

# **Healthy Living Symposium Proceedings Annex**

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## **Workshop I: Towards Integrated Strategies**

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### **Group 1: Leadership and Policy Development**

#### **Overview**

Leadership for healthy living must come from the federal government and must lead to the creation of coherent policies that re-examine and re-focus programs in all departments through a healthy living lens. Factors affecting the determinants of health fall under the purview of every government agency and department at every level of government.

The strategy must possess a coherent structure with well-articulated governance at all levels. Public health should be used as a framework, health promotion as a strategy, and the health system as a principle structure for delivery.

Success depends on adopting new and improving existing partnerships between all levels of government, with the private sector, NGOs, community sector, and the public. However, partnerships should not be used as a “buck-passing” mechanism to allow the federal government to relinquish its leadership responsibilities.

The provision of adequate resources and funding is the cornerstone for healthy living leadership and will drive the establishment of effective, coherent, comprehensive programs. While the strategy should target all segments of the population, there must be a special focus on children’s programs, whose success will depend on committed long-term planning and resourcing.

Although the strategy requires ongoing, long-term commitment, there are many initiatives and processes that can begin immediately. Acting quickly and decisively will convince all sectors that strong leadership is available and will enable the cultural shift that the transition to healthy living will require.

#### **Key Result: Policy Coherence Through a Healthy Living Lens**

All spending, policy, and regulatory decisions should be subject to health impact assessments to determine their consistency with the Healthy Living Strategy. This must include consideration of agriculture, consumer, and fisheries policies on the health of the food system and the promotion and availability of healthy food.

The roles of F/P/T, municipal, and Aboriginal governments in the overall policy delivery and governance process must be carefully examined and coherently restructured to create harmonies and avoid duplications. Workplace health and safety issues and occupational disease should be integrated into the broader Healthy Living Strategy.

It is easier to prevent disease if the “hows and whys” are understood; therefore good research is needed that clearly establishes the linkages between health determinants, physical activity, good nutrition, and healthy living. Existing research should be surveyed, and there should be an

alignment of public health infrastructures to support key research functions.

Some of the necessary funding for programs should come from the reinvestment of tobacco tax revenue into national healthy living initiatives. In addition, there should be tax incentives provided to consumers, employers, and industry for creating, promoting, and using healthy living programs or products and for making healthier choices (such as bicycling and joining registered health clubs).

At the same time, punitive taxes should be applied to unhealthy food vendors and products and services that create unhealthy conditions or contribute to an unhealthy environment. This taxation should be reinvested into healthy living programs.

### **Key Result: Enhanced and More Coherent Public Health System**

Systemic change should be supported at every level. This will require ensuring that there is an adequate, well trained, public health workforce, and providing coherent, directed front-line services. This will require national co-ordination of public health services, with locally tailored, culturally sensitive approaches. The adopted model should draw from best practices internationally, not just from the American model, and should be based on prevention and promotion. It must clearly establish national program and performance standards for public health and clearly define F/P/T responsibilities.

It was generally agreed that re-opening the *Canada Health Act* would be counterproductive and fraught with many political difficulties. However, a companion act dealing with public health should be adopted. It would be helpful to examine the new Quebec Public Health Act to determine if it might be used as a model for a federal act or provide guidance to other provinces and territories.

The public health system must focus on building community capacity and address the social determinants of health. Its mandate must include health promotion, population health, and the promotion of healthy eating and physical activity. Public health goal setting should begin immediately. Baselines and benchmarks should be established quickly and ongoing monitoring of programs and outcomes should take place.

### **Key Result: New Funding for Healthy Living Strategy**

Funds must be explicitly earmarked for healthy living. Participants recommended several target figures for adequate funding that varied between one per cent of the overall health budget to \$500 million over five years. Whatever the target funding is, it should be set after a thorough assessment of the resources necessary to provide adequate program development, initiation and operation, information dissemination, technology and surveillance.

The Canadian regulatory regime must put health first and should operate on the precautionary principle, rather than a risk management approach. National policies that promote healthy living

should include a nationally standardized minimum wage that will allow for basic healthy living.

Health research funding should be increased and stabilized, and should focus on increasing the success of existing surveillance and research programs. Health researchers should be better represented at CIHR, boards, and grant review committees. Peer review of health research should be promoted.

CDPAC must engage in a process of self-examination to determine how it can become truly cross-sectoral and better reflect input from non-government sources.

All funded programs should have established benchmarks and built-in evaluation and assessment mechanisms.

A broad range of taxes on unhealthy food and products should be evaluated as a potential source of funding for healthy living. However, these decisions should not be made before sound research is conducted into the possible effects of punitive product taxation, or Healthy Living tax rebates.

### **Key Result: Improved Healthy Living Practices in Childhood and Adolescence and Reduced Health Disparities**

Healthy living promotion should be a lifelong process that begins at birth and continues through the education system. Prenatal education for new mothers on the health impacts of breastfeeding and the importance of good nutrition during pregnancy should be the beginning of a continuous messaging process that elucidates and promotes. This must include policies on physical education and health education in schools, but must also acknowledge and address the impact of socio-economic factors on health and even on the ability of children to understand healthy living messages. Health and physical education should be extended from the classroom and gymnasium into the home and community.

Since injury is the seventh highest caused of death or disability in children, safety should be incorporated into healthy living approaches.

The government should consider a ban on ads directed at young children, similar to the one that has been in place in Quebec since 1981. The advertising of junk foods should be banned or, at least, regulated and curtailed. Any regulatory approach should build on existing legislation and regulations and should be modelled upon approaches that have already been proven to work.

### **Key Result: Reduced Social and Economic Inequities**

A healthy living strategy must be grounded in social, economic, and environmental policies advanced by governments, which form the foundation for healthy living opportunities and choices. The basic issue underlying the whole strategy must be that the reduction of inequities will improve the social determinants of health and enhance all Canadians' access to healthier

living.

Local, regional, provincial/ territorial, and federal policies should be examined to locate opportunities to reduce inequities in the access to healthy living. Prioritized income and social support, including programs focused on literacy, nutrition, and parenting, must be introduced for all low-income families with young children, at the very least. Ways of extending these programs to all segments of the population facing inequities should be examined.

All levels of government should be explicitly mandated to define and co-ordinate policy approaches and roles in poverty reduction. The federal government should “model” programs aimed at alleviating socio-economic inequities, rather than just providing advice or offering partial funding to programs operated at other levels of government.

There must be strong core value statements acknowledging that particular groups—such as the disabled, ethnic minorities, women, the elderly, Aboriginal people, and new immigrants—face particularly acute socio-economic inequities. Programs should be designed and implemented that address these inequities coherently and form the foundation for any approach to healthy living.

Provincial claw-backs of the National Child Benefit should be reversed and counterproductive measures that conflict with a healthy living approach should be discouraged in the future. Federal and provincial labour legislation should be extended to ensure adequate benefits and fair standards and treatment for all workers, including casual, part-time, and farm workers.

Health Canada should foster partnerships and innovation across sectors and at the provincial/ territorial and local levels by streaming funding through Health authorities to the voluntary/ NGO sector, which tends to have the best front-line relationships with their communities.

Since one of the most significant social determinants of health is income level, the federal government must provide clear leadership by establishing a national minimum wage that ensures all Canadians a fair living wage.

