HOUSE OF COMMONS
CANADA

HEALTHY WEIGHTS FOR HEALTHY KIDS

Report of the Standing Committee on Health

Rob Merrifield, MP
Chair

MARCH 2007

39th PARLIAMENT, 1st SESSION

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THE STANDING COMMITTEE ON HEALTH

has the honour to present its

SEVENTH REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied the subject of Childhood Obesity and presents its findings and recommendations.

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THE COMMITTEE APPROACH

Childhood obesity has become an "epidemic" in Canada. Obesity rates are increasing worldwide, but Canada has one of the highest rates of childhood obesity in the developed world, ranking fifth out of 34 OECD countries. Recent data reveals that 26% of young Canadians aged 2 to 17 years are overweight or obese. Even more distressing is the evidence that about 55% of First Nations children on reserve and 41% of Aboriginal children living off reserve are either overweight or obese.

Children who are obese are at increased risk of being overweight or obese as adults. The Committee shares the fears of many experts who predict that today's children will be the first generation for some time to have poorer health outcomes and a shorter life expectancy than their parents. The health implications of overweight and obesity — a range of preventable chronic diseases and premature death — are well documented. These implications are serious enough for adults who develop weight problems but pose an even greater threat for children who may develop chronic ailments at an uncharacteristic early age. Problems include (but are not limited to) the development of Type 2 diabetes, heart attack and stroke susceptibility, joint problems, and mental health issues.

On 15 June 2006, the House of Commons Standing Committee on Health initiated a study on childhood obesity in Canada with a particular focus on the responsibility of the federal government for First Nations and Inuit children. Through a series of thematic panels held from September 2006 to February 2007, the Committee aimed to: gather information on the dimensions of the overall situation; understand the influence of a wide range of health determinants; examine the approaches adopted in the provinces/territories and relevant countries; and define the role of the federal government in this area.

Knowing that this issue presents a complex public health concern, the Committee went beyond the traditional health community to hear from a wide range of witnesses about the role of income, education, social and physical environments in contributing to increasing rates of obesity among Canada's children. In addition to hearing specifically from First Nations, Inuit and other Aboriginal groups, it heard from witnesses representing health professionals, nutrition and fitness organizations, the food, telecommunication and advertising industry, recreation and sport groups, municipal and provincial governments, food security initiatives, and others. The Committee also held two videoconferences with consumer, industry and government representatives from the United Kingdom, a country with several years of experience in tackling childhood obesity.

But, most significantly, the Committee went beyond the federal health portfolio in its horizontal federal approach. In addition to representatives from Health Canada, the Public Health Agency of Canada, and the Canadian Institutes of Health Research, it invited a wide range of federal departments and agencies to talk about their responsibility in a broad and comprehensive approach to this serious problem. Finance Canada, Indian and Northern Affairs Canada, Sport Canada, Heritage Canada, Infrastructure Canada, the Canadian Food Inspection Agency, the Canadian Radio-television and Telecommunications Commission and Statistics Canada talked about their particular role in the multiple dimensions essential to effective federal action on healthy weights for children.

PART 1: HOW SERIOUS IS THE PROBLEM?

The Committee was shocked to hear how much overweight and obesity rates among children and adolescents in Canada have increased over the past three decades. In 1978, 12% of children and adolescents aged 2 to 17 years were overweight and 3% were obese — for a combined overweight/obesity prevalence of 15%. By 2004, 18% were overweight in this age group and 8% were obese — a combined prevalence of 26%.

While increases in overweight and obesity are similar among boys and girls, trends do vary with age. For example, the proportion of children aged 2 to 5 years who were overweight or obese remained virtually the same from 1978 to 2004 (around 21%). In contrast, the overweight/obesity rate in the other age groups doubled in the same period, from 13% to 26% for children aged 6 to 11 years and from 14% to 29% for adolescents aged 12 to 17 years. The adolescent obesity rate alone tripled from 3% to 9%.

The situation for Aboriginal children is the most alarming. Some 55% of First Nations children and 41% of Aboriginal children and adolescents living off-reserve are either overweight or obese. First Nations children aged 9 to 11 years are twice as likely to be overweight as their 3 to 5 year old counterparts (29% versus 13%). Younger First Nations children, however, are more likely to be obese than the older children (49% versus 26%). Unfortunately, no comparable data currently exist on the prevalence of overweight and obesity among Inuit children.

The Committee heard that rates of overweight and obesity among children and adolescents also fluctuate widely across the country. In 2004, the combined overweight/obesity rate of those aged 2 to 17 years was significantly above the national average (26%) in Newfoundland and Labrador (36%), New Brunswick (34%), Nova Scotia (32%) and Manitoba (31%). The prevalence of obesity was significantly higher than the national figure of 8% in Newfoundland and Labrador (17%) and New Brunswick (13%). Conversely, the combined overweight/obesity rate was below the national level in Quebec (23%) and Alberta (22%); however, the obesity rate in these provinces was similar to the national rate. The combined rates for the other provinces were 30% in Prince Edward Island, 29% in Saskatchewan, 27% in Ontario and 26% in British Columbia.

The Committee was surprised that, although childhood overweight/obesity is rising, there is a major gap between that reality and the perception of Canadian parents about the weight of their children. The Committee heard that one survey indicated that only 9% of parents of children under the age of 18 years identify their children as overweight or obese. This contrasts to the actual combined rate of 26%. This lack of recognition, or denial, raises a significant challenge in increasing parents' awareness, and it poses an even greater risk to the health of Canadian children.

The Committee heard that, as overweight children of today become tomorrow's obese adults, the burden on the health care and social systems is expected to increase. One estimate suggests that obesity in the overall population currently costs Canada about $1.6 billion annually in direct health care costs, or 2.4% of total health care spending. In addition, there is another $2.7 billion in indirect costs associated with obesity, including lost productivity, disability insurance, reduced quality of life and mental health problems due to stigmatization and poor self-esteem.

PART 2: WHY ARE OBESITY RATES RISING?

The Committee knows that overweight and obesity in children — as in adults — is linked to inadequate physical activity and to poor eating habits. Food intake (calories in) and level of physical activity (calories out) are therefore central elements in understanding childhood obesity. But, in turn, these variables are affected by multiple factors such as economic status, social and physical environments, genetics, education, and culture that determine how children eat and how active they are. Repeatedly, witnesses pointed to these multiple underlying determinants of health that affect children and their parents and the ability to make healthy choices.

A. Level of Physical Activity

The Committee heard that Canadian children and adolescents are not active enough. Objective measures of physical activity for children include studies where they wear pedometers that count the steps taken everyday. Only 49% are active during their leisure time, accumulating the equivalent of about one hour of walking a day. This finding is consistent for children and adolescents in rural, urban and Aboriginal communities alike. Moreover, girls consistently report less daily activity than boys. Most Canadian children do not participate in the 90 minutes per day of moderate activity (e.g., walking) or vigorous activity (e.g., running, climbing, swimming), as recommended by Canada's Physical Activity Guides for Children and Youth. It is estimated that only 21% of children and adolescents meet the international guidelines for daily activity for optimal growth and development.

Children and adolescents who participate in both unorganized and organized physical activity are at lower risk of being overweight and obese. In contrast, screen time (watching television, using the computer or playing video games) is associated with overweight and obesity. For example, children aged 6 to 11 years who engaged in more than two hours of screen time per day in 2004 were twice as likely to be overweight or

obese compared to those who logged one hour or less per day. On average, adolescents in Canada spend almost 35 hours a week in front of the screen, representing more time than in the classroom over the course of the year.

Witnesses pointed out that there are barriers to being more active and that children require more engagement by and commitment from parents, schools and neighbourhoods. For example, only about one third of parents report participation in active games with their children. A similar proportion indicates insufficient programs and facilities nearby for their children to be active. Research also indicates that children and youth with a parent who is inactive in his or her leisure time are also themselves more likely to be inactive. In addition, less than one in five children have daily physical education in school. For neighbourhoods, those with lower socio-economic status have higher levels of obesity, less participation in organized sports and a lack of safe parks and playgrounds.

B. Food Intake

The Committee was told that children are consuming too many calories. This was attributed to increased portions, increased intake of fatty and processed foods as well as greater consumption of sugary drinks. The link between obesity and the increased consumption of sweetened drinks is particularly disturbing. It has been estimated that sugary drinks may be responsible for as much as one pound per month weight gain in adolescents.

Witnesses provided data showing that in 2004 almost 60% of Canadian children and adolescents aged 2 to 17 years consumed fruits and vegetables less than five times per day — the Canada's Food Guide recommended daily minimum. Those who consumed fruits and vegetables either less than three times per day or between three to four times per day were significantly more likely to be obese (10% and 9% respectively) compared to those who ate fruits and vegetables five or more times per day (6%).

For children in First Nations and Inuit communities, witnesses linked the fact that they are eating less high-quality traditional foods than their parents to the rising obesity rate. The maximum daily average of energy consumption from traditional foods by Aboriginal children is around 10%, while 40% of their calorie intake is from sugar, fat, highly refined grains, or junk food. Research shows that there is better daily dietary nutrient adequacy when at least one daily serving of traditional food is contained in the diet of Aboriginal Canadians.

The Committee is concerned about research that suggests a correlation between food and beverage advertising and childhood obesity, particularly with respect to advertising of high-calorie and low-nutrient foods and beverages to children. Concerns about the negative consequences of marketing and advertising to children have led Quebec (since 1978), Sweden (since 1991) and Norway (since 1992) to ban direct television advertising to children. This ban prohibits all television advertising of any products to children; it is broader than food advertising, but is limited to television. As in Sweden and Norway, Quebec's ban covers only advertising originating within the

respective jurisdictions. In response to similar concerns about television advertising to children, the United Kingdom adopted in 2006 a more targeted approach by implementing a total ban on the advertising of food and beverage products that are high in fat, salt and sugar in and around all programs of particular appeal to children.

PART 3: WHAT DETERMINES HEALTHY WEIGHTS?

Most witnesses talked about how behaviours and patterns of food choice and physical activity are shaped by the child's environment. They saw a direct link between obesity and the key determinants of health, referring to multiple social, economic, physical, biological and other factors. They emphasized that assumptions about the responsibility of parents to ensure their children are adequately nourished and provided for in terms of their physical recreational needs must be balanced with the other realities facing many families.

A. Income

The Committee heard strong evidence that childhood obesity is linked to socio-economic factors. Family income in particular affects both food access and physical activity as cost places limitations on nutritious foods and restricts access to things such as equipment and organized sports. On one hand, there is a higher prevalence of food insecurity — that is, not having enough food to eat or not eating the quality or variety of food desired — among low income families, single mother households and Aboriginal Canadians. The likelihood of individuals reporting problems of food insecurity is tripled if they are on social assistance and almost four times if their main source of income is social assistance. On the other hand, low income families often do not have access to safe, adequate and appropriate facilities for recreation.

Concerning food specifically, witnesses cited data from surveys on household food expenditures showing the relationship between income and food purchasing. Thus, as income rises, the purchasing of fruits and vegetables steadily increases, and as income falls, the purchasing of fruits, vegetables and milk products declines sharply. Among the "meat and meat alternatives" group, low-income Canadians are more likely to purchase high fat meats while those with higher incomes purchase lean meats. With respect to nutrients in food, as income rises, so does the amount of nutrients in the food that is being purchased. Among low-income households, purchases in stores include a preponderance of foods that are higher in energy density and lower in nutrient density.

Food insecurity is a particular problem for First Nations children where one out of four lives below the poverty line and for Inuit where median incomes are significantly lower than non-Inuit populations. The cost of local nutritious food baskets in northern communities continues to rise far beyond the rates of minimum wages and social assistance. For urban Inuit and other urban Aboriginal populations, food insecurity means accessing food banks to meet the basic needs of their families for substance rather than nutrition. For northern communities, the high cost associated with hunting for traditional

country food means that those on low incomes cannot purchase boats, skidoos, gas and other necessary equipment.

Regarding physical activity, many witnesses saw low income as the largest barrier to participation in both unorganized and organized sports. This was particularly true for First Nations and Inuit children. For example, of the more than 500 First Nations schools, only half have a gym. Many parents in northern remote communities have limited capacities to finance facilities and equipment for recreational activities, indoor or outdoor. In addition to a lack of affordable programs in many of these communities, parents have limited time and money for transporting their children to programs over the long distances. Aboriginal children in urban settings face similar financial and time barriers. As well, the Committee was told that some children receive insufficient nourishment to provide the physical stamina to keep up with other children in physical activities.

