**Nutrition Surveillance Dissemination Platform- Requirements for Usual Intake Data Tools**

1. **Purpose**

This document describes the updated requirements for Nutrition Surveillance Data Tool. This tool is initially being designed for the dissemination of usual nutrient intake data from the 2015 Canadian Community Health Survey–Nutrition (CCHS-Nutrition). The long-term goal is to create a central hub for all FD nutrition surveillance data.

1. **Background**

National nutrition surveillance data are used by diverse audiences including but not limited to various federal departments, provinces, health care professionals, industry, academics, media and the public. The CCHS-Nutrition, a nationally representative survey of the nutrition of Canadians, provides essential data for an evidence-based food and nutrient standard setting and regulatory system and an important line of evidence to support policies related to dietary guidance. The latest survey was conducted in 2015. Development and implementation of the 2015 CCHS-Nutrition was a joint initiative between Health Canada and Statistics Canada (STC), similar to when this survey was last done in 2004.

Given the importance of the CCHS-Nutrition data for multiple themes in the HPFB’s Strategic Plan 2016-21 and the broad group of interested stakeholders, dissemination is a key priority. The Bureau of Food Surveillance and Science Integration (BFSSI) is responsible for this dissemination. For 2004 CCHS-Nutrition, nutrient intake data were released in the Compendium of Nutrient Intake Table that consisted of three volumes available on CD and a limited number of print copies. Food intake data were disseminated on the Government of Canada’s Open Government through the [Food Consumption Table](https://open.canada.ca/data/en/dataset/b18d19c9-f0d4-455b-b3eb-4cc38d6a3c53). Health indicators for each province (e.g. fruit and vegetable consumption, household food security, measured body mass index, nutrient intakes from foods) were disseminated through [Canada’s Nutrition and Health Atlas](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/canada-nutrition-atlas.html), which presented data visually through maps and tables. In addition, dissemination of various analyses occurred through publications in scientific journals and conference presentations.

The analysis of usual nutrient intakes for 2015 CCHS-Nutrition is complete and we are working to modernize how we disseminate the data. BFSSI will post the full dataset in one csv file on Open Government, thereby fulfilling the commitment to make the 2015 CCHS-Nutrition nutrient intake data available to the public; however, there is great value in sharing the data in a more interactive, easily digested and user-friendly way. Based on a scan of dissemination and data visualization methods being used in other departments, we identified the Public Health Agency of Canada’s (PHAC) [Health Infobase website](https://infobase.phac-aspc.gc.ca/index-en.html) as the ideal venue to share the data. Through the Health Infobase, PHAC helps users to discover and visualize public health data and health indicators. PHAC has expressed willingness to collaborate and to create a Nutrition Surveillance data tool on the Infobase. This collaboration is optimal as BFSSI has the expertise and capacity to develop the interactive data tools and PHAC has established an efficient process for posting. The Director General of the Food Directorate has expressed support for integrating nutrition surveillance data into the PHAC Infobase.

The initial visualizations being developed included data from both 2004 and 2015 as one of the objectives of 2015 CCHS-Nutrition was to evaluate changes from the 2004 CCHS-Nutrition. Differences in intakes between the two survey years may reflect changes in consumption patterns, changes in the nutrient composition of foods and/or changes in survey methodology among other potential explanations. It is challenging to quantify the contribution that methodological differences between survey years has on nutrient intake estimates. Thus, it was decided that we avoid direct between-year comparisons of estimates in the visualizations in an effort to minimize the risk of inappropriate conclusions being drawn from the data. In light of this decision, revised requirements for three tools to present the usual intake data are provided below.

1. **Overview of requirements:**

Main page

|  |  |  |
| --- | --- | --- |
|  | **English** | **French** |
| **Page title** | Usual intakes from food, 2015 | Apports usuels provenant des aliments, 2015 |
| **Tabs** | 1. About the data 2. Usual intake data table 3. Usual intake distribution curves 4. Geographic comparison | 1. Au sujet des données 2. Tableau des données sur les apport usuels 3. Courbes de distribution de l’apport usuel 4. Comparaison géographique |
| **Information to display at top of page**  **(When tabs 2 to 4 selected)** | For more information on the 2015 Canadian Community Health Survey - Nutrition, please consult the [Reference Guide to Understanding and Using the Data](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/reference-guide-understanding-using-data-2015.html) and the [Methodology Guide](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/compendium-data-tables-intakes-energy-nutrients-other-food.html). | Pour plus d’information sur l’Enquête sur la santé dans les collectivités canadiennes (ESCC) – Nutrition, 2015, veuillez consulter [le guide de référence pour comprendre et utiliser les données](https://www.canada.ca/fr/sante-canada/services/aliments-nutrition/surveillance-aliments-nutrition/sondages-sante-nutrition/enquete-sante-collectivites-canadiennes-escc/guide-reference-comprendre-utiliser-donnees-2015.html) et le [document méthodologique](https://www.canada.ca/fr/sante-canada/services/aliments-nutrition/surveillance-aliments-nutrition/sondages-sante-nutrition/enquete-sante-collectivites-canadiennes-escc/compendium-tableaux-donnees-apports-energie-nutriments-autres-aliments.html). |

Tab #1: About the data: The objective of this tab is to provide contextual information about CCHS – Nutrition, the objective of the Data Tool and supportive information that apply to all of the graphs and tables presented in the Data Tool.