### **Key Result: Build Partnerships on Policy Development**

Partnerships should not be viewed as ends in and of themselves, but as effective, resource-efficient ways to move forward. They can also provide unique venues for generating ideas, disseminating information, and building consensus. Working together is “the Canadian way,” and is what Canadians expect. Policy development partnerships and collaborations should be public/private, inter-jurisdictional and inter-sectoral. They should span age groups from children to seniors, and focus on establishing valuable relationships between governments and traditionally under-privileged and under-represented groups.

CDPAC and the provincial/territorial networks can actively facilitate and model partnerships. Their experiences should be used to build a more structured and codified approach to healthy effective partnerships. Research should be conducted to be determined what types of partnerships work best, and also the situations in which particular partnerships are

counterproductive.

A policy framework must be developed that identifies opportunities for collaboration and outlines roles and responsibilities of each government, department, and non-governmental organization, based on a clear commitment to what they're willing to contribute to the strategy. All policy development funding must be long term, to ensure that NGOs have the capacity to remain involved in the process.

### **Key Result: More Children Who Are Physically Active**

At the national level, a healthy schools policy should be initiated that will mandate daily quality physical education and ensure that all schools have qualified staff specialists in physical education and health. Before this policy is adopted, a thorough survey of existing provincial and territorial approaches should be conducted. Through the F/P/T process, provinces and territories should be encouraged to adopt similar healthy living education policies in schools.

Schools should be adequately funded to avoid having to seek financial support from corporate sponsors (such as soft drink and junk food companies). There is something counterproductive about athletics programs sponsored by “corporate junk food giants.”

Policies that encourage healthy eating in schools should be developed. Schools should also design and offer weekly nutrition and basic cooking courses so that young people have food options other than processed, fast foods at their disposal as young adults. These programs should be linked with others that continue or support the learning of these skills in the home and community settings.

Links between schools and communities should be forged and strengthened to reinforce their respective healthy living messages. While efforts need to focus on kindergarten to Grade 12, it is also important to address education for parents, young adults, and adult role models.

### **Key Result: Make a cultural shift**

The health care system and Canadian attitudes about healthy living need to be reconfigured to comprehensively address the broad range of issues that a healthy living strategy will encompass. It will be necessary to refocus priorities somewhat from the traditional medical model to a health promotion model. This does not mean that it's necessary to create dissonance between chronic and infectious disease practitioners or medical and social service providers. Rather it requires a balanced approach that mirrors the balance of a healthy life.

This will necessitate recognizing the value of capacity building in communities and shifting the understanding of healthy living funding, to enable it to be seen as an investment, rather than a cost.

The culture shift will require well-funded, long-term, cohesive F/P/T social marketing campaigns

regarding healthy eating, the social determinants of health, physical activity, and chronic disease prevention. It should also stress that a strong public health approach enables people to better cope with infectious disease and creates a more responsive capacity to the broadest possible range of health and social issues.

Plotting the course for this culture shift provides an opportunity for the public and private sectors to focus on collaboration, instead of confrontation. It must also create opportunities to engage citizens in the policy process, by providing meaningful avenues for consultation and feedback. This paradigm shift must broaden the view of healthy living (to ensure it includes mental health and wellness, for example) and create a public environment in which the health of all Canadians will flourish.

## **Group 2: Knowledge Development and Transfer**

### **Overview**

The group based its discussions on the definition of “knowledge development and transfer” provided in the background documents:

*A continuum of activities that includes gathering knowledge (e.g. research, surveillance, and reviews of best practices); analyzing and synthesizing knowledge; and making knowledge available to people who can use it, in forms that are most useful to them.*

Within the current context, there is an “artificial disconnect” between researchers, policy-makers, practitioners, and end users that impedes knowledge transfer and confuses knowledge development. Bridging that gap is a critical component for success.

Data gathering and surveillance must be improved through a nationally focused, stably funded approach that has built-in mechanisms for ongoing program evaluation and good feedback mechanisms to the public. It is extremely important that research is designed, conducted, and shared regarding the broad determinants of health and their concrete effects on daily living.

These comprehensive programs will require a broad-based infrastructure that fosters and supports research and facilitates the exchange of knowledge. Where possible, existing programs should be used as models or the basis for more all-encompassing research structures.

In order to accommodate the education of professionals, workers, and volunteers in a healthy living culture, it is important to identify key competencies in health promotion and disease prevention and develop strong education programs for implementing and improving those competencies.

Finally, it is not sufficient to just develop good research and surveillance programs—it is necessary to ensure that the basic information is gathered, analysed, tested, and presented in a way that will aid in the formulation of overall healthy living policies. That will require an appropriate system of governance and committed funding.

**Key Result: Bridge the gap between researchers and policy-makers, practitioners, the public, and other end users**

Research priorities should be needs based and established through a collaborative process that ensures two-way communication and provides end users with input into the research agenda. To encourage community input, consultation and collaboration with community partners should be made a condition of publicly funded research.

Once research is conducted, the information it provides must be useful for a broad range of purposes, including disease prevention, public education, health promotion, and program design. To facilitate this range of applications, research documents should be translated into straightforward and accessible language aimed at professionals, decision-makers, and the general public. An accountability mechanism for knowledge translation should also be created that assesses the effectiveness of the publication, translation, and distribution of information, and evaluates the effectiveness of their presentation.

Best practices in knowledge translation should be established and pilot projects in knowledge dissemination and translation should be initiated. These must recognize the different needs of end users and they must be designed to address particular needs, rather than broad areas of generalized research.

It is important that all research be good and valuable research: it must be conducted using the most rigorous scientific standards and serve a particular need or address relevant questions. While research and surveillance must be better funded, it will never be possible to fund **all** research, so careful, considered choices must be made.

Research and evaluation must be part of the earliest planning processes in policy development, and should be ongoing throughout the project. In addition to conducting “hard, scientific” research, it’s important to test and evaluate “soft” outcomes, such as the effectiveness of public information campaigns.

Any knowledge translation exercise must recognize groups requiring special mechanisms, such as new immigrants, Aboriginal people, seniors, and people with disabilities. Good research should be relevant to the population as a whole, while being flexible enough to address culturally sensitive or group-specific issues.

**Key Result: Improve data and surveillance systems by ensuring they are nationally focused and appropriately funded**

The process should begin with a comprehensive survey of what research and surveillance is currently available, how it’s funded and where the major gaps are. It is particularly important to identify gaps in children and youth indicators, and to identify valid and reliable indicators that are culturally and socially sensitive to the context of particular individuals or communities.

It would be helpful to establish a national clearinghouse for evidence and best practices, with a national focus to facilitate rapid, accurate knowledge exchange. Another suggestion is to possibly establish a Canadian Centre for Disease Control or some other mechanism for data sharing and collection that builds on existing programs (such as CIHI, StatsCan, CFCRI).

Common indicators must be established to allow for the comparison and interpretation of data collected nationally. Surveillance must be upgraded, particularly on the effects of the broad determinants of health on health outcomes, healthy eating, physical activity, healthy weights, and chronic disease.

A mechanism should be created to link and share databases, possibly through the enhancement of existing programs like Health Canada's Internet programs. Mechanisms must also be put in place to ensure accountability to public funders, and to the public itself. Data should be viewed as a public resource, be released in a timely manner, and be shared broadly.