B. Education

As with income, the Committee was told that the overall health status of individuals generally improves as education increases. Witnesses emphasized that effective education equips children and their parents with essential knowledge and skills for decision-making and problem-solving relevant to childhood obesity. For example, literacy and numeracy skills are important for understanding food labels as well as for making informed decisions about guides to physical activity and food. Witnesses pointed out that the practice of educating parents and families about good nutrition needs to be augmented with programs that teach parents and caregivers the necessary skills to prepare and plan nutritious meals. The Committee realizes that simple educational tools employing many different media can enhance learning about appropriate food and physical activity levels.

C. Social Environment

The Committee was told that healthy communities with sustained social support networks can provide a backdrop for greater overall health among children. In particular, many witnesses talked about the role of strong cohesive communities in combating childhood obesity. They described various promising practices whereby people share time and resources to engage children and parents in physical activities. Some talked about efforts to strengthen localized food systems, whereby neighbourhoods developed community kitchens, community gardens, food cooperatives and other food initiatives to support families with children.

Witnesses emphasized the importance of individual self-sufficiency in combination with socially stable and cohesive communities as important for parents when making choices that affected their children. For First Nations and Inuit, the lack of control over many aspects of their personal lives and within their communities, in combination with historical injustices, has created many negative outcomes for children. Witnesses called for a move to more self-determination and self-government whereby communities could take

greater control and provide oversight into the design as well as the delivery of programs and services relevant to and culturally appropriate for childhood obesity.

D. Physical Environment/Geographic Location

According to witnesses, where a child lives is a major determinant of obesity. For example, children living in better neighbourhoods are reported to have only 50% of the risk of becoming overweight or obese relative to children living in disadvantaged neighbourhoods. Factors such as greater access to playgrounds and parks combined with greater access to general supermarkets with a variety of modestly priced foods contribute to this difference.

The incorporation of mixed land use and greater density in neighbourhood design is particularly important with respect to physical activity. The Committee heard that people who live in walkable neighbourhoods are 2.4 times more likely to get the recommended amount of physical activity. Each additional hour spent in a car is associated with a 6% increase in the likelihood of being obese. Each additional kilometre that people walk translates into about a 5% reduction in the odds of obesity. For all age groups, the presence of open space and parks in the neighbourhood, within easy walking distance, is the single factor most likely to encourage walking. Parental perceptions of public safety with respect to automobile traffic as well as crime rates also affect walking in neighbourhoods. For example, about 27% of those living in low socio-economic neighbourhoods report that there is a lack of safe parks and playgrounds in their neighbourhoods, compared to 9% in the high socio-economic neighbourhoods.

Witnesses also talked about the differences between northern and southern communities with regard to food costs. Food-basket studies indicate that northerners pay far more than southerners for the same basket of food. For a family of four, the northern food basket in Kugaaruk, Nunavut, costs $327 weekly, an amount double that of Edmonton. With respect to physical activity, financing and promoting healthy and positive intercommunity competition is more difficult in isolated communities. In addition to the limited human capacity and lack of facilities, even getting a basic service such as transportation to and from events can be a challenge for locations accessible only by air or winter roads.

Rural and urban differences also exist among Aboriginal peoples. For example, although only about 10% of food energy in an urban child’s diet comes from traditional food, these urban diets generally contain less junk food than the rural ones. Witnesses noted that environmental deterioration and contamination has changed migration routes and patterns of herding animals as well as reducing the availability of food plants. These changes in turn have affected the access to traditional foods and associated traditional physical activities.

E. Culture

The Committee is aware that cultural values and norms can affect food and physical activity patterns among children. Witnesses noted the need to be specific and sensitive to diverse communities, recognizing cultural food habits and physical activity patterns. It was suggested that encouraging positive movement on either area does not work the same way from culture to culture and needs the engagement of connected people at the ground level to work with different communities to understand the effectiveness of various efforts.

One witness presented evidence suggesting that, for South Asian children, cultural food preferences could contribute to childhood overweight and obesity. A multi-tiered approach that involved community places of worship, schools and other centres for educational sessions was deemed important.

Witnesses representing First Nations and Inuit communities noted that success in reducing obesity levels among children occurred when people went back to culturally appropriate and traditional approaches. Both the continuation of traditional games, sports, and recreational activities and the provision of traditional foods were seen as inherent for the maintenance of physical health in this population. It was also pointed out that, for urban Inuit, language can be a barrier and when instructions are given for physical activities and food preparations, they can be misunderstood or interpreted. As well, awareness and understanding of healthy eating habits and food preparation in urban settings is actually a learned skill. Traditional knowledge passed down from grandparents to the young is not useful in urban settings and families who move actually have to re-learn what is nutritious and how to feed families.

F. Biological/Genetic Factors

Witnesses noted that both biology and genetics play a role in achieving and maintaining healthy weights. How children eat and how they move in physical activity are linked to both inherited traits and physiology.

For example, the Committee heard that some groups appear predisposed to certain obesity-related health conditions at an increased rate over the general population. Witnesses talked about a genetic susceptibility of individuals in Aboriginal and South Asian populations to Type 2 diabetes. They pointed out that, in the Aboriginal population, individuals develop diabetes an average of 10 to 20 years earlier than within the general population. For these children it was argued that intervention strategies must begin very early in life, since some of them are obese upon entering school, with weight problems starting as young as two years of age. As well, witnesses noted that there is considerable variability among children with respect to body size. It was emphasized that physical characteristics of population groups can vary significantly. For example, they challenged the use of the body mass index for assessment of childhood obesity among First Nations and Inuit children. They noted that these children may have birth weight and growth patterns that are different from the general population.

G. Services for Health

The Committee sees clearly that a range of services, many falling outside the traditional health sphere, are essential for any effective approach to childhood obesity. In addition to the availability of quality services for health promotion and health interventions, witnesses called for programs that focused on a wider array of professional skills. For many, nutritionists and dieticians were seen as key to the food side of the childhood obesity equation, with physical educator specialists as key to the physical activity side. Several witnesses called for more education for physicians and the medical community about the factors contributing to childhood obesity and argued that health care professionals need to be pushed to work across other sectors in prevention related activities.

In the overall context of health care for First Nations, it was pointed out that 30% of the communities are located more than 90 kilometres from a general practitioner. The nursing shortages are severe and nurses face a huge primary care burden that does not permit time to counsel people on how to improve their children's nutritional habits. The communities lack school-based nutrition and physical activity promotion programs and the resources to hire recreation directors, qualified physical education teachers, dieticians or nutritionists.

Although witnesses argued that the healthcare system and healthcare professionals must be more oriented to prevention of childhood obesity, they also spoke about the need to change the way that physicians and other health professionals intervene after the fact. They wanted better scientific evidence about the use of the body mass index for childhood obesity assessment versus other measures such as abdominal fat. They wanted more comprehensive work by general practitioners with the parents and families of children who were overweight and obese. They called for an increase in obesity treatment centres for children and adolescents.

H. Gender

The Committee heard that increases in overweight and obesity are similar among boys and girls. However, a few witnesses mentioned how the array of society-determined roles and behaviours that affect boys and girls differently could have a role in childhood obesity.

On physical activity, witnesses noted that surveys reveal that boys, on average, are more active and take more steps than girls. While the activity declines sharply by age for both boys and girls from 5 to 9 years olds through to teenagers, there is a sharper decline for girls. On a positive note, it was reported that the parents of girls, when asked about encouraging and supporting children's activities, are now more likely than in previous years to say that they play with girls in active games. As well, a study of the effect of physical activity on obese girls showed that they demonstrated less psychological health patterns when involved in higher levels of physical activity.

PART 4: WHAT WORKS?

The Committee heard repeatedly that investing in children now will pay off in this generation. It learned that effective programs promoting healthy weights for children need to be based on child development principles and be rewarding and non-punitive for those involved. Endeavours that recognize the influence of multiple sectors — health, education, environmental, social services, agricultural, transportation, community infrastructure, etc. — are deemed most likely to succeed. The interventions must take place at all levels — individual, family, community, school, municipal, provincial/territorial and federal, as well as extending into the international sphere where globalization of markets and media advertising play a role.

Witnesses told the Committee about a number of past as well as ongoing initiatives in the areas of food and physical activity that involved the federal government in some capacity. Many referred to the successes of the federal tobacco strategy, suggesting that similar practices could be employed to address childhood obesity. However, they cautioned against adopting measures that would stigmatize obesity or demonize food. As well, they emphasized that initiatives are more likely to succeed if children are included in their design. Witnesses were frank about the fact that, while some initiatives might yield unexpected results and might be limited in their scope, all had the potential to produce benefits and all provided a measure of learning for others involved in the promotion of healthy weights for children. They emphasized that it is rare for one intervention to demonstrate a direct link or change to weight.

A. Promising Practices in Physical Activity

i) Build Community Capacity

The initiative called Saskatoon In Motion was viewed as representing some best practices in terms of building capacity within the community, in mobilizing it and in making things happen with respect to physical activity. It involved a Canadian Institutes of Health Research (CIHR) Community Alliance for Health Research initiative where an investment from CIHR of $1 million per year for five years was leveraged tenfold by a researcher at the University of Saskatchewan. Once the CIHR money was on the table, the city and province came to the table with additional funds for the intervention activity. Witnesses acknowledged that the initiative did not solve the problem; childhood obesity in Saskatchewan is higher and its activity levels are lower than the Canadian average. However, they raised the question of how much worse obesity levels might have been in the absence of the initiative.

ii) Increase Public Awareness

ParticipACTION, a recipient of federal funding from 1970 to 2001 and recently re-launched, is internationally renowned as one of the most recognized public awareness campaigns in the world. The recognition of the ParticipACTION name still exceeds 80%,

despite the fact that there has been no extensive media campaign since 2001. Witnesses noted that social marketing campaigns require a long time to build awareness, especially understanding of things that can be changed, both at the broader societal level and individual parent and child level. They stressed that it is important not to isolate one aspect such as ParticipACTION recognition alone but to combine any related campaign with surveillance, research, school-based physical education, community infrastructure investments and other elements. While obesity rates have climbed since the 1970s, witnesses argued that this fact alone does not mean that ParticipACTION was not beneficial but rather that other factors need to be addressed such as the impact of increased computer and automobile use as well as increased portion sizes.

iii) Provide Access Through Federal-Provincial Partnerships

The Ontario Sport for More program resulted from a four-year $6.1 million bilateral federal-provincial agreement. This agreement was one of many signed between provincial governments and Sport Canada. This program currently provides weight training equipment to an Aboriginal high school in Thunder Bay, leadership clinics for Aboriginal coaches and is supporting the 2006 and 2008 Ontario Para-Olympic winter championships. It aims to increase sport participation and physical activity among under-represented groups including youth from low income families, ethnic minorities, Aboriginal communities and those with disabilities.

iv) Develop Cultural Connections

The Aboriginal Sport Circle funded by Heritage Canada has worked for ten years to develop the mechanisms for Aboriginal sport and recreation. The organization sees effective sport and recreation programs as a vehicle to promote healthy weights through the development of personal skills and self-esteem. Its programs aim to build community fabric, strengthen cultural connection and creative expression, and provide healthy alternatives for youth. Witnesses observed that, through fostering teamwork and leadership and providing a place to belong, sport and recreation are effective in social development, crime prevention, substance abuse recovery, social inclusion, and relief for young mothers. Witnesses noted that, where recreation directors and coaches exist, there are role models and avenues for communication about healthy eating, for education about racism, as well as for setting and reaching goals. The programs are seen as creating a powerful medicine related to the traditional teachings of the medicine wheel that encompass the spiritual, the emotional, the mental and the physical side and that heal from the inside.

v) Recognize Excellence in Schools

The Recognition Award Program (RAP) of the Canadian Association for Health, Physical Education, Recreation and Dance (CAHPERD) identifies, recognizes and encourages excellence in school physical education programs. Elementary and secondary schools that are committed to the RAP philosophy and meet the program's standards and criteria are eligible for an award banner ranging from gold to platinum to diamond. The

Fédération québécoise du sport étudiant manages a similar, but broader in scope, awarding program — called ISO ACTIVE/ACTIF — which promotes healthy choices not only through physical activity, but also through nutritious food and a smoke-free environment. The Fédération assesses the information provided by schools and rewards their efforts by awarding points. The awards include bronze, silver, gold and excellence. Both RAP and ISO ACTIVE are recognized as successful programs in emphasizing healthy eating, physical activity and their relationship to healthy weights.

vi) Legislate Economic Incentives

One recent initiative of Finance Canada was cited as having the potential to facilitate access by children and youth to physical activity and recreation programs. Announced by the federal government in the May 2006 Budget, the Children's Fitness Tax Credit on fees of up to $500 per child for enrolment in eligible physical activity programs was implemented on 1 January 2007 with a reported cost of approximately $160 million annually. An Expert Panel created to advise the Minister of Finance on the nature of programs that should be eligible for the tax credit released its report on 26 October 2006 and recommended that cardio-respiratory endurance (through aerobic activity) be a criterion for eligibility, combined with one or more of: muscular strength, muscular endurance, flexibility and balance. It also recommended that the physical activity or sport program be "ongoing," requiring a minimum of one session per week for eight weeks or a minimum duration of one week (or five consecutive days) for a camp and that there must be supervision. Eligible costs would also include extra-curricular school-based activities that meet the above criteria.

