An Integrated Pan-Canadian Healthy Living Strategy

A Discussion Document
For the
Healthy Living Symposium

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DRAFT FOR DISCUSSION

An Integrated Pan-Canadian Healthy Living Strategy

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PREFACE

Welcome to the Symposium on Healthy Living! This section describes the purpose of this document and the symposium, and reviews the strategy development process to date.

Purpose of This Discussion Document

This document is designed to facilitate discussion and the further development of the Integrated Pan-Canadian Healthy Living Strategy at the symposium. It is divided into three parts:

> Part I provides the context and an overview of the strategy as a whole by describing the umbrella framework and its components.
>
> Part II provides the context for the substance of Phase One of the strategy, which emphasizes healthy eating, physical activity and their relationship to healthy weights, and suggests how elements of the framework will be applied to Phase One.
>
> Part III describes some factors to consider in building an action plan for Phase One and suggests some draft outcomes and objectives.

Participants in the symposium are invited to comment on all parts and to provide their best advice on how the main recommendations arising from the consultation can be incorporated into the next step—the development of a Phase One action plan.

Why Are We Here?

The purpose of the symposium is to engage key stakeholders and partners in the further development of the Integrated Pan-Canadian Healthy Living Strategy by:

- sharing the expectations and interests of the Ministers of Health for the development of the Healthy Living Strategy
- reporting on the themes and key ideas gleaned from the consultation so far (which has focused primarily on Phase One of the strategy)
- inviting participants to further inform the development of the strategy by reviewing the umbrella framework and identifying priorities, initiatives and actions that can occur in the short-, medium- and long-term
- providing an opportunity to identify and build common ground for future collaboration for integrated action on healthy living initiatives.

What We Hope to Achieve

It is hoped that the symposium will achieve the following outcomes:

1. enhanced understanding of the proposed overall framework for the Integrated Pan-Canadian Healthy Living Strategy and its elements (vision, goals and objectives, foundational approach, principles, and strategic directions, and areas of emphasis); and agreement on areas (if any) on where further refinements are required
2. confirmation and validation of the input from the consultation process
3. agreement on priorities for a plan of action on the initial area of emphasis in the short-, medium- and long-term
4. agreement on mechanisms for the ongoing development and implementation of a plan of action, and the further development of the overall strategy.

What Is The Integrated Pan-Canadian Healthy Living Strategy?

The Integrated Pan-Canadian Healthy Living Strategy is an intersectoral initiative designed to improve health outcomes and reduce disparities in health status in Canada. It is based on a conceptual framework for sustained action (see Part I of this document). The strategy is founded on a population health approach and collaborative efforts to promote health and prevent disease and injury. Phase I of the strategy focuses on physical activity, healthy eating and their relationship to healthy weights. Future phases may focus on other priority issues and may include mental health, injury prevention or other important areas of emphasis.

What Has Led Up to This Symposium?

A number of critical events have led up to this stage of the development of an Integrated Pan-Canadian Healthy Living Strategy:

- In June 2002, the Conference of Federal/Provincial/Territorial (F/P/T) Deputy Ministers of Health approved the paper prepared by the Advisory Committee on Population Health (ACPH) called *Advancing Integrated Prevention Strategies in Canada: An Approach to Reducing the Burden of Chronic Diseases*. This paper defined the elements of an integrated strategy and proposed three areas for collaborative action—to develop a best practices initiative, to set a joint national research agenda, and to hold a national consultative conference on integrated approaches to preventing chronic disease in Canada.

- In September 2002, the F/P/T Ministers of Health agreed to develop a long-term comprehensive strategy to increase Canadians' participation in healthy living practices aimed to reduce the burden of disease. They stated that they would in the first phase "work together on short, medium and long-term, pan-Canadian healthy living strategies that emphasize nutrition, physical activity and healthy weights."

- The Ministers also announced that a national healthy living symposium would be held in 2003 to “bring together health and other sectors of government, non-government organizations, health specialists, First Nations and Inuit, business and other stakeholders to set out specific initiatives to support healthy living in the context of healthy communities, including rural, remote and Northern areas.”

- In October 2002, an F/P/T Healthy Living Task Group was formed to oversee the consultative process and the Healthy Living Symposium.

- To this point, the consultation process has included:

  - four pre-consultation meetings with representatives of key stakeholder organizations, coalition groups and alliances
  - a series of nine one-day roundtable discussions across the country
  - the completion and submission (on-line or by fax or mail) of workbooks by stakeholders and citizens who wanted to provide input to the strategy.

Some 370 people attended the Roundtables and 945 workbooks were completed. Reports from the Roundtables were produced and the data from the workbooks were analyzed to summarize the major themes and suggestions that were put forward. Summaries of the results of the consultation have been integrated into this text in some sections, to the extent that time constraints allowed. A summary document containing additional results of the consultation will be distributed at the symposium. All of the consultation documents will be available on the Healthy Living web site.

Part I: An Integrated Pan-Canadian Healthy Living Strategy

SETTING THE CONTEXT

Over the past fifteen years, a number of initiatives have demonstrated the value of collaborative action on health issues by governments, the voluntary sector and private industry. Coordinated strategies based on a population health approach and a comprehensive framework—such as National Strategy to Reduce Tobacco Use in Canada, the Canadian Heart Health Initiative, the Community Action Program for Children, Aboriginal Head Start, Canada Prenatal Nutrition Program and the Early Childhood Development Agreement—have paved the way for the success of future collaboration.

Initiatives like these, combined with overall improvements in the socioeconomic environment and the dedicated work of community leaders across the country have enabled Canada to have one of the highest standards of health and well-being in the world. Yet despite these successes, some major challenges remain.

Two Current Challenges

One of these challenges is the threat posed by chronic diseases to the health of Canadians and to the sustainability of our health system. Each year in Canada, more than two-thirds of deaths result from four groups of chronic diseases – cardiovascular, cancer, diabetes, and respiratory.[1] The estimated total cost in Canada of illness, disability, and death attributable to chronic diseases amounts to over $80 billion annually.[2]

These chronic diseases share common preventable risk factors—including physical inactivity, unhealthy diet and tobacco use—and the environmental determinants that underlie these personal health practices. These include income, employment, education, geographic isolation, social exclusion and other factors. According to the World Health Organization, over 90 percent of type 2 diabetes and 80 percent of coronary heart disease could be avoided or postponed with good nutrition, regular physical activity, the elimination of smoking and effective stress management.[3]

A second challenge is continuing disparities in health status. Vulnerable Canadians are at high risk for poor health, early death, chronic disease and inequities that influence health practices. These include individuals and families with low-incomes, people with disabilities, Aboriginal peoples and other population groups who are socially and/or economically disadvantaged, excluded or marginalized.

Until now, most initiatives related to healthy living have operated independently, resulting in duplication and missed opportunities to leverage resources and share knowledge. A concerted pan-Canadian and integrated approach to healthy living is necessary if we are to make substantive gains in health outcomes, reduce health disparities, and improve the quality of life of all Canadians.

Understanding Health and Healthy Living

As defined by the World Health Organization, ***health*** is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.[4] Many Canadians add spiritual well-being to this understanding of health. Within the context of health promotion, health is considered less as an abstract state and more as a resource that permits people to lead socially and economically productive lives. It is a positive concept emphasizing social and personal resources as well as physical capabilities.[5]

Healthy living applies to both individuals and the population in general. At a population level, healthy living refers to the practices of populations and sub-population groups that are consistent with improving, maintaining and/or enhancing health. As it applies to individuals, healthy living is the practice of health enhancing behaviours or living in healthy ways. Healthy living means making positive choices about personal health practices such as healthy eating, not smoking, and being physically active. These choices are strongly influenced by the environments where people live, work, learn, worship and play.

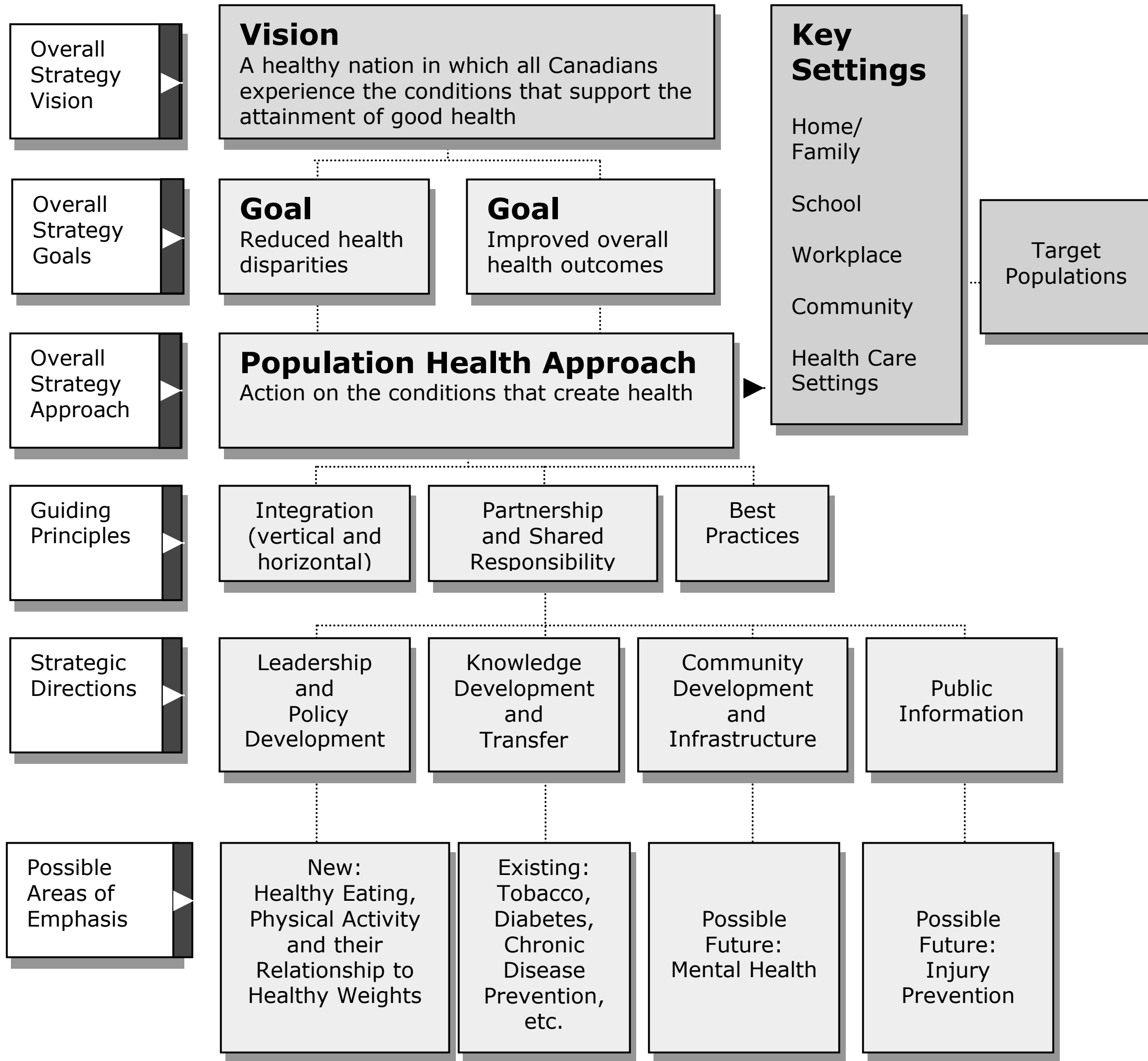
Integration: A Key to Success

Integrated action on healthy living is at the forefront of international efforts to improve health around the world. In May 2000, Canada, as a member of the fifty-third World Health Assembly, adopted a resolution endorsing the World Health Organization Global Strategy for the Prevention and Control of Non-Communicable Diseases. The strategy emphasizes integrated prevention efforts that target three main risk factors: tobacco, unhealthy diet and physical inactivity.[6] In 2002, the WHO adopted a further resolution on Diet, Physical Activity and Health (see Appendix A).

