IMPROVING THE HEALTH OF CANADIANS:
Health promotion priorities for Canada

September 2007

"The lives of far too many people in the world are being blighted and cut short by chronic diseases. Through investing in vigorous and well-targeted prevention and control now, there is real opportunity to make significant progress and improve the lives of populations across the globe."

LEE Jong-wook
Director-General, WHO[1]

IMPROVING THE HEALTH OF CANADIANS:
Health promotion priorities for Canada

Executive Summary

Preventing chronic diseases is a vital area for investment in Canada's future. Chronic diseases are the major cause of death in Canada, taking a significant toll on Canada's health care system, economy and quality of life. Two thirds of deaths in Canada result from cancer, cardiovascular disease, type 2 diabetes and chronic obstructive lung disorders[2]. However, a large proportion of these diseases could be prevented or delayed through reductions in modifiable risk factors. In order to reduce chronic disease and improve the health of Canadians, Canada needs a comprehensive chronic disease prevention system that includes coordinated research, surveillance, policy and programs.

CDPAC would like to highlight three priority areas for federal action on chronic disease:

1. **Addressing the determinants of physical activity, healthy eating and healthy weights by:**
    - Protecting children from inappropriate exposure to marketing
    - Reducing poverty to address income-related food insecurity
    - Integrating primary prevention goals within agriculture/agri-food policy
    - Creating a Coordinated System of Excellence for Physical Activity
    - Improving community level healthy living infrastructure

2. **Building a strong public health response to chronic diseases by:**
    - Supporting high quality research on population level interventions
    - Funding a country-wide birth cohort
    - Building Canada's chronic disease surveillance system
    - Supporting intersectoral collaboration

3. **Protecting Canadians from tobacco exposure by:**
    - Banning tobacco advertising and promotion
    - Requiring plain packaging for tobacco products
    - Curbing tobacco contraband

Introduction

Preventing chronic diseases is a vital area for investment in Canada's future. Two thirds of total deaths in this country are due to cancer, cardiovascular disease, type 2 diabetes and chronic obstructive lung disorders[3]. Chronic diseases are the major cause of death in Canada, taking a significant toll on Canada's health care system, economy and quality of life. At the same time, it is estimated that 80% of premature heart disease, stroke and type 2 diabetes, and 40% of cancer could be prevented through healthy diet, regular physical activity and avoidance of tobacco products[4].

In order to be successful in improving prevention and the health of Canadians, CDPAC believes we cannot limit our efforts to individual level factors. Instead, we need to take a population health approach, targeting the upstream social and environmental determinants of health and risk factors – including income adequacy, community level infrastructure and regulatory environments. We also need federal investment to enable a comprehensive chronic disease prevention system for Canada that includes coordinated research, surveillance, policy and programs.

CDPAC would like to highlight three priority areas for federal action to advance chronic disease prevention in Canada, with a focus on policies and interventions that will reduce risk factors and improve health at the level of whole populations:

1. Addressing determinants of physical activity, healthy eating and healthy weights
2. Building a Strong Public Health Response to Chronic Diseases
3. Protecting Canadians from tobacco exposure

PRIORITY AREA 1: Addressing determinants of physical activity, healthy eating and healthy weights

Failure to maintain adequate physical activity levels, healthy eating and healthy weights are key risk factors for many chronic diseases, including cardiovascular disease, cancer, diabetes and some respiratory illnesses. Yet the prevalence of these risk factors is high in Canada and many social and environmental factors act as barriers and deterrents to these healthy behaviours.

Over the last quarter century, adult obesity has increased from 14% to 23%[5]. Another 36% of adults are overweight, bringing the total proportion of Canadians who are overweight or obese to almost 60%. Obesity trends for children are very alarming as well, with child obesity levels increasing from 3% to 8% between 1979 and 2004[6]. International comparisons show that Canada as a country has among the highest prevalence of overweight kids[7].

The obesity rate for First Nations children is substantially elevated, at two and a half times the national average[8]. Children of parents with less education and lower income levels also have higher rates as do children in the Atlantic region[9] and rural areas.