### **Key Result: Evaluation**

In order to design evaluation tools, a broad-based process involving all the relevant partners should be established to set clear goals. In turn, these goals should be evaluated regularly and adjusted if necessary. Similarly, performance measures must be tested and evaluated to ensure they continue to be relevant and yield useful information that can aid in the promotion of healthy living.

A clearinghouse of evaluation tools, processes, and results should be established and regularly updated. It is imperative that these processes are culturally, linguistically, and ethnically accessible.

The National Research Consortium should develop a set of valid indicators that can be used nationally to measure physical activity, healthy weights, and social determinants. These indicators must be evaluated on an ongoing basis.

### **Key Result: A broad-based infrastructure that systemically fosters and supports the conduct of research and exchange of knowledge**

Comprehensive research should be conducted to establish the most effective linkages between research and practice. CDPAC should be resourced to convene a forum that includes F/P/T governments, NGOs, and community stakeholders, to determine the appropriate infrastructure and set the agenda and timetable for implementing strategies.

Regional Centres of Excellence in physical activity and healthy eating should be created, as should a national consortium of researchers and practitioners. These should ensure multi-disciplinary representation, including complementary and alternative health care providers.

Wherever possible, the emphasis should be on enhancing existing research mechanisms identify and prioritize all aspects of healthy living and co-ordinate the translation of that information and partnerships with the private sector should be fostered to disseminate research results to Canadians in an easy-to-understand format.

### **Key Result: Integration and collaboration between researchers**

A comprehensive research agenda must be created that goes beyond the traditional health sector and embraces all aspects of government (including urban planning, agriculture, finance, education, social sciences, and industry). Key research priorities must be identified using multi-disciplinary, evidence-based approaches. These priorities must be accompanied by a mechanism for information dissemination and a feedback cycle that empowers end users.

The term *integration* should be explicitly defined. While there are many benefits of collaborative research, it's important not to lose valuable inputs from independent initiatives. The infrastructure should be flexible enough to promote and encourage collaboration, while offering opportunities for independent researchers to share resources, information, and outcomes, when appropriate. Ultimately a flexible, integrated system will be most cost-effective and offer the best opportunities for public benefit.

Research partnerships must span F/P/T jurisdictions and engage in coherent surveillance of individual and population behaviours and the effects of environmental influences on healthy living.

### **Key Result: Education of professionals, workers and volunteers who interface with youth in achieving a healthy living society**

These professionals should include health educators, urban planners, recreation workers, early childhood educators, community organizers, and dietitians. Key competencies for health promotion and disease prevention should be identified and curricula reviewed and revised to support improved teaching and practice of these competencies. Professional accreditation for specific diploma/degree programs in health promotion should be established. These should be designed to interface easily with professionals working with other target populations, such as older adults, parents, and people with disabilities.

Community partnerships that extend beyond interdisciplinary education should be established to support health promotion and disease prevention. These should focus on training professionals and volunteers in a broad range of skills that help involve youth in decision-making and leadership processes.

Youth should be engaged in the process whenever possible, particularly through the support and training of peer educators on a range of topics, beginning with healthy decision-making. These skills can be applied through various life decisions, including nutrition choices, physical activity, safer sex, smoking, education, and work choices.

**Key Result: Ensure research is done and knowledge exchange occurs on the broad determinants of health**

Health Canada should translate its research on the twelve determinants of health into accessible information and disseminate it widely. Then a national research team comprised of core participants from each province and territory, and other relevant national organizations, should be formed to develop a research agenda for community nutrition and healthy living, physical activity, healthy weight, behaviour theory, and the determinants of health.

Allopathic, indigenous, complementary, spiritual, and naturopathic practitioners should be brought together in a forum to integrate models for disease prevention and healthier living. Using enhanced available technologies, these practitioners and the public should be linked in an accessible communication network that provides a tool for knowledge sharing.

Research into health determinants should identify causal mechanisms, not just correlations between determinants and health status, to assist in crafting meaningful interventions that address the underlying causes of poor health. Resources must be in place to translate research on health determinants into well-articulated cohesive principles for program planning and implementation.

Any programs or initiatives arising out of this research must have meaningful benchmarks and valid measures for assessment over reasonable timeframes. While it is counterproductive to expect instant results from programs addressing overarching socio-economic issues, it is important that assessment be comprehensive and ongoing.

Research—and policy arising from it—should connect mental and physical health and should aim to avoid the public’s tendency to “blame the victim.” It should create a sense of compassion in communities for people who live in environments that don’t support healthy choices and educate the broader public about the importance of creating supportive environments and removing barriers to healthy living to encourage communities to be more conducive to healthy choices.

**Key Result: Moving from buzzwords to action**

Knowledge development and exchange is important, but it must contain meaningful messages, not just empty catch phrases. While it is important to develop messages that are well received by policy-makers and the public, it is even more important to ensure those messages are rich and accurate and will motivate positive actions and healthier choices for Canadians. Health promotion and action must move forward together through a broad-based structure.

Existing knowledge should be compiled and translated to avoid duplication, while creating a national repository of best practices that can be widely drawn upon and that supports endeavours by groups like CIHR, government officials, NGOs, and ordinary citizens.

**Key Result: Integration creates added value**

It is assumed that integrating research, information dissemination, and knowledge translation initiatives will add value. Research should be conducted to assess whether and to what degree this is true. It should be noted, however, that co-operation, collaboration, and consultation are positive results in their own right, independent of the product they produce.

This examination of the value of integration should include inter-sectoral, inter-jurisdictional, and inter-departmental policy integration. Data that indicated the relative value of particular collaborations and integrations would be helpful, so that resources could be committed to those areas likely to produce in the greatest value (i.e. improved health determinants or more positive health outcomes).

**Key Result: Education of professionals**

Professionals in all fields that impact healthy living—including those working in areas that have an impact on socio-economic health determinants—should be better educated about healthy living. A comprehensive survey must identify opportunities for education and training, and be used as a basis to review and reform curricula and professional development and training.

It is important to ensure that trainers understand and value healthy living. Also, training initiatives that promote healthy living must not be perceived as competing with other aspects of health care or service provision. Professionals should be encouraged to see many components and goals working in tandem under the overarching umbrella of a healthy living strategy.

Education programs should be sector-appropriate, interesting, interactive, and connected to their target audiences.

**Key Result: Ensure research is done**

Too often, great initiatives, strategies, and studies “fade away” before the meaningful work is actually completed. It is imperative that this strategy be well resourced and sustainable. A group should be tasked with gathering all the existing research and identifying gaps, particularly around health determinants. They should use multiple channels to widely and effectively disseminate the information they gather.

**Group 3: Community Development and Infrastructure****Overview**

Communities must be involved, enabled, and empowered partners in the fashioning of healthy

living policy and messages, their dissemination, and application. However, while community leadership is important, federal leadership—including a sustainable funding commitment—is the key to avoiding skepticism.

To promote community development and involvement, infrastructure must be accessible and adequate and must address the issues of culture, poverty, and marginalization.

Community leadership must develop naturally within a context where communities are active and have a sense of ownership of healthy living, based on their understanding that healthy living is a right for every Canadian.

Solutions must be tailored to the communities they address and be responsive to each local environment's unique needs and members, while conforming to a set of well-researched and articulated basic standards.