The Children's Fitness Tax Credit is similar to the Healthy Living Tax Credit which was introduced in Nova Scotia in 2005 to help with the cost of registering children and youth in eligible sport and recreation activities that offer health benefits. This credit, which is non-refundable, was based on a maximum spending of $150 per child when established, and raised to $500 in 2006. It is estimated that the tax credit costs the Nova Scotia government $2.2 million annually. Although it is too early to evaluate the impact of the provincial tax credit the Committee heard that the first year of preliminary data indicates an uptake by about 30% of families with children. However, the first year data cannot indicate any change in behaviour and ongoing data collection and surveys will be used to understand the long-term implications of the tax credit.

B. Promising Practices Affecting Food Availability and Consumption

i) Emphasize Overall Nutrition

Various programs of Health Canada aimed at First Nations and Inuit populations such as Aboriginal Head Start, Canada Prenatal Nutrition Program, Community Action Program for Children and the Aboriginal Diabetes Initiative emphasize overall nutrition as well as encourage the intake of traditional country foods. Through these initiatives, parents participate in program activities, including nutrition counselling, community gardens and

kitchens, food purchasing, preparation and planning. Often, the focus is on community food security and the emphasis on localized food systems. However, Inuit and other Aboriginal peoples talked about the fact that there are still some barriers to the use of locally available country food. For example, in Nunatsiavut, food regulations do not allow the provision of country food in daycare centres without prior tests. However, in Nunavik, daycare centres are planning to provide 85% of the required nutrients per day, with 30% to 40% being filled by country food. Through the Canada Prenatal Nutrition Program, in some regions in Nunavik, char and caribou are provided to pregnant women.

ii) Subsidize Healthy Foods

The Food Mail Program represents an example of ongoing collaboration, between Health Canada, Indian and Northern Affairs Canada and Canada Post, that pays part of the cost of transporting nutritious perishable foods to isolated communities. This subsidy on air freight is intended to reduce the cost of shipping food and to enable retailers in these communities to sell fresh food at lower prices. About 140 communities, mainly Aboriginal communities, across northern Canada are eligible. Witnesses explained that the federal government increased the freight subsidy from 30 to 80 cents per kilogram of products like fruits, vegetables and dairy as part of a pilot project implemented in 3 communities. As a result of the augmented freight subsidy, the purchase of these products increased significantly. Although the long term contribution of this program on healthy weights has never been evaluated, witnesses suggested that this pilot project should be made permanent and extended to other communities under the Food Mail Program.

iii) Reduce Taxes on Healthy Foods

The question of whether to reduce taxes on healthy foods often turned to the question of federal taxation of unhealthy foods as part of an effort to promote healthy weights for children. Witnesses explained that federal and provincial taxation has already been used successfully to reduce tobacco consumption. Some wanted a tax on foods deemed to be energy dense but nutritionally poor, such as sweet and soft drinks, most snack foods and certain categories of fast food. Others talked about a related endeavour whereby large categories of food would be taxed on the basis of certain macro-nutrient content, such as a per unit tax on the saturated fat content. Some pointed out that, under the current federal *Excise Tax Act*, the GST is already levied on unhealthy foods such as soft drinks and various snack foods, including candies, potato chips, salted nuts and salted seeds, while the vast majority of other foods and beverages (or “basic groceries”) are zero-rated, i.e. not subject to the GST. However, the current GST legislation is not applied uniformly as it relates to healthy and unhealthy foods and beverages. For example, all foods and beverages supplied from vending machines or prepared by restaurants and caterers are subject to the GST without distinction between healthy and unhealthy foods. In contrast, while foods of questionable nutritive value such as sugary breakfast cereals, *trans* fat laden shortening and high fat dairy products are exempt from the GST when sold in retail stores, healthy beverages including water are not. Concerns focused on the behavioural changes and subsequent potential effect on obesity expected from different levels of taxation on unhealthy foods in contrast to the monetary impact on consumers who

would still consume them. In particular, witnesses noted the regressive nature of the taxation and its disproportionate impact on low income families that must spend a larger percentage of their income on food.

iv) Increase Awareness Through Front of Package Labelling

A number of front of package labelling practices have been promoted to permit the quick identification of healthy-choice foods. For example, the United Kingdom has implemented a voluntary sign-post labelling system which uses a traffic light symbol to distinguish between the healthiest food choices (green light), less healthy choices (amber light) and least healthy choices (red light) with respect to fat, saturated fat, salt and calories. In contrast to the mandatory nutritional labelling that is now largely in force in Canada, the UK traffic light system is voluntary, as is their nutritional labelling. Another example is the Health Check™ system which was created in 1998 by the Heart and Stroke Foundation in consultation with Health Canada; it is based on specific nutrient criteria developed using Canada's Food Guide. The criteria vary for different food groups. Moreover, various companies are also developing similar front of package symbols, such as PepsiCo's Smart Spot™, President's Choice Blue Menu™ and Kraft's Sensible Solutions™. These industry-sponsored initiatives do not adhere to any standardized criteria and are not subject to specific regulations. As such, they are not endorsed by Health Canada and the criteria are developed by the food manufacturers themselves. While nutrition information available on food packages can be an important guide to healthy eating for children and parents, some witnesses raised the concern that the proliferation of competing symbols and logos may create greater confusion among consumers.

C. Promising Practices Promoting Both Healthy Eating and Physical Activity

i) Customize to Meet Diverse Needs

Action Schools! BC is considered a best practices model designed to assist British Columbia schools in creating individualized action plans to promote healthy living. It is not a program, but a framework which provides resources and examples of best practices for integrating physical activity and healthy eating into the fabric of elementary schools. It facilitates what schools are already doing, provides evidence about interventions that work, and assists schools in customizing efforts to meet individual needs. The framework for action focuses on six zones to create a balanced portfolio of activities that promote healthy living: school environment, scheduled physical activity, classroom action, family and community, extra-curricular and school spirit.

ii) Implement a Multi-Sectoral Approach

Nova Scotia is one provincial government that has adopted a multi-departmental, multi-partnership and multi-pronged approach to achieving healthy weights for children. The approach addresses both healthy eating and quality physical activity and encompasses numerous initiatives. These include: the Active Kids, Healthy Kids strategy that, with three departments (Sport and Recreation, Health, and Education) and multiple non-government organizations, aims to increase the number of children and youth who are active every day in school and the community; the Food and Nutrition Policy for Public Schools that, with two departments (Health, Education), outlines standards for foods and beverages served and sold in schools; the Healthy Living Tax Credit that, with two departments (Finance and Health), helps with the cost (up to $500) of registering children and youth in eligible sport and recreation activities that offer health benefits. As well, for Aboriginal populations, it uses the Tripartite Forum, with Mikmaq, provincial and federal representatives, to set a number of goals for healthy eating and physical activity in Mikmaq schools.

iii) Create Supportive School Environments

The Annapolis Valley Regional School Board in Nova Scotia, with funding from Health Canada's Canadian Diabetes Strategy, adopted a Health Promoting School approach to create supportive school environments. The goal was to enable children to make healthy choices about nutrition and physical activity on a daily basis and for life, in order to reduce their risk of developing chronic diseases. The schools employed a variety of strategies including having wellness fairs involving students and parents, developing handbooks of new games for recess and lunch hour, opening school gyms after hours to non-competitive sport activities and increasing the availability of fresh fruits and vegetables. The result was 59% less overweight and 72% less obesity in the participating schools. The program has now been expanded by the provincial government from the initial seven schools to about forty.

iv) Develop Partnerships (School, Community, Research)

The Kahnawake schools diabetes prevention project began in Quebec in 1994 with health research funding from the federal government and continues with a combination of funding from private foundations, the CIHR and the community. In this model of community and research partnership, the community shares responsibilities around research and the research collected has to be useful and relevant to the community. The program focuses on nutrition, physical activity and diabetes prevention from kindergarten to grade six. It promotes healthy food and bans junk food in the schools. The intervention activities also extend beyond the schools with activities designed for families, organizations, and the community at large. The evaluation assessed the short-term and long-term effects on

behaviour change in two specific areas, physical activity and dietary practices. It detected no change in children's physical activity levels but did see a reduction in television watching during school days. It also revealed an overall decrease in the consumption of soda, chips and french fries and increased consumption of low-fat milk and whole wheat bread. However, despite the behavioural changes, the prevalence of those who were overweight and obese increased from 31% in 1994 to 47% in 2004. Witnesses pointed to several lessons learned from this initiative. First, approximately half the children entering grade one were already overweight or obese suggesting a need to refocus intervention efforts on preschoolers, infants, families, and even pregnant moms. They also noted that the number of physical activity minutes in the schools decreased during this time. In addition, they pointed to the need for greater organizational and resource support of front-line workers who carry the responsibility for implementing a primary prevention. Most importantly, the continuous process of presenting research back to the community has led to a continued community commitment.

D. Lessons Learned

These selected examples suggest the availability of a wide range of creative initiatives that have the potential to contribute to the reduction of childhood obesity. Witnesses called for linkages between existing provincial clearinghouses and knowledge exchange centres, measures to enable people to share information from one jurisdiction and one community to the next. They pointed out that there is no central federal mechanism for funding initiatives across the multiple departments and agencies and that many ongoing initiatives exist within departmental silos. They emphasized that the dollars invested in community interventions are miniscule when compared to the billions of dollars that marketing companies have to market foods and video games to children and parents. Witnesses from northern or remote areas noted that many existing programs are modelled on southern communities and are not appropriate in other settings, but that the funding criteria require the application of the specific model.

Furthermore, witnesses called for ongoing programs to be evaluated so that more interventions could have a solid evidence-based foundation. They wanted to know whether existing interventions that are related to diet and physical activity would be promising practices that can be replicated in other communities across the country. They insisted on the need to establish targets and to collect appropriate health indicators to measure effectiveness and monitor progress achieved.

PART 5: WHAT ARE THE ISSUES SPECIFIC TO FIRST NATIONS AND INUIT?

It is clear that the health of First Nations and Inuit as well as other Aboriginal children is shaped by the same determinants as the overall Canadian population. That is, factors such as income, geography, physical environment, and other determinants that influence the prevalence of childhood obesity are not particular to First Nations and Inuit. As such, issues pertinent to childhood obesity in the Canadian population as a whole also pertain to First Nations and Inuit.

Nonetheless, the Committee is acutely aware that the overall health status of First Nations and Inuit and their children is well below that of the rest of Canadians. Accordingly, there is a need to provide a separate focus for First Nations and Inuit children. Prevalence of childhood overweight and obesity among these populations is twice that of the general Canadian population. The increased rates of overweight and obesity in First Nations children translates into higher incidence of Type 2 diabetes (not a reportable disease) by the time they reach adolescence.

The federal government has direct responsibility for factors that affect the health status of First Nations and Inuit children. For status Indians and recognized Inuit, Health Canada has a lead role for health service delivery and Indian and Northern Affairs Canada for education and social assistance. Other departments have significant support roles through the funding of programs that impact on the broad determinants of health.