A number of countries have developed healthy living strategies addressing chronic disease prevention, healthy eating, physical activity and tobacco. We can learn a lot from examining initiatives that have been developed by Finland (The North Karelia Project), Sweden (Sweden on the Move 2001), Japan (Healthy Japan 21), and others.

THE STRATEGY FRAMEWORK

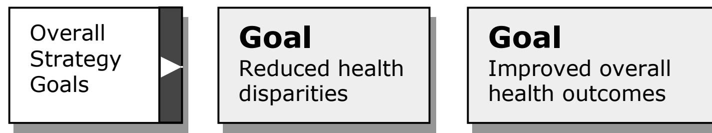
The umbrella framework shown below provides the overall direction for an Integrated Pan-Canadian Healthy Living Strategy as it evolves over the next five years.



Vision

The vision of the Integrated Pan-Canadian Healthy Living Strategy is that of a healthy nation in which all Canadians experience the conditions that support the attainment of good health.

Goals



Two over-arching goals have been identified for the strategy:

Goal I: to improve overall health outcomes
Goal II: to reduce health disparities.

To accomplish these goals, the following objectives are proposed:

- to build horizontal and vertical partnerships among key stakeholders, and health jurisdictions and other sectors that impact health, in order to take action on the determinants of health
- To develop an integrated and collaborative, long-term and broad-based F/P/T Healthy Living Strategy that is consistent with a population health approach, consisting of short-, medium-, and long-term actions that address the common risk factors for a range of priority health issues
- To draw upon and build on existing capacity, consolidating health promotion and disease prevention efforts targeting populations and sub-populations within life settings.

The following short-, medium- and long-term outcomes are proposed:

Short-term Outcomes:

- better collaboration and integration of approaches that address priority health issues
- increased access to health information and health promoting programs
- increased knowledge of health information by individuals and population groups of interest.

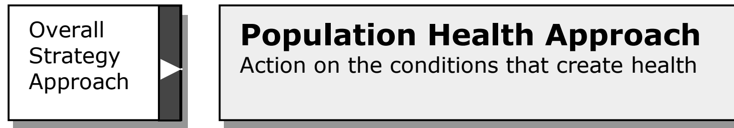
Medium-term Outcomes:

- increases in the proportion of individuals who engage in healthy behaviours
- increased capacity of communities to create health-promoting social and physical environments
- increased access to health-supporting physical and social environments in rural, remote and northern communities.

Long-term Outcomes:

- reduction in health disparities
- improved health outcomes
- reduced human and economic burden of major disease groups
- improved quality of life for Canadians.

A Population Health Approach



Population health concerns itself with the living and working environments that affect people's health, the conditions that enable and support people in making healthy choices, and the services that promote and maintain health. As an approach, it calls on the use of strategies that address the entire range of factors that determine the health and well-being of the overall population. It focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the well-being of those populations.[7]

Current research informs us that health is strongly influenced by the social, physical and economic environments of peoples' lives.[8] Thus, governments and other sectors need to focus on the underlying conditions that create or "determine" health:

- social support networks
- income and social status
- employment and working conditions
- education
- social environments
- physical environments
- healthy child development
- health services
- biology and genetic endowment
- gender
- culture
- personal health practices and coping skills.[9]

This requires advocating and supporting policies and practices outside of the health sector that get to some of the root causes that lead to unhealthy personal practices and poor health outcomes.

For example, exhorting low-income families to " eat better" and providing them with food preparation skills will not be enough to ensure that they will be able to choose diets that are consistent with healthy eating in Canada. According to the 1996 National Longitudinal Survey on Children and Youth, 54 percent of all hungry families received their main income from employment, and families whose incomes included social assistance had greater than an eight-fold risk for child hunger. This suggests that current low minimum wages and levels of social assistance are significant factors in food insecurity. The cost of housing is also problematic. Poor people run out of money for food because the grocery budget is considered flexible, unlike fixed payments such as rent and power bills.[10]

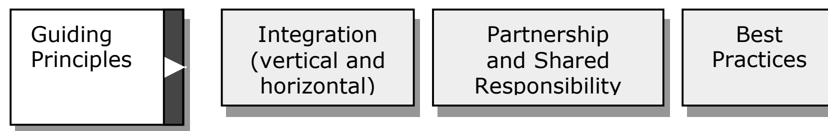
Similarly, low-income families cannot afford to pay user fees for recreation services or join a fitness club. The costs of many sports that children enjoy (such as hockey and snow-boarding) are prohibitive for most families with low and modest incomes.

Therefore, improving eating and activity patterns among poor families requires policies and programs that address the broader determinants of health, not just stopgap measures such as food banks or short-term nutrition and physical activity support programs.[11] Such programs and policies would deal with:

- the affordability and safety of food staples, and basic physical activity programs and facilities
- the implementation of sustained healthy living programs and policies in schools, workplaces and communities
- accessibility to schools for recreational activities and sports at low- or no-cost outside of school hours
- access to affordable housing so that more money is available for healthy foods and physical activity
- wage and social assistance levels and employment insurance policies that allow individuals and families to eat healthy foods and engage in enjoyable physical activity.

Most of the policy solutions described above fall outside of the formal health sector. Thus, in these examples, the role of the health sector becomes largely one of collaborator, knowledge broker and advocate for change.

Guiding Principles



Three guiding principles direct the actions of the strategy—integration, partnership and shared responsibility, and best practices.

Integration

While some strategies have been demonstrated to be effective, studies have also shown the limits of addressing risk factors and diseases in isolation, without placing greater emphasis on the contexts of peoples' lives. In particular, although some prevention strategies are effective, they are often unsuccessful in improving the health of disadvantaged groups, and thus tend to increase disparities in health status.[12]

Multi-factorial prevention strategies, targeting multiple risk factors for single diseases or disease clusters, have met with greater success. Evidence suggests that integrated, community-level interventions (e.g., complementary school and family support programs), when sustained over time, have been successful. Integration, therefore, offers the potential of not only being a more effective prevention strategy, but of focusing limited prevention resources.[13]

An integrated approach is anchored in three main pre-conditions: a solid foundation of experience, a growing evidence base, and emerging opportunities. Four key elements comprise an integrated approach:

- targeting the common sets of risk factors for major chronic diseases through approaches that promote and support healthy living
- working through the determinants of health, recognizing and addressing the relationship between lifestyle choices and social and environmental conditions
- consolidating promotion and prevention efforts within specific life settings
- mobilizing action and engaging partners within and across jurisdictions, the health system, and other sectors that affect health.[14]

The strategy will aim to consolidate currently fragmented or isolated health promotion and disease prevention efforts. An integrated approach will be applied to the development of public policies, research, programs and practice.

Partnership and Shared Responsibility

An Integrated Pan-Canadian Healthy Living Strategy will result from collaborative partnerships involving community, business, nongovernmental and national voluntary organizations, and government sectors. This reflects a shared responsibility in improving health and health outcomes.

Partnerships involve vertical integration through jurisdictional levels – federal, provincial and territorial, regional, and local, as well as horizontal integration across sectors (various government sectors, public, private, and not-for-profit) and systems. Experience has shown that building and sustaining partnerships takes time, supportive infrastructures and sustained efforts.

Working with sectors outside of health is challenging but necessary. The goal is to find win-win situations in which policies in another sector benefit their mandate as well as health. For example, when health supports the food industry in offering attractive, lower fat options such as one-percent milk, sales of consumer goods increase at the same time as nutritional health. Similarly, the health sector can influence private industry to provide opportunities and incentives for physical activity at work. The result benefits the bottom line (i.e., reduced absenteeism and increased productivity), as well as employee health.

The strategy will support the development of partnerships to strengthen the capacity for collaborative action in research, policy, programming, legislation, knowledge transfer, surveillance and communications. Consideration will be given to how existing partnerships can be strengthened and how new partnerships can be created for these purposes.

Partnerships will be enhanced by:

- F/P/T co-ordination and leadership and a commitment to F/P/T collaboration
- strengthening the links between population health, public health and primary health care
- developing sustainable infrastructures to address the determinants of health by partnering with sectors such as recreation and sport, transportation and income security

- forming and supporting networks and alliances, which allow for the sharing of ideas, set the stage for collaboration, and act as pivotal agents in the implementation of the strategy
- support for individual responsibility, commitment and action.

Best Practices

Best practices have been defined as those practices that are grounded in sound scientific evidence. There is a need to work more closely with partners in research to forge an integrated approach, and to ensure the transfer of research-based knowledge to health policy and practice.

Best practices in health promotion involve more than a scientific rationale for effectiveness. In a paper developed to inform a WHO collaboration, best practices in health promotion are defined as "those sets of processes and activities that are consistent with health promotion values, theories, evidence and understanding of the environment, and that are most likely to achieve health promotion goals in any given situation."[15]

At the community level, research suggests that interventions are more likely to be successful if they:

- involve multi-components in multiple settings (e.g., workplaces, health care settings, schools, homes, community parks, etc.)
- create and enhance access to nutritious foods and safe places for physical activity, combined with informational outreach activities
- incorporate community-wide health education and skill development campaigns that utilize evidence-based models of individual behaviour change
- provide incentives for individual healthy living practices and workplaces that support healthy living; provide disincentives such as higher prices on alcohol and non-nutritious foods
- enhance social support in community settings
- include activities in schools
- include both universal and targeted approaches
- are built on sustainable partnerships, long-term collaborations, viable infrastructures, and strong local leadership and commitment
- are based on expectations that are consistent with the resources available (adequate numbers and skill levels of human resources, as well as money), and are sustainable over an extended period
- build community capacity and ownership
- combine media appeals with other activities, such as community organization
- address the interests, needs and priorities of the target populations and involve them in the initiative.[16, 17, 18,19]

Key Settings

Key Settings

Home/
Family

School

Workplace

Community

Health Care
Settings

Home/Family: Families and neighbourhoods provide the foundation and context for knowledge, attitudes and practices related to healthy eating and physical activity and their relationship to body weight. Parents, caregivers, friends and peers serve as important role models and support.

Schools: Children and adolescents spend a large portion of time in school. Schools can provide opportunities for children and youth to engage in healthy eating and health-enhancing physical activity, either through the curriculum or activities before and after school and during lunchtime. A comprehensive school health approach extends beyond health and physical education to include school policy, the physical and social environment at school, and the links between schools, families and communities.

Workplaces: Most adults spend eight hours a day, five days a week (or more) at work. Workplaces can provide opportunities for adult Canadians to engage in healthy eating and health-enhancing physical activity, at the workplace, commuting to and from work, and in after-work activities. Policies such as flextime, extended maternity and paternity leaves and daycare support help employees adopt healthy living practices for themselves and their families. This is especially important for those who are looking after children or older relatives in addition to working outside the home. In most cases, these responsibilities fall on women.