At the same time as national standards impose a set of top-down values, the strategy must also build bottom-up approaches that allow grass roots involvement in the articulation of policies and priorities. This is particularly crucial for communities where the basic determinants of health are missing.

Beyond recognizing specific target populations, the Healthy Living Strategy should be vetted through a set of lenses that include the perspectives of Aboriginal communities, youth, seniors, women's health, and new immigrant communities. Just as all programs should be assessed and examined through a healthy living lens," the Healthy Living Strategy must be analysed through the perspectives of the many diverse communities, regions, and groups to which it applies.

### **Key Result: Developing community leadership**

Communities should have the opportunity to enhance and develop ideas and programs that are already working well for them. Many good initiatives exist that should be sought out and warehoused, so they can be adopted and adapted by other communities. The resources are not available to keep "reinventing the wheel."

New healthy living leaders can be developed in unusual places. Everyone from the caretaker to the senior executives of health organizations should be trained and encouraged to promote healthy lifestyles. Every organization should take responsibility for modelling healthy environments. Leaders often develop from the examples they see at home, at work, and at school—as well as from examples presented in formal government strategies, messages, and initiatives.

Building and encouraging leadership requires committed resources. Teachers, health professionals, recreation and sports practitioners, and other service providers need cross-sectoral training. Municipalities can't be expected to fund leadership and community development without access to new funding.

It must be acknowledged that every aspect of the strategy must address culture, poverty alleviation, and marginalization. Developing community leadership is beside the point for those who are impoverished and struggling to pay the rent or clothe their children. It's crucial to cross the boundaries of marginalization and be clear about whose perspective will dominate program development and delivery. (Many participants were skeptical that marginalized people would be engaged by the strategy at all.)

### **Key Result: Communities lead, are active in and own their own change process**

Communities should lead change. It's up to them to set their agendas and participate in the strategy to ensure that their work is supported by both internal and external forces and is well-resourced. Ongoing sustainable funding and staff are necessary to support community capacity.

Communities need better access to user-friendly research data, written in plain language. They won't have time to do the translation themselves. Communities also need better capacity for critical analysis, and broader opportunities to act as resources to each other. Governments and communities both need to increase their know-how of and commitment to work with each other. In the case of isolated, impoverished, or marginalized communities—particularly Aboriginal communities—governments must work hard to build and maintain the confidence and trust of individuals who are traditionally under-served and excluded from the system. A strategy that cannot reach those most at risk is a strategy doomed to fail.

Change management is always a challenge, but particularly when the stakes are so high and the disparities between communities so great. Sustained funding for community change is particularly important when timelines are incompatible with community needs and access is not community-friendly. Too often, communities are required to enter the funding cycle on a particular date, meet specific requirements, and conform to an agency's agenda in order to qualify for funds.

Over the medium term, government departments must change their ways of operating so they can understand each other better. If governments do not understand their own respective messages, how can individual Canadians be expected to do so—and how can communities access and participate in creating healthy choices and living options?

Increased co-operation across sectors—and between communities, governments, and agencies—will help people build better links between separate initiatives with similar or compatible goals. A community development foundation or centre of excellence would help bring together organizational and community cultures and create an opportunity for people to learn together.

### **Key Result: Equitable access and opportunity**

“Healthy living is a right. Everyone, every individual in Canada, should have equal opportunity and access to healthy living.” If it's a right for everyone, then policy, funding, and community action must follow.

Barriers to access are socio-economic as well as physical. Equitable funding is important because it determines the ability of organizations, governments, and schools to deliver services with a given funding base. For example, many schools have to fundraise, so that the financial capacity of the surrounding neighbourhood determines access to programs and services. In impoverished or isolated communities even those types of grass roots options are not available to generate resources.

*Equitable* should not be taken to mean that every community has exactly the same resources. There will be differences in the recreation infrastructure available to a small village or a neighbourhood in Toronto. Somehow, *equitable* has to be qualified in a way that recognizes smaller communities' right to basic, reasonable resources. It is irrelevant whether or not communities have equal programming; it's more important that what is there is appropriate and addresses the most critical needs.

An environmental scan is needed to identify and analyse programs, initiatives, and strategies—both universal and targeted—that already exist. The focus should be on finding programs that are easily adaptable to other communities and build on their successes by tailoring them to the needs of each unique environment.

Governments at all levels must commit to applying a healthy living lens to new policies and programs. Inter-departmental and inter-sectoral collaboration must be enhanced, and efforts made to ensure that the commitment to improving the basic determinants of health through all programs and policies exists, implicitly and explicitly, through those processes.

Support for grassroots initiatives is one of the best ways to create capacity for healthy physical education. At the same time, encouraging communities to grow food locally (and made accessible to all) through local agriculture, home and community gardens, and community kitchens would enhance food security.

### **Key Result: Awareness of healthy living/consciousness-raising**

There is a need to create a grassroots' uproar, using advocacy and awareness to entrench the concept that healthy living is the right of every Canadian in every community. Conversations about healthy living should not be limited to health itself. Silo approaches are not appropriate. Healthy living or healthy communities should be part of an overarching umbrella strategy that is pan-Canadian, multi-sectoral, and inter-jurisdictional. In short, there must be a place for every individual and organization in the country. This understanding should be the foundation for a benefit-based social marketing campaign that encourages physical activity and healthier eating.

People must begin to see recreation facilities through the same lens as hospitals and health facilities. Similarly, it is important to promote an understanding of how the determinants of health impede people's and communities' abilities to make healthy choices. The viewfinder through which Canadians look must encompass the broad range of inter-connected factors that create healthy living, and must allow them to see their communities holistically.

Awareness campaigns work when people understand the “why” behind the advocated change, including the cost of not making the change. When public support begins to build around an idea, the rest of society catches up and systems change. In Nova Scotia, a cost analysis of tobacco and obesity demonstrated that the cost of *not* putting effective programs in place was more than the province could afford. That type of research is invaluable for creating awareness and building support.

For example, it may be that people eat junk food because they cannot afford anything else, or because they are depressed. In those cases, people will not change simply because they are told it’s good for them. It is necessary to understand the determinants of such behaviour, which include poverty and affordable housing, among other things. That understanding can be used to craft community-led initiatives, where the process begins with an effort to identify issues and goals from the ground up.

A national movement is required to advocate change and build broad community awareness of healthy living priorities. One element should be a social marketing campaign linked to a call for action. It can combine hard facts with “shockers” to generate public attention and educate people about the advantages of behaviour change. Participaction is a useful model, expanded to include physical activity, nutrition, smoking, and healthy lifestyles.

There is a need to target specific groups and issues within the larger population, from pre-cradle to grave, to ensure that awareness campaigns are reaching these groups. Ongoing testing and assessment (market research) is also necessary.

Community mobilization should be linked to measurement. A national campaign must provide tools for community leaders to talk about the local effects of poor health, draw a picture of what it costs the community, and build partnerships with all sectors and links with other communities.

A national advocacy movement is also necessary to train and support communities to make the case for policy change and, ultimately, bring about cultural change.

### **Key Result: Collaboration and partnerships**

Key stakeholders must work together to adopt a common healthy living philosophy that cuts across sectors. This would create opportunities for groups to work together at the community level. Inter-generational activities, mentoring, and sharing are important mechanisms to ensure that sectors are not pitted against each other for attention and funding. They also build community capacity and help develop more aware and empowered communities.