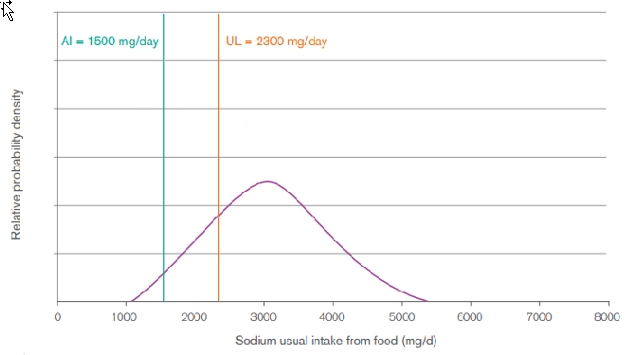
This should be the landing page when users navigate to the Nutrition Surveillance Data Tool.

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| **ENGLISH** | **FRENCH** |
| **About the Usual Intakes Data Tool**  The Nutrition Surveillance Data Tool presents usual intakes of energy, nutrients and other dietary components using data collected in the [2015 Canadian Community Health Survey – Nutrition](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/2015-canadian-community-health-survey-nutrition-food-nutrition-surveillance.html) (CCHS – Nutrition). The goal is to complement the full usual intake dataset published on the Government of Canada’s Open Data portal by presenting the data in an interactive and user-friendly way. This large dataset contains distribution of usual intakes of 41 nutrients/dietary component for 16 age-sex groupings and 13 geographical regions (Canada excluding the territories, provinces and regions). For nutrients for which [Dietary Reference Intakes](https://www.canada.ca/en/health-canada/services/food-nutrition/healthy-eating/dietary-reference-intakes.html) (DRIs) have been established, the dataset also contains comparisons of usual intakes of selected nutrients to the DRIs.  This data tool enables users to look at the 2015 CCHS – Nutrition usual intake data in three ways:   1. In a customizable table, that presents usual intake distributions for nutrient, age-sex group(s) and region(s) of interest. 2. In a graph, that displays the usual intake distribution among Canadians for a nutrient and age-sex group of interest and where these intakes fall relative to DRIs. 3. On a map of Canada, that shows the percentage of the population in each province consuming inadequate or excessive intakes of nutrients of interest.   **About the 2015 Canadian Community Health Survey – Nutrition (CCHS – Nutrition)**  The 2015 CCHS-Nutrition is a nationally representative survey of the nutrition of people in Canada. The survey provides detailed information on food consumption using a 24-hour dietary recall for the total sample and a repeat sub-sample, nutrient supplement intake, physical measurements, household food insecurity, and other topics that support the interpretation of the 24-hour recall.  **Information to support the interpretation of the data**  We encourage users to read the following Health Canada publications:   * [Reference Guide to Understanding and Using the Data - 2015 Canadian Community Health Survey – Nutrition](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/reference-guide-understanding-using-data-2015.html) * [Methodology document: Usual intakes from food for energy, nutrients and other dietary components (2004 and 2015 Canadian Community Health Survey - Nutrition)](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/compendium-data-tables-intakes-energy-nutrients-other-food.html).   The following notes apply to the graphs and tables presented in this Data Tool.   * 1. The survey excludes those living in the three territories, individuals living on reserves, residents of institutions, full‐time members of the Canadian Armed Forces and residents of certain remote regions.   2. The table excludes pregnant and breastfeeding females, subject to another set of nutritional recommendations. The sample of pregnant and breastfeeding females is not large enough to allow for reliable estimates at the provincial level.   3. Sample size is based on the first 24‐hour dietary recall (first day of interview) only.   4. Intakes are based on food consumption only. Intakes from vitamin and mineral supplements are not included. Inferences about the prevalence of nutrient excess or inadequacy based on intakes from food alone may respectively underestimate or overestimate the prevalence based on total nutrient intakes from both food and supplements.   5. The intake distribution (percentiles and percentage above or below a cut‐off when applicable) was adjusted using the National Cancer Institute (NCI) Method as described in the [Methodology Guide](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/compendium-data-tables-intakes-energy-nutrients-other-food.html).   6. Bootstrapping techniques were used to produce the coefficient of variation and the standard error (SE).   7. AMDR is the Acceptable Macronutrient Distribution Range, expressed as a percentage of total energy intake. Intakes inside the range (shown in the AMDR columns) are associated with a reduced risk of chronic disease while providing adequate intakes of essential nutrients. For further information on AMDR in assessing population groups, see the Health Canada publication [Reference Guide to Understanding and Using the Data - 2015 Canadian Community Health Survey- Nutrition](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/reference-guide-understanding-using-data-2015.html), Section 2.2.6 page 28.   8. EAR is the Estimated Average Requirement. In the context of reporting results in a population-based survey such as the 2004 and 2015 CCHS-Nutrition, the primary use of the EAR is to estimate the prevalence of inadequacy of some nutrients in a group. For further information on EAR and how to interpret the prevalence of inadequacy in a population see the Health Canada publication [Reference Guide to Understanding and Using the Data - 2015 Canadian Community Health Survey – Nutrition](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/reference-guide-understanding-using-data-2015.html), Section 2.2.2, page 24.   