Health Organisation in May 2013, including a target to reduce population salt intake to 5 g of salt per person per day. The Ministry of Health is progressing actions supporting the NCD resolution. The Ministry has been reporting to the WHO in 2016. The Ministry continues to work with key stakeholders and partners and support effective strategies and actions to address the burden of NCDs in New Zealand (personal communication, MoH, 2017). * The Nutrient Reference Values (NRVs) are a set of recommendations for nutritional intake based on currently available scientific knowledge (167). Acceptable daily macronutrients ranges are given with an upper limit of 10% of energy from saturated and *trans*-fat, and upper level of intake for added sugars and an upper limit of sodium of 2000mg per day for those aged 9 years and over, 1000mg 1-3-year olds, 1400 4-8 years. Reviews of nutrients take a phased approach by the Australian Department of Health and NZ Ministry of Health overseen by a steering and advisory group. A scoping study was conducted in 2011 and a methodological framework developed with public consultation undertaken in 2015. The review of fluoride for infants and young children is complete and was published in 2017. The review of the sodium upper limit and suggested dietary target for adults was published in September 2017. The remaining fluoride and sodium and all iodine NRVs will be reviewed over three years beginning in 2018 (168).   **International best practice examples (benchmarks)**   * **Brazil**: The Strategic Action Plan for Confronting NCDs in Brazil, 2011-2022 specifies a target of increasing adequate consumption of fruits and vegetables, from 18.2% to 24.3 % between 2010 and 2022 and reduction of the average salt intake of 12 g to 5 g, between 2010 and 2022 (169). * **South Africa**: The South African plan for the prevention and control of non-communicable diseases includes a target on reducing mean population intake of salt to <5 grams per day by 2020 (170). * **UK**: In July 2015, the government adopted as official dietary advice the recommendation of the Advisory Committee on Nutrition that sugar should make up no more than 5% of daily calorie intake (30g or 7 cubes of sugar per day). Current sugar intake makes up 12 to 15% of energy. An evidence review by Public Health England outlines a number of strategies and interventions (171). |

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| **8 LEADERSHIP:** The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities. |
| LEAD3**: Clear, interpretive, evidence-informed food-based dietary guidelines have been established and implemented.** |
| **Evidence of implementation**   * The 2015 Eating and Activity Guidelines for adults (172) is the first publication using a new model to provide comprehensive advice on nutrition, physical activity and obesity prevention. There is a central guidelines document with eating and activity advice for all population groups accompanied by issues-based papers with in-depth information links to evidence and health education resources for the public. The publication recommends decreasing sodium intake but does not have a target level. The guidelines recommend decreasing free sugar intake, while there is no target for free sugars, the WHO recommendation of <10% of total energy from free sugars and preferably <5% is in the section on choosing foods with little or no added sugar. The recommended intake for saturated fat and *trans* fats combined is <10% energy. * Future editions will include key advice for other ages and pregnant and breastfeeding women, and in-depth information on topical issues. The guidelines for pregnant and breastfeeding women, infants and toddlers were reviewed in 2019 overseen by a Technical Advisory Group. The guidelines will be released in 2020 (personal communication, University of Auckland, 2020). * The contracts with the Ministry of Health include a clause that all messages must be in line with the food and nutrition guidelines of the MoH current (personal communication, MoH, 2020). * The 2018 HPA annual report (173) states a focus on “good nutrition, regular physical activity, adequate sleep and healthy body size are important for maintaining health and wellbeing both now and in the future”. HPA has also completed providing health promoters and others with resources to support their work including two new recipe pads. * Through the healthy kids website (healthykids.org.nz), *Quick Bites* newsletter and Facebook page, HPA encourages families to prepare healthier meals, be active together and sleep well. Food ideas and suggested activities are designed to provide solutions for low-income, Māori and Pacific families with young children. Through the Nutrition and Activity Hub ([www.nutritionandactivity.govt.nz](http://www.nutritionandactivity.govt.nz)) HPA provides health promoters and others working in the nutrition and physical activity sector with resources, tools and information to support their work. A number of HPA resources are also available on [www.healthed.govt.nz](http://www.healthed.govt.nz), such as how much sugar do you drink posters and behind the hype fact sheets.   **International best practice examples (benchmarks)**   * **Brazil**: The national dietary guidelines of Brazil address healthy eating from a cultural, ethical and environmental perspective, rather than based on the number of servings per food group. The main recommendations are: ‘Make natural or minimally processed foods the basis of your diet’; ‘use oils, fats, salt, and sugar in small amounts for seasoning and cooking foods’; ‘use processed foods in small amounts’; ‘avoid ultra-processed foods’. They also provide advice on planning, shopping and sharing meals, as well as warning people to be wary of food marketing and advertising (174,175). |

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| **8 LEADERSHIP:** The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities |
| LEAD4**: There is a comprehensive, transparent, up-to-date implementation plan (including priority policy and program strategies, social marketing for public awareness and threat of legislation for voluntary approaches) linked to national needs and priorities, to improve food environments, reduce the intake of the nutrients of concern to meet WHO and national recommended dietary intake levels, and reduce diet-related NCDs** |
| **Evidence of implementation**   * The Childhood Obesity Plan was introduced in October 2015 (176) by the Ministry of Health. The Childhood Obesity Plan is a package of initiatives to prevent and manage obesity in children and young people up to 18 years. There were three focus areas with 22 initiatives: 1. Targeted interventions for those who are obese. 2. Increased support for those at risk of becoming obese. 3. Broad approaches to make healthier choices easier for all New Zealanders.   The package brought together existing and new initiatives across government agencies, the private sector, communities, schools, families and whanau. Five of the actions focus on improving the healthiness of environments (DHB healthy food policies, marketing and advertising to children, food industry pledges, health-promoting schools, Healthy Families NZ). A technical advisory committee provided advice and a forum was held with members of the processed food and beverage industries, and relevant government agencies (Sport NZ, MoE, ERO, HPA, MPI). All the cabinet papers, health reports, forum notes and technical advisory group meeting agenda and minutes are publicly available on the MoH website.   * Background documents (177) provided initial advice on setting a childhood obesity target (2015) and further advice (2015) recommended setting an initial healthy weight target for children at the age of four before starting school. It was suggested that the target was a Better Public Health Services Target as health alone cannot achieve the target. A Cabinet Strategy Committee did not support this approach (15 June 2015) A new health target was implemented from 1 July 2016 ‘By December 2017, 95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.’ By quarter one 2019/20 17 out of 22 DHBs had met the target (178). The target was selected as the B4SC focuses on early intervention to ensure positive, sustained effects on health. The coverage of services such as Active Families needed to be expanded and the age of eligibility lowered from five to four years at an indicative cost of $3.8 M per annum to be reprioritised from funding identified in the obesity stocktake. * A reducing childhood obesity intervention logic model aligns with the direction of the Childhood Obesity Plan and recommendations of the World Health Organization Commission on Ending Childhood Obesity. The model sets out several shared goals, outcomes and indicators for the New Zealand Childhood Obesity Programme (179). However, there have been no regular progress reports on the outcomes of the plan. * Many nutrition-related projects and areas of work are carried out within MPI to support the development of fit for purpose food regulations. These include monitoring and implementation of the New Zealand and Australian front of pack labelling (the Health Star Rating system), monitoring voluntary folic acid fortification and the New Zealand Total Diet Study (which includes measurement of fluoride, iodine, selenium and sodium) and significant input into global food regulations that are related to nutrition especially the Codex Committee on Nutrition of Foods for Special Dietary Uses and the Codex Committee for Food Labelling. MPI is currently reviewing the approach to folic acid fortification in New Zealand (180). Public consultation on options for strengthening folic acid fortification in New Zealand closed in November 2019. MPI is currently analysing the submissions. MPI is also responsible for New Zealand input into the Food Standards Code: the trans-Tasman food regulations that include aspects of nutrition in the composition and labelling requirements (personal communication, MPI, 2020).   **International best practice examples (benchmarks)**   * **EU**: The European Food and Nutrition Action Plan 2015-20 outlines clear strategic goals, guiding principles, objectives, priorities and tools. The Plan aligns with the WHO Global Action Plan and under ‘Objective 1 – Create healthy food and drink environments’ there are clear policy and program actions identified (181). |