Communities: Local governments have a major role in providing supportive environments for healthy living. They have primary responsibility for many areas that have a direct impact on healthy living, e.g., transportation, recreation, land use planning. Businesses and industries--particularly restaurants, grocery stores, fitness centres and other businesses that offer goods or services with a direct relationship to healthy living practices--are key settings for encouraging healthy living. Local media is an important part of the community that can greatly influence the understanding and adoption of healthy living practices, as well as serving as an important partner for community members who are addressing the social, economic, environmental and political factors related to healthy living.

Health Care Settings: The majority of Canadians interact with the health care system several times a year. Recommendations by pediatric and adult health care providers can influence dietary practices, physical activity patterns and body weight. In collaboration with schools, worksites, private businesses, recreation departments and seniors groups, public health workers, physical activity specialists and dietitians can reinforce the adoption and maintenance of healthy living practices in a variety of settings. Homes and institutions for older Canadians need to provide opportunities for institutionalized seniors to enjoy healthy eating and daily physical activity. Health care providers can also serve as effective advocates for healthy living in media and community settings.

Target Populations

Target Populations

An Integrated Pan-Canadian Healthy Living Strategy is based on a population health approach that uses universal strategies to address the entire population, as well as targeted interventions for groups and individuals with particular risks and needs.

The rationale for targeting will be based on levels of risk for experiencing disparities in health status related to particular chronic diseases and/or health practices that lead to chronic diseases, and or the importance of preventing illness and injury in the first place.

Culture and gender must be considered in both the choice of groups for interventions, and in how activities are planned and implemented. In all cases, the group or audience should be involved in all stages of the development of policies, practices and research that affect them.
Two subgroups in the population have been designated by the F/P/T Ministers of Health as deserving special attention in an Integrated Pan-Canadian Healthy Living Strategy:

- ***Aboriginal peoples*** suffer dramatic disparities in the incidence of chronic disease and lack of access to opportunities for healthy living. Within the Healthy Living Strategy Framework, there is a need to address the specific circumstances, issues and needs of Aboriginal peoples. This is discussed further in Part II of this document.

- ***Children and youth*** are key to the prevention of chronic diseases in later life. Personal health practices such as regular physical activity, healthy eating and not smoking are risk factors for many disease states that originate during childhood yet only become apparent in adulthood.

The Integrated Pan-Canadian Healthy Living Strategy will also need to address **regional and community differences** in health status and healthy living practices, including an emphasis on isolated and rural areas.

Estimates of life expectancy, disability-free life expectancy (DFLE) and the percentage of residents reporting fair or poor health are associated with the occurrence of several risk factors, including smoking, obesity, physical inactivity, heavy drinking, high stress and depression. These associations persist even when the analysis controls for the socioeconomic status of the health regions.

- Life expectancy varies considerably from region to region, from a low of 65.4 years in the Région du Nunavik, Québec, to a high of 81.2 years in Richmond, British Columbia.
- People living in Canada's northern remote communities have the lowest DFLE and lowest life expectancy in the country. Rates of smoking, obesity and heavy drinking are above Canadian averages.
- The proportion of people reporting fair or poor health range from a low of 6.8% in the former Headwaters Regional Health Authority in Alberta to a high of 22.3% in Campbellton, NB and Parkland, Manitoba.[20, 21]

Strategic Directions

Four main strategic directions are proposed in the healthy living framework.

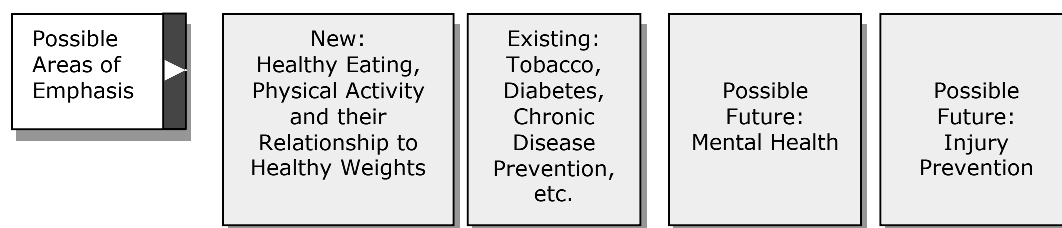
***Leadership and Policy Development*:** a federal/provincial/territorial commitment to provide strong and continuing leadership to a sustainable, long-term strategy, and the creation of policies at all levels (public and private) that enable people to lead healthy lives.

Knowledge Development and Transfer*:* 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.

Community Development and Infrastructure*:* support for effective, sustainable community actions and infrastructures that build community capacity to promote healthy living and provide supportive environments for health.

***Public Information*:** provision of information and other communication strategies to motivate people and groups to adapt positive health practices throughout the lifecycle, to develop the skills they need to be healthy and to support others in healthy lifestyle decisions.

Areas of Emphasis



The healthy living framework shows a new area of emphasis on healthy eating, physical activity and their relationship to healthy weights (Phase One of the strategy). This is linked to existing strategies dealing with tobacco, diabetes and chronic disease prevention. Common goals and action areas will be identified in order to align and strengthen collective efforts, and to build on, not duplicate, work that is successfully underway. The framework also links these initiatives with possible future areas of emphasis; for example, mental health and injury prevention, and others to be identified in the future.

PART II: BUILDING AN ACTION PLAN FOR PHASE ONE

In 2002, the F/P/T Ministers of Health agreed that the initial area of emphasis (Phase One) of the strategy would focus on healthy eating, physical activity and their relationship to healthy weights. This section provides some information to consider in Phase One, including:

- some background information on the issues
- some considerations in applying the healthy living framework to these issues
- some existing initiatives that work, which were identified in the consultation.

This discussion paper uses the following definitions:

Physical activity is any form of body movement, produced by skeletal muscles, that increases energy expenditure. This includes physical activity in all aspects of daily living –at home, school, work and play, and on the way (active transportation such as walking and cycling).

Healthy eating refers to eating practices and behaviours that are consistent with improving, maintaining, and/or enhancing health.

Healthy weights focus on health, not appearance. Healthy weight generally means a weight that is associated with a low risk of developing health problems.

THE ISSUES

Why Focus on Healthy Eating, Physical Activity and their Effect on Body Weight?

The personal costs of sedentary living, poor eating habits, overweight and obesity are high. Over the past two decades, these factors have been increasingly implicated in the major causes of death, illness and disability, especially cardiovascular disease and its risk factors, certain cancers, osteoporosis and diabetes.[22] Healthy eating, physical activity and body weight also have an important effect on mental, emotional and social well-being, as well as one's capacity to participate in family and community life.

The collective cost to the health care system is also high. In 1997, total direct costs of obesity in Canada were estimated at $1.8 billion or 2.4 percent of the total health care expenditure for all diseases.[23] The cost of poor diets in Canada is estimated to be $6.3 billion.[24] It is estimated that about $2.1 billion, or 2.5 percent of the total direct health care costs in Canada, were attributable to physical inactivity in 1999, and that about 21,000 lives were lost prematurely in 1995 because of inactivity.[25]

Facts and Trends

(Note: because there has been no national food and nutrition survey since the early 1970s, and Canada has just begun to build its national food and nutrition surveillance capacity, statistics related to the eating practices of Canadians need to be interpreted with caution).

In addition to acting as common risk factors for a range of diseases, data suggest some common trends in current eating and physical activity patterns, and in the consequent development of overweight and obesity.

For the majority of Canadians, current physical activity patterns are not optimal for health. While less is known about the eating practices of Canadians, we do know that the proportion of Canadians reporting poor eating habits is increasing.

- In 2001, 21% of Canadians reported their eating habits as fair or poor compared to 17% in 1997, and 15% in 1994.[26]
- Almost two-thirds (63%) of Canadians aged 12 and over are not sufficiently active to benefit their health.[27] The majority of Canadians aged 12 and over (57%) were classified as "inactive" in the 1996/97 National Population Health Survey.[28]
- Similarly, three out of five children and youth aged 5 to 17 are not active enough for optimal growth and development.[29]

There appears to be an increase in sedentary living and unhealthy eating among Canadian children and youth.

- Surveys show that while one-half to three-quarters of girls and three-quarters of boys in Grades 6 to 10 participated in vigorous physical activities outside of school at least twice a week, the percentage of young Canadians doing so decreased by approximately 10% from 1990 to 1998. They also show that the more young people exercise, the greater the likelihood they will feel healthy, have a healthy diet, and have positive peer relationships.[30]
- According to Statistics Canada, in 2001 children aged 2 to 11 watch on average 14.2 hours per week of television and adolescents aged 12 to 17 watch about 13 hours per week.[31] Between 1994 and 1998 there was a dramatic increase in the number of boys in grades six to ten who played computer games at least four hours per week (approximately 40%). [32]
- While data on healthy eating among children and youth is sparse, in the cross-national WHO/ Health Canada survey, school-aged children and youth reported a slight reduction in the consumption of nutritious foods and an increased consumption of less nutritious foods such as French fries, hot dogs and potato chips between 1990 and 1998. Almost one-quarter of boys in Grades 6 and 10 reported that they ate potato chips daily.[33]

The number of Canadians who are overweight or obese has steadily increased over the last 20 years.

- Today, approximately 47% of adult Canadians aged 20 to 64 years (56% of men and 39% of women) are either overweight or obese (body mass index greater that 25). [34]
- Based on findings from three national population-level surveys that measured height and weight, between 1970 and 1992 overweight (body mass index greater than 25) increased among men from 38.9% to 44.7%, and among women from 15.4% to 21.2%. During the

same time period, obesity (body mass index greater than 30) increased among women from 12.7% to 15.4%, and among men from 8.1% to 13.4%.[35]

- In keeping with international trends, Canadian children and youth appear to be getting heavier; however, it is difficult to quantify the increase, since Canada does not yet have a health surveillance system in place to monitor the prevalence of childhood obesity and overweight. Tremblay and Wilms reported that the prevalence of childhood overweight doubled and juvenile obesity tripled among children aged 7 to 13 between 1981 and 1996.[36] These findings need to be interpreted with caution since different methodologies were used in the two surveys compared in this study.

At the same time, weight preoccupation can lead to inappropriate dieting and exercise, and a negative body image. In the extreme, these practices can lead to serious health consequences.

- In 1994-95, approximately 40% of women and 23% of men who had weights within the healthy weight range were trying to lose weight.[37]
- Canadians with negative body images have a higher risk of engaging in unhealthy eating practices (e.g., bingeing and purging, refusing to eat) and excessive exercise, as well as developing actual eating disorders. Anorexia and bulimia are life threatening psychiatric illnesses. Health problems can be caused by nutrient deficiencies and overuse injuries, and eating disorders can have severely negative effects on mental health and well-being.[38]
- Some adolescents are particularly susceptible to poor eating habits and extreme exercising as they strive to attain a culturally influenced body shape, assert themselves and become more independent from parents and teachers.[39]
- Underweight is associated with a higher risk of health problems such as under nutrition, osteoporosis, infertility and impaired immunocompetence.[40]

Disparities and Barriers

All Canadians do not enjoy the same levels of good nutrition and physical activity, particularly those who are socioeconomically disadvantaged. For example,

- Some 10% of Canadian households, representing three million people, experience food insecurity each year. Prevalence is greatest among those who rely on social assistance, lone mothers with children, Aboriginal people and Canadians who live in remote communities.[41] Food insecurity is associated with increased odds of poor or fair self-rated health, multiple chronic conditions, distress, and depression.[42]
- For all ages, sedentary living practices, and rates of obesity and are higher among Canadians living in lower socioeconomic circumstances.[43]

Barriers to physical activity and healthy eating are both personal and systemic. For example,

- Most Canadians say that a lack of time and motivation are the greatest personal barriers to becoming more active.[44] Most children (and their parents) say that they drop out of sport or structured activities because they take too much time[45]or stop being fun (i.e., are too competitive).[46]

- Approximately 13 percent of Canadians say they don't have enough time to prepare a nutritious meal.[47] Almost three-quarters of employed Canadians (74%) say they eat in a hurry; and at least once a week, 39% of employed Canadians and 26% of homemakers say they eat in the car or other vehicle because of a busy schedule.[48]
- Other personal factors that influence choices about eating and physical activity include awareness, knowledge, attitudes, intentions, skills and capacities. Having and understanding information provided by sources such as *Canada's Food Guide to Healthy Eating* and *Canada's Guides to Physical Activity* influence what we eat and how we are active, as does advertising and information in the media.