All levels and departments of government should integrate healthy living strategies into their mandates, funding formulas, policies, and procedures.

Provincial and municipal networks are as important as national ones. Organizations and governments must be provided the opportunity to define their roles and design policy and action

through “bottom-up” processes.

Coalitions should be developed to create synergies. It is important to analyse the successful experiences of other communities or regions to learn the best ways to fashion partnerships and allegiances, and how to decide what model will work best in each particular community setting.

An active school/community initiative would improve community access to community facilities that are underutilized in the evening due to a lack of funding. Emphasis should be placed on organized programming, not merely on keeping the gym open. In many jurisdictions, this would require better provincial (and perhaps federal) funding support for schools.

Public-private partnerships should be encouraged as a way to build facilities, especially in those communities that lack them.

Rather than developing adversarial relationships, healthy living should be incorporated in the medical model, and vice versa. The use of “green prescription pads” (“take two pills and ride a bike”) should be promoted, as should the distribution of handouts on nutrition. Recreation professionals, physical education teachers, and others with similar expertise should be encouraged to serve on hospital boards and regional health authorities.

### **Key Result: Supportive environments**

Community environments should be designed to ensure the healthy choice is the easy choice. For example, an avid bicyclist will find it hard to bike to work without shower facilities and safe bike routes. Improved urban planning includes safer roads to support urban environments that encourage physical activity. The key is to plan communities better.

Different players need to see that they have common agendas for different reasons. For example, transportation infrastructure is equally important to encouraging physical activity and improving air quality—for both reasons, streets should be built with sidewalks, to encourage walking. More broadly, community representatives should be aware of healthy living issues when they make decisions. When a road is to be built, or a recreation or seniors’ program is being planned, the first question should be *What does a healthy community look like?*

Existing community assets, especially schools, should be available for community use at no extra cost. Recreation facilities should be built and retrofitted to be accessible to all age groups, and to persons with disabilities. The infrastructure that enables communities to lead the change process needs support from other levels of government. Community change and healthy living cannot evolve in isolation.

A supportive, healthy environment is a smoke-free environment.

Work and family schedules have a major impact on eating habits and food choices. It is counterproductive to skirt around the fact that fundamental social and economic change are needed. The environment is not simply the local community environment. The larger society

must support families having enough time to spend together and the financial resources to make healthy choices.

An inventory of existing best practices should look at opportunities in urban design, walking school buses, and other community initiatives. Existing successful physical education and nutrition standards for schools should be appropriately adapted and implemented across the country.

### **Key Result: National healthy living standards and policies**

A national healthy living steering committee should be formed, with representatives from NGOs, government, the private sector, and communities. The steering committee should develop national standards to entrench healthy living as a right for all Canadians, regardless of age, geography, socio-economic status, ability or gender, and achieve national agreement on principles and standards.

An integrated funding model is required to support both research and community action, so that grassroot initiatives and ideas can find sustainable funding. Policies and funding mechanisms must be reviewed on an ongoing basis.

Federal standards and funding arrangements are needed for after-school programs for six- to twelve-year-olds, similar to the programs in place from birth to five years of age.

A national plan of action for Canadian implementation of the Convention on the Rights of the Child should include provisions for children to have a direct impact on their own healthy living.

Effective action will depend on a cycle that runs from research (including anecdotal community stories) to promotion and awareness, to actions, strategies, and training, to evaluation and monitoring, and then back to research. Any investment in healthy living must cover the whole cycle. To achieve that investment, communities will have to communicate their needs and build political will. The end goal is healthy public policy, but the “how” is to create a groundswell of needs-based research that enables people to articulate and prioritize their needs.

### **Key Result: Long-term, sustained investment in healthy living initiatives**

Long-term, sustained resources are necessary to generate long-term, profound results. Social marketing alone will not bring about change. The first step is to build on existing strategies. A short-term listing and assessment of current strategies and best practices should be undertaken by CDPAC. CDPAC could also assemble a comprehensive list of existing policies and curricula that deal with physical activity and healthy living.

The next step would be to integrate existing healthy living strategies and initiatives to ensure they work in a more collaborative manner. Over the medium term, another gathering will be needed to set the stage for collaboration and clarify the roles of the voluntary, public, and private sectors.

A new integrated funding mechanism is needed for healthy living. A start would be the \$500 million allocated to the Coalition for Active Healthy Living.

## **Group 4: Public Information**

### **Overview**

The group began with a working definition of “public information,” as the provision of information and other communication strategies to motivate people and groups to adapt health and practices that promote healthier living. Throughout the discussion, participants acknowledged the complexity of the task before them and expressed skepticism that the results of the symposium would accurately reflect the diversity and subtlety of their discussions.

Participants stressed the need for accountability and well-defined lines of responsibility for the Healthy Living Strategy and programs arising out of it. They focused a great deal of attention on how to best fashion the message to “brand” healthy living and on the best vehicles for message delivery. While it was agreed that unanimity on all components of the strategy might be difficult to attain, building commitment to a set of basic common themes was important. The healthy living message must clearly state the importance of all the determinants of health.

In the latter rounds of discussion, participants designed a set of “overarching key results,” that underline the importance of designing healthy public policy that uses a healthy living lens. They also stressed the importance of addressing specific issues, including healthy body weight and mental health.

Adequate resources are required to create an environment and infrastructure that promotes healthy living through sustained, short-, medium-, and long-term planning and committed funding in an environment that spans jurisdictions, departments, and sectors.

### **Key Result: Awareness and understanding**

The public needs concrete information on “how to” accomplish healthier living, not just why. This should be accomplished through a comprehensive approach that outlines issues of basic nutrition and physical activity and their relationship to healthy living. The message must be crafted in language that is suited to its various audiences and should be advanced through public-private partnerships, which go beyond government and industry to include NGOs, community groups, grassroots organizations, and special needs groups. It is also important to ensure that positive messages about healthy weight do not exacerbate the negative consequences associated with weight preoccupation, particularly in youth and women.

The issue of health literacy was discussed, as well as the difficulty in translating information publicly for Canadians. One participant suggested the development of guiding principles to

address common themes and the possibility of creating a menu relevant to a particular audience and/or sector. He suggested that instead of concentrating on finding a unanimous theme, determining the core themes would be an enabling approach instead of a limiting one, and one that would facilitate moving forward.

Messages should focus on positive, rather than negative results (i.e. healthy living as opposed to chronic disease). Special attention must be paid to designing messages aimed at children and youth that integrate existing public knowledge and information on physical activity, healthy eating, and healthy body weight.

Any awareness-building exercise should bridge research and practice by involving a broad range of qualified practitioners, researchers, scientists, public health professionals, and community leaders, and should go beyond allopathic practitioners to include naturopathic doctors, midwives, chiropractors, and complementary care specialists.

Physical education should be reinstated as mandatory for all students from kindergarten to Grade 12 and should provide a regimen that is balanced, daily, gender appropriate, and harmonized with the rest of the curriculum. Health education should also be mandatory and more comprehensive to include analysis of the broader determinants of health and how they relate to healthy lives. Wherever possible, new education and promotional initiatives should build on successes that already exist and should dovetail with the initiatives of community partners and agencies outside the academy.