The federal government employs the same complex and unconnected sectoral arrangements to engage First Nations and Inuit children as it does for the rest of the Canadian population. In addition, many federal programs have adopted a pan-Aboriginal approach that suggests that Aboriginal peoples are a homogeneous group and that underplays the diversity within and between the constitutionally recognized groups of "Indian, Inuit and Métis peoples of Canada."

As a result, some federal investments specifically for First Nations and Inuit are difficult to track. For example, although the federal transfers for healthcare and social programs apparently are calculated using First Nations statistics, Finance Canada does not monitor whether they reach the children in First Nations communities. Also, while Sport Canada has committed to build capacity for sport and recreation in the broader Aboriginal population, Health Canada and Indian and Northern Affairs Canada have not partnered in this endeavour by supporting the community health promotion or the school physical education components.

Representatives from First Nations and Inuit organizations observed that, at the community level, there are many administrative obstacles related to the management of programs supported by Health Canada and Indian and Northern Affairs Canada. They pointed out that communities are structured like the federal government with no communication between sectors. There is little flexibility allowing for the transfer of resources, the identification of priorities or the determination of the need for recruiting additional skilled personnel. They noted that this inflexibility restricts the ability to implement the necessary holistic approach whereby all sectors (health, education, social services, etc.) could work hand in hand. They argued that opportunities to promote healthy weights for First Nations and Inuit children can be provided in early learning programs, after school programs and through multiple community initiatives.

In addition, witnesses pointed out that many programs for First Nations and Inuit continue as pilot projects for years, leaving communities with no expectation of continuity. They noted that projects are often based on an initial five year process followed by year-by-year extensions. They argued that this approach generates instability with respect

to staff commitment and prohibits long-term changes within a child's life as well as in the supporting community.

Witnesses also talked about the jurisdictional gap with federal, provincial and territorial governments reluctant to assume responsibilities that each feels belongs to the other. While First Nations representatives stated that the federal government has a distinct fiduciary obligation through treaties and inherent rights wherever First Nations reside, representatives from Health Canada and Indian and Northern Affairs Canada talked only about services delivered on reserves. The divide between on-reserve and off-reserve has particular significance for the health and wellbeing of children living in urban settings. In some instances, the program is entirely absent and in other cases, the child can lose access to the programs by moving.

For Inuit children, funding allocations are problematic. Most initiatives are based on a per capita cost analysis. This funding approach fails to recognize the complexity of the access and other issues facing the northern and remote populations. It also disregards the particular needs of small communities. For Inuit children living outside their land claim regions, there is a need for funding and programs with Inuit-specific components. For urban initiatives, it is difficult to track the specific program funding allocation as Inuit are often lumped together with other Aboriginal peoples.

PART 6: WHAT MUST BE DONE?

The Committee recognizes that childhood obesity is a complex and multi-dimensional problem that must be tackled immediately. The two key variables of food intake and physical activity output require simultaneous but separate actions. Each of these variables is, in turn, influenced by the complex interplay among several social, economic and environmental factors that must be taken into account.

Decisive action with a federal commitment of adequate resources is needed now to counter this growing problem affecting Canada's children. However, the Committee acknowledges that there is no single intervention or magic bullet that can effect change. As such, it understands that a comprehensive and multi-sectoral approach for all Canadian children is essential. It is also aware that there are groups of children within Canada that require very specific actions in recognition of their diverse circumstances, most particularly First Nations and Inuit children.

Foremost, the Committee is aware of the jurisdictional cross-over on this issue. The federal actions that it recommends respect provincial and territorial responsibilities and insist on federal/provincial/territorial collaboration. All governments — federal, provincial and territorial — must work with children and parents, schools, health communities, neighbourhoods and businesses to stem the rising rates of overweight and obesity.

However, the Committee wants action now in areas that fall under federal jurisdiction and nowhere is the need for a comprehensive, coordinated and collaborative approach more evident than within the federal sphere of direct responsibility for First

Nations and Inuit. The two key departments — Health Canada and Indian and Northern Affairs Canada — run separate and apparently unconnected programs related to the health of children. Other departments and agencies have sparse key initiatives. The Canadian Institutes of Health Research, Heritage Canada, Infrastructure Canada and others provide funds within the scope of their mandates, without structure and regular horizontal consultation.

To tackle the issue of childhood obesity on both fronts — either in direct federal areas of responsibility or through federal/provincial/territorial collaboration — the Committee believes it is essential to establish health targets. Setting targets and identifying specific health indicators will help monitor progress achieved. The Committee also supports the view of numerous witnesses that federal action requires a positive dual focus on healthy weights for children through the promotion of both healthy food choices and quality physical activity, rather than a single negative focus on childhood obesity. All provinces and territories have already adopted physical activity targets and many jurisdictions also have targets on healthy eating and healthy weights. The federal government should align its health targets accordingly so as to generate further synergy and accelerate change.

The Committee also realizes that, to produce sustainable long-term change, the federal government cannot act alone. This is why it strongly believes that it is necessary to engage all Canadians in a collaborative and coordinated effort to reduce childhood overweight and obesity. First and foremost, it wants the federal government to consult with children. When federal departments and agencies take on the necessary efforts to promote healthy weights for children, they have a duty to connect with and to listen to the children who will be directly affected by these initiatives. Families also play a key role in the battle against childhood obesity and the federal government must be conscious of ways that it can assist them in setting goals related to food and physical activity choices that can reinforce and sustain change for children. Overall, the Committee sees vast opportunities for partnerships that involve individuals, schools, communities, businesses, non-governmental organizations as well as municipal, provincial and territorial governments.

A. Set Specific Measurable Targets

Several witnesses noted the importance of establishing targets when tackling childhood obesity. Some pointed to the *Integrated Pan-Canadian Healthy Living Strategy* that was approved by federal, provincial and territorial governments in October 2005 with proposed targets to help support Canadians in achieving healthy weights through physical activity and healthy eating. Witnesses from the United Kingdom talked about the specific target developed in 2004 “to halt the increase in obesity among children under the age of 11 by 2010.” This target was established in response to the rapid rise in childhood obesity from 9.6% in 1995 to 13.7% in 2003.

According to one witness, the UK is trying to tackle childhood obesity “on a number of layers” with supporting action plans on diet and on physical activity. This has resulted in the development of supporting objectives or goals with timelines. Thus, the objective of increasing the consumption of fruits and vegetables to at least five portions per day

resulted by 2005 in the provision of a fresh fruit or vegetable to children every school day. On physical activity, the objective was to give every child, from the age of 5 to 16 years, two hours of quality physical activity or sport every week and by 2006, the 75% target was passed.

The Committee feels strongly that Canada needs some specific and measurable targets to propel the move toward healthy weights among an increased number of children. While only 3% of children and adolescents aged 2 to 17 years were considered obese in 1978, by 2004 this rate had increased to 8%. When overweight rates are combined with those for obesity, the combined overweight/obesity rate changed from 15% in 1978 to 26% in 2004.

The Committee sees the years leading up to the 2010 Winter Olympics to be hosted in Vancouver as an opportune time for halting childhood obesity. It also wants a longer term health target that reduces the prevalence of childhood obesity by 2020. Further recommendations address some key actions needed by the federal government to ensure the achievement of these goals, specifically immediate measures to halt obesity among First Nations and Inuit under federal jurisdiction and a progress report on all targets to Parliament. The *Public Health Agency of Canada Act* states that the Chief Public Health Officer may prepare and publish a report on any issue relating to public health and the Committee sees this as one possible avenue for annual reporting to Parliament. The Committee therefore recommends that:

RECOMMENDATION 1

The federal government:

- **Establish targets to achieve healthy weights for children through physical activity and healthy food choices including:**
    - **A halt to the rise in childhood obesity by 2010,**
    - **A reduction in the rate of childhood obesity from 8% to at least 6% by 2020;**
- **Implement, in collaboration with First Nations and Inuit, immediate measures to halt obesity among First Nations and Inuit children; and,**
- **Report annually to Parliament on overall efforts to attain healthy weights for children and on the results achieved.**

B. Implement a Comprehensive Public Awareness Campaign

Witnesses emphasized the need for a comprehensive, multidimensional campaign to increase public awareness. They stressed the importance of addressing both physical activity and healthy food choices in the pursuit of healthy weights for children. They introduced various components of such a campaign and proposed some target audiences. Several witnesses identified the challenge of reaching children with messages that counter the extensive advertising of food and video games. Others felt that the adults in close contact with children, including parents, physicians, and teachers were most in need of targeted messages. Most important, witnesses pointed out that there are diverse ethno-cultural communities requiring appropriate and multi-lingual messages.

Witnesses underscored the need to have a clear message and to avoid confusion with multiple messaging. Several wanted to ensure that a campaign did not demonize food or stigmatize children who were already overweight or obese. Some felt that food and physical activity needed separate and clearly differentiated campaigns. Others felt that an emphasis on the balance between calories in (food) and calories out (physical activity) could be a primary focus of the campaign.

The Committee is aware of recent short-term campaigns undertaken by the federal government to promote physical activity and healthy eating. The print-based campaign called Encouraging Physical Activity for Children/Promoting the Children's Fitness Tax Credit and the television advertising campaigns called Healthy Eating are directed at parents. They are part of a healthy Canadians initiative shared by Health Canada and the Public Health Agency of Canada. The Committee also acknowledges the two-year federal contribution to support renewal of ParticipACTION, a charitable not-for-profit organization that promoted physical fitness and activity from the 1970s to the end of the 1990s. The Committee supports these efforts and calls for an expanded longer-term multi-media, culturally diverse public awareness campaign that involves schools, health professionals, community planners, and others responsible for supporting healthy weights among children. Therefore, the Committee recommends that:

RECOMMENDATION 2

The federal government:

- **Establish a comprehensive public awareness campaign on healthy weights for children;**
- **Promote both quality physical activity and healthy food choices as key elements of the campaign;**
- **Employ all available media in all regions of the country;**
- **Develop and disseminate clear, easy to use, multi-lingual, culturally diverse educational tools for parents, children,**

teachers, health professionals, community planners, etc.; and,

- **Collaborate with provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

C. Implement Mandatory Front of Package Labelling

The Committee heard from Health Canada, which has the responsibility and authority to establish food labelling requirements through the *Food and Drugs Act*, and from the Canadian Food Inspection Agency, which has the enforcement responsibility. Regulations for the mandatory nutrition labelling on most pre-packaged foods in the form of a "Nutrition Facts Table" have been in force for larger companies since 12 December 2005. The new regulations require that labels indicate the number of calories per serving as well as the content of 13 nutrients.

The Committee was told that, although these tables provide useful information and are easier to interpret than their voluntary predecessor, labels may still be too complicated and require too much time to decipher. Many witnesses stressed that, in addition, there should be a more simplified labelling scheme. Examples included the traffic light approach used in the United Kingdom and the Health Check™ developed by the Heart and Stroke Foundation of Canada. It was suggested that a simple front of package approach allows parents and children to make better food choices.

The proliferation of unregulated, front of package logos, based on different criteria and delivering different information, has led to confusion and mistrust among consumers. Although most witnesses were supportive of a simplified labelling scheme, the Committee also heard that it was important that any new requirements not affect the price of foods. However, it feels that the simplified labelling can build on the information already calculated for the Nutrition Facts Table and, as such, should not substantively add to the product cost.

The Committee insists that a clear and simple approach to labelling be instituted by the federal government as soon as possible and recommends that:

RECOMMENDATION 3

The federal government:

- **Implement a mandatory, standardized, simple, front of package labelling requirement on pre-packaged foods for easy identification of nutritional value;**

- **Apply a phased-in approach starting with foods advertised primarily to children; and,**

- **Promote the new labelling requirement to parents through an aggressive media campaign.**

D. Limit *Trans* Fats

Some witnesses proposed that industrially produced *trans* fats should be eliminated. While small amounts of natural *trans* fats can be found in some animal products, *trans* fats are industrially produced when unsaturated fats like vegetable oils are processed in such a way that the structure of the unsaturated fat is transformed to resemble that of a saturated fat. The majority of *trans fats* are consumed as shortening and margarine, or in foods that are baked or fried using these substances, such as cakes, cookies, bread, potato chips and commercial french fries. It is well established that saturated fats are linked to heart disease by elevating blood levels of "bad" cholesterol. However, *trans* fats have been shown to have an even more profound effect, as much as six-fold, by elevating "bad" cholesterol while also lowering "good" cholesterol.