Systemic barriers are related to the underlying determinants of health (discussed below) and the need for policies and practices in a variety of sectors that reduce these barriers.

Links to Other Determinants of Health

Healthy eating, physical activity and their effect on body weight play a key role in determining health. But all personal health practices are influenced by the other major determinants of health, as shown in the examples below.

Age, gender and culture

- Levels of physical activity decline with age.[49] In contrast, people are more likely to report healthy eating practices in the adult stage of life.[50] In the senior years, nutrition may be compromised by numerous factors such as problems chewing foods, changes in metabolism and a compromised ability to shop for food.[51]
- Among Canadians aged 45 and older, 70 percent reported one or more chronic conditions directly related to physical inactivity in 1998.[52]
- For all ages, rates of engaging in physical activity are higher for men than women.[53] Canadian girls are less active than boys. For children aged 5 to 12, 44 percent of girls versus 53 percent of boys are considered active enough for optimal growth and development.[54]
- Women are more likely than men to be concerned about nutrition, to report taking action to improve their eating behaviours, and to go on diets, regardless of their status in the healthy weight range.[55]
- In general, Canadian girls report eating nutritious foods more often than boys, except for whole-wheat breads and low-fat milk in 1998.[56]
- Women and younger adults are more likely than men and older adults to have knowledge and awareness of Canada's Food Guide to Healthy Eating.[57]
- Non-European immigrants are less likely to be inactive in their leisure-time, regardless of their length of time in Canada.[58]
- For all ages, rates of overweight and obesity are higher among men and Aboriginal peoples.[59]
- In 1998, more than 40% of girls in grades 8 (41%), 9 (47%) and 10 (45%) said they were either already on a diet or felt they needed to lose weight.[51]
- Boys are not immune to negative body image. In 1998, 5 percent of 13 year- old -boys and 4 percent of 15 year-old boys used anabolic steroids to gain weight and muscle mass.[61]

Socioeconomic status

- Canadians with low incomes are more likely to report fair or poor eating habits and to believe that low-fat foods and grains are expensive.[62]
- In 1995, almost half of families with incomes below $20,000 per year cited high costs as a reason for not participating in physical activities.[63]
- Being overweight is most common in low-income groups and the chances of being overweight decreases with each successive level of education.[64]
- There is a strong relationship between education and breastfeeding. In 1996/97, recent mothers with less than a high school education were least likely to have breastfed (60%) and mothers with university educations were the most likely (95%).[65]

Physical environment

- The type of food available in grocery stores, workplaces, schools and from the food service sector is a powerful influence on food choices. Large portion sizes and "mega meals" have dramatically changed expectations of suitable amounts of food. Ready access to fast food outlets and convenience stores 24-hours a day, seven days a week supports lifestyles that include "diets high in fat and/or in sugar, and higher in energy level than appropriate for individual activity level".[66]
- Almost one-quarter of adult Canadians find their neighbourhoods unsafe for exercise, citing traffic, crime, poorly lit and maintained sidewalks and cycling lanes as specific examples.[78]
- Most communities are designed to facilitate transportation by car instead of by foot or bicycle. Canadians spend about five percent of their time in cars and other vehicles, as much time as they spend outdoors.[68]

Social environment and social support

- The social environment, with its diverse social mores, cultural values, support networks, traditions and practices, strongly influences food choices.
- Rates of smoking, obesity and heavy drinking are above Canadian averages in Canada's northern remote communities.[69]
- Parents' concern about their child's weight status and restriction of access to food are associated with negative self-esteem and self-evaluations among girls.[70]
- Social involvement and the support of peers are predictive factors in the adoption of physical activity among men.[71]
- Popular media and advertising are key influencers and sources of information about food, physical activity and social norms related to weight, shape and size.

Early Child Development

- Overweight children and adolescents are more likely to become overweight or obese in adulthood. Young people who are overweight have increased risks for diabetes, high blood lipids, hypertension and mental health problems due to discrimination and social exclusion.[72]
- Participation in supervised sport and recreation activities can build children's sense of mastery and self-esteem.[73]

RESPONDING TO THE ISSUES

An Integrated Approach

As described in Part I of this document, integration relates to the combining of issues in policy, research and program development, as well as the horizontal and vertical integration of partnerships and strategies, and the use of coordinated interventions in specific settings.

This is not to say that separate efforts to promote physical activity, healthy eating and healthy weights should not continue. It does mean collaboration among leaders and volunteers in different settings so that Canadians are not overwhelmed with competing messages and program duplication. Pooling resources and efforts can also help reduce disparities in service.

Phase One will need to:

- use an appropriate mix and intensity of interventions in specific settings (e.g., schools) and groups (e.g., a specific cultural community) so that they are not bombarded with competing issues
- strengthen alliances with a number of sectors that influence all three areas, such as recreation, sport, health, transport, urban planning, workplaces, education and private industry.

Creating Supportive Environments for Healthy Living

A population health approach calls for the creation of supportive environments for healthy living that work to eliminate disparities in health practices and health outcomes. Phase One will:

- adopt an inclusive approach, which ensures that vulnerable populations are always considered in policy, research and program development and have full access to research, programs and activities
- work in partnerships to reduce disparities through a concerted effort to enhance opportunities, access, and skills among Canadians with disabilities, people with low incomes and low education or literacy levels, and among those for whom geography presents significant barriers (e.g., residents of rural, remote and Northern communities).

The environments that surround individuals and groups influence personal health practices such as healthy eating and physical activity and their effect on body weight. For example, at the individual level, overweight and obesity ultimately results from an energy imbalance. However, societal and environmental influences include the globalization of food markets and urban lifestyles that promote high-fat, high-energy diets; more people working at sedentary jobs and at the same time not being more active in their time off; and increases in the use of automobiles, and home technology and passive leisure activities, such as television viewing and computers.[74]

Kino-Québec's Scientific Committee suggests the following reasons for the decrease in physical activity in children and adolescents: fewer young people walk to school; greater number of inactive leisure activities, such as computers and electronic games; less time allotted at school for physical education; parents seem less inclined to send their children to play outside and go to

parks alone; shopping malls and new residential communities are so far from essential services that traveling by foot or bicycle is difficult; traffic in urban centres is increasingly congested, making bike riding for work, school or exercise dangerous.[75]

Making changes in the environment (thereby minimizing barriers to physical activity and healthy eating) can include alterations to:

- the natural environment (e.g., providing parks and recreation land for unstructured activities)
- the built environment (e.g., putting sidewalks in new sub-divisions, safe cycling trails in rural areas)
- the workplace environment (e.g., healthy food options, flextime policies, accessible stairs)
- the school environment (e.g., healthy food options, safe and accessible outdoor play structures, quality daily physical education policies, education and skill-building)
- products and services (e.g., labelling regulations for foods and natural products)
- the transportation environment (e.g., adopt policies to support walkers and cyclists)
- the financial environment (e.g., food pricing policies, tax incentives for healthy living)
- the media environment (e.g., food advertising during television programs for children)
- the social environment (e.g., peer education and mentoring programs in healthy living for seniors and young people); societal change leading to recognition of the value of daily physical activity.

> The most promising avenues for effective prevention support healthy living in healthy environments, and are based on an understanding of lifestyle choices within the possibilities and constraints of people's living conditions.[76] If the healthy living strategy is to take a population health approach, it must reframe efforts away from individual admonitions to "eat and exercise", toward the creation of environments that "make the healthy choices the easy choices", and enable people to practice healthy behaviours.

Partnerships in Phase One

In Phase One of the Integrated Pan-Canadian Healthy Living Strategy, a diversity of jurisdictions and sectors have mutually reinforcing roles to play.
Interdisciplinary partnerships are particularly important among leaders in health (e.g., public health nutritionists and nurses, and primary care providers, pediatricians, dietitians), recreation, sport and fitness, and education (e.g., teachers, school principals).

While the health sector has a lead role to play in many areas, an effective strategy requires the participation of numerous sectors outside of health. While not an inclusive list, those sectors that have a strong influence on environments that support healthy eating, physical activity and their effects on healthy weights include:

- education
- recreation, active living, fitness and sport
- transportation
- food and agriculture
- environment

- social and financial sectors (policies related to disparities such as social assistance levels, child care and unemployment policies)
- media and advertising
- culture
- urban and rural planning
- business and industry
- employers
- justice and crime prevention.

Partnerships among these sectors need to be formed at every level—national, provincial and territorial, regional and local—through intersectoral mechanisms and collaborative initiatives. Local governments, including school boards, health authorities and municipal councils have a particularly important role to play at the community level. For example, education, recreation, health, transportation, media, culture, urban and rural planning and crime prevention could all collaborate to create school and community environments that support healthy living.

Building on Existing Efforts

An integrated strategy will not "re-create the wheel". Rather, it will benefit from and build on existing initiatives by governments and nongovernmental partners in the areas of chronic disease prevention, healthy eating and physical activity, diabetes, and tobacco control. Some of the key initiatives at the national, provincial, territorial, regional and international levels are summarized in Appendix A.

Nationally, the Chronic Disease Prevention Alliance of Canada is well positioned to support an integrated approach. The alliance has broad representation including, among others, the Heart and Stroke Foundation, the Canadian Cancer Society, the Canadian Diabetes Association, the Canadian Council on Tobacco Control, Dietitians of Canada, the Coalition for Active Living, the Canadian Public Health Association and Health Canada. The alliance is also forging relationships with the provincial and territorial ministries of health.

Learning from What Works

In the consultation roundtables and workbooks, people were asked to give examples of programs that work well and then to identify the factors that made them successful. The key themes that emerged for the success factors are:

1. **Collaboration:** partnerships, sharing, multisectoral, interdisciplinary, community-wide; building on existing networks, coordination at all levels with one clear lead organization in each community or neighbourhood; create and use synergy.

2. **Comprehensive:** multi-pronged (e.g., combines legislation, advocacy, education, communications and social marketing, community programs, research, etc.)

3. ***Community-driven:** community-based and community-specific, target group-specific and target groups involved - driven by the people affected by the issues; empowerment and capacity building; reach young children and their parents; community champions; established relationships with target populations.

4. **Effective messages:** consistent evidence-based messages everywhere - awareness, education (knowledge), understanding; take advantage of all opportunities to get message out; positive messages; humour, engagement; plain, simple, quick and gives direction (encourages concrete changes as opposed to abstract ideas).