While a focus on children and youth is critical, it is important that the message be clear for all age and cultural groups. Key individuals or organizations should be identified to effectively deliver messages and provide leadership and behaviour modelling. This should include CDPAC, provincial networks, and organizations, such as the Coalition for Active Living and the Canadian Strategy Through Physical Activity for Girls and Women.

### **Key Result: Accountability for healthy living issues is shared by public and private sectors**

The articulation of a cross-sectoral community approach to healthy living is important because although Canadians are aware of the burden of chronic disease on national, provincial, and local communities, more clarity is needed around the specifics. These include definitions of healthy choices about nutrition and exercise and a broader understanding of how social issues affect health.

To this end, an independent, accountable agency should be established to monitor and report on the actions of industry, government, the voluntary sector, and other partners involved in the health of Canadians and public health needs. Any accountability structure that is emplaced must be designed to provide sustained long-term, results-based monitoring, possibly in conjunction with existing health surveillance mechanisms.

It is also important that the strategy provide a mechanism for ongoing feedback to First Ministers to ensure that all relevant governmental departments are involved (e.g. transportation, justice,

environment, health, education and training, etc.), as well as ensuring that non-governmental partners are kept informed.

The accountability agency should establish baseline data and indicators for assessing the health of all Canadians and comparing them to people living in other countries. Although CDPAC and provincial/territorial networks should be key players within this agency, the agency itself should be mandated to operate at an overarching level to identify gaps, monitor progress, identify best-practices, and report to all levels of government, the private and voluntary sectors, and the community at large.

### **Key Result: Ensure and enable long-term funding and resources**

The most important primary target audience is politicians at all levels who need to be convinced of the importance of health and physical activity and the benefits to citizens, so they will fight to guarantee adequate long-term sustainable funding and resources for the strategy. A well-informed public can create the political pressure to press the healthy living agenda forward and maintain it over the longer term.

Parents and teachers can play a key role by working together to create school programs that challenge politicians to act for children's health. The cost of these programs should be weighed against the costs associated with poor health, including an assessment of "softer" social costs as well as health care dollars.

Employers should be encouraged to promote good health practices for workers and should work with government to implement healthy living practices inside and outside the workplace. A strong business case should be developed to help convince the private sector of the value of healthy living to their organizations. All levels of government should provide incentives (monetary and otherwise) for the private sector promotion of healthy living.

A coherent, consistent program will require partnership among many organizations and the re-evaluation and re-alignment of funding to focus the prevention/promotion aspects of healthy living over the "disease-based" models that currently exist. It's important that these organizations not be abandoned, but rather are actively recruited to participate in moulding and disseminating healthy living messages.

### **Key Result: Children and youth**

Messages need to reach children younger than fifteen years of age in order to affect lifelong healthy living choices. This requires the creation of a multi-sectoral national strategy that is simultaneously aimed at home, school, and community, to create supportive physical and social environments. This strategy should focus on establishing best practices from among existing programs and integrating them into a comprehensive framework. Program settings should include a range of locations beyond schools, such as community centres, childcare settings, and local neighbourhoods.

The strategy should provide guidance for provincial and territorial governments around healthy living curricula, which must include physical education, health education, healthy food policies, and active transportation programs. Community resources should be used whenever possible to support traditional school instruction. Although piecemeal approaches will not work, unique health promotion and learning programs can be tailored to specific groups or communities by building on existing grassroots expertise and activities.

A separate messaging program should be developed for very young children (birth to five years of age). This program would need to be situated in childcare facilities and must be particularly sensitive to the needs of the children of recent immigrants, Aboriginal children, and children living in poverty.

A national surveillance survey for children and youth around physical activity and nutritional habits should be established to provide baseline data and benchmarks for the ongoing assessment of programs.

Wherever possible, approaches should be child-centred and peer-focused. Parents and other adults should be encouraged to provide inter-generational interaction and role modelling to influence value and attitude development, particularly around healthy eating, tobacco use, and physical activity.

All messages must be culturally and socio-economically sensitive and particular audiences (such as children with disabilities, adolescent girls, or Aboriginal youth) should be targeted with culturally specific messages.

All these programs need to be funded and organizations should not be expected to integrate these new programs into existing funding bases. In addition, there should be specific committed funding for nutrition programs in all schools and childcare facilities.

### **Key Result: Canadians are engaged in making healthy choices**

The first step to engaging Canadians in healthy living is to ensure that service providers, intermediaries, and delivery agents are aware of the specific goals and targets of the strategies (such as the ten- per cent reduction in obesity/overweight by 2010). Messages need to present a balanced approach of the benefits of physical activity and healthy living as well the risks associated with particular behaviours or sedentary lifestyles.

A national strategy to reduce poverty must be instituted to reinforce the Healthy Living Strategy's commitment to the determinants of health. This strategy must include a review of Employment Insurance, Social Assistance, Old Age Security, CPP, and the Canadian Health and Social Transfer (CHST).

Effective, results-based intervention programs should be developed in such a way that permits them to be re-packaged by all parties to suit local, regional, community, or specific cultural

needs. Partnerships with the private sector (such as grocery stores and restaurants) should be established to deliver healthy living messages to consumers. Inter-sectoral information sessions should be held to update various partners with action plans and program information.

**Key Result: Canadians are engaged in creating a healthy social, economic and physical environment**

Healthy living depends on engaging and empowering all Canadians to participate in a paradigm shift, which will transform the socio-economic and physical environment. As a catalyst for this participation, F/P/T governments must communicate a sense of urgency about the epidemic proportions of the problem and the cost of chronic diseases. Government leadership should stress that healthy living is both an end and a means to an end, and the artificial friction between disease prevention and treatment models is not helpful. A comprehensive healthy living approach encompasses both.

Educational efforts should focus on how multiple determinants of health are at play. Healthy choices can happen only in an environment that is conducive to those choices. Health care, professionals, policy-makers, and the general public must understand the importance of not stigmatizing or blaming the victim, and every opportunity to reinforce positive messages should be used.

This social marketing campaign must occur over the longer-term (10 years) and must be adequately funded and resourced by all levels of government with the input, support, and assistance of volunteer and private partners.

To enable Canadians to make healthy choices, the choices must be affordable and accessible to all Canadians, including those living in poverty, people with disabilities, Aboriginal people, children and youth, and those in remote communities.

Sustained funding for integrated public education campaigns on nutrition, mental health, injury prevention, physical activity, healthy weight, and healthy environments must be available and well co-ordinated.

**Key Result: Healthy living is a cultural norm in Canada**

The expression, “I am Canadian,” should be about deeper issues than the beer we prefer to drink. It should “brand” Canada as a country where healthy living is a social norm and, conversely, that Canada is a culture that supports and promotes healthy living. To that end, it is necessary to develop targeted complementary messages, outlining simple steps people can take to improve their healthy choices and positively impact their communities. All programs, sponsored at every level of government, should provide messages that are safe and depict healthy and active living, using the guidelines from Health Canada’s Healthy Images Policy.

These messages must be gender-specific and relevant to various populations and should be

implemented outside the traditional public health “box.” They should build on momentum where it already exists and identify current points of pride in our culture and align healthy living with those. Successful healthy choice programs, whether formal or informal, should be promoted and reinforced, and then used as models to be adapted in other milieus. The roles and contributions of NGOs, health intermediaries, professionals, and volunteers must be better acknowledged and all should be encouraged to participate in the crafting of a simple message that integrates all aspects of the path to healthy living.