A multi-stakeholder Trans Fat Task Force was created in early 2005 with a mandate to develop recommendations and strategies to eliminate or reduce processed *trans* fats in Canadian foods to the lowest level possible. Its final report, issued in June 2006, recommended a regulated approach to achieve this goal. The report included a recommendation that the *trans* fat content of foods purchased by a retail or food service establishment be limited to a maximum of 5% of the total fat by regulation. They further recommended that regulation be in place by June 2008.

The Committee understands that *trans* fats do not in themselves contribute to the obesity problem; however they want to emphasize that these fats substantially aggravate the health implications of overweight. Although it heard that *trans* fat consumption has gone down since labelling became mandatory on the Nutrition Facts Table, it wants to encourage all Canadians, but especially children, to continue to reduce their overall fat intake, including saturated, unsaturated and *trans*, and sees an imperative to eliminate *trans* fats which have been labelled as having no safe level for consumption.

To address the *trans* fats concerns, the Committee recommends that:

RECOMMENDATION 4

The federal government:

- **Establish regulations by 2008 that limit *trans* fat content in food as recommended by the Trans Fat Task Force, while not increasing saturated fat content.**

E. Collect Data for Targets

Witnesses referred to the need to base targets and initiatives on reliable and consistent data, both quantitative and qualitative. They noted that the 2004 Canadian Community Health Survey carried out by Statistics Canada was the first to actually measure height and weight of children as opposed to self-reporting or reporting by parents. This same survey was also the first one in 35 years to ask for detailed nutrition information on the consumption of foods and beverages. While physical activity measures for children were also included in the 2004 Canadian Community Health Survey, the Canadian Fitness and Lifestyle Research Institute in 2000 and 2005 collected data on children through its Physical Activity Monitor survey. For First Nations children, the 2002-2003 First Nations Regional Longitudinal Health Survey collected data on heights and weights as reported by family members in 238 communities across Canada. Overall, this sample covered about 6% of the national population of First Nations children under 11 years of age and about 10% of First Nations adolescents aged 12 to 17 years.

With respect to childhood obesity, witnesses noted that substantial pieces of the data picture are missing. Not only is the data on obesity prevalence limited, but there is a need for longitudinal information on various measures of food intake and physical activity. Without a complete and accurate picture of the current situation, it is difficult to set precise, numerical targets and to determine the level of resources required to improve the situation. Although there is no specific identifiable healthy weight that applies to all children at any given age or height, data provides the ability to establish a baseline so that trends in childhood obesity can be tracked over time.

Witnesses stressed the importance of obtaining and analyzing Aboriginal-specific data on children. In particular, there is little data for Inuit children. Also, witnesses questioned the accuracy of various accepted national indicators such as the body mass index and the waist-to-hip ratio as relevant to Aboriginal children. In addition, they stressed that no coherent national picture exists for the Inuit population. For example, it was pointed out that the National Diabetes Surveillance System collects data on diabetes rates for Inuit in the Northwest Territories and in Nunavut; Santé Quebec collects the data in Nunavik and in Labrador Nunatsiavut, nothing is collected.

Witnesses emphasized that data need to be collected and monitored on an ongoing basis, to be analyzed systematically and to be regularly evaluated in order to assess progress and allow for adjustments as appropriate. They called for regular national surveys to support understanding of the relationships between obesity and the needs of specific populations in terms of age, sex, ethnicity, location, socio-economic circumstance, etc.

The Committee feels strongly that there is a need for a national picture on childhood obesity. It wants the federal government to work in collaboration with provincial and territorial governments in collecting compatible and consistent data. The Committee recommends that:

RECOMMENDATION 5

The federal government:

- **Collect data on a regular and continuous basis on healthy weights for children;**
- **Make data available on both physical activity levels and food choices;**
- **Provide data from a variety of biometric measurements, including body mass index, waist-to-hip ratio and abdominal circumference;**
- **Include data on diverse ethno-cultural and socio-economic groups, specifically including Inuit; and,**
- **Collaborate with provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

F. Collaborate on Knowledge Exchange

Witnesses provided information about multiple initiatives related to childhood obesity, some that have produced results, some that require adjustments, and some that are at very early stages of development. These included provincial and municipal efforts to ban junk food in schools and promote more physical activity everywhere. Community initiatives that encourage children to get out and play in an unstructured way were seen as a way of counteracting over-organized and over-structured schedules that may contribute to obesity. Organizations involved in measuring activity levels of Canadian children emphasized how these vary depending on age, gender, neighbourhood, etc. and noted that less than half of children actually enjoy the physical education that is offered by their school. Regardless of the initiative or approach, witnesses emphasized the need to evaluate effectiveness and, perhaps more importantly, disseminate the results of these evaluations.

The Committee is particularly mindful of the jurisdictional restrictions with respect to education initiatives, nutrition and physical activity programs as well as the built municipal environment. It feels however that even in those areas where the federal government has a role, such as with federal clients, there should be a mechanism available for all jurisdictions, whether provincial, territorial, municipal, community or school, to share information on specific initiatives. These include not only established best practices and promising practices, but also those programs which may not have brought the expected results. This information exchange could help accelerate program uptake across the country.

The Committee identified several key elements for success on physical activity and food interventions: the views of children are central; actions are multi-dimensional; parents are involved; the environments surrounding children (e.g., home, classroom, school, community) are changed. Moreover, the Committee recognizes the value of having an accessible, easy to maintain and up-to-date repository of information about best practices and lessons learned with respect to healthy weight initiatives. Enhanced knowledge transfer will help identify the most effective interventions and will provide direction in adjusting ongoing programs so that they will contribute to established targets. The Committee recommends that:

RECOMMENDATION 6

The federal government:

- **Create a mechanism for knowledge exchange on healthy weights for children that:**
  - **Includes a focus on both physical activity and food choices;**
  - **Disseminates ongoing and published research, results of evaluations, best practices, promising practices, unsuccessful practices, etc.,**
  - **Collects and makes information available in diverse languages, reflective of multiple ethno-cultural demographic communities, including First Nations, Inuit and Métis; and,**
- **Collaborate with provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

G. Increase Multi-Dimensional Research Capacity

The federal government currently funds childhood obesity related research primarily through the Canadian Institutes of Health Research. CIHR has a focus on diabetes and other related diseases, but it is unclear how much of its federally-funded research focuses on prevention and on the various broad determinants affecting food intake and physical activity level. In order to provide a more proportionate number of projects oriented to the cultural, behavioural, economic and non-medical aspects of childhood obesity, other federal granting councils such as the Social Sciences and Humanities Research Council (SSHRC) could also be engaged in developing new approaches. Broader areas of inquiry must include work around poverty, culture, identity, self-esteem, etc. In addition, while these federal granting councils are the pre-eminent resource for most university researchers, the Committee feels that the departments and agencies responsible for federal action must develop their own research agendas for assessing and supporting

various policy initiatives. For example, Statistics Canada has a key role in data collection and assessment, while Human Resources and Social Development Canada examines the relevant issues such as the impact of poverty on families. Similarly, Infrastructure Canada has the ability to study the effect of land use on access to food and physical activities facilities.

One of the major gaps in obesity research concerns Aboriginal children. First Nations, Inuit and Métis children are rarely the focus of health research and knowledge of rates of obesity in children is restricted to a few intensively studied communities. For these populations, the research cannot be restricted to documenting dietary intake and activity levels of children, but must include information about community factors contributing to obesity. Understanding, measuring and altering the broad physical, social, economic environment is critical to effective reduction of the rates of obesity. Focused work is needed by existing federal research mechanisms such as the CIHR Institute of Aboriginal Peoples' Health and the National Collaborating Centre for Aboriginal Health established by the Public Health Agency of Canada.

The Committee is very aware of how the environments surrounding children affect the maintenance of healthy weights. Members understand that children encounter social, economic, physical, and other barriers that undermine and inhibit the ability to access quality physical activity and healthy foods. Members know that any targets for halting or reducing obesity can only be achieved if there are interventions in place that have a proven effectiveness. They agree that increased research capacity is needed to understand the key determinants that support healthy weights in children and to assess how to direct resources such that movement toward established targets is maintained. The Committee recommends that:

RECOMMENDATION 7

The federal government:

- **Build research capacity across the broad range of health determinants related to healthy weights for children;**
- **Ensure a research focus on both quality physical activity and healthy food choices;**
- **Include, but not limit research efforts to, federal departments and agencies such as the Canadian Institutes of Health Research, Social Sciences and Humanities Research Council, Statistics Canada, Health Canada, Public Health Agency of Canada, Indian and Northern Affairs Canada; and,**
- **Develop individual research components on the determinants of health for First Nations, Inuit, and Métis children.**

H. Develop A Coordinating Mechanism

Many witnesses pointed out that it is difficult to organize a comprehensive federal effort across the multiple federal departments and agencies that have important roles with respect to childhood obesity. In addition to Health Canada, the Public Health Agency of Canada and the Canadian Institutes of Health Research, the Committee heard from Finance Canada, Indian and Northern Affairs Canada, Sport Canada, Heritage Canada, Infrastructure Canada, the Canadian Food Inspection Agency, the Canadian Radio-television and Telecommunications Commission and Statistics Canada. As well, other departments such as Agriculture Canada and Human Resources and Social Development Canada have relevant mandates.

Witnesses noted the complicated nature of federal government organization and called for efforts to reduce the silos created by federal government structures. They wanted less fragmentation and greater communication that would facilitate a more holistic approach among public health, tax policy, education, social benefits, food policy, sport endeavours and others.

For First Nations and Inuit children, the situation is even more complicated. The two key departments — Health Canada and Indian and Northern Affairs Canada — that oversee relevant programs distinguish among those children and families that live on First Nations reserves, those that live off-reserve, and those that live in Inuit land claims areas. Thus, when parents and other responsible adults in the registered Indian and recognized Inuit population move away into larger urban settings, children lose access to most of the programs offered on reserves and in land claim areas.

Several United Kingdom witnesses noted that the target to halt childhood obesity in their country by 2010 involves a joint collaboration among three departments (Health; Culture, Media and Sport; and Education and Skills) with each collaborator taking responsibility for different aspects. They also emphasized the need for consensus and engagement by multiple actors and pointed out that efforts to achieve the target involve partnerships with other government departments and agencies as well as local authorities, businesses and charitable organizations. As well, because the UK target is linked to specific resources, clarity about and coordination of the respective roles is important to ensure that resources are directed to the most effective and appropriate interventions and to those children most at risk.

Drawing from the UK experience and recognizing the need for a coordinating mechanism at the federal level, the Committee recommends that:

RECOMMENDATION 8

The federal government:

- **Identify immediately a lead department or agency for federal interdepartmental action on healthy weights for children;**
- **Include but not limit action to the following departments: Health Canada, Public Health Agency of Canada, Canadian Institutes of Health Research, Finance Canada, Indian and Northern Affairs Canada, Sport Canada, Heritage Canada, Infrastructure Canada, Human Resources and Social Development Canada, the Canadian Food Inspection Agency, the Canadian Radio-television and Telecommunications Commission and Statistics Canada;**
- **Ensure that action encompasses a healthy eating and a physical activity focus; and,**
- **Establish an ongoing mechanism for consultation with First Nations, Inuit and other national Aboriginal organizations.**

I. Control Children's Food Advertising

Currently, all advertising for foods and beverages in Canada, except in Quebec where advertising to children is not permitted, is subject to industry self-regulation through a set of voluntary guidelines called the Broadcast Code for Advertising to Children. The purpose of this code is to "serve as a guide to advertisers and agencies in preparing commercial messages which adequately recognize the special characteristics of the children's audience." Broadcasters in Canada (excluding Quebec) have agreed to adhere to these guidelines as a condition of license by the Canadian Radio-television and Telecommunications Commission (CRTC) that, through the *Canadian Radio-television and Telecommunications Act,* can regulate the broadcasting industry. Advertising to children is also covered by the general Canadian Code of Advertising Standards, which provides that "advertising that is directed to children must not exploit their credulity, lack of experience or their sense of loyalty, and must not present information or illustrations that might result in their physical, emotional or moral harm." Advertising Standards Canada, an industry body, administers these two codes.