5. **Accessibility:** addresses literacy (e.g., clear language, telephone access); addresses low incomes (programs with fees are not accessible).

6. **Population health approach:** looks upstream at the root causes of unhealthy eating, and low levels of physical activity, particularly inadequate income; approaches that change systems, not just individual behaviour.

7. **Leadership and sustained investment:** policies, legislation, buy-in and commitment at a high level (governments and cabinet); clear vision and mandate; long-term (continues despite changes in governments); dedicated, sustained funding and human resources, infrastructure funding; resources at the community level; public health and municipal capacity are a priority for sustained investment.

8. **Values-based:** trust, understanding and respect; inclusiveness; belief in the ability of communities; accountability.

9. ***Culturally sensitive:** takes a wholistic rather than an issue-by-issue approach and is culturally appropriate to individuals, groups, communities and populations.

10. **Evidence based**: built on reliable evidence and demonstrated success.

***** While Aboriginal respondents supported all of the above success factors, items 3 (community-driven) and 9 (culturally sensitive) were most often identified as critical to success.

Participants in the consultation cited over 100 examples of initiatives that they believe work well. Appendix B contains a selected list of some that were mentioned numerous times and were supported with a rationale for their success. These examples are based on participants' experience, not necessarily formal evaluations.

Approach to Target Groups in Phase One

Culture, language, spirituality and identity—and respect for these factors—play a key role in improving health status. A **gender and culture analysis** needs to be applied to all policies and activities, and to setting priorities for action. Similarly, representatives of the intended participants need to be involved in all stages of policy and program development.

Culture has a profound effect on eating styles, activity patterns and attitudes towards body weight. Messages and activities need to be especially sensitive to attitudes and practices among newcomers to Canada and Aboriginal peoples. Gender also plays a critical role. Men and boys are more active than girls and women at all ages. Men are more likely to be overweight than women are, and to be less concerned about the need for a healthy diet. In families, women tend to be the primary influencers of food choices and do more meal preparation and child care than men do. As such, it will be important to address women as a key intermediary audience in the strategy, while supporting the importance and need for women themselves to enjoy regular physical activity and healthy eating.

The strategy is also amenable to a **lifestage approach** that focuses on issues of particular importance at various stages and transitions. For example:

Pre- and Postnatal: The health of both mother and child is strongly influenced by the mother's nutritional health status prior to and during pregnancy. Healthy eating and adequate weight gain during pregnancy helps to improve birth outcomes. Healthy eating and active living in pregnancy, combined with breastfeeding in infancy supports healthy weights in both mothers and children, and enables optimal growth and development in children.

Children: Increasing opportunities for all children to everyday physical activity, active play, sport and recreational activities, and helping children and families to decrease their consumption of foods and drinks that lead to healthier body weights among Canadian children.

Youth: Reversing the decline in physical activity levels in adolescence and young adulthood is important for delaying the development of heart disease and preventing overweight. Supporting media literacy and social acceptance of a diverse range of acceptable body types will help young people develop self-esteem and healthy body images, and may help to prevent disordered eating and exercising among vulnerable populations.

Midlife: Targeting middle-aged adults (the large boomer generation) will help delay or decrease the onset of risk factors for chronic disease.

Older adults: Active living and healthy eating have the potential to significantly enhance independence and quality of life in old age, and to prevent or delay costly disabilities and diseases.

As described in Part One of this document, two groups will receive special emphasis in Phase One of the strategy—children and youth, and Aboriginal peoples. The next section addresses Aboriginal peoples.

A Strategy for Aboriginal Peoples

Overall, Aboriginal peoples have poorer health than other Canadians.[77]

- In 2002, 38% of First Nations people on reserves reported very good to excellent health (compared to 61% of all Canadians), while 28% reported fair to poor health (compared to 13% of all Canadians).[78]

- In the past several decades, diseases that were previously rare in Aboriginal communities have become more common.[79] For example, the prevalence of diabetes among Aboriginal populations is estimated to be at least three times that of the Canadian population as a whole.[80]
- Rates of obesity are approximately twice as high among Aboriginal people than among Canadians of European ancestry.[81] In addition, up to 78 percent of Inuit children and up to 64 percent of First Nations children are overweight.[82]

A recent article on Aboriginal people living off-reserve analyzed data from the CCHS to produce a snapshot of the health of this population in comparison to non-Aboriginal people living in communities across Canada. Here are some of the findings:

- 23.1% of Aboriginal people living off-reserve rated their health as fair or poor, a level 1.9 times higher than the non-Aboriginal population. While the proportion of Aboriginal people reporting fair or poor health decreased as household income increased, the gap between Aboriginal and non-Aboriginal people persisted for all three-income levels.
- 60.1% reported at least one chronic condition (most common were arthritis, high blood pressure and diabetes), compared to 49.6% of the non-Aboriginal population.
- 16.2% reported a long-term activity restriction, 1.6 times higher than the rate for the non-Aboriginal population
- 54.1% were inactive (little difference compared to the non-Aboriginal population); 33.5% were overweight (little difference) and 24.7% were obese (almost twice as likely as the non-Aboriginal population).[31]

While genetic predisposition may be a contributing factor in some cases, it is thought that the rise of diseases such as diabetes and cardiovascular disease, can be attributed to the rapid social, dietary and lifestyle changes experienced by some Aboriginal communities over this period.[84] Aboriginal people who live in remote communities exhibit a wide range of conditions as a result of inadequate nutrition and poor access to healthy foods. These include anemia, dental caries, obesity, respiratory illness and type 2 diabetes.[85]

In remote communities, quality nutritious food, especially perishable items, are expensive and sometimes difficult or impossible to obtain, regardless of cost. In many Inuit communities, 95 percent of after shelter social assistance income is required to purchase sufficient healthy food for a family of four.[86] Traditional country foods are increasingly unavailable for a variety of reasons, including the effect of climate change on hunting in the north. When they are available, traditional foods, especially sea mammals and fish, may contain high levels of contaminants, resulting in public fears about whether it is safe to eat them.

Increases in overweight and obesity are likely due to the transition from a traditional way of life to a modern Western one. This has resulted in: more people eating high sugar, high-fat, high-energy diets; more people working at sedentary jobs and at the same time being less active in their time off; and increases in the use of cars, snow machines and passive leisure activities, such as television viewing.

Health inequalities are also explained, in part, by the fact that Aboriginal people have lower socioeconomic status than other Canadians. For example, in the 1996 National Longitudinal Survey of Children and Youth, persons of aboriginal descent living off-reserve were four times more likely to report hunger than other respondents.[87] Other factors, such as the social and

psychological outcomes of residential schooling have negatively affected Aboriginal peoples' experience of health.

The Need for an Integrated Wholistic Plan

Aboriginal peoples require a distinct action plan that is culturally relevant and wholistic in its approach. A wholistic integrated approach is one that addresses healthy living from a physical, emotional, spiritual, and mental perspective. This approach is central to designing a strategy that promotes healthy eating and physical activity, and reduces rates of overweight and obesity.

Physical activity is critical to health and well-being at all ages. Outdoor activities provide important opportunities to enjoy nature and wildlife including activities such as berry picking, hunting and fishing. Sport and recreation are important parts of Aboriginal culture and heritage; many people are involved in amateur sport, and athletes are a source of pride and inspiration.

Nutritional well-being is a crucial determinant of overall health and community wellness. Good nutrition during childhood and adolescence is essential for children to develop and learn. During the adult years, good nutrition helps ensure a healthy immune system, helps to prevent many chronic diseases, and contributes to optimal physical and mental health. It influences the ability of people to be productively employed and to participate effectively in the lives of their families and communities.

Weight is one of the most important modifiable risk factors for chronic disease. Unhealthy weights seems to be a greater problem among Aboriginal people in certain geographical areas, but there is not yet good comparative information on this issue at a national level.

An integrated approach to healthy living for Aboriginal peoples needs to:

- be culturally sensitive and include a spiritual component
- be community driven
- address the unique issues and needs of people living both on- and off-reserve
- address disparities and the broad determinants of health
- be long-term and intersectoral
- emphasize youth and give them a voice, while also supporting adults at risk. Activities with Elders have the potential to significantly enhance independence and quality of life in old age, and to prevent or delay disabilities and diseases that have great social and economic costs.

The proposed Strategy for Nutrition and Activity Promotion (SNAP) was developed in response to escalating rates of obesity, diabetes and heart disease; lack of food security; poor nutritional status; and the role that physical activity and nutrition play in overall health. SNAP considers the determinants of healthy eating and physical activity across the life cycle, as well as existing programs and services. It is based on partnerships with First Nations and Inuit groups.

The goal of SNAP is to improve health and well being, and the objectives are to:

- increase community capacity to address nutrition and physical activity needs and to create supportive environments
- increase food security
- improve nutritional health
- increase participation in physical activity

- reduce risk and the impact of chronic disease.

SNAP was designed for Aboriginal communities living on-reserve. While Aboriginal peoples living off reserve may have unique needs that require some alterations, SNAP may provide a model for action in off-reserve communities as well. This idea needs to be developed in consultation with Aboriginal communities and in partnership with provincial and territorial governments.

PART III: MOVING AHEAD

This section:

- summarizes the challenges to taking action that were identified in the consultation process
- describes some additional factors to consider in designing Phase One
- suggests some draft outcomes, objectives and accountability mechanisms for Phase One
- briefly discusses evaluation and accountability.

Challenges to Taking Action

In the consultation roundtables and workbooks, people were asked to list the greatest challenges for those working in the fields of healthy eating, physical activity and healthy weights. The workbook responses tended to focus on the challenges of personal and systemic barriers that individuals and families experience, whereas the discussions at the roundtables tended toward the challenges to those working in these fields.

1. The key themes that emerged as **challenges for individuals and families** for healthy eating, physical activity and healthy weights are:

Personal barriers:

- *Time and convenience*: increasingly hectic pace of life; unhealthy food choices are more accessible than healthy ones; lack of time and energy to plan, shop for and prepare nutritious meals; difficult to fit regular physical activity into daily routines; few or no opportunities for physical activity at work; school bus ride replaces walking to school; decreased physical activity at schools.

- *Motivation*: idea that physical activity is not fun, too much work; fear of failure, of looking stupid; low self-esteem; lack of encouragement and support; idea that nutritious food is not tasty food; personal complacency about overweight or unrealistic goals based on media images.

- *Knowledge and skills*: lack of knowledge about: good nutrition and its benefits, the effects of unhealthy foods on the body and the relationship to chronic illnesses, energy, stress, mental health, how to read food labels, how to budget, shop, prepare foods; decline in country and traditional foods and knowledge about how to grow, catch, prepare foods; lack of knowledge about ways to get more physically active, how to prevent injury, how to be more physically active if you have activity limitations (e.g., frail seniors, disabled, obese).

- *Affordability:* for those on low incomes, paid recreation and sacrificing food quality are the first things to go when someone runs out of money

- *Safety*: fear of falling for seniors and others with limited mobility on rough sidewalks, paths, and on ice; fear of violence outside in some communities; parents' fear of unsupervised activities.

Systemic Barriers

- *Physical environment*: lack of healthy food choices in restaurants, schools, workplaces; large portion sizes in restaurants; lack of fresh foods in the north; lack of facilities for physical activity in workplaces, communities, schools; lack of parks and green space for fun, family activities for all ages; communities built around cars not pedestrians; weather, cold; pollution and air quality in some places; safety: sidewalks, lighting, winter conditions, fear of dogs; degradation of northern lakes and forests (declining and/or contaminated country foods); some remote communities lack the resources for construction and expensive operation of facilities for physical activity (gymnasium, arena), especially Aboriginal communities.