### **Overarching key results**

A successful strategy depends on strong and clear underpinnings that ensure that healthy public policy is supported at all levels and that all programs are viewed through a “healthy living lens.”

Healthy public policy will require amendments to the *Canada Health Act*, or the enactment of a new public health act, as well as support for public health infrastructure, the education system and municipalities. Public health funding should be federal and sustained over the long term. Provincial/territorial initiatives should dovetail with healthy federal policy, particularly around issues like environmental protection, highway safety, and labour standards.

Policies and processes must be established to examine and review important issues:

- Inter-governmental funding transfers, regulations, and taxes;
- How to secure cheaper, healthier food;
- Healthy children’s advertising;
- Employer incentives to promote healthy choices;
- Subsidies and tax incentives for healthy food and healthy choices.

Approaches to healthy living depend on breaking down existing silos, particularly disease-based models. They depend on integrated ongoing messaging that acknowledges that healthy living starts with individuals’ physical and mental wellness, and will lead to a healthier, richer life for all Canadians.

## **Workshop II: Toward Integrated Strategies for Aboriginal Peoples**

### **Group 1**

The facilitators presented a brief overview of the process that led to the development of the Healthy Living Strategy and highlighted some of the special circumstances and challenges that confront Aboriginal communities. These include rates of chronic disease up to five times the national average, poor nutritional health, deficiencies not seen in mainstream populations, lack of food security, and gaps in health outcomes and services provided.

Next they outlined some of the guiding principles identified by previous groups in earlier consultations, including holistic approaches based on tradition and culture. These “Selected Key

Results for Discussion” were presented:

- Improved access to safe, affordable, quality foods
- People are more active
- People are eating healthy foods
- Increased access to traditional foods
- Increased access to culturally relevant health services
- Environments that support wellness
- More people living balanced lives
- Effective engagement of other sectors
- Knowledge of what contributes to good health

The results brought forward to this session were obtained from both the Aboriginal Roundtable and from workbooks completed by Aboriginal people.

One participant pointed out the wrongfulness of conducting a “consultation” without contributions from people with disabilities when 31 per cent of Aboriginal peoples have disabilities. It was agreed that a demand for more extensive consultation be brought forward as a desired key result.

Several participants called the proposed areas of discussion artificial, unhelpful, and externally imposed. One participant raised the issue of jurisdiction, expressing a desire for a system in which provincial governments are accountable for the funding they receive for Native peoples. Others concurred, proposing dedicated monies for an Aboriginal strategy rather than incorporating “Aboriginal peoples as an afterthought” on big initiatives.

It was suggested that the provided key results were “a bit soft,” and tended to correspond with the strategy’s preconceived notions of what an Aboriginal strategy should look like, rather than the vision created by Aboriginal people themselves in earlier consultations and other fora.

Expressing a desire to see a change in attitude in youth, another participant proposed role modelling, similar to the “Esteem Team” program in the NWT, as a means to promote a holistic healthy lifestyle for Aboriginal Canadians.

Citing a Third World growth rate in Aboriginal communities and the disabilities related to that growth, he envisioned a modelling of family responsibilities, and family connection to reduce high teen pregnancy rates and other problems affecting youth. Participants agreed that “healthy holistic parenting” be presented as a key result that would embody both role modelling and the responsibility of the government to support it on an ongoing basis with dedicated funding.

Other participants questioned the fashioning of the selected key results, noting their focus on healthy foods and active sports was beyond the capacity of most Aboriginal communities. “How can I be concerned about eating healthy or walking when I don’t have the basic amenities in my house?” one participant asked.

Expressing concern with the basic strategy, this group wanted to address means to holistic

wellness, encompassing emotional, spiritual, mental, and physical aspects within home, family, and community. As an ultimate outcome, they wanted to eradicate disparities and inequities within Aboriginal communities.

It is possible to live well, even with a health condition, participants stressed. Moreover, since so many Aboriginal people suffer from chronic and infectious disease, mental illness, and other disabilities, it is imperative that the strategy address realistic, holistic, Aboriginally-relevant approaches to wellness.

A participant described how she had used the Medicine Wheel teachings in order to bring the four strategic directions into a model of holistic wellness from a First Nations perspective. She emphasized the need for a community-driven process, one for which they had ownership. “There’s already work done from a First Nations perspective, for example, the Mental Health Framework, that hasn’t gone anywhere,” she reminded participants.

The group interpreted the demand for a community-owned and driven process as an “organizing principle.”

Another participant proposed designing and implementing pilot projects, arguing there is not enough evidence about what works and what does not, and what kinds of initiatives and interventions best suit Aboriginal needs and are most compatible with First Nations’ traditions and cultures.

A participant disagreed with the demand for research or data collection, stating that Aboriginal people have typically shared knowledge to ensure health and wellness not through data collection, but through sharing experiential knowledge with each other.

A discussion ensued about the group’s objections to the tentative key results as “too soft, too mainstream, and not coming from a holistic perspective.” Participants expressed the desire to give voice to the crisis in Aboriginal communities with respect to poverty, mental health, and the importance of distinguishing this situation from that of the mainstream health picture.

As a result of this discussion, it was agreed that dedicated funding to address the crisis in Aboriginal health was a key result being proposed. One participant argued that funding based on the block-funding model, typically allocated to First Nations on a “make do the best you can” system, is insufficient to address the needs of Aboriginal health. Unlike the needs-based model applied to SARS, the “risk-based model is completely ignored in Aboriginal health.” Participants said it is imperative to move to a needs-based model because of the profound difference in health indicators for Aboriginal people, where upstream determinants typically include extreme poverty, marginalization, and poor mental health.

One participant noted the detrimental effect of a government tendency to turn the philosophy of equitable opportunity into one meaning equal access. “There is a different principle involved,” he said. Participants agreed that any model should seek equity, not equality.

Participants proposed amending “Improved access to safe, affordable quality foods” to “Access

to safe, affordable, quality foods, and water.”

They amended another proposal to read, “People are more holistically active,” to incorporate the spiritual aspects of activity and try to create harmony with traditional Aboriginal approaches.

They also stressed the importance of altering the language of the key results to reflect more inclusive language, respecting lifestyles, and specifically including Métis, and Inuit.

Participants also recommended amending the key results to reflect and promote a community approach, acknowledging that there are many different and valuable approaches among different First Nations communities.

Another group of participants recommended amending item d) to read “increased knowledge/tools and access to traditional foods.” As one participant explained, it’s “alright to get fish, but we need to show people what to do with it.” The group discussed healthy preparation of traditional foods. For example, a traditional method of preparation involves boiling bones and eating the fat, but as one noted, “because we’re not as active as we used to be, it’s not healthy to prepare our food like that any longer.”

They also pressed for acknowledgement and inclusion of people with disabilities in each of the key results.

Other participants expressed frustration, noting that some of the key issues raised in Ottawa, like mental health, wellness, and fundamental broad issues that are determinants of health, were not reflected in the key results provided for discussion at the symposium. “We’re not seeing the crisis brought forward,” said a participant.

Most participants agreed that Phase 1 is not the priority for Aboriginal people, echoing what had been expressed throughout. They put forward alternatives to Phase 1 key results.