Numerous witnesses suggested that the Broadcast Code for Advertising to Children and the Canadian Code of Advertising Standards should be strengthened and that the advertising of high-calorie, low-nutrient foods and beverages to children should be discouraged as a means to combat childhood obesity. They stated that the lower

prevalence of childhood overweight/obesity in Quebec might in part be explained by the prohibition in place in the province. In contrast, others contended that there is no correlation between the prohibition of advertising and childhood obesity, pointing out that childhood obesity in Quebec grew in the past 25 years despite the prohibition. They felt that the current system of self-regulation was sufficient. They also explained that the CRTC has no jurisdiction over the content of food advertising originating from stations outside of Canada. In addition, foreign services carried by cable companies do not have to follow Canada's codes and regulations. Moreover, they stressed that there is currently no specific legislation or regulations to deal with food advertising on the Internet despite the fact that numerous interactive online games appealing to children are centred on brands and products or brand-related characters.

The Committee was told that the advertising of foods and beverages to children has also been an area of concern in the United Kingdom. After intensive research and literature review, the UK Office of Communications concluded that television advertising has a modest direct effect on children's food and beverage preferences, consumption and behaviour, but that a total ban on food and beverage advertising would be ineffective and disproportionate given the other factors influencing children's eating habits. It therefore decided to implement a total ban on the advertising of selected food and beverage products, namely those that are high in fat, sugar and salt (HFSS). The ban, which is to be phased in over a two-year period, applies "in all and around all programmes of particular appeal to children under the age of 16, broadcast at any time of the day or night on any channel". The Committee was told that advertising restrictions targeting HFSS products would help shift the balance toward the advertising of healthier foods and beverages. The UK Food and Standards Agency — the equivalent to Health Canada's Food Directorate — had responsibility for developing a nutrition scoring scheme to identify those HFSS products. Food and beverage products that are below the benchmark can be advertised, while those above that benchmark are less healthy and thus cannot be advertised.

The Committee heard that food advertising to children through the Internet is also an issue of concern in the United Kingdom. However, like the CRTC, the UK Office of Communications has no role in respect of Internet advertising.

During the Committee hearings, witnesses also insisted on media literacy. They explained that it is not always possible to control what children are exposed to beyond Canada and beyond children's programming, or through the Internet. They noted, however, that there are measures to help them understand how the media may influence their behaviour in the areas of nutrition and physical activity.

The Committee shares the concerns about the potential association between food advertising to children and increased childhood overweight and obesity. It feels that a review is required on the effectiveness of the current self-regulation of such advertising as well as the prohibition in place in some jurisdictions. Such a review should indicate whether or how the two voluntary codes should be strengthened. The Committee is also concerned about the impact on children of food advertising on the Internet and believes the potential for regulation in this area must be examined. The Committee therefore recommends that:

RECOMMENDATION 9

The federal government:

- **Assess the effectiveness of self-regulation as well as the effectiveness of prohibition in the province of Quebec, in Sweden and in other jurisdictions;**
- **Report on the outcomes of these reviews within one year;**
- **Explore methods of regulating advertising to children on the Internet; and,**
- **Collaborate with the media industry, consumer organizations, academics and other stakeholders as appropriate.**

J. Increase Healthy Food Choices

Rather than focusing on economic disincentives (such as “fat taxes”) to discourage the consumption of unhealthy foods, some witnesses suggested the subsidization of healthy food items in order to encourage the consumption of, for example, fresh fruits and vegetables. In their view, such subsidies have the potential to benefit all consumers and could provide the greatest benefits to low income families. Research suggests that this so-called “thin subsidy” can increase the consumption of healthy foods which in turn prevent illness and reduce the burden of disease. While such subsidies involve spending by government, over time they may also result in lower public expenditure on health care.

The federal Food Mail Program, which pays part of the cost of transporting nutritious perishable foods to isolated northern communities, is one example of a healthy food subsidy. The Committee was impressed to learn that the purchase of healthy foods increased when the federal freight subsidy under the program was augmented through pilot projects involving three northern Aboriginal communities. It believes that the program should be evaluated, given its potential for improving food choices. Other measures that could promote healthy food choices and healthy weights for First Nations and Inuit children should also be examined to determine their effectiveness. These include initiatives to build capacity for local food production, harvesting and processing such as northern community-wide gardening, hunting, fishing and gathering combined with collective food preservation. Projects could also identify and apply greenhouse and other innovative technology to grow fruits and vegetables. With a view to increasing the availability of healthy foods to First Nations, Inuit and other people in isolated and remote areas, the Committee recommends that:

RECOMMENDATION 10

The federal government:

- **Evaluate, with First Nations and Inuit, methods to provide their remote communities with access to nutritious food at a reasonable cost, including the Food Mail Program, the use of traditional foods, and various self-sustaining initiatives.**

K. Evaluate the Impact of Tax Credits

As with any new tax measure, the effectiveness of the Children's Fitness Tax Credit is currently open to debate and witnesses contributed to this discussion. Some of them expressed reservations pointing out that some families would have difficulty spending $500 upfront per child in order to get the tax credit at the end of the taxation year, while others in low income families that do not pay taxes simply would not qualify for the tax credit. Thus, they argued that the tax credit could potentially widen the differential that currently exists between low income families and families of higher socio-economic status. Others suggested that the tax credit be transformed into a refundable tax credit, like the GST rebate, in order to ensure its availability to a larger number of families.

Still, other witnesses welcomed the Children's Fitness Tax Credit, contending that it is not designed to address the full complexity of childhood obesity issues but can nonetheless be an important catalyst in helping children to be more active and healthy. They also recommended that the tax credit be coupled with an evaluation component to assess its effectiveness in increasing the number of children and adolescents enrolling in sports and physical activity.

The Committee concurs with witnesses that the Children's Fitness Tax Credit is one positive step in promoting healthy weights among children. It also acknowledges the importance of undertaking an evaluation of the tax credit, once sufficient taxation data are available to assess adequately its impact and effectiveness. Research is particularly underdeveloped in this area and more information would help identify what works and for whom.

As part of its ongoing evaluation of taxation policy, the Committee recommends that:

RECOMMENDATION 11

The federal government:

- **Establish immediately a reliable baseline with respect to the number of children who enrol in sports and physical activity;**
- **Report on the uptake of the Children's Tax Credit within two years; and,**
- **Evaluate the effectiveness of the Children's Fitness Tax Credit and report within five years.**

L. Support Appropriate Food and Physical Activity in Schools

The recently established Joint Consortium for School Health acts as a means to strengthen cooperation among federal, provincial and territorial departments and agencies along with their partners. Endorsed by education and health ministers, this mechanism aims to create healthy schools through an intersectoral approach to health and social initiatives for school aged children. The healthy school concept considers schools as key to the promotion of healthy living among Canadian children and youth. That is, healthy children are better able to learn, and schools can directly influence children's health.

Multiple witnesses called for mandatory quality daily physical activity and for healthy food policies in schools. They wanted changes to the curriculum to ensure the participation by all children in classes designed to teach food preparation skills, to instill physical activity abilities, and to encourage critical thinking about healthy choices in both areas. They recognized that the jurisdiction for education, with the exception of First Nations schools, falls to provinces and territories. However, they saw a role for the federal government to work with partners to build capacity and develop effective mechanisms to implement such changes.

Indian and Northern Affairs Canada has jurisdiction over the schools of First Nations. However, witnesses pointed out that many schools lack a gymnasium and physical education specialists. They also noted that, when schools develop food policies or programs to promote healthy eating, they must draw on already limited resources. As well, First Nations representatives observed that they have not been full partners in the healthy schools initiative and the pan-Canadian healthy living strategy.

First Nations and Inuit witnesses wanted enhancements to programs related to food and physical activity for school aged children as well as increased investments in early

childhood and preschool nutrition. They recognized that sports and recreation programs can influence both physical activity and eating patterns as well as broader social habits.

The Committee agrees that the federal government should be a leader in ensuring that the First Nations children under its responsibility are provided with the resources and the infrastructure necessary to encourage healthy eating and physical activity. The Committee recognizes that the Joint Consortium for School Health can build the capacity for health, education and other systems to work together and it recommends that:

RECOMMENDATION 12

The federal government:

- **Work to facilitate, in collaboration with the Joint Consortium for School Health, appropriate healthy food and physical activity standards and programs in schools;**
- **Provide appropriate healthy food and physical activity standards and programs in First Nations schools within federal jurisdiction; and,**
- **Collaborate with the provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

M. Enhance Community Infrastructure

Witnesses called for improved community infrastructure, which supports the organization of recreational and physical activity programs that can benefit children of all ages, all ability levels, all socio-economic strata and all ethno-cultural groups. Witnesses noted that the vast majority of the existing recreational infrastructure, including community centres, swimming pools and arenas, was built between the 1950s and 1970s. Other elements that are part of the built environment, such as play structures and cycling and walking paths, are more recent additions. As well, urban planning and renewal in the 1970s and 1980s resulted in downtown and suburban communities with few or distant general grocery stores, but with multiple fast food outlets. Municipal governments have limited fiscal capacities to produce the revenue needed to cover these infrastructure deficits.

The federal government through departments, agencies and crown corporations has developed initiatives to support investments in municipal infrastructure that are sustainable from environmental, cultural, social, and economic perspectives. Infrastructure Canada, Transport Canada, and Canada Lands Company are among those working in partnership with cities and communities, while respecting provincial and territorial jurisdiction. Gas tax agreements with the provinces and territories include municipalities or municipal associations as signatories for the sharing of revenues from the federal excise tax on gasoline for the purpose of investing in municipal infrastructure. The agreements

stipulate that a municipality must develop an integrated community sustainability plan for urban development and land use planning that relates to urban densification, transportation, green space, and community services. As well, some sport and recreational infrastructure has received funding through the Canada Strategic Infrastructure Fund, in particular, large-scale facilities for major amateur sport and athletic events, and through the Municipal Rural Infrastructure Fund, which is primarily designed to meet the needs of smaller Canadian communities.

The Committee heard that sport and community activity infrastructure programs fall to the bottom of the municipal list; below, for example, sewer and bridge repair. Witnesses called for a dedicated federal allocation to increase physical activity at the municipal levels, similar to the 10% of infrastructure funding currently designated by the U.S. federal government. They urged the federal government to broaden the definition of infrastructure under the gas tax transfer to include social infrastructure such as parks, recreation centres and community centres. Witnesses also stressed the need for federal actions that would enable municipalities to address those issues that link the built environment with healthy food and physical activity. They called for support of municipal planning that ensures a balance of general food outlets with varied and low priced foods with fast food outlets.