- *Social environment*: shift to sedentary recreation (TV, computers) and sedentary employment; culture of convenience (use of cars, ATVs); workplaces and schools do not encourage healthy food choices and regular physical activity; emphasis on competitive sport rather than fun; aggressive marketing of unhealthy foods, especially to children; too much emphasis on overweight, pressure to be thin, prejudices against people who are overweight, unrealistic body images.

- *Socioeconomic status*: healthy foods are more expensive especially in remote or northern Aboriginal communities; those with no or low incomes (and increasingly those with middle incomes) cannot afford recreation programs or equipment for organized sports and physical activity.

- *Health services*: preoccupation with disease and injury at the acute stage as opposed to prevention; especially relevant for Aboriginal health services disproportionately overburdened by high poverty levels, mental illness, suicides, homelessness, violence, high rates of multiple chronic diseases, health problems due to poor nutrition (e.g., dental problems) and inactivity.

2. The key themes that emerged as **challenges for leaders**, i.e., those who work to improve healthy eating and physical activity practices and healthy weights are:

- *Need for improvements in government coordination and intersectoral partnerships*: government departments are not often working together, within and between departments (departments other than health are not participating); health, sport and recreation, and education systems need to understand each other's systems and language; silo policies can be barriers to taking action; isolated efforts across the country; integration of existing strategies and activities difficult; coordination of spending is needed, duplication of efforts by different sectors wastes money; partnerships are necessary but time consuming.

- *Confusing messages, need for a coordinated media campaign and lack of knowledge and skills:* conflicting, often inaccurate messages about nutrition, physical activity and weight from media and fitness and food industries; misunderstandings and prejudice related to weight; little or no instruction on shopping, budgeting and cooking in schools; people don't know how to read food labels; most children do not learn lifelong physical activity skills (such as swimming and skating) in school; many public and professionals do not now about or use available nutrition and physical activity guides; messages that are not culturally sensitive (e.g., never mention the fitness value of fixing a skidoo, skinning a caribou, building

a snow house); lack of a positive media campaign (ParticipACTION is gone).

- *Gaps in research and knowledge*: lack of baseline data, surveillance information, behavioural motivation factors and evaluation due to time, funds, and duration of projects; disconnect between research done and the needs of practitioners; lack of translation of research findings into a usable, accessible form for practitioners and the public; lack of information on identifying and explaining inequities.

- *Lack of support for a comprehensive, multi-level* strategy that supports community development and community-driven approaches.

- *Resource needs:* adequate financing is required over the long-term; more efforts on recruiting and training volunteers; need dedicated, trained human resources (especially outside large centres); governments need to provide core funding for programs that work

- *Strength of industry opposition:* while some industries can partner in healthy living strategies, those that promote non-nutritious foods, sedentary leisure, and motorized vehicle travel have large budgets and resources to promote their products and counter arguments to healthy living.

- *Need for sensitive policies in key areas:* lack of healthy school policies including QDPE and nutrition education; access for lower income children to physical activity is often only during school hours; need for food pricing and accessibility policies that will reduce disparities and increase food security in remote regions; policies do not recognize importance of spiritual and mental health; all groups in Canada need a wholistic, culturally sensitive approach as articulated by the Aboriginal representatives.

- *Social values*: Canadian culture does not value physical activity; too much emphasis on weight (slimness), instead of on health, enjoyable physical activity and healthy eating; healthy living and prevention not perceived as important in comparison to treating illness; emphasis on slimness does not take genetic diversity into account.

- *Social exclusion*: initiatives are not inclusive enough regarding gender, ability etc.; lack of accessibility and accommodations for Canadians with disabilities and other vulnerable groups; challenge of reaching Canadians with low literacy skills.

Aboriginal participants emphasized that healthy eating and physical activity must not be addressed in isolation from the other challenges currently facing many Aboriginal communities and urban Aboriginal people including: employment and income issues, poverty, the slow pace of land claims resolutions, inadequate housing, inadequate water supplies and sewage treatment, rapidly changing lifestyles and increases in sedentary leisure especially for youth, poor access to health care facilities and professionals, lack of social opportunities, low self-esteem.

Additional Factors to Consider in Designing Phase One

Standardized measurements and ongoing surveillance are required to understand the problem and monitor progress.

A variety of population-based surveys have measured participation in physical activity over the period from 1981 to 2001. The National Population Health Survey (NPHS) asks participants to

describe their leisure-time physical activities for the previous three months. Levels of activity are classified according to estimated kilocalories per kilogram of body weight per day: active (3.0 or more) moderate (1.5 to 2.9) or inactive (less than 1.5). It is important to standardize this measurement and the way that the questions are asked on all future population surveys. There is also an urgent need to standardize and collect measures of physical activity and fitness levels in children and adolescents.

The recent funding announcement of the Nutrition Focus component of the Canadian Community Health Survey is an important start to providing essential baseline data on the food and nutrient intake of Canadians. This information will enhance the evidence-base for food and nutrition policies designed to promote and protect health, and to reduce the risk of chronic diseases. However, there continues to be a need for ongoing, comprehensive surveillance in order to better monitor and track information on food and nutrition issues. The First Nations and Inuit Regional Longitudinal Health Survey is another important tool for learning about food and eating patterns in these communities.

The recent report titled *Canadian Guidelines for Body Weight Classification in Adults* updates the weight classification system used in Canada since 1988, and aligns it with World Health Organization recommendations. At the population level, the system can be used to compare body weight patterns and related health risks within and between populations and to establish population trends in body weight patterns. There is a need to collect measured data periodically to quantify the problem more precisely and to monitor changes over time. The 2004 Canadian Community Health Survey will measure height and weights, as well as waist circumference measurements for the first time at a national level.

From a public health perspective, the most important gains are likely to be made through prevention and enabling large population groups to make modest, incremental changes in their health practices and overweight status.

- Research in physical activity suggests that the greatest benefit to a population's health is likely to be achieved by moving inactive Canadians into the moderate category.[88]
- Similarly, randomized controlled trials have shown that weight loss as modest as 5 to 15 percent of excess total body weight reduces the risk factors for some diseases, particularly cardiovascular disease. Weight loss results in lower blood pressure, lower blood sugar, and improved lipid levels.[89]
- Since the long-term treatment of obesity has yielded limited success,[90] increasing the proportion of Canadians who attain and maintain a body weight within the healthy weight range is a key objective.
- While prevention of overweight and obesity is critical, addressing weight issues in children and youth must be done carefully. Changes in adiposity are normal as children go through growth spurts, and excess weight may be lost through normal growth and development. A good prevention program is one that encourages family lifestyle changes by promoting healthy eating patterns, protecting children against advertisements for unhealthy, fatty foods and large format servings, and decreasing sedentary behaviours.[91]

Consistent standards and messages are important and available.

- Canada's Food Guide to Healthy Eating and Canada's Physical Activity Guides to Healthy Active Living (for children, youth, adults and older adults) provide clear recommendations

for healthy eating and levels of physical activity, and serve as the basis for consistent information and advice.

- The challenge related to healthy weights is to craft messages and interventions that prevent and ameliorate overweight and obesity in a manner that does not exacerbate negative health consequences associated with weight preoccupation, especially with children and young women. It will be important to stress *health*, rather than appearance, and *healthy weights*, rather than excess weight.

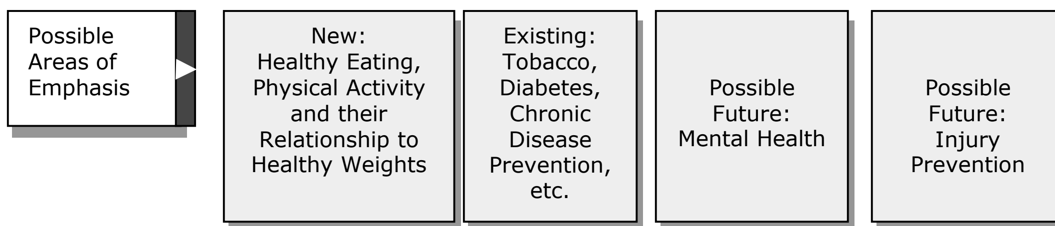
Efforts will need to reflect and build on several national-level policies that recently have been put in place, such as:

- *National Target for Physical Activity*. In 2003, federal, provincial and territorial Ministers responsible for Physical Activity, Recreation and Sport set a national target to increase levels of physical activity by 10 percentage points in each province and territory by the year 2010.

- *An Act to Promote Physical Activity and Sport.* Legislation (Bill C-12) received Royal Assent in the House of Commons on March 19, 2003. The objectives of the Government of Canada's policy regarding physical activity are: to promote physical activity as a fundamental element of health and well-being; to encourage all Canadians to improve their health by integrating physical activity into their daily lives; and to assist in reducing barriers faced by all Canadians that prevent them from being active. This recognition of the value of being physically active creates an opportunity to explore integrated strategies in physical activity, sport and healthy living.

- *New Nutrition Labelling Regulations and Education Programs*. On January 1, 2003, new nutrition labelling regulations were published, requiring most pre-packaged food to have a Nutrition Facts table listing 13 core nutrients, permitting 5 health claims and updated nutrient content claims. Nutrition labelling provides consumers with a tool to make informed food choices. Health Canada's nutrition labeling education initiative is designed to increase awareness and knowledge; build skills; build partnerships; and increase capacity. A toolkit for educators that includes background information and ready to use resources has been distributed to over 8500 health professionals. Distinct resources have also been developed for Aboriginal people. "Healthy Eating is in Store for You" is lead by Dietitians of Canada and the Canadian Diabetes Association with the support of nine other organizations. This program includes nutrition labelling resources for health intermediaries, in-store nutrition education and a virtual grocery store.

Proposed Outcomes and Objectives for Phase One



The first phase of the Integrated Pan-Canadian Healthy Living Strategy seeks to achieve the following positive outcomes.

1. ***Improved capacity to provide supportive environments for healthy living by:***

- increasing the number of federal, provincial, territorial and municipal policies, regulations and standards that support healthy living and reduce disparities in access to opportunities for healthy living
- strengthening community capacity by increasing the number of integrated multisectoral and multi-setting community activities that use evidence-based models of best practice to prevent weight problems, poor eating patterns and sedentary living among children, youth, adults in midlife and older adults
- bridging the gap between researchers, policy-makers and practitioners through improved communication and dissemination strategies and the use of innovative communication technologies
- enhancing partnerships and collaboration among intersectoral and interdisciplinary networks, alliances and coalitions that have the mutual goal of promoting healthy living.
- Enhancing partnerships with the private sector to create commercial and workplace conditions that support healthy living.

2. ***Improvements in personal health practices and reductions in the prevalence of weight problems by:***

- increasing the proportion of Canadians who understand and follow the recommendations of Canada's Physical Activity Guides to Healthy Activity Living
- increasing the proportion of Canadians who are active by 10 percentage points by 2010
- increasing the proportion of Canadians who understand and follow the recommendations of Canada's Food Guide to Healthy Eating
- increasing the proportion of Canadians who understand and use nutrition labels to help them make healthy food choices
- reducing the amount of time that children and youth spend in passive recreation such as watching television and playing computer games
- increasing breastfeeding initiation and duration rates
- increasing the proportion of Canadians who attain and maintain healthy weights and reducing the proportion of Canadians who are overweight and obese
- reducing the number of young Canadians who suffer from disordered eating and extreme exercise behaviour.