Physical inactivity is also widespread in Canada. Over half of the population 12 years of age and over is not physically active[10], and the majority of Canadian children don't get the levels of physical activity needed for healthy growth and development[11].

Research has increasingly shown that social and environmental factors, such as income levels, the way our communities are designed, and regulatory environments have an impact on healthy behaviours. CDPAC would like to point out a number of ways in which public policy can address these factors in order to help Canadians improve their health and reduce their risk of chronic disease.

Strategy a. Protecting children from inappropriate exposure to marketing

CDPAC encourages federal action to examine policy options and develop appropriate measures to address the issue of marketing to children and its relationship to childhood obesity.

Several international organizations have concluded that commercial food advertising directed at children most probably contributes to an environment that promotes the development of childhood obesity[12]. Today's children are treated as consumers and marketed to aggressively from many sources including television, the Internet, billboards, product placements in movies and fast food chains. Children are being bombarded with junk food advertisements. As content analyses in Canada and other countries have shown, the food products most frequently marketed to children are energy dense or high fat foods.[13]

Research has shown that television advertising manipulates children, since young children do not have the cognitive abilities to view advertising critically. In fact, preschoolers are unable to tell the difference between advertising and regular programming[14]. A 1989 Supreme Court of Canada ruling found that "…advertising directed at young children is *per se* manipulative. Such advertising aims to promote products by convincing those who will always believe".[15]

In most of Canada, advertising to children is self-regulated by the advertising industry. However, in Quebec, the *Consumer Protection Act* bans all commercial advertising directed at children under thirteen years of ages. Although a comprehensive health evaluation of this ban has not been undertaken, it is interesting to note that Quebec boasts the lowest obesity rate in Canada among 6 to 11 year olds, has among the highest consumption of fruit and vegetables, and among the lowest consumption of soft drinks[16]. Research has also shown that Francophone and Allophone Quebecers (whom are presumably most influenced by the advertising ban) consume less junk food and more fruits and vegetables than Anglophones in Quebec and Ontario. English speaking Canadians are presumably more influenced by English television broadcast from outside of Quebec and from the United States[17].

Environics polling done by the Heart and Stroke Foundation of Canada indicated that 74% of Canadians agree that the government in Canada should prohibit or restrict advertising of unhealthy/junk foods that are aimed at children. In Quebec, 90% of those polled in another recent survey indicated they support the current Quebec ban on advertising to children[18].

To advance policy development in this area, CDPAC will be hosting a scientific, multi-sectoral policy consensus conference in March 2008, with funding support form the Public Health Agency of Canada through the Canadian Diabetes Strategy, as well as the government of BC and the Canadian Institutes for Health Research. We look forward to sharing the results of this important conference.

Strategy b. Reducing poverty to address income-related food insecurity

CDPAC believes federal action is critical to addressing the root cause of individual and household food insecurity – poverty. Key strategies to address poverty include improvements to social safety net programs, ensuring that individuals and families have sufficient financial resources to meet basic needs for food, clothing, shelter and other basic needs.

Approximately one in every ten Canadian households – representing approximately 3 million people – is currently food insecure and cannot count on a healthy diet[19]. Lack of food security is a key social determinant of health[20], and research has shown that individuals in food insecure households have poorer dietary intakes[21]. Food insecurity also has devastating impacts on every aspect of child development[22]. Improving food security is therefore a primary prevention strategy for chronic illness.

Specific measures the federal government could take include:

- Eliminating the current option permitted by the federal government for provinces and territories to claw back the National Child Benefit Supplement (NCBS). The claw back penalizes the poorest families in Canada and is biased against families with single parents, most of whom are women.[23]
- Reassessing and reforming the Employment Insurance program to ensure that eligibility requirements and payment levels actually provide an acceptable living wage. Previous restructuring of this national income security program has imposed an economic burden, by reducing the numbers eligible for benefits (38% in 2001 compared with 75% in 1990), providing lower benefit levels and shorter benefit periods[24].
- Reinstating the federal Social Housing Program and increasing funding to the Affordable Housing Initiative to ensure low income wage earners and those on social assistance have safe and affordable housing alternatives. The proportion of income allocated to housing of low wage earners and those on social assistance can range from 55%-99%, leaving little money for food and other expenses.[25]

Strategy c. Integrating primary prevention goals within agriculture/agri-food policy

Federal action is needed to develop and implement a national food policy that addresses the food system from production to consumption and harmonizes agriculture and public health goals.