9. AI is the Adequate Intake. The level of intake at the AI (shown in the AI columns) is the recommended average daily intake level based on observed or experimentally determined approximations or estimates of nutrient intake by a group or groups of apparently healthy people that are assumed to be adequate. It is developed when an EAR cannot be determined. The percentage of the population having a usual intake above the AI (shown in the %>AI columns) almost certainly meets their needs. The adequacy of intakes below the AI cannot be assessed, and should not be interpreted as being inadequate. For further information on AI and how to interpret the prevalence of inadequacy in a population, see the Health Canada publication [Reference Guide to Understanding and Using the Data - 2015 Canadian Community Health Survey – Nutrition](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/reference-guide-understanding-using-data-2015.html), Section 2.2.4, pages 25-26.   10. UL is the Tolerable Upper Intake Level. The level of intake at the UL (shown in the UL columns) is the highest average daily intake level that is likely to pose no risk of adverse health effects to almost all individuals in the general population. For further information on UL and how to interpret the prevalence of intakes above the UL in a population, see the Health Canada publication [Reference Guide to Understanding and Using the Data - 2015 Canadian Community Health Survey – Nutrition](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/reference-guide-understanding-using-data-2015.html), Section 2.2.5, page 28. In 2017, the Guiding Principles for Developing Dietary Reference Intakes Based on Chronic Disease recommended that the UL be retained in the expanded Dietary Reference Intake (DRI) model, but that it should characterize toxicological risk.   11. The Chronic Disease Risk Reduction Intake (CDRR) is the lowest level of intake for which there is sufficient strength of evidence to characterize a chronic disease risk reduction. For more detailed understanding of the CCDR and its interpretation when assessing intakes of particular nutrients, consult the 2017 National Academies report, [Guiding Principles for Developing Dietary Reference Intakes Based on Chronic Disease](http://www.nationalacademies.org/hmd/Reports/2017/guiding-principles-for-developing-dietary-reference-intakes-based-on-chronic-disease.aspx).   12. For a more detailed understanding of DRIs and their interpretation when assessing intakes of particular nutrients, consult the summary of the series of publications on DRIs published by the Institute of Medicine: [Dietary Reference Intakes: The Essential Guide to Nutrient Requirements](https://www.nap.edu/catalog/11537/dietary-reference-intakes-the-essential-guide-to-nutrient-requirements), (2006).   13. For more detailed understanding of DRIs and their interpretation when assessing intakes of sodium and potassium, consult the [Dietary Reference Intakes for Sodium and Potassium](https://www.nap.edu/catalog/25353/dietary-reference-intakes-for-sodium-and-potassium), 2019.   14. Data on trans-fat intake cannot be obtained from the 2015 CCHS-Nutrition dataset and therefore are not reported separately. However, the estimates for percent energy from total fat comprise all fats, including trans-fats. Note that the estimates provided for energy intake from the individual types of fat will not add up to the estimates provided for total fat due to measurement error as well as the lack of data on trans-fat intake.   15. In terms of precision, the estimate 0.0 with a SE of 0.0 refers to a standard error smaller than 0.1%.   16. Data with a coefficient of variation from 16.6% to 33.3% are identified as follows: (E) use with caution.   17. Data with a coefficient of variation greater than 33.3% with a 95% confidence interval entirely between 0 and 3% are identified as follows:  <3 interpret with caution.   18. Data with a coefficient of variation greater than 33.3% were suppressed due to extreme sampling variability and are identified as follows: (F) too unreliable to be published.   **Suggested citation:** Nutrition Surveillance Data Tool, 2020 Edition. A joint initiative of Health Canada and the Public Health Agency of Canada.  **Correspondence:** Bureau of Food Surveillance and Science Integration, Food Directorate, Health Canada, 251 Sir Frederick Banting Driveway, A.L. 2201E, Ottawa, ON K1A 0K9; Email: HC.Nutrition.Surveillance-Nutritionelle.SC@canada.ca  **Acknowledgements:** The development of this Data Tool was made possible through collaboration of the Public Health Agency of Canada (PHAC) and Health Canada. The production of the intake estimates was a joint venture between Health Canada and Statistics Canada. | To be translated |

Tab #2 - Usual intake data table: The objective of this tool is to enable users to sub-set, display and download the usual intake data included in the csv file on Open Government (2015 data only) in a visually-appealing table format.