3. ***Reduced disparities in access to opportunities for safe, enjoyable physical activity and healthy food by:***

- increasing the number of low-income families and children who have access to healthy foods and who participate in physical activity, supervised sport and recreation activities
- increasing access to healthy foods and enjoyable physical activity (including traditional foods and activities) in rural, remote and Northern areas
- increasing the number of workplaces, communities and schools that have policies and practices that reduce disparities in access to opportunities for healthy living
- increasing the number of Canadians with disabilities of all ages who are physically active and prepare and consume healthy foods.

Evaluation and Accountability

Regular monitoring and reporting on the progress of the Integrated Pan-Canadian Healthy Living Strategy helps governments and others improve policymaking and share information on effective practices.

Phase One of the strategy proposes an outcome-oriented approach that reflects the vision and goals of the overall framework for the strategy. Measurable indicators are proposed in the outcome statements. The health sector needs to continue to take the lead in measuring and reporting on these indicators. Monitoring reports should describe current status and trends over time. It should be compiled at the community level, as well as at provincial, territorial and national levels, so that communities and governments can monitor their progress and community and regional comparisons can be made.

Existing data sources, such as population and community health and social surveys, the National Longitudinal Survey of Children and Youth, the cross-cultural WHO survey on school-aged children, provincial and territorial surveys, surveys and studies by the Canadian Fitness and Lifestyle Research Institute, Aboriginal surveys, and disease surveillance statistics will provide baseline data with which to compare future outcomes. The adoption of a standard set of indicators will ensure that governments and others are able to measure the immediate and longer-term impacts of healthy living programs and policies.

In 1998, the WHO Working Group on Health Promotion Evaluation stressed the importance of political and academic support for evaluating community initiatives. Policies and funding programs should encourage participatory approaches that involve the target group and the use of multiple methods.

Proposed Actions:

- Community and/or regional public health departments to report on local progress using agreed upon indicators every second year of the strategy.
- The federal and provincial/territorial governments to use this input as well as other data to report on progress using agreed upon indicators every second year of the strategy.
- A joint progress report combining all data and written in clear language to be made available to the Canadian public at year 3 and year 6 of the strategy.
- Policy makers at all levels to support the evaluation of all activities by allocating sufficient resources and supporting infrastructures and alliances that enable participatory approaches.

CONCLUSION: GETTING FROM HERE TO THERE

While further development and fine-tuning of the Integrated Pan-Canadian Healthy Living Strategy is required, the major challenges are not a lack of knowledge about what needs to be done, nor a willingness to work together toward common goals. Rather, the success of the initiative depends on establishing the various mechanisms and infrastructure components that are needed to support an integrated approach. This is especially challenging when it involves sectors outside of health that need to be engaged to reduce disparities and improve health outcomes. A strong collaboration within and across sectors, systems and jurisdictions is an important first step.

Participants in the symposium will be asked to contribute to the next steps in the formulation of the healthy living strategy and the development of an action plan for Phase One. This includes the identification of key activities, and of mechanisms that will facilitate shared policy and program development among government departments, their nongovernmental partners and other sectors that influence health outcomes. These ideas will be forwarded to the F/P/T Task Force charged with moving the strategy ahead.

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APPENDIX A: EXAMPLES OF CURRENT INTEGRATED INITIATIVES IN HEALTHY LIVING

NOTE: The examples in this Appendix focus primarily on integrated activities initiated by governments. It is not an exhaustive list and there are many more examples of integrated initiatives in the nongovernmental sector. Many of these are listed and described in a document titled *Chronic Disease Prevention Initiatives* prepared by the Chronic Disease Prevention Alliance of Canada. The intent of this appendix is not to duplicate that lengthy document but to provide examples of the types of initiatives in jurisdictions across Canada.

Some National Level Initiatives

Nutrition for Health: An Agenda for Action (1996). In response to the World Declaration on Nutrition (World Health Organization and Agriculture Organization, 1992), Health Canada established a Joint Steering Committee to prepare a national nutrition plan. It builds on the population health model and sets out strategic directions to encourage policy and program development that is coordinated, multisectoral, supports new and existing partnerships, promotes the efficient use of limited resources and strengthens research to improve the nutritional health of Canadians.

Canada's Action Plan for Food Security: A Response to the World Food Summit (1998) is Canada's response to the 1996 World Food Summit where the international community committed to reduce by half the number of undernourished people no later than the year 2015. The Action Plan is the result of extensive consultations between governments and civil society, and builds, in part, on commitments and actions flowing from Nutrition for Health: An Agenda for Action (1996).

Canadian Diabetes Strategy (CDS). In 1999, the federal government pledged $115 million over five years to the development of the CDS. Partners in this national initiative include the provinces and territories, stakeholder groups that include national Aboriginal organizations, and the nongovernmental sector represented by the Diabetes Council of Canada. Initial efforts have been directed toward four areas: Promotion and Prevention, the Aboriginal Diabetes Initiative, a National Diabetes Surveillance System and National Diabetes Coordination. A Blueprint *for Action Plan for the National Diabetes Strategy* is currently under development.

National Strategy on Tobacco Control. In 1999, the federal, provincial and territorial ministers of health endorsed *New Directions for Tobacco Control in Canada: A National Strategy*. The Strategy is based on a population health framework that takes into consideration social, economic and environmental factors that influence smoking trends, as well as personal health practices and coping skills, and the accessibility of appropriate services. It also emphasizes sustained, comprehensive, integrated and collaborative approaches to reducing tobacco use and encourages shared responsibility among all levels of government -- federal, provincial, territorial and local -- with non-governmental organizations.

In April 2001, the Government of Canada launched the **Federal Tobacco Control Strategy** (FTCS), which outlines how the federal government will carry out its role as a partner in the National Strategy. The FTCS recognizes that the key to success is comprehensive, integrated, and sustained actions carried out in collaboration with all partners and directed at Canadians of all

ages. More information about the FTCS is available on Health Canada's Web site at **www.hc-sc.gc.ca/hecs-sesc/tobacco/about.html**.

Canadian Heart Health Initiative (CHHI) is a countrywide multi-level strategy for the prevention of cardiovascular disease (CVD), which takes an integrated approach to the control of the multiple risk factors responsible for CVD. Partnerships and coalitions are built around policy, research and action. The Initiative has resulted in extensive networks and coalitions involving federal and provincial departments of health, the Heart and Stroke Foundation of Canada, and over 1,000 voluntary, professional, and community organizations across the country.

Provincial/Territorial/Regional Initiatives

Yukon Active Living Strategy is a territory-wide initiative designed to decrease the number of inactive people in the Yukon. Anticipated outputs include increased knowledge of the benefits of activity, increased physical activity levels and in healthy eating behaviours, and a decrease in the incidence of chronic diseases and deaths due to chronic disease.

HEAL – Healthy Eating and Active Living in Northern British Columbia is a joint project of four northern health regions in B.C., which is managed by the Northern Health Authority and funded by Health Canada. HEAL will build community capacity to prevent type 2 diabetes by supporting regional and local networks, and by sponsoring demonstration projects, regional workshops and public awareness activities.

Alberta Active Living Strategy. In 1997, the Alberta Active Living Task Force developed 23 incremental recommendations to promote active living in communities, schools and workplaces. The Minister's Active Living Coordinating Council, which includes several government departments, collaborates to influence legislation, policies, information, community design and incentives to support the implementation of these recommendations.

Alberta Integrated Healthy Living Framework. Within the context of this framework, an Alberta Healthy Living Network (AHLN) has been formed to provide leadership for integrated, collaborative action to promote health and prevent chronic disease in Alberta. The AHLN will address the issues of healthy eating, physical activity and tobacco reduction within a population health approach. Alberta has also developed or is in the process of developing strategies related to diabetes prevention, tobacco reduction, cancer control and injury prevention.

Saskatchewan Population Health Promotion Strategy. Saskatchewan Health is working with Regional Health Authorities, health groups, the business community, municipal governments, human service agencies, and other partners in education and social services on a strategy to guide health promotion activities across the province. The strategy will identify the priority areas for health promotion and disease prevention initiatives, and will be guided by research that looks at the needs of Saskatchewan people and communities. Using the provincial priorities as a foundation, the Regional Health Authorities will develop action plans based on the needs of their communities, and will report annually on the initiatives underway.

Saskatchewan Northern Health Strategy. A group involving four northern health regions along with northern First Nations health authorities, Saskatchewan Health and Health Canada are working co-operatively to improve the health status of all residents in northern Saskatchewan. This partnership is based on a common history of northern Metis and First Nation peoples and common issues in health and socioeconomic circumstances. The strategy involves working across

jurisdictions in the development of health services delivery and health promotion frameworks; increasing family, community and northern region capacity; and developing partnerships while ensuring diversity and equitable resource allocation. Health promotion and disease prevention is a cornerstone of the strategy through health and intersectoral partnerships.

Saskatchewan Métis and Off-Reserve Strategy. This strategy is working toward a vision in which "all residents of Saskatchewan, including Métis and off-reserve First Nations people, will have the opportunities and resources to participate fully in our communities and our economies." Partnerships among the federal and provincial governments, local governments, existing and evolving Aboriginal organizations and institutions, crown corporations, businesses, unions, other non-government sectors, communities and individuals will be key to implementing the four goals of the strategy: to enhance the successful entrance and completion of primary, secondary and post-secondary education for Métis and off-reserve First Nations People; to prepare Métis and off-reserve First Nations people to participate in a representative provincial workforce; to ensure representative workforce participation by Métis and off-reserve First Nations people in the provincial economy; and to improve individual and community well-being of Métis and off-reserve First Nations people.

The Saskatchewan Disability Action Plan is based on the principle of full citizenship for all individuals including those who have disabilities. This principle supports a vision of society that recognizes the needs and aspirations of all citizens, respects the right of individuals to self-determination, and provides the resources and supports necessary for full citizenship. Action on seven elements is key to achieving this vision: awareness and understanding, safety and security, disability supports, health, education, employment and income support.

Manitoba Physical Activity Action Plan was developed by a multisectoral alliance of stakeholders after extensive consultations and physical activity summit. The plan focuses on necessary actions to be taken at the provincial and the community/regional levels, in three broad categories: policy, leadership and programs.

***The Manitoba Healthy Schools Initiative**,* which addresses healthy eating, physical activity and healthy weights, was developed in partnership with related government departments and students, teachers, parents, health professionals and the community. The mission is to create school environments that enhance the healthy development of children and their families by working in partnership with community resources and service providers. The initiative uses a population health focus that recognizes determinants of health; acknowledges the influence of neighbourhoods, families and community partners; complements existing services and supports; recognizes the interdependence of health and learning; encourages partnerships and community development; focuses on a healthy schools - healthy community approach; and incorporates the principles of best practices and evidence.

Active Ontario is an integrated strategy with initiatives for seven key settings – communities, schools, workplaces, homes, the recreation system, the sport system, and the health care system. It was developed jointly by the Ontario Ministry of Health and Long Term Care and the Ministry of Citizenship, Culture, and Recreation (now Ministry of Tourism and Recreation), together with their partners in health, education, recreation and sport with the goal of increasing the number of Ontarians (including children and youth) that are active enough to benefit their health.