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| **8 LEADERSHIP:** The political leadership ensures that there is strong support for the vision, planning, communication, implementation and evaluation of policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities. |
| LEAD5**: Government priorities have been established to reduce inequalities in relation to diet, nutrition, obesity and NCDs.** |
| **Evidence of implementation**   * The New Zealand Public Health and Disability Act 2000, which the statement of intent refers to (182) sets the strategic direction and goals for health and disability services in New Zealand, including improving the health of Māori and other specific population groups. * Relevant items in the Ministry of Health Statement of Intent 2017-21 (153) are that the Government’s cross-sector priorities in the health and social sector include supporting vulnerable mothers, children and babies, and under health system outcomes, improving outcomes for particular groups such as Māori, Pacific, older people and children. * ‘Ala Mo’ui: Pathways to Pacific Health and Wellbeing 2014-2018 (183) is a plan for improving health outcomes for Pacific peoples with a vision of achieving health equity for all Pacific peoples in NZ. The plan is guided by Pacific principles including supporting Pacific people and communities to be healthy and to experience improved broader determinants of health. The plan has indicators related to the number of Pacific children aged 2-14 years who are obese. All parts of the health and disability sector are responsible for improving Pacific health outcomes and reducing inequalities. The 2018 Progress Report has no mention of food, nutrition or obesity (184). In the MoH, all business units and teams retain responsibility for Pacific health outcomes as part of their work programmes and operational activities. DHBs take responsibility with District Strategic Plans and District Annual Plans of DHBs describing plans for improving Pacific health and reducing inequalities (185). * He Korowai Oranga (186) is NZ’s Māori Health Strategy that sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Maori. Pae Ora (Healthy Futures) is the Government’s vision and aim for the refreshed strategy. It builds on the initial foundation of Whanau Ora to include Mauri Ora (healthy individuals) and Wai Ora (healthy environments). It is a living web-based strategy. It supports the MoH and DHBs to improve Māori health by addressing the: NZ Health Strategy, NZ Disability Strategy and the NZ Public Health and Disability Act 2000. Wai ora includes access to healthy food. Pathway 3 includes focusing on reducing risk and strengthening prevention. * The Ministry continues to administer and monitor the Māori Provider Development Scheme to develop more accessible and effective Māori health and disability service providers, and the Māori Health Innovation Fund (Te Ao Auahatanga Hauora Māori) to support innovation in health services for Māori (187). A key priority for the current funding round is improving the health and wellbeing of whānau and children. * DHBs are the primary funders of Māori health providers. Under legislation the NZ Public Health Act 2000, DHBs have a responsibility to support Māori involvement in service delivery. Each DHB has a Māori Health plan (188). DHBs are required to improve the health of Māori and reduce health disparities for Māori compared to other population groups in NZ. DHB Māori health plans are fundamental planning, reporting and monitoring documents. DHB Māori health profiles present a snapshot of Māori health compared with non-Māori across a range of health and disability-related indicators (189). * The MoH continues to report the estimates derived from health surveys and nutrition surveys by four subpopulation groups including age group, gender, ethnic group and an area level deprivation index (15, 190). Similarly, estimates derived from other data types (e.g. mortality) are presented by these subpopulation groups. A Māori health statistics page presents a range of statistics including socioeconomic determinants of health and there are statistics for Māori from the NZ Health Survey presented in this section (189). * The contracts between MoH and NGOs or other institutions continue to include a section on Māori Health and state: “An overarching aim of the health and disability sector is the improvement of Māori health outcomes and the reduction of Māori health inequalities. You must comply with any: a) Māori specific service requirements, b) Māori specific quality requirements and c) Māori specific monitoring requirements”. In addition, the provider quality specifications for public health services include specific requirements for Māori:” C1 Services meet needs of Māori, C2 Māori participation at all levels of strategic and service planning, development and implementation within the organisation at governance, management and service delivery levels, C3: support for Māori accessing services”. * Healthy Families NZ was launched in 2014 and is carried out specifically in lower-income communities: The Far North district, Waitakere, South Auckland, Rotorua, East Cape, Whanganui-Rangitikei-Ruapehu, Lower Hutt, Christchurch and Invercargill. This has changed to remove Manukau and Manurewa-Papakura ward and Spreydon-Heathcote Ward to more generalised location settings (192). The 10 communities come from areas with higher-than-average rates of preventable chronic diseases (such as diabetes), higher-than-average rates of risk factors for these diseases (such as smoking), and/or high levels of deprivation. The 10 communities are geographically spread and are a mixture of urban and rural areas, so the Healthy Families NZ can provide valuable evidence on what works (and what doesn’t) for a diverse range of communities (193) (See platforms for interaction 4). * Some of the Science Challenges have a strong focus on reducing health inequalities (see Funding 2 for details). * In 2019, KidsCan charitable trust delivered a pilot programme with 26 early learning services in Auckland, Northland and Hawkes Bay. The pilot provides the centres with jackets, boots, nit treatment and food. The Heart Foundation has supported the initial pilot with menu advice and hands-on support for the participating centres. The programme is being extended to an additional 37 centres in 2020 (personal communication, Heart Foundation 2020). * The Heart Foundation partners with the HPA and Vegetables.co.nz to support families to improve their food skills and increase their consumption of vegetables. Currently, 25 food skill cards and over 120 recipe videos have been developed and promoted. Over the past year, this work has been adapted to support The Pacific team with resources and the National support agency for budgeting services with videos to use regarding budgeting (personal communication, Heart Foundation 2020).   **International best practice examples (benchmarks)**   * **New Zealand**: The Ministry of Health reports the estimates derived from health surveys and nutrition surveys by four subpopulation groups including age group, gender, ethnic group and an area level deprivation index. Similarly, estimates derived from other data types (e.g. mortality) are presented by these subpopulation groups. The contracts between MoH and NGOs or other institutions include a section on Māori Health and state: “An overarching aim of the health and disability sector is the improvement of Māori health outcomes and the reduction of Māori health inequalities. You must comply with any: a) Māori specific service requirements, b) Maori specific quality requirements and c) Māori specific monitoring requirements”. In addition, the provider quality specifications for public health services include specific requirements for Māori:” C1 Services meet needs of Māori, C2 Māori participation at all levels of strategic and service planning, development and implementation within the organisation at governance, management and service delivery levels, C3: support for Māori accessing services”. * **Australia**: The National Indigenous Reform Agreement (Closing the Gap) is an agreement between the Commonwealth of Australia and the States and Territories. The objective of this agreement is to work together with Indigenous Australians to Close the Gap in Indigenous disadvantage. The targets agreed to by Council of Australian Governments relate to health or social determinants of health. For the target ‘Closing the life expectancy gap within a generation (by 2031)’, one of the performance indicators is the prevalence of overweight and obesity. |

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| 9 GOVERNANCE**:** Governments have structures in place to ensure transparency and accountability and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities. |
| GOVER1**: There are robust procedures to restrict commercial influences on the development of policies related to food environments where they have conflicts of interest with improving population nutrition.** |
| **Evidence of implementation**   * There are legal expectations with regard to lobbying and commercial influences, contained in legislation including the Crimes Act (194), Electoral Act (195), Secret Commissions Act (196) and others (communication, State Services Commission 2014). New Zealand does not have a legislated lobbying regime. There are no lobbying registers available in New Zealand. Before Parliament was the Lobbying Disclosure Bill which seeks to regulate lobbying in New Zealand. The following link contains information on the Bill including submissions made to Select Committee (197). This has been rejected. * Submissions from stakeholders to policy documents are generally publicly disclosed in New Zealand. * The State Services Commission (SSC) in New Zealand has published Best Practice Guidelines for Departments Responsible for Regulatory Processes with Significant Commercial Implications (198). They cover the development and operation of a regulatory process. They also include specific references to principles around stakeholder relationship management and departmental dealings with former staff who may be employed by, or from, stakeholders. SSC has the power to set minimum standards of conduct for many of the agencies which make up the State Services and to apply those standards by way of a code or codes of conduct. * The current Health Star Rating Group is a mix of industry, academics and public health nutritionists (45). Appointments of members to sit on working groups, committees, advisory groups and standing committees are made in accordance with any relevant legislation, the body’s terms of reference and the State Services Commission’s Board Appointment and Induction Guidelines. * The State Services Commission have codes of conduct for State Services (standards of integrity and conduct) (199) Advice and guidance is provided on understanding and implementing the guide. There are guidelines for board appointments and induction guidelines (200) and for managing conflicts of interest for public entities (201). The SSC conducts regular integrity and conduct surveys.   **International best practice examples (benchmarks)**   * **Australia**: The Australian Public Service Commission’s Values and Code of Conduct includes several relevant sections such as the Conflict of Interest, Working with the Private Sector and other Stakeholders and the Lobbying Code of Conduct. * **US:** Mandatory and publicly accessible lobby registers exist at the federal level, as well as in nearly every state. Financial information must be disclosed, and the register is enforced through significant sanctions. Several pieces of legislation uphold compliance with the register including Lobbying Disclosure Act of 1995 and the Honest Leadership and Open Government Act 2007. |

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| **9 GOVERNANCE:** Governments have structures in place to ensure transparency and accountability and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities. |
| GOVER2**: Policies and procedures are implemented for using evidence in the development of food policies.** |
| **Evidence of implementation**   * A 2013 report by Sir Peter Gluckman, Chief Science Advisor (202), requested by the government to improve decision-making, found that there is a wide and rather inconsistent range of practices and attitudes with respect to understanding and application of robust evidence for policy formation and the evaluation of policy implementation across government agencies. To encourage development improvement at the interface of science and New Zealand public policy, ten new departmental science advisors were appointed, and a Committee of Science Advisors (CoSA) from across government established (203) convened by the Chief Science Advisor. There is additional support from co-opted members to ensure that the forum can provide a full range of advice, and an extensive range of contacts as needed. There are currently 18 members including the Chief Science Advisor (204). National Science Challenges have a societal or environmental impact as a fundamental pillar in their framing and a focus of the Health Research Council is to support policy-relevant research. There is more microdata available to researchers.  To support novel data science, catalyst projects are underway to encourage more use by the academic community. In 2016 the Department of the Prime Minister and Cabinet and the State Services Commission launched the Policy Project (<http://www.dpmc.govt.nz/policyproject>) to advance the training and culture within the civil service to support a more evidence focused policy practice. The Crown entity, SUPERU (Social Policy Research and Evaluation Unit) provided a component of promoting evidence-informed policy but closed in 2018 (205). * The first Chief Education Health and Nutrition Advisor in April 2017 was appointed to work across Government agencies to help NZ learners achieve their potential through the use of international and national health and nutrition research (206,207). The role was to lift the quality of public debate around health and nutrition education and bring together analytical, research and policy experts to assist the Ministry of Education. The role provided advice around the design, integration and implementation of the curriculum to strengthen the Food and Nutrition and Physical activity learning areas aimed to foster good practice within the Ministry and build bridges to academia and the profession. At the end of 2018, the Advisor resigned from the role and has not been replaced. * There is a Chief Science Advisor to the Ministry of Health (208), the Ministry for Primary Industries and the Ministry of Education. * The SSC produced advice for central government agencies on the basis of this review which included advice about the use of accurate information/evidence and steps to ensure its availability when needed (209). An updated guidance series was released on the 30th August 2018. It reflects developments in the suite of Performance Improvement Framework products and services (210). * The policy advice produced by a number of government agencies including the MoH is regularly reviewed by The NZ Institute of Economic Research (211). * The latest report on performance improvement framework website for MoH was 2017 report: State Services Commission (SSC) Performance Improvement Framework (PIF) Review for Manatū Hauora, the Ministry of Health (212). * FSANZ includes evidence in their regulatory impact assessments (personal communication, FSANZ, 2020).   **International best practice examples (benchmarks)**   * **Australia:** The National Health and Medical Research Council Act 1992 (NHMRC Act) requires NHMRC to develop evidence-based guidelines. These national guidelines are developed by teams of specialists following a rigorous nine-step development process (213). |