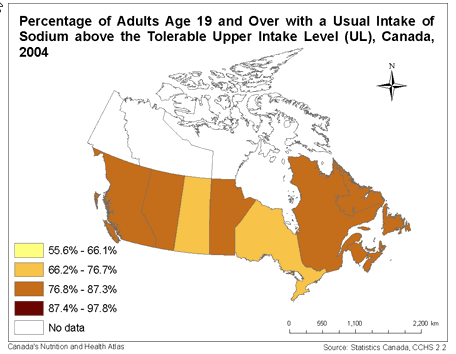
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| Data files | Y:\HC\HPFB\FD\BFSSI\HEALTH RISK PROTECTION HC6\SURVEILLANCE\2015 CCHS Nutrition\Dissemination\Infobase\Data files\Usual Intake Data Table |
| Tab title | ENGLISH: Usual intake data table  FRENCH: Tableau des données sur les apport usuels |
| Selectable fields | Which rows to display   * Nutrient/Item 🡪 limited to selecting only one * Region 🡪 multiple selections * Sex 🡪 multiple selections * Age🡪 multiple selections   Which columns to display   * Data: Mean, Percentiles, % above or below DRIs. Enable multiple selections * NOTE: If % above or below DRIs is selected, the table should only display the DRI columns relevant to the selected nutrient. For example: Sodium has an AI and a CDRR, so the table should not include the columns for EAR, AMDR, UL |
| Default selection | ▪ Nutrient: total energy intake  ▪ Region: Canada excluding the territories  ▪ Sex: all  ▪ Age: all  ▪ Data: all available options (for energy intake: this would only include mean and percentiles) |
| Table title - English | “ [Nutrient]: Usual intakes from food, [sex], [age], [region], 2015”  *Example: “Sodium (mg/d): Usual intakes from food, males, 19-30 years, Alberta, 2015”*  *Example: “Potassium (mg/d): Usual intakes from food, males and females, 9-13 years, Canada excluding the territories and Alberta, 2015”* |
| Table title – French | *To complete once English finalized* |
| Table footnotes - English  [to be included when people download the table] | Data Source: Statistics Canada, 2015 Canadian Community Health Survey - Nutrition, 2015, Share File. |
| Table footnotes - French  [to be included when people download the table] | Source des données: Statistique Canada, Enquête sur la santé dans les collectivités canadiennes (ESCC) - Nutrition , 2015 - Fichier partagé. |
| Notes and Legend - English | Please refer to the “About the data” tab for detailed notes that apply to all of the tables and graphs in the Usual Intake Data Tool.  E: Data with a coefficient of variation (CV) from 16.6% to 33.3%; interpret with caution.  <3: Data with a coefficient of variation (CV) greater than 33.3% with a 95% confidence interval entirely between 0 and 3%; interpret with caution.  F: Data with a coefficient of variation (CV) greater than 33.3% with a 95% confidence interval not entirely between 0 and 3%; suppressed due to extreme sampling variability.  AI: Adequate Intake  AMDR: Acceptable Macronutrient Distribution Range  CDRR : Chronic Disease Risk Reduction Intake Level  d: Day  DFE: Dietary folate equivalent  DRI: Dietary Reference Intake  EAR: Estimated Average Requirement  g: Gram  kcal: Kilocalorie  mcg: Microgram  mg: Milligram  NE: Niacin equivalent  P: Percentile, e.g. 'P95' describes the 95th percentile.  RAE: Retinol activity equivalent  SE: Standard Error  UL: Tolerable Upper Intake Level |
| Notes and Legend - French | Veuillez référer à l'onglet « A propos des données » pour des notes détaillées qui s'appliquent à tous les tableaux et graphiques de l'outil de données sur les apports usuels.  E: Données dont le coefficient de variation (CV) se situe entre 16,6% et 33,3%; utiliser avec prudence.  <3 : Données dont le coefficient de variation (CV) est supérieur à 33,3%, avec un intervalle de confiance de 95% entièrement compris entre 0 et 3%; utiliser avec prudence.  F : Données dont le coefficient de variation (CV) est supérieur à 33,3%, avec un intervalle de confiance de 95% pas entièrement compris entre 0 et 3%; supprimées en raison de l'extrême variabilité d'échantillonnage.  