Several participants demanded an implementation and re-initiation of the discussions around the First Nations/Inuit Mental Health Framework, but with a Métis component added.

Another requested an “Inuit-specific consultation in the North as part of any Aboriginal process.” She furthermore objected to the breakout approach as a “goal-oriented, linear process” which “doesn’t sit well in terms of the views of people at this table.” Echoing the sentiment of many others, she said she found the “whole process to be uncomfortable.”

Other amendments to results were proposed, including a desire to see increased “promotion and use” of traditional foods.

There was a request for increased human community resources to provide counselling and training to accomplish these strategies: counselling around food use, food preparation, and healthy eating.

A criticism was levelled at SNAP. It “lacks policy outcomes and has no accountability

framework,” participants said. These deficiencies were seen to be the result of not having been developed through legitimate, meaningful consultation.

Participants agreed to demand the development of policy outcomes and an accountability framework for SNAP that are validated (ratified) by stakeholders/communities of First Nations/Inuit/Métis.

General concern was raised about the treatment of Métis in this strategy as “an afterthought of an afterthought.”

Repeating her frustration with the HLR process, one participant elaborated on an earlier point: “It’s not recognized enough that our Inuit way of thinking is not exercised in terms of the program, policy, and strategy development. For example, with respect to goal-setting—how we would be thinking about improving wellness would be lifelong wellness taught in cycles, stages, phases of life...taught over a lifetime versus end result, linear-based thinking. As an Inuit family, we value elders, and a continuing learning process—father, grandfather are always there. When we turn 16, we should know how to live a healthy life.”

The facilitator asked the group to take time to formulate action plans around the proposed results.

One participant identified some telling gaps in the process. Stating the need for a “miracle” to accomplish the task in a few hours, he then spoke to what was missing. “So many who have gone through the residential [school] process can’t do this. We have been degraded—it’s tough to talk about what happened in boarding school. You go through that process, you don’t feel good.”

He spoke of the personal experiences of people whose cases have been delayed by the government. “Thousands of people going to court have been preyed on by lawyers, and sometimes only get \$10,000 or \$5,000. These people are really hurting and sometimes we forget about them and the legacy left for their children. Some people are committing suicide before they get to court. You want to talk about healthy living? That’s where we should start.”

Participants expressed appreciation for these words and for their contribution to “our aspirations for our mental health.” Participants agreed it was important to make the organizers aware of the inadequacy of time to do justice to these issues.

Many emphasized their refusal to regard these discussions as a proper consultation. “This has not been endorsed,” insisted one member.

Another argued, “We have eight minutes to present what we’ve done here. Our priorities are still not being reflected and Health Canada will have to acknowledge that these [results] are not our priorities.”

“These are only our ideas,” agreed another. “They have not been endorsed. They can’t say they have consulted Aboriginal peoples, because they haven’t.”

## **Group 2: Contributions From Non-Aboriginal Symposium Participants**

Participants presented feedback on a number of the key results and actions drafted by the Aboriginal Peoples' workshop the previous day:

- “Encouraging communities to build healthier environments that support wellness,” through a “community development approach,” whereby sustained funding and resources were provided to support local decision-making and implementation.
- Creating a central “clearing house” to share information and tools among several communities.
- Identifying adequate and healthy housing as an important objective, with the development of a “philosophy of ownership” as a component.
- Making education more locally available, incorporating traditional values in both process and content of the curriculum, and promoting joint stewardship of resources, involving input from all community members.
- Stressing the immediacy: there is a crisis in Aboriginal health that needs immediate funding and resources.
- Creating a National First Nations/Inuit/Métis Steering Committee, as well as a study of existing integrated funded programs, such as the Aboriginal Diabetes Strategy, for best practices.
- Conducting a review of the current determinants of health from an Aboriginal perspective and a demand to complete and implement land claims.
- Identifying the need for capital funding and training to obtain safe drinking water.
- Promoting shared responsibility between corporations, retailers, and governments for the ethical supply and pricing of food, as well as the development of food policy councils and the promotion of breast-feeding education and support.
- Special training for professionals in Aboriginal communities to recognize the signs of mental health problems; the recruitment and training of Aboriginal mental health counsellors, and the incorporation of mental/spiritual/emotional wellness components in schools.
- Developing communication mechanisms modelling Aboriginal pride and heroes.
- Resolving jurisdictional barriers.
- Undertaking special research to identify all the factors that are determinants of health,

including residential school effects, genetic pre-disposition, and a multiplicity of unexplored issues.

- Citing a disparity in food costing (watermelon costs \$18, a Big Mac \$1), participants suggested implementing food mail programs.
- Providing leadership training for children, culturally appropriate parent-effectiveness training, increased research on traditional foods and cultural meal patterns, provision of healthy foods in school, and exploration of competitive food pricing, among other proposals.

The final group in the Carousel Sessions discussed their objections to the process and what they would like to see presented in the closing plenary.

A representative of the Assembly of First Nations acknowledged the good ideas put forward by the previous group, but stressed that the reality of most First Nations is that even basic amenities are lacking. “We can’t start at exercise and food when we don’t have the basics,” she insisted. “We want to take the process back,” she said, adding that First Nations were denied access to the Ministers’ conference in September. She suggested that Aboriginal people submit a proposal to Treasury Board asking for resources to conduct meaningful consultation with their communities to develop a healthy living strategy.

The representative of the Métis National Council insisted there be a willingness and obligation to deal with all three Aboriginal groups in an F/P/T process specific to Aboriginal people. Each Aboriginal group needs its own process and funding to do it right, she pointed out.

Another participant agreed, arguing that the health of Aboriginal people shouldn’t be driven by the mandates of DIAND and the Minister of Health and other Ministries of which First Nations peoples are not constituents.

Participants agreed that, “the first step toward health is control over our own lives through a government decision to support self-government.”

A participant argued it was necessary to advocate for the desire to change a system that has put barriers in place that impede development, both externally and internally imposed. “We’ve been struggling for 100 years,” he argued, “but at the end of the day, we have to take charge.”

A participant expressed concern that the good ideas expressed by supportive Canadians not be lost, but be used to strengthen Aboriginal voices. Several participants objected, arguing the message remains solely a demand to “respect our process. *Then* we’ll talk about next steps.”

It was suggested that Aboriginal communities, “through *their own process* can look at those suggestions.” With a separate strategy, Aboriginal people can conduct proper, meaningful consultation in their own communities using processes appropriate to each. “If governments are going to make an investment, if they want positive outcomes, they must have us as full participants,” a participant said.

Several participants raised the spectre of being denied available funding simply because the current Ministry agenda of encouraging healthy eating, physical activity, and healthy weights was not a viable place for First Nations.

A representative of Health Canada clarified that there is no specific funding set aside at this point, only a “possible window.” Furthermore, she stated, the F/P/T Ministers tasked this group to look as a first priority at Phase 1. “It is appropriate,” she assured participants, “for Aboriginal communities to say this is not the train that we’re on.”

A participant asked whether what was being requested was an Aboriginal strategy including all three groups (First Nations, Inuit, and Métis), or three separate sub-strategies. In order for all groups to be heard, what process will facilitate that, she asked.

A participant suggested there might be a need for separate mini-strategies, but with opportunities to share among each other and work with each other.