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| **9 GOVERNANCE:** Governments have structures in place to ensure transparency and accountability and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities. |
| GOVER3**: Policies and procedures are implemented for ensuring transparency in the development of food policies** |
| **Evidence of implementation**   * The State Services Commission (SSC) reviews each government department each year on performance and these reports are available online through the SSC website. The latest review report for the MoH and for MPI can be found online (214). FSANZ publishes all material related to processes and outcomes online. Public consultation on standards is possible on several occasions. Submissions from stakeholders are publicly disclosed. NZ was ranked first in the Open Budget Index rankings in 2017 scoring 89/100 (215) indicating a high level of fiscal transparency with extensive information available. * New Zealand was ranked second in Transparency International’s Corruption Perceptions Index 2018, behind Denmark, obtaining a score of 88% on a total of 1780 countries (216) with high levels of press freedom, access to budget information, high levels of integrity among people in power, and fair access to independent judiciaries. Areas where NZ can monitor its scores and improve, include: access to information, order and security, fundamental rights and civil justice, lack of constraints on government powers and criminal justice, absence of corruption, regulatory enforcement, open government.   **International best practice examples (benchmarks)**   * **Australia/NZ**: FSANZ is required by the Food Standards Australia NZ Act 1991 to engage stakeholders in the development of new standards. This process is open to everyone in the community including consumers, public health professionals, and industry and government representatives. FSANZ has developed a Stakeholder Engagement Strategy 2013-16 that outlines the scope and processes for engagement. One of the first priorities outlined was ‘maintain our open and transparent approach’ (217). |

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| **9 GOVERNANCE:** Governments have structures in place to ensure transparency and accountability and encourage broad community participation and inclusion when formulating and implementing policies and actions to create healthy food environments, improve population nutrition, and reduce diet-related inequalities. |
| GOVER4**: The government ensures access to comprehensive nutrition information and key documents (e.g. budget documents, annual performance reviews and health indicators) for the public.** |
| **Evidence of implementation**   * Key budget documents (e.g. Vote Health), annual performance reviews of the different government departments and reports on nutrition guidelines and survey results are available for download online through the library of the MoH. In addition, in NZ the public can request specific information through the Official Information Act. * Through the official information act 1982, information on budgets spent on population nutrition promotion by MoH, MPI, the Health Promotion Agency and DHBs and PHUs were easily obtained. * The general approach is that information formally generated by the MoH is published on the web. Decisions about work programmes and funded priorities are published through the Ministry’s statement of intent and output plan, both of which are on the web. Decisions about the publication of material on the web or through publications are usually made by business unit producing that information, but there are no formal policies covering what is published (information obtained from MoH through official information request). MPI publishes most reports on its website. In cases where reports are withheld from publication, it is because of commercial or other sensitivities. * Background documents for Childhood Obesity Plan published including Health Reports to the Minister, minutes of the technical advisory group meetings and a food and beverage industry forum (177). * NZ was ranked 7th in the Open Data barometer in 2017 scoring 79/100 (218). NZ was ranked 6th in 2015.   **International best practice examples (benchmarks)**   * **Australia/New Zealand**: The Freedom of Information Act provides a legally enforceable right of the public to access documents of government departments and most agencies. |

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| 10 MONITORING AND INTELLIGENCE**:** The government’s monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans. |
| MONIT1**: Monitoring systems, implemented by the government, are in place to regularly monitor food environments (especially for food composition for nutrients of concern, food promotion to children, and nutritional quality of food in schools and other public sector settings), against codes/guidelines/standards/targets.** |
| **Evidence of implementation**  Food composition   * The NZ Total Diet Survey is conducted approximately every five years and monitors concentration levels in foods and dietary intake of contaminants and some key elements (including sodium) from a simulated NZ diet for key population groups. MPI undertook a New Zealand Total Diet Study (NZTDS) in 2016 with the final reports released in May 2018 (219). The 2016 NZTDS was undertaken with a proposal consultation paper released for public consultation. Feedback was sought on whether the list of chemicals proposed is enough, changes to the key foods list, any population groups missing, and any new data on NZ infants, children and adolescents. Because of the submissions, a simulated diet for Pacific people was included. A sampling of 132 key foods over four quarters was undertaken throughout 2016, and laboratory results are available on the MPI website. This includes sampling 132 foods for sodium content and conducting a dietary exposure assessment of sodium for several population sub-groups. The modelled sodium intake in diets has not changed since the 2009 NZTDS. The food supply has sufficient iodine since the fortification of bread with iodised salt. The 2016 NZTDS found a high level of safety regarding chemical hazards that may be present in the food supply and exposure to agricultural chemicals and contaminants from food remains low (personal communication, MPI, 2020). * In 2017 FSANZ and the Ministry for Primary Industries completed an evaluation of *trans*-fats in imported oils. It was found there has been a significant decline in the importation of vegetable fats and oils that could potentially include *trans*-fats (220). Reported levels of *trans*-fats from product labels and industry product specifications indicated that the levels were consistent with results from previous analytical surveys undertaken from 2006-13. The 2017 evaluation and the earlier surveys indicate that dietary intakes of *trans*-fats have continued to reduce overtime (221). * The New Zealand Institute for Plant & Food Research Limited and the MoH jointly own the New Zealand Food Composition Database (NZFCD) which is a comprehensive collection of nutrient data in NZ. It contains nutrient information on more than 2600 foods. The nutrients sodium, fat, saturated fat, *trans*-fatty acids, sugars and total fibre are included. Accredited laboratories in New Zealand and Australia are used to analyse these nutrients in the foods. The output products of the NZFCD are NZ FOODfiles, the Concise NZ Food Composition Tables and NZ food composition data for NIP. An updated version of the FOODfiles and Concise Tables is published every 2-3 years. The New Zealand FOODfiles 2018 version was published in 2019 and presents 2,767 foods: 86 core components in the standard version and up to 363 components in the unabridged version (222). * Since 2011 researchers at The National Institute for Health Innovation have been collecting data on packaged foods available for sale in supermarkets and fast-food restaurants and was funded partially by the MPI until the end of 2018 (personal communication, MPI, 2020). In supermarkets, photographs are collected from all sides of the package of all packaged foods (displaying a NIP).  Data are entered into an online database (Nutriweb).  Products are categorized according to the categorisation system used by the Global Food Monitoring Group and INFORMAS. In 2019 14,978 unique products (foods and beverages) were collected.   Products are categorised into 16 main food groups and 41 smaller categories. For fast-food restaurants data are collected online and in-store on all products available for sale at major fast-food chains (at least 20 stores nationwide).  Where available serving size and nutrition information per 100g and per serve is collected. * Since 2019 MPI have contracted access to a branded food product database collated by GS1 New Zealand. This searchable database contains images of over 36,000 New Zealand packaged food products across all food categories. Foods are categorised according to the GS1 Global Product Classification (223).   Food promotion   * No monitoring of food promotion in place in New Zealand. Some research has been done in the area, but not nation-wide and not across all types of media.   Food provision   * In 2016 ERO reported on the current status of food, nutrition and physical activity in schools and ECE (224), though the focus was on education and the curriculum rather than the food environment. It was gathered from 202 ECEs, 46 primary schools and 29 secondary schools to assess recommendations for childhood obesity initiatives (225). * No monitoring of food environments in other public sector settings by the NZ government is currently conducted.   **International best practice examples (benchmarks)**   * **Many countries**: Many countries do have food composition databases available. For example, the New Zealand Institute for Plant & Food Research Limited and the Ministry of Health jointly own the New Zealand Food Composition Database (NZFCD) which is a comprehensive collection of nutrient data in New Zealand containing nutrient information on more than 2600 foods. * **UK**: in October 2005, the School Food Trust (‘the Trust’; now called the Children’s Food Trust) was established to provide independent support and advice to schools, caterers, manufacturers and others on improving the standard of school meals. They perform annual surveys, including the latest information on how many children are having school meals in England, how much they cost and how they’re being provided (226). |