AMT : Apport maximal tolérable  ANREF : Apports nutritionnels de référence  AS : Apport suffisant  BME : Besoin moyen estimatif  ÉAR: Équivalent d’activité du rétinol  ÉFA: Équivalent de folate alimentaire  ÉN: Équivalent de niacine  ET : Erreur type  ÉVAM : Étendue des valeurs acceptables pour les macronutriments  g: Gramme  j : Jour  kcal: Kilocalorie  mcg : Microgramme  mg : Milligramme  P : Percentile, p. ex. “P95” decrit le 95e percentile.  RRMC : Apport relié à un risque réduit de maladie chronique |
| Notes for specific nutrients | * Folacin: There are two chemical forms in foods that contribute to folate bioactivity: naturally occurring folate called “food folate” and the added synthetic form of folate called “folic acid”. The term “folacin” is a measuring unit referring to the simple arithmetic sum of the content of both food folate and folic acid in foods (in micrograms). * Iron: Iron inadequacy was estimated using the full probability method as described in section 2.3.4 of the [Methodology Guide](https://www.canada.ca/en/health-canada/services/food-nutrition/food-nutrition-surveillance/health-nutrition-surveys/canadian-community-health-survey-cchs/compendium-data-tables-intakes-energy-nutrients-other-food.html). * Linolenic acid: Linolenic acid is an alternative name for α‐linolenic acid (n‐3). * Moisture: The term “moisture” includes water from all food and beverage sources. * Protein: Although DRIs for protein have been established on a “per kg body weight” basis, no DRIs have been established for the absolute amount of protein. * Vitamin A: No prevalences of intakes above the UL are shown for vitamin A. The UL for vitamin A applies to preformed vitamin A only, and those estimates had not yet been conducted at the time these tables were produced. |
| Notes relatives aux nutriments spécifiques | * Acide linolénique: Acide linolénique est un autre nom pour acide α‐linolénique (n‐3). * Eau totale: Le terme « eau totale » inclut l’eau provenant de toutes les sources d’aliments et de boissons. * Fer: L'insuffisance en fer a été estimer à l'aide de la méthode fondée sur les probabilités totales, comme décrit à la section 2.3.4 du [document méthodologique](https://www.canada.ca/fr/sante-canada/services/aliments-nutrition/surveillance-aliments-nutrition/sondages-sante-nutrition/enquete-sante-collectivites-canadiennes-escc/compendium-tableaux-donnees-apports-energie-nutriments-autres-aliments.html). * Folacine: Dans les aliments qui présentent une teneur en folate, ce dernier prend actuellement deux formes chimiques : le folate alimentaire, c’est à dire le folate d’origine naturelle, et l’acide folique, soit la forme synthétique de folate ajoutée aux aliments. Le terme « folacine » correspond à une unité de mesure correspondant à la simple somme arithmétique du contenu en folate alimentaire et en acide folique présent dans les aliments, en microgrammes. * Protéines: Bien que des ANREF pour les protéines aient été établis sur la base de la quantité par kg de poids corporel, aucun ANREF a été établi pour les quantités absolues de protéines. * Vitamine A: Aucune prévalence pour les apports en dessus du AMT n’est calculée pour la vitamine A. Le AMT pour la vitamine A est fixé pour la vitamine A préformée seulement, et ces estimations n’avaient pas encore été faites lorsque ces tableaux ont été produits. |
| Download options | ▪ Download table as displayed [would it be possible to download the table as formatted on the webpage and not as an excel file?]  ▪ Download full dataset |