Aboriginal Healing and Wellness Strategy is an intersectoral strategy involving Aboriginal groups in Ontario and four government ministries. It is wholistic and comprehensive and provides a culturally appropriate alternative to the way mainstream services are typically designed and

delivered. It focuses on lifelong healing and wellness. Renewed in 1999, it now includes a network of Health Access centres, healing lodges, shelters for women and children, increased staff in Aboriginal organizations for healing and wellness, a clearinghouse, recruitment centre for posting health and social service positions, a lodge for housing families of loved ones in Toronto hospitals, and a network of advocates who sensitize hospitals and health care professionals to Aboriginal needs. The project has led to a better understanding of Aboriginal health issues by government, and new relationships among Ontario First Nations, urban Aboriginal and Métis organizations.

Framework for Action: A Population Health Approach to Preventing Type 2 Diabetes released November 7, 2002, outlines the components of a provincial primary prevention strategy for Ontario. It endorses the need to build and use existing infrastructures and resources. A practical process for achieving the objectives of the diabetes primary prevention framework is described in a companion document, **Preventing *Type 2 Diabetes: The Ontario Plan of Action.*** The *Plan of Action* describes four functions to be used in the implementation process: planning, coordination, establishing appropriate links and partnership and resource development. A series of projects to address four implementation objectives are proposed which provides flexibly in partnership arrangements and focuses efforts on key results. Additional resources have been provided to plan and implement a province-wide prevention activity which focusing on school-based approaches to preventing type 2 diabetes by increasing positive behaviours related to physical and healthy eating habits for youth and adolescents and to create a school environment that fosters these behaviours.

Progamme national de santé publique 2003 – 2012 au Québec is a new program that takes action on the factors that influence the health of the whole population or population groups and is characterized by actions that are preventative in their approach. The program consists of a series of objectives and measures to attain them. Quebec has also developed physical activity programs for secondary students (Ça bouge après l'école), and has introduced an integrated chronic disease prevention program (Le Programme Intégré de Prévention des Maladies Chroniques 2002 – 2012).

The ***Pan-Atlantic Wellness Strategy for Healthy Eating and Active Living*** is designed to increase healthy living in Atlantic Canada as defined by improvements in healthy eating and active living. The strategy has three interconnected goals: enhancing community capacity for promoting healthy eating and active living; increasing awareness and understanding of the benefits of healthy eating and active living through a collaborative social marketing campaign; and, identifying the policy framework needed to support people and communities in making healthy eating and active living choices.

Working Together for Wellness: A Wellness Strategy for New Brunswick is deigned to address the challenge of how government and society can better promote wellness, prevent illness, and address the factors that influence wellness. The five priority areas for action are healthy lifestyles, children and youth, seniors, communities and workplace wellness.

***Active Kids, Healthy Kids**,* the Nova Scotia Physical Activity Strategy for Children and Youth was created by a working group of government and nongovernmental organizations on behalf of the Minister responsible for the Sport and Recreation Commission. The three-year strategy (2002 – 2005) is supported and funded by the Sport and Recreation Commission, the Department of Health and the Department of Education. The long-term goal is to increase the number of children and youth who accumulate at least 60 minutes of moderate or higher-intensity physical activity on a daily basis. The six complementary components of the strategy include policy and

program development, active communities, active school communities, active community environments, public education, and evaluation and monitoring.

Nova Scotia Chronic Disease Prevention Strategy will take a comprehensive, integrated, population health approach to the primary prevention of chronic disease. The strategy will address preventable, non-communicable chronic diseases (cardiovascular, cancer, diabetes, respiratory, mental illness) that are influenced through common risk factors (physical inactivity, unhealthy eating, distress, tobacco use), determinants of health, and co-morbidity, which collectively contribute to the burden of illness.

The ***Healthy Eating Strategy for Island Children and Youth 2002 – 2005*** is an initiative of the Prince Edward Island Healthy Eating Alliance, a group of some 40 government and nongovernmental organizations and individuals dedicated to the improvement of eating habits of children and youth. The goals of the Alliance are to increase nutrition education and promote healthy eating to students, parents, teachers, and those who work with children; to increase access to safe and healthy foods in every place where children gather; and, to increase understanding of how children and youth are currently eating and why, and how their eating behaviours can be improved through up-to-date research.

Healthier Together – A Strategic Health Plan for Newfoundland and Labrador identifies three major goals: improve the health status of the population of Newfoundland and Labrador; improve the capacity of communities to support health and well-being; and improve the quality, accessibility, and sustainability of health and community services. One of the strategic challenges of the plan is to lessen the incidence of chronic disease by promoting healthy behaviours, preventing the onset of disease, and managing disease in an effective manner. This population health approach aims to improve quality of life, length of life, and reduce the burden on the health system of treating chronic diseases.

Some International Initiatives

The North Karelia Project was a national demonstration program that was initiated in the early 1970s in the province of North Karelia, which had the highest rates of cardiovascular disease in Finland. The goal was to see if integrated, community-based interventions would lead to major changes in dietary habits, in population cholesterol levels and, ultimately, in coronary heart disease (CHD) rates.

In the 25 years since its inception, the population's mean serum cholesterol levels of North Karelia has been reduced by 18 percent. During the same period, the age-adjusted CHD mortality has declined by 73 percent among 35 to 64 year-old men.

Intervention targets and methods were based on epidemiological considerations, and relevant theories from behavioural and social sciences. Innovative media campaigns combined with the systematic involvement of local health care and community organizations was a key component. The demonstration project in North Karelia was eventually extended on a national basis.

The North Karelia Project has contributed to major changes in Finland, involving intersectoral collaboration, national focal point(s), long-term nutrition education programs, collaboration with

voluntary organizations and the food industry, food labelling policies, price policies, research, demonstrations and international collaboration.

The World Health Organization Countrywide Integrated Noncommunicable Disease Intervention Programme (***(CINDI)*** establishes cooperative projects and programmes to prevent and control noncommunicable diseases (NCDs) and to promote healthier lifestyles. It is based on an integrated approach towards the prevention and control of NCDs. The approach recognizes that a few modifiable risk factors are common to major NCDs. It covers the full continuum of health promotion, disease prevention and health care actions. Implementation involves combining population-based strategies with high-risk strategies aimed at improving the risk profile of individuals through preventive practice. Priorities include reducing smoking, unhealthy diets, alcohol abuse, physical inactivity and psychosocial stress. Monitoring and evaluation are carried out at regular intervals, using agreed upon indicators and methodologies for epidemiological surveys.

Integration offers a number of advantages, such as increased consistency among health policies, public education messages that are coherent and mutually reinforcing, the sharing of intervention results with other communities, and resource savings.

The CINDI Canada Programme functions at the national and demonstration levels. The backbone of CINDI Canada has been the Canadian Heart Health Initiative. This program implemented an integrated approach to a single disease, and is now moving toward an integrated approach across diseases and risk factors. The demonstration area for CINDI Canada is Nova Scotia.

The WHO Global Strategy on Diet, Physical Activity and Health is a follow-up to the resolution of the Fifty-third World Health Assembly on preventing and controlling noncommunicable diseases. The global strategy will guide the development of actions at local, national and international levels that, when taken together, will lead to measurable improvements in risk factor levels and chronic diseases related to diet and physical activity.

APPENDIX B: EXAMPLES FROM THE CONSULTATION OF ACTIVITIES THAT WORK WELL

Many more examples of initiatives that work well were given during the consultation. This is a partial list of some of the programs that were repeatedly mentioned and given a rationale for success.

The Tobacco Reduction Strategy
Successful because: collaborative, multisectoral approach; combats norms; comprehensive, multi-pronged (policies, legislation, media, public education, enforcement pieces.); long-term and sustained effort; targets youth (prevention)

Saskatoon in Motion (and Active Surrey, etc.)
Successful because: infrastructure was developed, community driven, effective partnerships, sustainable, schools included, different settings etc.

Aboriginal Head Start
Successful because: holistic and culturally relevant, targets early years, offers formal and informal social support to parents, families and children

National Aboriginal Diabetes Program (diabetes prevention project)
Successful because: focuses on prevention, research component (evidence-based), sustainable funding, looked at multiple interventions

Canadian Heart Health Initiative
Successful because: government leadership, political will; multisectoral; comprehensive; all levels of government involved; evidence-based

Alberta Active Living Strategy
Successful because: intersectoral--involves six government departments and the workers' compensation boards.

Nova Scotia and PEI Tobacco Reduction Strategies
Successful because: long-term, clear vision, partnerships, political buy-in; legislation; human resources at the different levels; built in sustainability, a social marketing campaign and accountability from the corporate sector.

The Real Program (St. John's Newfoundland).
Successful because: provides recreation and leisure activities for children and youth from socio-economically disadvantaged backgrounds (accessibility); grass roots identified and acted on the problem (community driven); multisectoral partners including education, private sector and volunteers; modeled on a "best practice" program from Thunder Bay

ParticipACTION
Successful because: effective messages, used different mediums to get the message out, accessible language and images, long-term (over 30 years)

Montreal Diet Dispensary
Successful because: demonstrated cost and human value of directly providing food and counseling to pregnant women at risk; collaboratively at the federal, provincial and local levels

ISO Actif
Successful because: includes nutrition and physical activity elements, promotional campaigns (public education element), is geared towards achieving goals (different levels such as bronze, silver and gold), takes place in 100 schools

The Public Service Workplace Wellness Initiative in PEI.
Successful because: initiated through research that identified employee needs and recognized the barriers they face; recognized the need for the various departments to organize committees to develop healthy living activities for all staff (multisectoral); staff awareness of (public information) and participation in the initiative is high

Healthy Learner's Program (New Brunswick).
Successful because: includes partnership between health and education sectors; funding is provided for public health nurses in the school districts to bring partners together by linking the schools and communities with existing resources; focus on physical activity and nutrition, with goals identified by the community (teachers, kids and parents); takes a comprehensive approach by looking at environment, support and services, and instruction in classes; based on a population health approach and builds community capacity

The Walking/Cycling School Bus (Go For Green/ Active and Safe Routes to School project)
Successful because: partnerships national NGO and regional/local delivery agents; intersectoral-involves parents and caregivers, teachers and principals, public health nurses, police, city planners and engineers; addresses safety, environmental issues and child development in addition to healthy living; community driven; fun!

Canada's Prenatal Nutrition Program and Community Action Program for Children
Successful because: strong partnerships federal, provincial and territorial governments; strong community involvement, including volunteers; accessible-breaks down disparities; evidence-based; value-driven; demonstrated results (well evaluated)

Cultural/Traditional Camps
Successful because: traditional, holistic and involve spiritual elements (community-based); it involves the whole community (inclusive); strengthens supports and culture and focuses on on physical activity, healthy eating, and spiritual enlightenment

Traditional Health Model
Successful because: a community-driven, First Nations program that corresponds with the seasons; integrates families, communities, different groups, specialists and agencies

Food Mail Project
Successful because: number of partners enable shipping of healthy foods to remote communities at a reduced freight price; has resulted in a reduced cost of food; includes an educational component around reading food labels

The Centre for Indigenous Nutrition and Education
Successful because: offers on-line education courses for community health representatives, and those who work in the Canada's Prenatal Nutrition Programs (CPNP) and other programs; participants are supported by the government to take the courses (accessible)

Aboriginal Nutrition Network
Successful because: promotes good nutrition information and generates more Aboriginal nutritionists; provides links for those working at the grass roots; increases communication of best practices; national in scope; partners with schools and other agencies