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| **10 MONITORING AND INTELLIGENCE:** The government’s monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans. |
| MONIT2**: There is regular monitoring of adult and childhood nutrition status and population intakes against specified intake targets or recommended daily intake levels.** |
| **Evidence of implementation**   * In 2011 all topic-specific surveys (including nutrition) were combined into a single continuous survey called the NZ Health Survey. Each year, the survey collects data from approximately 14,000 adults and 4500 children via a face-to-face interview in respondents’ homes. The survey includes core questions and measurements that are repeated each year, as well as a series of modules that collect more detailed data on a topic. A nutrition module was planned for 2017/18 but it did not go ahead as it did not fit the module format in terms of time and cost. The survey is currently being refreshed, which includes a review of core (annual) content and the future programme of modules. The refreshed survey will go into the field in 2021. The core survey collects the following data related to nutrition, obesity and NCD risk factors. Results from the core survey are reported annually.  1. *Nutrition*: self-reported fruit and vegetable intake (adults); for children 2-14 years fruit and vegetable intake, breakfast consumption, fizzy drink consumption and fast food consumption; and for children under 5 years breastfeeding and solid foods. 2. *Overweight and obesity:* measured height and weight (2+ years), waist circumference (5+ years). 3. *NCDs and risk factors (15+ years):* measured blood pressure; self-reported high cholesterol, high blood pressure, heart disease, stroke, diabetes, arthritis, asthma, mental health conditions, chronic pain, physical activity, smoking, alcohol consumption, sleep (from 2017/18).  * Some modules have collected data related to nutrition and NCD risk factors. The 2014/15 survey included biomedical module, which involved collecting blood and urine samples from a subset of adult respondents (n=5027). Tests included biomarkers of cardiovascular disease (total and HDL cholesterol), diabetes (glycated haemoglobin), kidney and liver function; and nutrition intake/status (blood folate, urinary iodine, sodium and potassium). Biomedical results will be released in February 2020. * The 2018/19 survey included a module on dietary habits for adults and children. The dietary habits module covers: frequency of intake (of processed meats, red meat, fish or other seafood, legumes, nuts or seeds, biscuits or cakes, lollies, fast food or takeaways, drinks made from cordial, concentrate or powder, fruit juice and soft drinks or energy drinks); quality of intake (type of bread, milk, butter or spread and cooking oils used most often); cooking practices (removing excess fat from red meat before cooking or eating it); food groups excluded from diet (e.g. red meat, dairy products etc); and weight perceptions and intentions. The module is being repeated for 2019/20 so results will not be published until 2021. * Household food (in)security for children was included in 2012/13, 2013/14 and 2015/16 and is currently in the field (2019/20). * The last nation-wide adult nutrition survey was carried out from October 2008-October 2009 (4721 adults aged 15+ years participated). Results were presented separately for Pacific people (n=757) and Māori people (n=1040). The results included information on energy and macronutrient intake, dietary habits, measured body mass index, measured waist circumference, blood pressure, cholesterol and diabetes (15). Subsequent publications include estimated sodium intake (227) and free and added sugars intake (228). There were separate estimates for sucrose, fructose, lactose and total sugar intake, as well as for saturated and total fat intake but not intake of trans fats. The latest nationwide survey on children was conducted in 2002. Researchers can apply to access the micro-data (229). * HPA annual report 2019 (230): The national Health and Lifestyles Survey measures trends in New Zealander’s behaviours, attitudes and knowledge on a range of health and lifestyle topics including food and drink. This is a biennial monitor and has been carried out since 2008. * MPI had a request for a proposal in November 2019 to complete a food and nutrient intake survey of young children in New Zealand which was closed in December 2019 (231).   **International best practice examples (benchmarks)**   * **US**: The National Health and Nutrition Examination Survey (NHANES) is a program of studies designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations (232). The NHANES program began in the early 1960s and has been conducted as a series of surveys focusing on different population groups or health topics. In 1999, the survey became a continuous program that has a changing focus on a variety of health and nutrition measurements to meet emerging needs. The survey examines a nationally representative sample of about 5,000 persons each year. These persons are in counties across the country, 15 of which are visited each year. |

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| **10 MONITORING AND INTELLIGENCE:** The government’s monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans. |
| MONIT3**: There is regular monitoring of adult and childhood overweight and obesity prevalence using anthropometric measurements.** |
| **Evidence of implementation**   * The NZ health survey continues to measure weight and height and publish the results annually (229). The survey has over 13000 adults and 4000 children participating annually. A publication on 16 April 2015 ‘Understanding excess body weight: New Zealand Health Survey’ (233), explores the increase in obesity over a 36-year period to 2013 and investigates the impact on different birth cohorts. It reviews the status of adult and child obesity in NZ, looking at the population groups that are affected most. A questionnaire gathers information on key questions on nutrition, general health; anthropometry, NCDs. The health surveys also measure waist circumference among children and adults. The latest results are set to be released in 2020. * The B4 School Check (234) is a nationwide programme offering a free health and development check for four-year-olds. B4 School Checks were rolled out nationwide in September 2008. The B4 School Check includes the measurement of height and weight for recording in the Well Child health book and B4 School Check database. The Ministry of Health prepared a document on the Access, Use and Disclosure Policy for B4 School Check Information System Users (235). * Access to the data can be requested. All requests for access to B4SC data that do not fit neatly into one of the purposes for originally collecting the information held on the B4 School Check system are considered by a Ministry governance body guided by an access policy. (Personal communication, MoH, 2017). * One of the NZ Maternity Clinical Indicators is ‘women with BMI over 35’ (236). This indicator is reported by DBH and ethnicity. This indicator was recommended to be deleted due to it not meeting the description of a clinical indicator and was removed in 2017.   **International best practice examples (benchmarks)**   * **UK**: England’s National Child Measurement Programme was established in 2006 and aims to measure all children in England in the first (4-5 years) and last years (10-11 years) of primary school. In 2011-2012, 565,662 children at reception and 491,118 children 10-11 years were measured (237). |

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| **10 MONITORING AND INTELLIGENCE:** The government’s monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans |
| MONIT4**: There is regular monitoring of the prevalence of NCD risk factors and occurrence rates (e.g. prevalence, incidence, mortality) for the main diet-related NCDs** |
| **Evidence of implementation**   * The current health survey reports on health status, health behaviours and risk factors (smoking, alcohol consumption, fruit and vegetable intake, self-reported physical activity, body weight, health conditions (blood pressure, high cholesterol, IHD, stroke, diabetes) (229). The 2014/15 survey conducted biomedical tests on a sub-sample (aim 5000) adults 15+ years, total, HDL cholesterol; glycated haemoglobin; indicators of kidney diseases and liver function; folate (blood), iodine, sodium, potassium (urine) (survey content guide) (238). These results are set to be released in 2020. * Blood pressure is measured among adults in NZ health surveys (229), ‘Doctor-diagnosed’ Heart disease, stroke, diabetes, asthma, arthritis, mental health conditions, chronic pain, high blood pressure, high blood cholesterol are self-reported. * The Mortality Collection (MORT) classifies the underlying cause of death for all deaths registered in New Zealand, and all registerable stillbirths (foetal deaths), using the ICD-10-AM 6th Edition and the WHO Rules and Guidelines for Mortality Coding. Deaths registered in New Zealand from 1988 onwards are held in the Mortality database (239). The National Minimum Dataset (NMDS) is a national collection of public and private hospital discharge information, including coded clinical data for inpatients and day patients (240). It is updated annually and includes leading causes of death, demographics and historical trends in mortality. * The New Zealand Cancer Registry (NZCR) is a population-based register of all primary malignant diseases diagnosed in New Zealand, excluding squamous and basal cell skin cancers (241). Updated annually, it includes cancer registrations, deaths from cancer, most common cancers, leading causes of death. * The [New Zealand Burden of Disease, Injury and Risk Study 2006-2016](http://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/new-zealand-burden-diseases-injuries-and-risk-factors-study-2006-2016) (NZBD) (242) was a systematic analysis of health loss by cause for New Zealanders of all ages, both sexes and both major ethnic groups. It includes estimates of fatal and nonfatal health losses from 217 diseases and injuries and 31 biological and behavioural risk factors. This information is intended to support health policy and planning. It includes estimates of health loss due to diet and high BMI. * There is a virtual national diabetes register based on data from primary care. The diabetes register is collated annually and is an estimate of 5 national collections (243). * Statistics NZ compiles life tables every five years with information on life expectancy including patterns of mortality, NZ life-period tables, births and deaths (244).   **International best practice examples (benchmarks)**   * **OECD countries**: Most OECD countries, including New Zealand, have regular and robust prevalence, incidence and mortality data for the main diet-related NCDs and NCD risk factors. |

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| **10 MONITORING AND INTELLIGENCE:** The government’s monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans. |
| MONIT5**: There is sufficient evaluation of major programs and policies to assess effectiveness and contribution to achieving the goals of the nutrition and health plans.** |
| **Evidence of implementation**   * There is no comprehensive nutrition and health plan in NZ. The Childhood Obesity Plan is a package of initiatives to prevent and manage obesity in children and youth up to 18 years. Much of the initiatives already existed at the time (e.g. Eating and Activity Guidelines) with some that were new (e.g. DHB healthy food policies). The Cabinet Social Policy Committee did not provide clear actions for evaluation, only that obesity would be monitored using the NZ Health Survey data (177). One of the initiatives has a health target ‘95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions’. An update on the Childhood Obesity Plan (Oct 2016) reported progress made on 14 initiatives (245) but there have been no further reports since. * A Healthy Families summative evaluation report was conducted by Massey University in 2018 (246). There is a national evaluation team that supported each Healthy Families NZ location to develop a local evaluation plan that will identify priorities for evaluation. The local evaluation supported each location to evaluate, learn from and continuously adapt their activities. The local plans encouraged regular review of data to provide rapid feedback. The national evaluation found that Healthy Families continue to be strongly and successfully implemented across the 10 locations. Some highlights included that they noticed a shift towards organisations increasingly valuing and acting on prevention for better health outcomes, leadership as a key focus of recent healthy family efforts and an increasing collaborative community approach. As always in evaluation, there are limitations when expecting to see change in long-term health conditions and no change has yet been seen this early. The available funding is currently $9,403,000 per annum which was the same as the 2016/17 financial year (OIA request, MoH). * The ‘NationalHealthy Food and Drink Policy’ will be evaluated by the University of Auckland with funding from the Healthier Lives National Science Challenge. The aim of the research is to find out how well the policy has been implemented, and its impact on food availability and purchases. It will explore resources required to support the further implementation of the policy and maximise its adoption by public sector institutions (247).   **International best practice examples (benchmarks)**   * **US**: The National Institutes for Health provide funding for rapid assessments of natural experiments. The funding establishes an accelerated review/award process to support time-sensitive research to evaluate a new policy or program expected to influence obesity-related behaviours (e.g., dietary intake, physical activity, or sedentary behaviour) and/or weight outcomes in an effort to prevent or reduce obesity (248). |

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| **10 MONITORING AND INTELLIGENCE:** The government’s monitoring and intelligence systems (surveillance, evaluation, research and reporting) are comprehensive and regular enough to assess the status of food environments, population nutrition and diet-related NCDs and their inequalities, and to measure progress on achieving the goals of nutrition and health plans. |
| MONIT6**: Progress towards reducing health inequalities and societal and economic determinants of health is regularly monitored.** |
| **Evidence of implementation**   * All Ministry of Health surveys (including the more recent nutrition and health surveys) report on estimates for different population groups particularly by ethnicity (including Maori and Pacific peoples), by age, by sex and by NZDep). The NZ Health survey reports results for Asian people (229). * Ministry of Health contracts includes a section on Maori Health and state: “An overarching aim of the health and disability sector is the improvement of Maori health outcomes and the reduction of Maori health inequalities. You must comply with any: a) Maori specific service requirements, b) Maori specific quality requirements and c) Maori specific monitoring requirements”.   **International best practice examples (benchmarks)**   * **New Zealand**: All annual Ministry of Health Surveys report estimates by subpopulations by ethnicity (including Maori and Pacific peoples), by age, by gender, and by New Zealand area deprivation. |