Committee members agree that community infrastructure and the built environment play a major role in encouraging children to get involved in physical activity and in supporting children and parents' access to healthy foods. They heard that easy access is crucial; that decisions and choices about food and physical activity have to be a short step away. They envision multiple options for physical activity that involve infrastructure for walking paths, bicycle routes and green spaces close to houses. They also see opportunities to create community infrastructure that supports diverse commercial food outlets that provide multiple healthy food choices as well as community gardens and community kitchens. They want to empower communities to authorize and sanction certain planning strategies and they see a shared role among the federal, provincial, and other levels of government as well as non-governmental organizations. Therefore, the Committee recommends that:

RECOMMENDATION 13

The federal government:

- **Provide new and dedicated infrastructure funding to facilitate access to varied options for children with respect to quality physical activity and healthy food choices; and,**

- **Collaborate with the provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

LIST OF RECOMMENDATIONS

RECOMMENDATION 1

The federal government:

- **Establish targets to achieve healthy weights for children through physical activity and healthy food choices including:**
    - **A halt to the rise in childhood obesity by 2010,**
    - **A reduction in the rate of childhood obesity from 8% to at least 6% by 2020;**
- **Implement, in collaboration with First Nations and Inuit, immediate measures to halt obesity among First Nations and Inuit children; and,**
- **Report annually to Parliament on overall efforts to attain healthy weights for children and on the results achieved.**

RECOMMENDATION 2

The federal government:

- **Establish a comprehensive public awareness campaign on healthy weights for children;**
- **Promote both quality physical activity and healthy food choices as key elements of the campaign;**
- **Employ all available media in all regions of the country;**
- **Develop and disseminate clear, easy to use, multi-lingual, culturally diverse educational tools for parents, children, teachers, health professionals, community planners, etc.; and,**
- **Collaborate with provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

RECOMMENDATION 3

The federal government:

- **Implement a mandatory, standardized, simple, front of package labelling requirement on pre-packaged foods for easy identification of nutritional value;**
- **Apply a phased-in approach starting with foods advertised primarily to children; and,**
- **Promote the new labelling requirement to parents through an aggressive media campaign.**

RECOMMENDATION 4

The federal government:

- **Establish regulations by 2008 that limit *trans* fat content in food as recommended by the Trans Fat Task Force, while not increasing saturated fat content.**

RECOMMENDATION 5

The federal government:

- **Collect data on a regular and continuous basis on healthy weights for children;**
- **Make data available on both physical activity levels and food choices;**
- **Provide data from a variety of biometric measurements, including body mass index, waist-to-hip ratio and abdominal circumference;**
- **Include data on diverse ethno-cultural and socio-economic groups, specifically including Inuit; and,**
- **Collaborate with provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

RECOMMENDATION 6

The federal government:

- **Create a mechanism for knowledge exchange on healthy weights for children that:**
    - **Includes a focus on both physical activity and food choices;**
    - **Disseminates ongoing and published research, results of evaluations, best practices, promising practices, unsuccessful practices, etc.,**
    - **Collects and makes information available in diverse languages, reflective of multiple ethno-cultural demographic communities, including First Nations, Inuit and Métis; and,**
- **Collaborate with provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

RECOMMENDATION 7

The federal government:

- **Build research capacity across the broad range of health determinants related to healthy weights for children;**
- **Ensure a research focus on both quality physical activity and healthy food choices;**
- **Include, but do not limit research efforts to, federal departments and agencies such as the Canadian Institutes of Health Research, Social Sciences and Humanities Research Council, Statistics Canada, Health Canada, Public Health Agency of Canada, Indian and Northern Affairs Canada; and,**
- **Develop individual research components on the determinants of health for First Nations, Inuit, and Métis children.**

RECOMMENDATION 8

The federal government:

- **Identify immediately a lead department or agency for federal interdepartmental action on healthy weights for children;**

- **Include but do not limit action to the following departments: Health Canada, Public Health Agency of Canada, Canadian Institutes of Health Research, Finance Canada, Indian and Northern Affairs Canada, Sport Canada, Heritage Canada, Infrastructure Canada, Human Resources and Social Development Canada, the Canadian Food Inspection Agency, the Canadian Radio-television and Telecommunications Commission and Statistics Canada;**

- **Ensure that action encompasses a healthy eating and a physical activity focus; and,**

- **Establish an ongoing mechanism for consultation with First Nations, Inuit and other national Aboriginal organizations.**

RECOMMENDATION 9

The federal government:

- **Assess the effectiveness of self-regulation as well as the effectiveness of prohibition in the province of Quebec, in Sweden and in other jurisdictions;**

- **Report on the outcomes of these reviews within one year;**

- **Explore methods of regulating advertising to children on the Internet; and,**

- **Collaborate with the media industry, consumer organizations, academics and other stakeholders as appropriate.**

RECOMMENDATION 10

The federal government:

- **Evaluate, with First Nations and Inuit, methods to provide their remote communities with access to nutritious food at a reasonable cost, including the Food Mail Program, the use of traditional foods, and various self-sustaining initiatives.**

RECOMMENDATION 11

The federal government

- **Establish immediately a reliable baseline with respect to the number of children who enrol in sports and physical activity;**

- **Report on the uptake of the Children's Tax Credit within two years; and,**

- **Evaluate the effectiveness of the Children's Fitness Tax Credit and report within five years.**

RECOMMENDATION 12

The federal government:

- **Work to facilitate, in collaboration with the Joint Consortium for School Health, appropriate healthy food and physical activity standards and programs in schools;**

- **Provide appropriate healthy food and physical activity standards and programs in First Nations schools within federal jurisdiction; and,**

- **Collaborate with the provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

RECOMMENDATION 13

The federal government:

- **Provide new and dedicated infrastructure funding to facilitate access to varied options for children with respect to quality physical activity and healthy food choices; and,**

- **Collaborate with the provincial and territorial partners, national Aboriginal organizations and other stakeholders as appropriate.**

APPENDIX A
LIST OF WITNESSES

Organizations and Individuals	Date	Meeting
Canadian Council of Food and Nutrition	2006/06/15	10
Francy Pillo-Blocka, President and Chief Executive Officer		
Canadian Institutes of Health Research		
Diane T. Finegood, Scientific Director, Institute of Nutrition, Metabolism and Diabetes		
Heart and Stroke Foundation of Canada		
Sally Brown, Chief Executive Officer		
Stephen Samis, Director, Health Policy		
Queen's University		
Peter Katzmarzyk, Associate Professor, School of Physical and Health Education and Department of Community Health and Epidemiology		
Statistics Canada		
Margot Shields, Senior Analyst, Health Statistics Division		
Canadian Food Inspection Agency	2006/09/21	14
Debra Bryanton, Executive Director, Food Safety		
Canadian Institutes of Health Research		
Diane T. Finegood, Scientific Director, Institute of Nutrition, Metabolism and Diabetes		
Department of Health		
Janet Beauvais, Director General, Health Products and Food Branch, Food Directorate		
Mary Bush, Director General, Office of Nutrition Policy and Promotion, Health Products and Food Branch		
Kathy Langlois, Director General, Community Programs Directorate, First Nations and Inuit Health Branch		
Public Health Agency of Canada		
Gregory Taylor, Acting Director General, Centre For Chronic Disease Prevention and Control		
Active Healthy Kids Canada	2006/09/26	16
Mark Tremblay, Chairman of the Board		

Organizations and Individuals	Date	Meeting
Canadian Fitness and Lifestyle Research Institute	2006/09/26	16
Cora Craig, President and Chief Executive Officer		
Queen's University		
Ian Janssen, Assistant Professor, School of Kinesiology and Health Studies, and Department of Community Health and Epidemiology		
Bariatric Medical Institute	2006/09/28	17
Yoni Freedhoff, Medical Director		
Canadian Restaurant and Foodservices Association		
Jill Holroyd, Vice-President, Research and Communications		
Joyce Reynolds, Senior Vice-President, Government Affairs		
Centre for Indigenous Peoples' Nutrition and Environment		
Harriet Kuhnlein, Founding Director		
Food and Consumer Products of Canada		
Phyllis Tanaka, Director, Food and Nutrition Policy		
McMaster Children's Hospital		
Linda Gillis, Registered Dietitian, Children's Exercise and Nutrition Centre Hamilton Health Sciences		
Refreshments Canada		
Calla Farn, Director of Public Affairs		
Assembly of First Nations	2006/10/03	18
Valerie Gideon, Senior Director, Health and Social Secretariat		
Katherine Whitecloud, Regional Chief		
Department of Health		
Kathy Langlois, Director General, Community Programs Directorate, First Nations and Inuit Health Branch		
Indian and Northern Affairs Canada		
Robert Eyahpaise, Director, Social Services and Justice, Social Policy and Programs Branch		
Fred Hill, Manager, Northern Food Security, Northern Affairs Program		

Organizations and Individuals	Date	Meeting
Inuit Tapiriit Kanatami	2006/10/03	18
Kristy Sheppard, Representative of the National Inuit Committee on Health		
Kahnawake Schools Diabetes Prevention Project		
Margaret Cargo, Researcher, Psychosocial Research Division, Douglas Hospital Research Centre		
Treena Delormier, Member, Community Advisory Board		
Sheila Wari Whitebean, Manager and Intervention Coordinator		
National Aboriginal Health Organization		
Mark Buell, Manager, Policy and Communications		
Carole Lafontaine, Acting Chief Executive Officer		
University of Alberta		
Noreen Willows, Assistant Professor, Department of Agricultural, Food and Nutritional Science		
Centre for Science in the Public Interest	2006/10/05	19
Bill Jeffery, National Coordinator		
Department of Finance		
Alex Lessard, Tax Policy Officer, Sales Tax Division, Tax Policy Branch		
Katherine Rechico, Special Advisor, Personal Income Tax Division, Tax Policy Branch		
Geoff Trueman, Chief, Sales Tax Division, Air Travelers Security Charge, Tax Policy Branch		
Nova Scotia Agricultural College		
J. Stephen Clark, Associate Professor of Economics, Department of Business and Social Sciences		
University of Alberta		
Sean B. Cash, Assistant Professor, Department of Rural Economy		
Aboriginal Sport Circle	2006/10/17	20
Rod Jacobs, Manager, Aboriginal Sport Development		
Stephanie Smith, Interim Executive Director		
Department of Canadian Heritage		
Michael Chong, Minister for Sport		

Organizations and Individuals	Date	Meeting
Department of Canadian Heritage	2006/10/17	20
Jacques Paquette, Associate Deputy Minister, International and Intergovernmental Affairs and Sports		
Tom Scrimger, Director General, Sport Canada		
The Silken Laumann Active Kids Movement		
Sandra Hamilton, Director of Marketing and Corporate Relations		
Silken Laumann, President		
Advertising Standards Canada	2006/10/19	21
Linda Nagel, President and Chief Executive Officer		
Association of Canadian Advertisers		
Robert Reaume, Vice-President, Policy and Research		
Canadian Medical Association		
Colin McMillan, President		
William Tholl, Secretary General and Chief Executive Officer		
Canadian Paediatric Society		
Marie Adèle Davis, Executive Director		
Claire LeBlanc, Committee Chair, Healthy Active Living Committee		
Canadian Radio-television and Telecommunications Commission		
Denis Carmel, Director, Public Affairs		
Martine Vallee, Director, English Pay, Specialty and Social Policy		
Concerned Children's Advertisers		
Cathy Loblaw, President		
Media Awareness Network		
Catherine Thurm, Project Manager, Education		
Department of Health	2006/10/24	22
Danielle Brulé, Director, Research, Monitoring and Evaluation, Office of Nutrition Policy and Promotion		
Mary Bush, Director General, Office of Nutrition Policy and Promotion, Health Products and Food Branch		

Organizations and Individuals	Date	Meeting
Department of Health	2006/10/24	22
Élaine De Grandpré, Nutritionist, Planning, Dissemination and Outreach, Office of Nutrition Policy and Promotion		
Lori Doran, Acting Director, Chronic Disease and Injury Prevention, First Nations and Inuit Health Branch		
Janet Pronk, Acting Director, Policy and Standard Setting, Office of Nutrition Policy and Promotion		
KMH Cardiology and Diagnostic Centres	2006/10/26	23
Arvi Grover, Cardiologist and Director, International Heart Institute		
Simon Fraser University		
Lisa Oliver, Ph.D. Candidate, Department of Geography		
University of Toronto		
Valerie Tarasuk, Professor, Department of Nutritional Sciences, Faculty of Medicine		
Canola Council of Canada	2006/11/02	25
Barbara Isman, President		
Chronic Disease Prevention Alliance of Canada		
Jean Harvey, Interim Executive Director		
Stephen Samis, Chair		
Federation of Canadian Municipalities		
John Burrett, Senior Manager, Social Policy, Policy, Advocacy and Communications Department		
Gord Steeves, First Vice-President		
University of Alberta		
Paul Veugelers, Associate Professor, School of Public Health		
University of British Columbia		
Lawrence Frank, Bombardier Chair in Sustainable Transportation, School of Community and Regional Planning		
Aboriginal Nutrition Network	2006/11/07	26
Bernadette deGonzague, Registered Dietitian		
Affordable Food Alliance		
Helen Barry, Retail Store Advisor, Store Development Services		