Tab #3 – Usual intake distribution curves:The objective of this tool is to enable users visualize the distribution of intakes of nutrients of public health concern and easily see where intakes fall related to Dietary Reference Intakes. A rough idea of what the graph should look like is coped below:



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| Data files |  |
| Tab title | ENGLISH: Usual intake distribution curves  FRENCH: Courbes de distribution de l’apport usuel |
| Selectable fields | ▪ Nutrient 🡪 limited to selecting only one  ▪ Sex 🡪 limited to selecting only one  ▪ Age 🡪 limited to selecting only one  ▪ Option to add or remove the Dietary Reference Intake values from the graph |
| Default selection | ▪ Nutrient: total energy intake  ▪ Sex: males  ▪ Age: 19 years and over |
| Graph & axis titles - English | ▪ Graph title: [Nutrient] usual intake distribution, [sex], [age], Canada, 2015  *Example:* *Sodium usual intake distribution curve, males, 19-30 years, Canada, 2015*  ▪ Y-axis title: Relative probability density  ▪ X-axis title: [Nutrient] usual intake from food ([nutrient unit]) |
| Graph & axis titles - French | ▪ Graph title: Courbe de distribution de l’apport en [Nutriment] usuel, [sexe], [âge], Canada, 2015  *Exemple:* *Courbe de distribution de l’apport en sodium usuel, hommes, 19 à 30 ans, Canada, 2015*  ▪ Y-axis title: Densité de probabilité relative  ▪ X-axis title: Apport usuel en [nutriment] provenant d’aliments ([nutrient unit]) |
| Graph footnotes - English  [to be included when people download the graph] | Data Source: Statistics Canada, 2015 Canadian Community Health Survey - Nutrition, 2015, Share File. |
| Graph footnotes - French  [to be included when people download the graph] | Source des données: Statistique Canada, Enquête sur la santé dans les collectivités canadiennes (ESCC) - Nutrition , 2015 - Fichier partagé. |
| Summary data table note: | \* Because the data points used to create the visualization are less meaningful than the percentiles of usual intakes, the table should display the corresponding mean and percentiles of intake for the selected nutrient and age-sex group as presented in the Data Table in Tab #1. |
| Summary data table\* title - English | Percentiles of [Nutrient] usual intake, [sex], [age], Canada, 2015  *Example:* *Percentiles of sodium usual intake, males, 19-30 years, Canada, 2015* |
| Summary data table\* title - French | Percentiles de l’apport usuel en [Nutrient], [sexe], [âge], Canada, 2015  *Exemple:* *Percentiles de l’apport usuel en sodium, hommes, 19 à 30 ans, Canada, 2015* |
| Other requirements | ▪ To remain compliant with accessibility standards, a text description of the graph as it is displayed will also be provided. [Julie is working on these]  ▪ Dynamic text box with important nutrient-specific statements. See appendix 1 for list of statements. |
| Notes and Legend - English | Please refer to the “About the data” tab for detailed notes that apply to all of the tables and graphs in the Usual Intake Data Tool.  Relative probability density estimates were generated from the percentiles of usual intake data set using a Gaussian Kernel density estimation method.  E: Data with a coefficient of variation (CV) from 16.6% to 33.3%; interpret with caution.  <3: Data with a coefficient of variation (CV) greater than 33.3% with a 95% confidence interval entirely between 0 and 3%; interpret with caution.  F: Data with a coefficient of variation (CV) greater than 33.3% with a 95% confidence interval not entirely between 0 and 3%; suppressed due to extreme sampling variability.  AI: Adequate Intake  AMDR: Acceptable Macronutrient Distribution Range  CDRR : Chronic Disease Risk Reduction Intake Level  d: Day  DFE: Dietary folate equivalent  DRI: Dietary Reference Intake  EAR: Estimated Average Requirement  g: Gram  kcal: Kilocalorie  mcg: Microgram  mg: Milligram  NE: Niacin equivalent  P: Percentile, e.g. 'P95' describes the 95th percentile.  RAE: Retinol activity equivalent  SE: Standard Error  UL: Tolerable Upper Intake Level |
| Notes and Legend - French | Veuillez référer à l'onglet « A propos des données » pour des notes détaillées qui s'appliquent à tous les tableaux et graphiques de l'outil de données sur les apports usuels.  E: Données dont le coefficient de variation (CV) se situe entre 16,6% et 33,3%; utiliser avec prudence.  <3 : Données dont le coefficient de variation (CV) est supérieur à 33,3%, avec un intervalle de confiance de 95% entièrement compris entre 0 et 3%; utiliser avec prudence.  F : Données dont le coefficient de variation (CV) est supérieur à 33,3%, avec un intervalle de confiance de 95% pas entièrement compris entre 0 et 3%; supprimées en raison de l'extrême variabilité d'échantillonnage.  AMT : Apport maximal tolérable  ANREF : Apports nutritionnels de référence  AS : Apport suffisant  BME : Besoin moyen estimatif  ÉAR: Équivalent d’activité du rétinol  ÉFA: Équivalent de folate alimentaire  ÉN: Équivalent de niacine  ET : Erreur type  ÉVAM : Étendue des valeurs acceptables pour les macronutriments  g: Gramme  j : Jour  kcal: Kilocalorie  mcg : Microgramme  mg : Milligramme  P : Percentile, p. ex. “P95” decrit le 95e percentile.  RRMC : Apport relié à un risque réduit de maladie chronique |
| Download options | ▪ Download graph  ▪ Download table as displayed  ▪ Download full dataset |

Tab #4 – Geographic comparisons: The goal of this tool is to enable users to see whether Canadians are consuming inadequate or excessive amounts of nutrients of public health concern and if this differs across the provinces. This is an update to the maps presented in the Nutrition and Health Atlas. An example figure is presented below:



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| --- | --- |
| Data file | Y:\HC\HPFB\FD\BFSSI\HEALTH RISK PROTECTION HC6\SURVEILLANCE\2015 CCHS Nutrition\Dissemination\Infobase\Data files\Percent Below EAR with SE from Cunye |
| Notes about the data | Some nutrients only have data for males and females combined |
| Tab title | ENGLISH: Geographic comparison  FRENCH: Comparaison géographique |
| Selectable fields | ▪ Nutrient 🡪 limited to selecting only one  ▪ Sex 🡪 limited to selecting only one |
| Default selection | ▪ Nutrient: sodium  ▪ Sex: Both |
| Graph and summary data table title - English | ▪ Graph title: Percentage of adults age 19 and over with a usual intake of [Nutrient/Item] [Prefix-EN] the [DRI type], [Sex], Canada, 2015  *Example: Percentage of adults age 19 and over with a usual intake of calcium below the Estimated Average Requirement, Canada, 2015* |
| Graph and summary data table title - French | ▪ Graph title: Pourcentage d'adultes de 19 ans et plus dont l'apport usuel en [Nutriment/Item] est [Prefix-FR] [Type de ANREF], [Sex], Canada, 2015  *Exemple : Pourcentage d'adultes de 19 ans et plus dont l'apport usuel en calcium est inférieur au besoin moyen estimatif, Canada, 2015* |
| Summary data table note: | The summary data table can reflect the data as presented in the graph. |
| Graph footnotes - English  [to be included when people download the graph] | Data Source: Statistics Canada, 2015 Canadian Community Health Survey - Nutrition, 2015, Share File. |
| Graph footnotes - French  [to be included when people download the graph] | Source des données: Statistique Canada, Enquête sur la santé dans les collectivités canadiennes (ESCC) - Nutrition , 2015 - Fichier partagé. |
| Notes and Legend - English | Note: Some maps for males and females separately are unavailable due to extreme sampling variability in some provinces.  AI: Adequate Intake  AMDR: Acceptable Macronutrient Distribution Range  CDRR : Chronic Disease Risk Reduction Intake Level  DRI: Dietary Reference Intake  EAR: Estimated Average Requirement  P: Percentile, e.g. 'P95' describes the 95th percentile.  SE: Standard Error  UL: Tolerable Upper Intake Level |
| Notes and Legend - French | Note : Certaines cartes ne sont pas présentées en raison de la variabilité extrême de l’échantillonnage dans certaines provinces.  AMT : Apport maximal tolérable  ANREF : Apports nutritionnels de référence  AS : Apport suffisant  BME : Besoin moyen estimatif  ET : Erreur type  ÉVAM : Étendue des valeurs acceptables pour les macronutriments  P : Percentile, p. ex. “P95” decrit le 95e percentile.  RRMC : Apport relié à un risque réduit de maladie chronique |
| Other requirements | ▪ Dynamic text box with important nutrient-specific statements. See appendix 1 for list of statements. |