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| 11 FUNDING AND RESOURCES**:** Sufficient funding is invested in ‘Population Nutrition Promotion’ to create healthy food environments, improved population nutrition, reductions in obesity, diet-related NCDs and their related inequalities. |
| FUND1**: The ‘Population Nutrition Promotion’ budget, as a proportion of total health spending and/or in relation to the diet-related NCD burden, is sufficient to reduce diet-related NCDs. Section to be updated after all OIAs received.** |
| **Evidence of implementation**   * Through the Official Information Act 1982, information on budgets spent on population nutrition promotion by MoH and most of the Public Health Units of DHBs was obtained. Three DHBs requested an extension after the due date so is not included in the figures in this booklet. The spending of the Ministry of Education on population nutrition promotion is difficult to retrieve so has not been included. * Many of the OIA responses from DHBs indicated the difficulty in separating out nutrition funding, often population health nutrition included physical activity funding. For a few of the DHBs the figures included Raising Healthy Kids and breastfeeding promotion. Healthy Families was not included as this is directly funded by the Ministry of Health. Generally the funding included public health units, NGOs funded by the DHB but not Green Prescription (as focused on individuals). Some DHBs estimated the nutrition component of contracts with external providers (for example, 25%). The budget for DHBs (excluding the 3 DHBs who did not respond) during 2017/18 to 2019/20 was $4 million per annum and during 2014/15-2016/17 was $4.8 million per annum $ (response to OIA requests). * HPA’s budget for the Nutrition and Physical Activity Programme is $1.022 Million (inclusive of overheads to deliver the programme). Given that empowering our whānau with young tamariki to have a healthy lifestyle is a key objective for HPA, nutrition and physical activity messages are also incorporated into other HPA programmes. For example in the mental health programmes, healthy food and exercise are promoted as a way of enhancing wellbeing. (personal communication, HPA, 2020) * The total spending by the MoH on population nutrition promotion was $39 million in 2017/18, $38.4 million in 2018/19 and $38.4 million in 2019/20. This was 1.2%, 1.1% and 1.0% of the total non-departmental expense funding (excluding capital and DHB baseline funding and MOH departmental funding). The total spending by the MoH on population nutrition promotion was $40.2 million in 2016/17 (1.38%). The budget for physical activity is included as it could not be separated. * The Ministry of Health budget (below) excludes all individual health promotion, primary care, B4 school checks, Wellchild, Plunketline, Telehealth, antenatal services, maternal and child nursing services, food safety, micronutrient deficiencies, breastfeeding promotion and under nutrition programmes. Note that some of the above may include other services outside nutrition when paid as part of other services, including nutrition as the primary service.  |  |  |  |  | | --- | --- | --- | --- | | **Ministry of Health nutrition budget** | **2017/18** | **2018/19** | **2019/20** | |  | $000 | $000 | $000 | | Education Setting | 1,498 | 1,498 | 1,498 | | Food Industry | 918 | 918 | 918 | | Fruit in Schools | 8,125 | 8,125 | 8,125 | | Health promotion and advertising (Health Promotion Agency) | 7,290 | 7,290 | 7,290 | | Health Star Rating | 667 |  |  | | Healthy Families NZ | 9,403 | 9,403 | 9,403 | | Maternal and Child Nutrition | 3,347 | 3,347 | 3,347 | | Other nutrition activities | 284 | 284 | 284 | | Pacific Heartbeat | 834 | 834 | 834 | | Physical activity and nutrition | 5,730 | 5,730 | 5,730 | | Under 5 Energize | 500 | 500 | 500 | | School health promotion | 451 | 451 | 451 | | **Total** | **39,045** | **38,378** | **38,378** | | % of total non-departmental expense funding (excluding capital and DHB baseline funding and MOH departmental funding) | 1.2% | 1.1% | 1.0% | |
| **International best practice examples (benchmarks)**   * **New Zealand**: The total funding for population nutrition was estimated at about $67 million or 0.6% of the health budget during 2008/09 Healthy Eating Healthy Action period. Dietary risk factors account for 11.4% of health loss in New Zealand. * **Thailand:** According to the most recent report on health expenditure in 2012 the government greatly increased budget spent on policies and actions related to nutrition (excluding food, hygiene and drinking water control). Total expenditure on health-related to nutrition specifically from local governments was 29,434.5 million Baht (about 840 million USD) (7.57% of total health expenditure from public funding agencies), which was ten times over the budget spending on nutrition in 2011. Dietary risk factors account for about 10% of health loss in Thailand. |

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| **11 FUNDING AND RESOURCES:** Sufficient funding is invested in ‘Population Nutrition Promotion’ to create healthy food environments, improved population nutrition, reductions in obesity, diet-related NCDs and their related inequalities. |
| FUND2**: Government-funded research is targeted for improving food environments, reducing obesity, NCDs and their related inequalities.** |
| **Evidence of implementation**   * All funding recipients from the Marsden Fund and the Health Research Council NZ were evaluated. * For Marsden (249), in 2017 (total budget $84.6m), 2018 (total budget $85.6m) and 2019 (total budget $83.671m) the only funding for projects related to population nutrition or prevention of obesity and non-communicable disease was approximately $5.24m between 2017-19 out of a potential $253.871m. For Marsden, both in 2012 (total budget=$54,960,000) and 2013 (total budget=$58,965,214) there was no funding for projects related to population nutrition or prevention of obesity and non-communicable diseases, therefore, funding has increased. * For the Health Research Council (250) the amount of research budget spent on population nutrition and/or prevention of obesity and non-communicable diseases was: 12 research projects in 2017 totalling $4.296m (3.4% of total funds), 6 research projects in 2018 totalling $8.16m (6.5%) and 4 research projects in 2019 totalling $1.695m (1.3%). This comes to a total of $14.151m spent by the Health Research Council between 2017-19 relevant to these health issues. In 2015 3.9% (total budget=$73,025,001) and 2016 7.2% (total budget=$119,100,991) was spent on population nutrition and/or prevention of obesity and non-communicable diseases * MPI policy and science functions contribute to some areas of nutrition work with unspecified budget allocation. Examples include health claims and monitoring surveys (251). * The funding programmes from MPI relate to Agriculture, Forestry, Environment and Natural Resources, Biosecurity and animal welfare and are not considered relevant. * The High-Value Nutrition Science Challenge is focused on increasing export revenues rather than population nutrition in New Zealand (252). * The National Science Challenge: * *‘A Better Start’* is working to reduce obesity and improve learning skills and mental health in NZ children (253). The mission is to find better ways to predict, prevent and treat obesity, learning and mental health problems in NZ children and teenagers. The work is a collaboration of experts and institutions. The focus is children early in life and most in need (Māori, Pacific, poorer children), to engage families and communities and take a holistic approach to obesity, learning and mental health difficulties. Funding is $34.7 million over ten years 2015-2024. It is hosted by Liggins Institute. Themes have recently been re-titled in positive, non-deficit language with obesity now referred to as ‘healthy weight’ (254). In 2017, ‘A Better Start’ and Cure Kids launched a $2.8million pool to fund research to find better ways to reduce childhood obesity along with literacy, mental health and Autism Spectrum Disorders (255). * The Healthier Lives challenge is undertaking innovative research aimed at reducing death and disease burden from NCDs (cancer, CVD, diabetes, obesity) (256) prevention and treatment. There is a commitment to WHO goals of reducing the burden of NCDs by 25% by 2025 and reducing health inequalities between populations by 25% by 2025. There is funding up to $31.3 million over 10 years (256). * *Ageing Well* has a research stream ‘Staying UPright and Eating well’ (SUPER), aiming to test the impact and cost-effectiveness of physical activity and/or nutrition, and social group attendance, to reduce frailty and falls of older people (257). * The *Life Course Project* is a collaboration with the two health and well-being National Science Challenges, Healthier Lives and Ageing Well. This initiative focuses on a life course perspective on health and well-being throughout the life span to intervene and reduce the impact of illness through early detection and prevention. The work will capture synergies across the three Challenges to form an approach to achieve a long, healthy, well-adjusted and productive life by examining early risk factors and associations for later disease, together with the prevention of major illnesses and methods to quantify the health and economic benefits of avoidance of non-communicable disease (256). * The MoH has a Pacific Innovations Fund. In December 2019 almost $10 million in funding was invested to better resource, drive and assess innovative community health projects that improve Pacific peoples’ health and wellbeing (258).   **International best practice examples (benchmarks)**   * **Australia**: The National Health and Medical Research Council (NHMRC) Act requires the CEO to identify major national health issues likely to arise. The National Health Priority Areas (NHPAs) articulate priorities for research and investment that have been designated by Australian governments as key targets because of their contribution to the burden of disease in Australia. For the 2015-16 Corporate Plan, obesity, diabetes and cardiovascular health are three of these NHPAs. * **Thailand**: The National Research Council funded more research projects on obesity and diet-related chronic diseases (such as diabetes, cardiovascular diseases and hypertension) in 2014, accountable for almost six times over the research funding in 2013 (from 6,875,028 Baht in 2013 to 37,872,416 baht in 2014). |