Organizations and Individuals	Date	Meeting
Affordable Food Alliance	2006/11/07	26
Jim Deyell, Director, Public Affairs, Northern Canada		
Alasdair MacGregor, Retail Store Advisor, Store Development Services		
Manitoba First Nations Education Resource Centre		
Lorne Keeper, Executive Director		
Manitoba Keewatinowi Okimakanak		
George Neepin, Chief		
National Association of Friendship Centres		
Peter Dinsdale, Executive Director		
Tungasuvvingat Inuit		
Ernie Kadloo, Child and Family Programs Facilitator		
Christine Lund, Diabetes Awareness and Prevention Coordinator		
Connie Seidule, Program Coordinator, Inuit Family Resource Centre		
Childhood Obesity Foundation of British Columbia	2006/11/09	27
Christina Panagiotopoulos, Executive Director		
Government of Ontario		
Colleen Kiel, Senior Consultant, Ministry of Health Promotion		
Jeffery Pearce, Special Assistant, Minister's Office		
Jim Watson, Minister of Health Promotion		
Infrastructure Canada		
Adam Ostry, Director General, Policy Directorate, Cities and Communities Branch		
Institut national de santé publique du Québec		
Lyne Mongeau, Professional Coordinator		
Northern Health		
Joanne Bays, Regional Manager		
Canadian Cardiovascular Society	2007/02/12	38
Anne Ferguson, Chief Executive Officer		
Trans Fat Task Force		
Sally Brown, Chief Executive Officer, Heart and Stroke Foundation of Canada and Co-Chair of the Task Force		

Organizations and Individuals	Date	Meeting
Trans Fat Task Force	2007/02/12	38
Paul Hetherington, President and Chief Executive Officer, Baking Association of Canada and Member of the Task Force		
Joyce Reynolds, Senior Vice-President, Government Affairs, Canadian Restaurant and Foodservices Association and Member of the Task Force		
University of Guelph		
Alejandro Marangoni, Professor, Department of Food Science		
Action Schools! BC	2007/02/14	39
Heather McKay, Principal Investigator, Professor, University of British Columbia and Vancouver Coastal Health Research Institute		
Canadian Association for Health, Physical Education, Recreation and Dance		
Andrea Grantham, Executive Director		
Department of Health		
Ann Ellis, Nutrition Advisor, Office of Nutrition Policy and Promotion, Health Products and Food Branch		
Marie-France Lamarche, Director, Chronic Disease Prevention, Community Programs Directorate, First Nations and Inuit Health Branch		
Department of Indian Affairs and Northern Development		
Joan Katz, Director, Education Planning and Policy, Education Branch		
Nova Scotia Department of Health		
Farida Gabbani, Senior Director, Office of Health Promotion, Sport and Recreation Division		
Public Health Agency of Canada		
Kelly Stone, Director, Childhood and Adolescence, Centre for Health Promotion		
Food Standards Agency UK	2007/02/19	40
Gill Fine, Director, Consumer Choice and Dietary Health		
Rosemary Hignett, Head, Nutrition Division		
Deirdre Hutton, Chair, UK Headquarters		

Organizations and Individuals	Date	Meeting
House of Commons of the United Kingdom	2007/02/19	40
Richard Caborn, Minister of State (Sport), Department for Culture, Media and Sport		
Canadian Food Inspection Agency	2007/02/21	41
Debra Bryanton, Executive Director, Food Safety		
Centre for Science in the Public Interest		
Bill Jeffery, National Coordinator		
Department of Health		
Janet Beauvais, Director General, Health Products and Food Branch, Food Directorate		
Heart and Stroke Foundation of Canada		
Sally Brown, Chief Executive Officer		
Carol Dombrow, Nutrition Consultant		
McCain Foods Canada		
Fred Schaeffer, President and Chief Executive Officer		
Health Education Trust	2007/02/26	42
Joe Harvey, Director		
King's College London		
Tom Sanders, Head, Nutritional Sciences Research Division		
Tesco PLC		
Karen Tonks, Chief Nutritionist		
UK Food and Drink Federation		
Jane Holdsworth, Consultant to the Food Industry		
University College London		
Roger Mackett, Professor, Centre for Transport Studies		
University of London		
Sandy Oliver, Reader in Public Policy, Social Science Research Unit, Institute of Education		

APPENDIX B
LIST OF BRIEFS

Organizations and Individuals

Aboriginal Nutrition Network

Aboriginal Sport Circle

Action Schools! BC

Active Healthy Kids Canada

Advertising Standards Canada

Affordable Food Alliance

Assembly of First Nations

Association of Canadian Advertisers

Baking Association of Canada

Bariatric Medical Institute

Breakfast for Learning

British Columbia Ministry of Health

Canadian Association for Health, Physical Education, Recreation and Dance

Canadian Council of Food and Nutrition

Canadian Council of Grocery Distributors

Canadian Fitness and Lifestyle Research Institute

Canadian Institutes of Health Research

Canadian Medical Association

Canadian MedicAlert Foundation

Canadian Obesity Network

Canadian Public Health Association

Canadian Radio-television and Telecommunications Commission

Canadian Restaurant and Foodservices Association

Organizations and Individuals

Canola Council of Canada

Centre for Indigenous Peoples' Nutrition and Environment

Centre for Science in the Public Interest

Childhood Obesity Foundation of British Columbia

Chronic Disease Prevention Alliance of Canada

Concerned Children's Advertisers

Congress of Aboriginal Peoples

Department of Health

Dietitians of Canada

Dow AgroSciences Canada Inc.

Entertainment Software Association of Canada

Federation of Canadian Municipalities

Fitness Industry Council of Canada

Food and Consumer Products of Canada

Heart and Stroke Foundation of Canada

House of Commons of the United Kingdom

Inuit Tapiriit Kanatami

Joint Consortium for School Health

KMH Cardiology and Diagnostic Centres

Laval University

Loblaw Companies Limited

Manitoba First Nations Education Resource Centre

McCain Foods Canada

McMaster Children's Hospital

Organizations and Individuals

National Aboriginal Health Organization

National Association of Friendship Centres

Nova Scotia Agricultural College

Nova Scotia Department of Health

Queen's University

Refreshments Canada

Simon Fraser University

Statistics Canada

The Silken Laumann Active Kids Movement

Tungasuvvingat Inuit

UK Food and Drink Federation

UK Office of Communication

University College London

University of Alberta

University of Guelph

University of London

University of Toronto

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 10, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 30, 31, 33, 34, 38, 39, 40, 41, 42, 43, 44 and 45) is tabled.

Respectfully submitted,

Rob Merrifield, MP
Chair

DISSENTING OPINION

Presented by the Bloc Québécois MPs

Christiane Gagnon (Québec) and Luc Malo (Verchères – Les Patriotes)

A. INVOLVING THE RIGHT PEOPLE

1. Juvenile obesity: an important issue

The Bloc Québécois members recognize the gravity of the epidemic of juvenile obesity raging through Quebec and Canada. This situation is not, moreover, limited to Quebec and Canada, since many western countries are grappling with the same problem.

There is consensus on the Committee's findings based on the evidence it heard during the study. The Bloc Québécois members agree with the Committee's observations in chapters 1 to 5 of the Report. The Bloc Québécois feels that this situation is extremely serious and is paying careful attention to the issues raised by the Committee. Juvenile obesity is an important issue that requires quick and effective action. Quebec, in any case, has responded, by announcing an action plan to counter this epidemic in autumn 2006.

2. A question of jurisdictions

The Standing Committee on Health agreed in June 2006 to begin a study on juvenile obesity in Canada, "with a particular focus on the responsibility of the federal government for First Nations and Inuit children." The Bloc Québécois finds it regrettable that the Committee deviated from its original mandate by extending the study to areas that are outside the federal government's jurisdiction.

The Committee's hearings demonstrated beyond any doubt that the overall health of members of the First Nations and Inuit is much worse than that of the rest of the Canadian population. Here alone there are massive challenges facing the federal government, which is constitutionally responsible for the healthcare of these populations. Rather than seeking to extend its efforts into areas where it does not have the expertise, the federal government should be seeking to distinguish itself in its approach to its own client groups.

B. WELL UNDER WAY IN QUEBEC

The Bloc Québécois feels that the Standing Committee on Health's report contains recommendations that, were they to be applied by the federal government, would constitute an unnecessary duplication of the efforts already being made in Quebec.

1. Acting within its areas of jurisdiction

The *10-Year Plan to Strengthen Health Care* adopted by the federal, provincial and territorial first ministers in September 2004 recognizes the Government of Quebec's authority to carry out its responsibilities for planning, organizing and managing health care services within the province. The agreement calls for Quebec to apply its own strategies for health promotion and prevention of chronic diseases, which includes, *de facto*, any question of obesity.

The Government of Quebec reports to the public on its use of healthcare funds.

2. A well-defined strategy

Within the framework of the 2004 agreement, the Government of Quebec undertook a study of juvenile obesity that culminated in the *Plan d'action gouvernemental de promotion des saines habitudes de vie et de prévention des problèmes reliés au poids 2006-2012; Investir pour l'avenir* [Government action plan to promote healthy lifestyles and prevent weight-related problems 2006-2012]. This process represents a major step in the prevention of juvenile obesity in Québec.

The Quebec plan *Investir pour l'avenir* [Invest for the future] covers all the areas covered by the House of Commons Standing Committee on Health report. Nutrition, physical activity, advertising, research, health, education and infrastructures are all issues that Quebec has given careful consideration. The process involved seven departments and three government agencies, as well as private-sector and community partners.

The results of this exercise led to targeted and quantifiable objectives in priority areas. A total of $400 million is to be invested over 10 years, including $20 million a year from the Government of Quebec.

Open federalism notwithstanding, the Bloc Québécois members are not surprised to note that the Standing Committee on Health, despite the change in government, continues to interfere in areas of Quebec's and the provinces' jurisdiction rather than concentrating on its own areas of jurisdiction, which in this case include the government's responsibility for First Nations and Inuit children.

The Bloc Québécois also finds it regrettable that the Standing Committee on Health did not agree to recognize in its report that Quebec can conduct its own initiatives

and obtain its fair share of the funding for federal initiatives on juvenile obesity, in complete compliance with its areas of jurisdiction and the 10-Year Plan of 2004.

That is why the Bloc Québécois recommends:

- **That, if the federal government takes actions to counter juvenile obesity, these actions not restrain Quebec;**
- **That the federal government's initiatives on juvenile obesity in areas of provincial responsible include an unconditional right for Quebec to withdraw with full compensation.**

C. TARGET THE FEDERAL GOVERNMENT'S INTERVENTION

1. Act immediately for the First Nations and Inuit communities

Although it exceeded the federal government's jurisdictions, the Standing Committee on Health did examine the situation of the First Nations and Inuit. The Bloc Québécois members support the recommendations relating to these communities,[1] provided the communities are allowed to participate in the development and evaluation of the initiatives to counter juvenile obesity.

The Bloc Québécois urges the federal government to make these recommendations a priority and quickly implement measures that will allow it to effectively attack the problems experienced by these communities.

2. Respect Quebec's and the provinces' areas of jurisdiction

Under the *10-Year Plan of 2004*, the Government of Quebec is to share information and best practices with the governments of the other provinces and territories. Quebec is meeting its obligations, since a number of mechanisms are in place, such as FPT round tables[2], formal and specific agreements, and regular and continuous contacts with the other provincial governments and the federal government.

Given that it is respecting its commitments, Quebec should not be required to acquiesce to federal initiatives impinging on its areas of jurisdiction, such as research, education, advertising, etc. The Bloc Québécois cannot agree to recommendations 1, 2, 5, 6, 7, 8, 9, 10, 12 and 13 of the Standing Committee on Health report. If the other Canadian provinces agree to give the federal government responsibilities in the fight against juvenile obesity, Quebec should, at the very least, be given an unconditional right to withdraw with full compensation.

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1 Recommendations 1, 2, 5, 6, 8, 10 and 12 contain sections on the First Nations and Inuit.

2 FPT: federal-provincial/territorial.

For example, what would be the point of creating a new knowledge exchange structure (Recommendation 6) when such exchanges already occur between Quebec, the federal government and the provinces? One might also question the relevance of the federal government's evaluating Quebec legislation on advertising to children (Recommendation 9) and of measures aimed at schools (Recommendation 11) when this is clearly an area of provincial jurisdiction. Finally, what justification is there for the federal government's imposing conditions on the provinces' management of infrastructure programs (Recommendation 13)?

3. Better targeted federal action

The Bloc Québécois members recognize that the federal government may act within its areas of jurisdiction to combat juvenile obesity. That is why it supports recommendation 11 on the evaluation of the children's fitness tax credit. We also support Recommendation 4, to limit the amount of trans fat, which is supported by the report from the panel of experts who studied the question in 2006.