Nutrient-specific information:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Nutrient** | **English** | **French** | **Distribution** | **Map** |
| Vitamin D | **⚠ Estimates of the prevalence of inadequate intakes of vitamin D from food must be interpreted with caution.**  Vitamin D is unique as it can be obtained from diet and supplements and can also be synthesized by the body from sunlight (UVB radiation). Vitamin D intake from supplements has not been considered in this assessment. While there appears to be a high prevalence of inadequate intakes of vitamin D from dietary sources, available blood biomarker measures do not suggest widespread vitamin D deficiency in the Canadian population.1,2,3 While there appears to be a low prevalence of vitamin D deficiency, some sub-populations may warrant further consideration.  References   1. Langlois K, Greene-Finestone L, Little J, Hidiroglou N, Whiting S. Vitamin D status of Canadians as measured in the 2007 to 2009 Canadian Health Measures Survey. Health Rep. 2010;21(1):47–55. 2. Whiting SJ, Langlois KA, Vatanparast H, Greene-Finestone LS. The vitamin D status of Canadians relative to the 2011 Dietary Reference Intakes: an examination in children and adults with and without supplement use. Am J Clin Nutr. 2011;94(1):128–135. doi:10.3945/ajcn.111.013268 3. Statistics Canada. Canadian Health Measures Survey: Non-environmental laboratory and medication data, 2016 and 2017. The Daily. 2019. Available from: https://www150.statcan.gc.ca/n1/daily-quotidien/190206/dq190206c-eng.htm | **⚠ Les estimations de la prévalence d’un apport alimentaire insuffisant en vitamine D doivent être interprétées avec prudence.**  La vitamine D est unique car elle peut être obtenue par l’alimentation et les suppléments et peut également être synthétisée dans l'organisme à partir de la lumière du soleil (rayonnement UVB). L'apport de vitamine D provenant des suppléments n'a pas été considéré dans cette analyse. Bien que la prévalence d'un apport insuffisant de vitamine D semble élevée, les mesures de biomarqueurs sanguins disponibles ne suggèrent pas que la carence en vitamine D soit généralisée dans la population canadienne.1,2,3 Bien qu'il semble y avoir une faible prévalence de carence en vitamine D, certaines sous-populations pourraient mériter un examen plus approfondi.  References   1. Langlois K, Greene-Finestone L, Little J, Hidiroglou N, Whiting S. Vitamin D status of Canadians as measured in the 2007 to 2009 Canadian Health Measures Survey. Health Rep. 2010;21(1):47–55. 2. Whiting SJ, Langlois KA, Vatanparast H, Greene-Finestone LS. The vitamin D status of Canadians relative to the 2011 Dietary Reference Intakes: an examination in children and adults with and without supplement use. Am J Clin Nutr. 2011;94(1):128–135. doi:10.3945/ajcn.111.013268 3. Statistique Canada. Enquête canadienne sur les mesures de la santé : Données des mesures non environnementales de laboratoire et de médicaments, 2016 et 2017. Le Quotidien. 2019. Disponible à: https://www150.statcan.gc.ca/n1/daily-quotidien/190206/dq190206c-fra.htm | Y | Y |
| Sodium | [Click here for more information on the Sodium intake of Canadians.](https://www.canada.ca/en/health-canada/services/publications/food-nutrition/sodium-intake-canadians-2017.html) | [Cliquez ici pour plus d'informations sur l'apport en sodium chez les Canadiens.](https://www.canada.ca/fr/sante-canada/services/publications/aliments-et-nutrition/sodium-chez-canadiens-2017.html) | Y | Y |
| Folate | * What DRI is based on? * Statement re: females capable of becoming pregnant * References for CHMS status articles |  | Y | Y |
| Calcium |  |  | Y | Y |
| Carbohydrate (total) | N/A | N/A | Y | N |
| Iron | Link to iron status paper using CHMS cycle 2?  Anything about iron bioavailability? |  | Y | Y |
| % of total EI from carb | N/A | N/A | Y | Y |
| % of total EI from protein | N/A | N/A | Y | Y |
| % of total EI from fat | N/A | N/A | Y | Y |
| % of total EI from sat fat | [Canada’s Dietary Guidelines](https://food-guide.canada.ca/en/guidelines/) recommend that Canadians consume less than 10% of total energy intake from saturated fat. | Les [Lignes directrices canadiennes en matière d’alimentation](https://guide-alimentaire.canada.ca/fr/directrices/) recommandent que les canadiens consomment moins de 10 % de l’apport énergétique total provenant des gras saturé. | Y | N |
| % of total EI from sugars | Anything about total vs. free vs. intrinsic sugars? |  | Y | Y |
| Cholesterol |  |  |  |  |
| Potassium |  |  | Y | Y |
| Total energy intake | The interpretation of self-reported energy intake should be done with caution as energy intake tends to be underestimated by survey respondents. The Institute of Medicine (IOM) suggests using indicators of relative body weight, such as the Body Mass Index (BMI), as markers of energy intake adequacy within groups. | Il faut interpréter prudemment les données concernant l'apport énergétique auto-rapporté, car les répondants ont tendance à sous-estimer leur apport énergétique lors d'une enquête. L'Institute of Medicine (IOM) suggère d'utiliser certains indicateurs du poids corporel relatif, comme l'Indice de masse corporelle (IMC), en tant que marqueurs d'un apport énergétique adéquat chez des groupes. | Y | Y |
| Total sugars | Anything about total vs. free vs. intrinsic sugars? |  | Y | Y |
| Total dietary fibre | The AI is based on total fibre intakes, which encompass both naturally occurring dietary and functional fibre. Since the Canadian Nutrient File does not contain data on functional fibre (i.e. isolated, extracted or synthetic fibre added to food), the estimated fibre intakes of Canadians only reflect naturally occurring dietary fibre intake. Therefore, total fibre intakes are likely underestimated. | L'AS est fondé sur l'apport de fibres totales qui comprend à la fois les fibres naturellement présentes dans l'alimentation et les fibres fonctionnelles. Étant donné qu'on ne retrouve pas de données relatives aux fibres fonctionnelles dans le Fichier canadien sur les éléments nutritifs (c.-à-d. fibres isolées, extraites ou synthétiques ajoutées aux aliments), l'apport de fibres estimé chez les canadiens reflète uniquement les fibres naturellement présentes dans les aliments. L'apport total de fibres est donc probablement inférieur à l'apport réel. | Y | Y |
| Phosphorus |  |  |  |  |
| Vitamin B6 |  |  |  |  |
| Vitamin C |  |  |  |  |
| Zinc |  |  |  |  |
| Magnesium |  |  |  |  |
| Niacin |  |  |  |  |
| Riboflavin |  |  |  |  |
| Thiamin |  |  |  |  |
| Vitamin A |  |  |  |  |
| Vitamin B12 |  |  |  |  |
| % of total EI from linoleic |  |  |  |  |
| % of total EI from linolenic |  |  |  |  |
|  |  |  |  |  |