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| **11 FUNDING AND RESOURCES:** Sufficient funding is invested in ‘Population Nutrition Promotion’ to create healthy food environments, improved population nutrition, reductions in obesity, diet-related NCDs and their related inequalities. |
| FUND3**: There is a statutory health promotion agency in place that includes an objective to improve population nutrition, with a secure funding stream.** |
| **Evidence of implementation**   * The Health Promotion Agency is a Crown entity established by the NZ Public Health and Disability Act 2000 (51). HPA has an overall function to lead and support activities to promote health and wellbeing and encourage healthy lifestyles, prevent disease, illness and injury; enable environments which support health, wellbeing and healthy lifestyles; reduce personal, social and economic harm. HPA is required to give effect to Government policy when directed by the responsible Minister. HPA has a central role as the Government’s expert on health promotion. Within the HPA’s 2018-19 Statement of Performance Expectations ‘Nutrition and Physical Activity’ are considered a major domain for the HPA (161).   **International best practice examples (benchmarks)**   * **Australia**: The Victorian Health Promotion Foundation (VicHealth) was the world’s first health promotion foundation, established by the Victorian Parliament as part of the Tobacco Act of 1987 (for the first 10 years through a hypothecated tobacco tax) through which the objectives of VicHealth are stipulated. VicHealth continues to maintain bipartisan support. |

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| 12 PLATFORMS FOR INTERACTION**:** There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities. |
| PLATF1**: There are robust coordination mechanisms across departments and levels of government (national and local)) to ensure policy coherence, alignment, and integration of food, obesity and diet-related NCD prevention policies across governments.** |
| **Evidence of implementation**   * The requirement for co-ordinated action across Government continues to feature in the Ministry of Health Statements of Intent. The introduction of the 2017-21 MoH Statement of Intent (153) states the need for our system to adapt to the changing needs of our diverse communities living in a rapidly advancing digital society with a burden of disease shifting to lifestyle and life-long chronic conditions. There is a greater focus on wanting to improve outcomes for people with long-term health conditions, especially those who are obese or who have diabetes and discuss collaboration across multiple sectors to reach success. * The Healthy Families NZ (193) and Childhood Obesity Plan (176) encourages organisations to work across sectors. * The Childhood Obesity Plan includes sports and education sectors (176). Healthy Active Learning is a new initiative from the 2019 Wellbeing budget that is a collaboration between the Ministry of Health and Sport New Zealand (123). * Whānau Ora is an inclusive interagency approach to providing health and social services to build the capacity of all New Zealand families in need. It empowers whānau as a whole rather than focusing separately on individual family members and their problems (259). It is jointly implemented by MoH, MSD and TPK.   **International best practice examples (benchmarks)**   * **Australia**: There are several forums and committees for strengthening food regulation with representation from New Zealand and Health Ministers from Australian States and Territories, the Australian Government, as well as other Ministers from related portfolios (e.g. Primary Industries). Where relevant, there is also representation from the Australian Local Government Association. * **Finland**: The Finnish National Nutrition Council is an inter-governmental expert body under the Ministry of Agriculture and Forestry with advisory, coordinating and monitoring functions. It is composed of representatives elected for three-year terms from government authorities dealing with nutrition, food safety, health promotion, catering, food industry, trade and agriculture (86). * **Malta**: Based on the Healthy Lifestyle Promotion and Care of NCDs Act (2016), Malta established an inter-ministerial Advisory Council on Healthy Lifestyles in August 2016 to advise the Minister of Health on any matter related to healthy lifestyles. The Advisory Council advises on a life course approach to physical activity and nutrition, and on policies, action plans and regulations intended to reduce the occurrence of NCDs. The prime minister appoints the chair and the secretary of the Advisory Council, while the ministers of education, health, finance, social policy, sports, local government, and home affairs appoint one member each (86). |

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| **12 PLATFORMS FOR INTERACTION:** There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities. |
| PLATF2**: There are formal platforms between the government and the commercial food sector to implement healthy food policies.** |
| **Evidence of implementation**   * The advisory groups related to HSR (45) are the front-of-pack labelling steering committee, trans-Tasman HSR advisory group (NZ holds one of 10 seats), NZ HSR advisory group. The NZ Health Star Ratings Advisory Group was established to provide advice on an approach to the voluntary interpretive front of pack labelling in New Zealand. This committee has wide representation and includes commercial food, academia and public health and is chaired by MPI. * In June 2018 leading food and beverage industry members formed the Food Industry Taskforce on Addressing Factors Contributing to Obesity, at the request of the Ministers of Health and Food Safety. * The Food Industry Taskforce is comprised of members from primary production and processing, manufacturing (food and beverage), quick service (including outlets in fuel stations), food service, hospitality, retail and representatives from several industry associations. In 2018 the Taskforce conducted an industry survey on information and suggestions from industry companies and associations on measures they could or have taken to reduce obesity. The three most important activities considered were; reformulation, health star rating and education (260). On 20 December 2018, the Taskforce provided the ‘Final Report to Ministers of Health and Food Safety’ identifying actions that industry members could take to further address obesity. The Taskforce also sent a letter dated 13 September 2019 providing an update on progress towards the recommendations. * The Minister for Health and Minister for Food Safety responded to the taskforce one year later in December 2019. The Ministers encouraged the Taskforce to prioritise the following workstreams based on the WHO publication ‘Essential Nutrition Actions – mainstreaming nutrition through the life-course’. However, the Ministers did not provide any information on how the government would contribute to progress on these recommendations. The Ministers propose formalising engagement between industry and government to identify common goals and establish a joint work programme. * The Government is taking a broad population approach to achieve a healthy weight with a focus on improved nutrition and increased physical activity. The approach is designed to help address the significant health losses associated with non-communicable diseases in New Zealand. Building on the Child Obesity Plan 2015, the Government is focussing on the following actions to create supportive environments:   + - 1. Healthy Active Learning       2. Working with DHBS to implement the National healthy Food and Drink Policy       3. Updating the Food and Nutrition Guidelines for pregnant women and children 0-2 years       4. Co-leading New Zealand’s response to the World Health Organization’s Global Action Plan on Physical Activity       5. Supporting the implementation of the Clinical Guidelines for Weight Management in New Zealand Children and Young People       6. Working with the food and beverage industry sector to identify actions to create healthier food environments * Some of NZ’s largest supermarket retailers (Foodstuffs, Countdown, Moore Wilson, Bin Inn, Four Square, New World, PAK'nSAVE, SuperValue and FreshChoice) pledged to support product reformulation, education, provision of healthy choices, use of HSR, ethical and responsible advertising of food to children and reporting activities (3). * The Chip Group is run by Potatoes New Zealand with a Training & Education Manager, and an Education & Communications Manager with support from PNZ Staff and Board. This is equally funded by Industry (Potatoes New Zealand) and the Ministry of Health. The MOH contribution is $85,000 NZD per annum and is currently contracted until July 2020 (personal communication, MOH, 2020). A Technical panel including industry representatives from *McCain’s*, *Mr Chips* and *Talley’s* provides industry perspective and promotion of the Chip Group training to their food service clients (personal Communication, The Chip Group, 2017). * Since 2007, the Heart Foundation has implemented a food reformulation programme focused primarily on reducing salt levels and also sugar levels across packaged (6). This is a service delivery approach rather than a direct engagement platform. See food composition target (Appendix A). * An important document in the conflicts of interest sphere is the Office of the Auditor-General’s ‘Managing conflicts of interest: Guidance for public entities’ (201). Current in relations to conflicts of interest, State Servants are bound by the ‘Standards of Integrity and Conduct’ (‘The Code’) which sets out the standards expected of State servants.  The Code includes the statement ‘we must ensure our actions are not affected by our personal interests or relationships.’  A breach of this (or any aspect) of the Code may be grounds for disciplinary action (261). * Controller and Auditor General. ‘Reflections from our audits: Governance and accountability’, has a chapter ‘Managing conflicts of interest’ April 2016 (262). * The SSC in New Zealand has published Best Practice Guidelines for Departments Responsible for Regulatory Processes with Significant Commercial Implications (198). These guidelines cover a section on managing conflict of interest issues in different government departments as well. As a principle, it is stated that Departments should have clear, effective and robust processes in place for identifying and addressing potential conflicts of interest (198). * The 2013 Integrity and Conduct Survey (263) by the State Services Commission was an overall assessment of integrity and conduct in the State Services covering 40 agencies. * There is conflict of interest registers available for senior management staff by each department. Board members have duties under the Crown Entities act (much stricter for boards than committees). The conflicts of interest are looked after through the crown ownership unit at the treasury. HPA manages conflicts of interest (declaration of interests was received) in accordance with the provisions of the Crown Entities Act 2004 and advice provided to the state sector from the Office of the Auditor-General and the State Services Commission. Once board members are appointed, the following HPA procedures apply; A register of interests, regularly updated, in accordance with policy. Identification and noting of interests in preparing agenda Interest disclosure to be the first item at each meeting. Affected member leaves room for discussion/decision (personal communication, HPA, 2020). * The Treasury’s guideline for public-private partnerships in New Zealand (2009) refers to public-private initiatives as being direct agreements between the Crown and the private sector. The Ministry of Health does not have any direct agreements with the Private Sector for nutrition initiatives. However, the Ministry has a small number of contracts with NGOs who have either memorandum of understandings or other formal arrangements with the private sector; or the Ministry funds NGOs who also receive separate funding from the private sector for different services. These are managed separately by the NGO. Two nutrition-related Ministry funded joint public-private initiatives are as follows: * Food for Thought is owned by Foodstuffs and delivered by Heart Foundation regional staff in low decile schools throughout the country. * Voluntary Schools Beverage Agreement between NZ Government and beverage industry leaders, Coca-Cola Amatil NZ and Frucor Beverages (264).   **International best practice examples (benchmarks)**   * **UK:** The UK ‘Responsibility Deal’ was a UK government initiative to bring together food companies and non-government organisations to take steps (through voluntary pledges) to address NCDs during 2010-2015. It was chaired by the Secretary of State for Health and included senior representatives from the business community (as well as NGOs, public health organisations and local government). Several other subgroups were responsible for driving specific programs relevant to the commercial food sector. |

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| **12 PLATFORMS FOR INTERACTION:** There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities. |
| PLATF3**: There are formal platforms for regular interactions between government and civil society on food policies and other strategies to improve population nutrition.** |
| **Evidence of implementation**   * There is a network of Chief Science Advisors based in different departments, Ministries and agencies across government. The Advisors support ministry/department to better use evidence to inform policy, to perform a brokering role within their respective agencies and as a forum of science advisors along with the chief economist, chief statistician and deputy head of the State Services Commission. The Chief Science Advisor Forum provides a sounding board for the Prime Minister’s Chief Science Advisor and allows for a more coordinated whole-of-government view of science advice. There are 18 members of the forum. A priority of the Chief Science Advisor is to give this group more form and a higher profile, establishing a community of practice for science advice across government (265). * There are academics on the Health Star Rating advisory committee (45) and the HPA Board. * The current advisory groups with a focus on nutrition, obesity or prevention of NCDs are: Maternal, Infant and toddler Eating Guidelines Technical Advisory Group, Physical Activity Technical Advisory Group, National Diabetes Leadership Group, Well Child Tamariki Ora Review Rōpū (personal communication, MoH, 2020). Each Healthy Families NZ location has a governance/strategic leadership group comprised of leaders who can influence change locally. These may include leaders from local government, regional sports trust, education, health, iwi, business. This group oversees the investment of the Action Budget and the alignment with spending with the principles of Healthy Families NZ (personal communication, Healthy Families NZ, 2017). * Some NGOs in NZ receive MoH funding, for example, the Heart Foundation food reformulation programme (266). * Civil society is encouraged to participate in public submissions in certain aspects of food policy development (e.g. to Parliamentary Inquiries, Select Committees). * The HPA (110) community partnership funding was first offered in 2013/14. In 2017, sixteen community projects were funded and monitored, though not nutrition related. * The National Science Challenges encourage collaboration with academia, Crown Research Institutes and NGOs and Malaghan Institute. Challenges are funded by MBIE (267). * ​​The FSANZ Consumer and Public Health Dialogue provides a means by which FSANZ can engage in deeper and more meaningful consultation with peak consumer and public health bodies and academics (268). The objective is to improve FSANZ’s awareness and understanding of community food and health issues; and public priorities, and through this communication, provide a more effective food regulatory response. The Ministry of Health and Ministry for Primary Industries attend as observers.   **International best practice examples (benchmarks)**   * **Brazil**: The National Council of Food and Nutrition Security (CONSEA) is a body made up of civil society and government representatives, which advises the President’s office on matters involving food and nutrition security (269). CONSEA is made up of one-third government and two-thirds non-government executives and workers. It has special powers. It is housed in and reports to the office of the president of the republic. It is responsible for formulating and proposing public policies whose purpose is to guarantee the human right to healthy and adequate food. There are also CONSEAs at state and municipal levels that deal with specific issues, also responsible for organising CONSEA conferences at their levels. CONSEAs are charged to represent Brazilian social, regional, racial and cultural diversity at municipal, state or national level. The elected politicians in Brazil's parliament formally have the power to challenge and even overturn proposals made by CONSEA. In practice, it is most unlikely that any Brazilian government whether of the left or right would wish to do so, partly because of the constitutional status of the CONSEA system, and because, being so carefully representative of all sectors and levels of society, it remains strong and popular. |

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| **12 PLATFORMS FOR INTERACTION:** There are coordination platforms and opportunities for synergies across government departments, levels of government, and other sectors (NGOs, private sector, and academia) such that policies and actions in food and nutrition are coherent, efficient and effective in improving food environments, population nutrition, diet-related NCDs and their related inequalities. |
| PLATF4**: The government leads a broad, effective and sustainable systems-based approach with local organisations to improve the healthiness of food environments at a national level.** |
| **Evidence of implementation**   * Project Energize began in 2005 in the Waikato region (270). It is funded by Waikato District Health Board. Project Energize partners with Maori and Pacific providers, and organisations that are experts in community development, research, nutrition, sports science and clinical skills, Sport NZ, AUT, Wintec. A total of 45,438 primary and intermediate school children are now part of Project Energize through 240 Waikato schools. 5417 children and 126 early childhood centres (personal communication, Sport Waikato, 2020). Vital to the success of Project Energize is the 21 ‘Energizers’ who work with schools, teachers and parents, giving physical fitness and nutritional advice and helping implement health and fitness programmes. In New Zealand, a 2011 evaluation of Project Energize (Waikato) found that ‘Energize’ children had: smaller waist circumferences and lower body-mass index than Waikato children of the same age measured in 2004 and 2006, obesity rates three percent less than the national level and faster running times over 550m compared to national data (271). There are an additional 5787 children and 137 early childhood centres involved in Under 5 Energize supported by 4 Energizers. (personal communication, Sport Waikato, 2020). * Project Energize has expanded to early childhood and other areas (including Ireland). Under 5 Energize is funded through MoH. AUT is evaluating and monitoring the project. It is active in four communities in Waikato (272). Capital Coast Health funds the Heart Foundation to deliver Project Energize in the Wellington region. Currently, there is 2.8FTE working with 30 Wellington schools. Energizers provide practical 'hands-on' support and assistance to schools and teachers with initiatives that will increase the quality and quantity of physical activity or improve the uptake of healthy eating (personal communication, Heart Foundation, 2020). * Project Energize in Northland funded by Northland DHB and Sport NZ with 90 primary and intermediate schools involved, 9 energizers and over 10 000 school children (personal communication, Sport Northland, 2020). * Healthy Families NZ (HFNZ) was launched in 2014 (193). Healthy Families NZ is a collaborative, whole of the community, collective approach to prevention. It aims to make changes to systems that influence the health and wellbeing of families and communities. The Ministry of Health has led the establishment of HFNZ communities in 10 locations across NZ (The Far North, Waitakere, South Auckland, Rotorua, East Cape, Whanganui-Rangitikei-Ruapehu, Lower Hutt, Christchurch and Invercargill). HFNZ supports local leaders to implement voluntary initiatives that encourage families to live healthy, active lives. Through investment in community partnerships and a skilled health promotion workforce, these communities find local solutions to local needs, supporting healthy living. Activities initially focus on the settings where people live, learn, work, and play. The 10 HFNZ communities come from areas with higher-than-average rates of preventable chronic diseases, risk factors for these diseases (such as smoking), and/or high levels of deprivation. It is expected that HFNZ communities will reach approximately 900,000 New Zealanders. The design for Healthy Families NZ communities draws on evidence from the Be Active Eat Well pilot (Colac, Australia), EPODE pilots (France) and Project Energize (New Zealand), which have been associated with several measurable improvements that will support the health and wellbeing of children. A skilled prevention team is established at each site to bring together partnerships of key organisations and local leaders who can influence transformational change in their communities. The approach is based on a dedicated, reflective and skilled workforce, building leadership and relationships for prevention across the system, allocating resources to effect sustainable change, capturing and feeding back knowledge and data. It is guided by principles: implementation at scale, collaboration for collective effect, equity of outcome, line-of-sight, adaptation, experimentation and leadership. A range of organisations is leading Healthy Families NZ including sports trusts, iwi organisations, councils, Pacific PHOs. Massey University has conducted a progress evaluation. * Healthy Auckland Together (HAT) (273): Auckland Regional Public Health Service facilitates a coalition of local government, NGOs, health, iwi, and others working collaboratively to make it easier for everyone to reach the 3 goals: improving nutrition, increasing physical activity, reducing obesity. There is a strategic framework with a vision and the context the group operates within with six action plans of which one is food environments and marketing. There are a set of 17 indicators and targets and a baseline monitoring report showing baseline status of these. Nutrition and obesity-related targets: dental caries in children, adults eating more fruit and vegetables, reduction obesity 4-5-year olds, reduce excess supply fast food outlets, increase availability healthy food in outlets, more schools and ECEs providing a heart-healthy environment, more Pacific Heartbeat community nutrition courses. HAT focuses on collaboration, profile raising, monitoring across streets, parks and places, food environments and marketing, schools and early childhood education services, workplaces and community settings. HAT has committed to implementing the Healthy Food and Drink Policy for Organisations (developed by the National DHB Food and Drink Environments Network) within their own organisations with each member currently at different stages with implementation. Every year HAT complete a Monitoring Report on Auckland progress on population weight, diet and lack of physical activity with supportive infographics and updated information (274,275) * The National Good Food Network (http://sustainable.org.nz/good-food-nation-2/) is a coordinated approach driven by Sustainable Business Network, to bring together and strengthen organisations working regionally in their food system through sharing learning and building capacity.   **International best practice examples (benchmarks)**   * **New Zealand**: Healthy Families NZ is a large-scale initiative that brings community leadership together in a united effort for better health. It aims to improve people’s health where they live, learn, work and play, to prevent chronic disease. Led by the Ministry of Health, the initiative will focus on ten locations in New Zealand in the first instance. It has the potential to impact the lives of over a million New Zealanders. The Government has allocated $40 million over four years to support Healthy Families NZ (276). * **Australia**: Healthy together Victoria in Australia aims to improve people's health where they live, learn, work and play. It focuses on addressing the underlying causes of poor health in children's settings, workplaces and communities by encouraging healthy eating and physical activity and reducing smoking and harmful alcohol use. Healthy Together Victoria incorporates policies and strategies to support good health across Victoria, as well as locally-led Healthy Together Communities. The initiative was originally jointly funded by the State Government of Victoria and the Australian Government through the National Partnership Agreement on Preventive Health (277,278). It is unclear at this stage whether funding for Healthy Together Victoria will continue. |

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| 13 HEALTH IN ALL POLICIES**:** Processes are in place to ensure policy coherence and alignment, and that population health impacts are explicitly considered in the development of government policies |
| HIAP1**: There are processes in place to ensure that population nutrition, health outcomes and reducing health inequalities are considered and prioritised in the development of all government policies relating to food** |
| **Evidence of implementation**   * FSANZ does not undertake health impact assessments. However, their standards development process (which is based on the Codex risk analysis model) incorporates key elements, including assessment of issues (including health impacts, if relevant) and consultation. Their process also includes a regulatory impact analysis, and a Regulation Impact Statement (RIS) may be prepared to inform this process. Regulatory impact assessments usually compare several scenarios: no regulation, voluntary regulation and mandatory regulation (1 or 2 different scenarios), but this is not considered a health impact assessment.   **International best practice examples (benchmarks)**   * **Slovenia**: Slovenia undertook a Health Impact Assessment (HIA) in relation to the agricultural policy at the national level. This was the first time that the health effects of an agricultural policy were assessed at the country level. The HIA followed a six-stage process: policy analysis; rapid appraisal workshops with stakeholders from a range of backgrounds; review of research evidence relevant to the agricultural policy; analysis of Slovenian data for key health-related indicators; a report on the findings to a key cross-government group; and evaluation (279). |

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| **13 HEALTH IN ALL POLICIES:** Processes are in place to ensure policy coherence and alignment, and that population health impacts are explicitly considered in the development of government policies |
| HIAP2**: There are processes (e.g. health impact assessments) to assess and consider health impacts during the development of other non-food policies** |
| **Evidence of implementation**   * The MoH released HIA guidelines in 2007 with a focus on whānau ora (health and well-being for Māori, their families and communities) (280). It can still be accessed online through the Ministry of Health (281). * Health in All Policies (HiAP) is defined as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity" (282). Local examples include Canterbury Health in All Policies Partnership (283), an approach to public policies across sectors that takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and equity.   **International best practice examples (benchmarks)**   * **Australia**: Established in 2007, the successful implementation of Health in All Policies (HiAP) in South Australia has been supported by a high-level mandate from central government, an overarching framework which is supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process. The government has established a dedicated HiAP team within South Australia Health to build workforce capacity and support Health lens Analysis projects (284). Since 2007, the South Australian HiAP approach has evolved to remain relevant in a changing context. However, the purpose and core principles of the approach remain unchanged. There have been five phases to the work of HiAP in South Australia between 2007 and 2016: 1) Prove concept and practice emerges (2007-2008), 2) Establish and apply methodology (2008-2009), 3) Consolidate and grow (2009-2013), 4) Adapt and review (2014) and 5) Strengthen and systematise (2015-2016). * **Finland**: Finland worked towards a Health in All Policies (HiAP) approach over the past four decades (285). In the early 1970s, improving public health became a political priority, and the need to influence key determinants of health through sectors beyond the health sector became evident. The work began with a policy on nutrition, smoking and accident prevention. Finland adopted HiAP as the health theme for its EU Presidency in 2006 (286). |

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# Appendix:

### Table of Heart Foundation Reformulation Targets 2019 (6)

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Nutrient Target** | **Timeframe** | **Progress** |
| **Bread**  Leavened bread  Unleavened bread | **Sodium**  380mg/100g  Sodium 450mg/100g | Target reset August 2018;  target review December 2022 | 2007-2008: Many companies did large reductions of around 20% to meet the target 450mg.  2014: over 80% market share (by sales volume) met the 450mg target. Target was rest to 400mg/100g.  2017: an additional 4.8% reduction had been achieved across the category. 73% market share (by sales volume) met the 400mg target. Over 176 tonnes of salt per annum removed from this category (2007-Dec 2017). |
| **Breakfast Cereal**  Puffed rice and corn flakes  Oat based muesli, porridge  Biscuits  Other Ready-to Eat cereals  All breakfast cereals | **Sodium**  500mg/100g  200mg/100g  300mg/100g  400mg/100g  **Total Sugar**  22.5g/100g OR 20% reduction for products significantly over 25g/100g | Targets reset August 2016; target review August 2021  Target set August 2016;  target review August 2021 | 2010: targets set  2016 review: over 80% market share met the 2010 sodium targets. Over five years (2010-2016) there was around a 25% reduction in breakfast cereals largely due to large reductions being made in rice bubble, cornflake and other children’s styled cereals. Our research looking at changes in the sodium content of breakfast cereals over a 10-year period (2003 – 2013) indicated that some children’s cereals had on average a 33% reduction in sodium levels.  From 2010 – 2016 an estimated 27 tonnes of salt per annum removed across the category.  Aug 2016: Sodium targets reset, and sugar target set |
| **Processed Meats**  Sausages  Bacon  Ham | **Sodium**  650mg/100g  1090mg/100g  1090mg/100g | Targets reset December 2015;  target review December 2020 | 2011: Targets set  2015 review: over 80% market share of sausages met 800mg/100g (2011 target).  Over 1 year (2015-2016) two manufacturers, reduced the average sodium levels by 12% across 30 products. This is equivalent to over 13 tonnes of salt per annum removed.  Over 50 tonnes of salt per annum removed from this category (2011-2016) |
| **Savoury Pies**  Mince/Steak  Mince & cheese/steak & cheese | **Sodium**  400mg/100g  **Saturated fat**  5g/100g  **Sodium**  400mg/100g  **Saturated fat**  7g/100g | Targets set 2012  Targets set 2012 | Over 10 tonnes of salt per annum removed from this category since target set 2012. |
| **Soups**  All soups | **Sodium**  280mg/100g (maximum) or 20% reduction for products significantly over  280mg/100g | Targets reset 2017;  Target review August 2022. | 2016 review: 11% sodium reduction in matched reformulated pairs. 2.4 tonnes salt removed (2014-2016). |
| **Cheese**  Cheddar and Cheddar-style  Mozzarella cheese  Processed cheese | **Sodium**  710mg/100g  550mg/100g  1270mg/100g OR 10-15% ↓ in products significantly above 1270mg/100g | Targets set 2014 | In progress |
| **Savoury snacks**  Potato chips  Salt and vinegar snacks  Extruded snacks  Corn (cereal based) snacks | **Sodium**  550mg/100g (average)  800mg/100g (maximum)  850mg/100g (average)  1100mg/100g (maximum)  950mg/100g (average)  1250mg/100g (maximum)  550mg/100g (average)  700mg/100g (maximum) | Targets set 2014;  target review in process | 2014: Average and maximum targets set.  2018 review: Three categories had over 90% of their SKUs below the maximum sodium targets; the exception being extruded snacks (81%). Based on the top selling SKUs (80% sales volume), the average sodium for each of the 4 categories met the average target. There has been between 10% and 32% reduction in the median sodium content for each of the four categories of snacks (April 2014 - April 2018). This considers product reformulation, product deletion and new product development. Based on sodium reduction in matched pairs of products, almost 11 tonnes of salt have been removed from reformulated snacks since 2014.  2019: The reset sodium targets represent 26-38% reductions from the previous targets set in 2014. |
| **Cooking Sauces**  Pasta, Indian-style and other sauces which are a major characterising component of a meal  Asian sauces | **Sodium**  380mg/100g OR 15% reduction for products significantly above 380mg/100g100g  **Total Sugar**  5g/100g OR 15% reduction for products significantly above 5g/100g  **Sodium**  680mg/100g OR 15% reduction for products significantly above 680mg/100g  **Total Sugar**  20g/100g OR 15% reduction for products significantly above 20g/100g | Targets reset 2018;  target review June 2023 | 2014: Targets set  2017 review: Pasta/Indian sauces:77% (by sales volume) met 420mg target; 11%-13% reduction in mean sodium across categories. But of the companies that make up 70%. Asian sauces: 50% (by sales volume) met the 680mg target. Total 6.3 tonnes salt removed per annum from matched pairs (also includes reformulation of Asian sauces) 2014-2017. |
| **Powdered Meal Bases** | **Sodium**  5000mg/100g OR 15% reduction for products significantly above 5000mg/100g | Targets set December 2017; Target review 2023 | In progress |
| **Edible Oil Spreads**  Margarine/oil-based spreads | **Sodium**  400mg/100g | Target set 2014;  Review to be confirmed |  |
| **Savoury Crackers**  Plain crackers  Flavoured crackers  Rice crackers and corn crackers | **Sodium**  610mg/100g  800mg/100g  610mg/100g  OR  2020% reduction for those significantly above targets | Targets reset 2017;  target review June 2022 | 2014: Targets set  2016 review: 10.5% reduction in category median sodium. 7.2 tonnes salt removed from reformulation of matched pairs. 77% (by sales volume) of the top-selling 40 products) met the 2014 targets. |
| **Table Sauce**  Tomato Sauce | **Sodium**  680mg/100g OR 15% reduction for those significantly above target  **Total Sugar**  23g/100g OR 15% reduction for those significantly above target | Targets set May 2016; target review May 2021 | In progress |
| **Canned Baked Beans** | **Sodium**  350mg sodium/100g  **Total Sugar**  5g sugar/100g | Targets set May 2016; target review May 2021 | In progress |
| **Canned Spaghetti** | **Sodium**  350mg/100g  **Total Sugar**  4.5g/100g | Targets set May 2016; target review May 2021 | In progress |
| **Cereal and Nut/Seed Bars** | **Total sugar**  25g /100g OR 15% reduction for products significantly above target | Target set May 2017; target review May 2021 | In progress |
| **Dairy yoghurt & Dairy foods** | **Total Sugar**  8.5g/100g OR15% reduction for products significantly above 8.5g/100g | Target set February 2018; target review February 2023 | In progress |
| **Flavoured Dairy Milk** | **Total Sugar**  7g/100g OR10% reduction for products significantly above 7.0g/100g | Target set April 2018; target review April 2023 | In progress |
| **Crumbed and Battered Proteins**  Meat and poultry  Seafood | **Sodium**  A reduction in sodium across defined products to 450mg/100g OR 15% reduction for products significantly over 450mg/100g  A reduction in sodium across defined products to  270mg/100g OR 15%  reduction for products  significantly over 270mg/100g. | Target set December  2019;  target review December  2023 | In progress |
| **Ready Meals** |  | Target setting in consultation |  |

1. Food environments are defined as the collective physical, economic, policy and socio-cultural surroundings, opportunities and conditions that influence people’s food and beverage choices and nutritional status. Unhealthy food environments lead to unhealthy diets and excess energy intake which have consequences in levels of morbidity and mortality. Dietary risk factors (high salt intake, high saturated fat intake and low fruit and vegetable intake) and excess energy intake (high body mass index) account for 11.4% of health losses in New Zealand. [↑](#footnote-ref-2)