Specifically, we recommend:

- Establishing a national food policy that supports the accessibility and promotion of healthy foods, and promotes intersectoral collaboration and decision making between Agriculture/Agri-Foods Canada, Health Canada, the Public Health Agency, Environment Canada, Transport Canada and Foreign Affairs/International Trade Canada.
- Promoting and supporting food production and distribution practices that reduce the negative impact on the environment and improve the safety and sustainability of our food supply. Intensive farming techniques such as use of artificial nitrogen-based fertilizers and pesticides, and intensive livestock production pollute lakes and water reservoirs and threaten the sustainability and safety of our food supply[26]. In addition, changes in animal

feed, increased shelf life of foods and transportation of foods across great distances have resulted in the emergence of certain food-borne pathogens[27].

Strategy d. Creating a Coordinated System of Excellence for Physical Activity

To address Canada's high levels of physical inactivity and their role in chronic disease CDPAC recommends investing in a Coordinated System of Excellence for Physical Activity, as proposed by the Coalition for Active Living (CAL), a national action group made up of over 100 organizations and alliances.

Increased physical activity levels can save lives, reduce chronic disease, reduce wait times and save health-care dollars. CDPAC supports CAL's proposal for a federal investment of $100 million per year to create a Coordinated System of Excellence for Physical Activity in Canada to address the current levels of physical inactivity. This coordinated approach would ensure that the best possible strategies are undertaken to increase physical activity among the greatest possible number of Canadians. It would also ensure that national services meet identified needs, and build capacity in the provinces and territories for communities.

The proposed plan is based on key elements of the Pan Canadian Physical Activity Framework and outlines what is needed to achieve a 20% increase in the proportion of Canadians who are physically active by 2015 (the goal set out in the Integrated Pan Canadian Healthy Living Strategy).[*]

Planning, management, and monitoring accountability would be shared by federal government, F/P/T and NGO partners, with CAL as the coordinating voluntary sector partner. Municipalities would be represented through mechanisms identified by the provinces and territories.

The proposed Coordinated System of Excellence includes activities in six strategic priority areas:

1. Healthy Public Policy
2. Community Physical Environments
3. Supportive Social Environments
4. Public Education
5. Research, Monitoring and Knowledge Exchange
6. Strategic Partnerships, Infrastructure and Capacity Building

Strategy e. Improving community level healthy living infrastructure

Federal funding can play a key role in ensuring communities have the infrastructure that supports physical activity. CDPAC recommends that

- *At least 7% of transportation-related infrastructure funds be dedicated for and allocated towards the development of community infrastructure that promotes the use of active modes of transportation, and*
- *A specific percentage of funding from existing infrastructure programs be dedicated for and allocated to social infrastructure that facilitates physical activity, such as parks, swimming pools, community recreation centres, etc.*

[*]The goal for physical activity identified in the Integrated Pan Canadian Healthy Living Strategy for 2015 is to increase by 20% the proportion of Canadians who participate in regular physical activity based on 30 minutes per day of moderate to vigorous activity as measured by the CCHS and the Physical Activity Benchmarks/ Monitoring Program.

Numerous studies have found a relationship between how communities are designed and current obesity levels. For example, individuals living in moderate to high density areas with a variety of land use types and interconnected street networks spend less time driving, are more likely to meet recommended levels of physical activity, and are less likely to be overweight or obese than those living in low density, single use areas[28]. The "walkability" or "cyclability" of a neighbourhood enables individuals to be physically active and maintain a healthy body weight. On the other hand, low density communities that are spread far apart, encourage automobile use and sedentary behaviour, and contribute to higher levels of air pollution. Air pollution, a risk factor for heart disease and stroke, discourages physical activity and can worsen existing heart and lung problems.

Building on the federal government's commitment to community infrastructure, serious consideration should be given to earmarking existing infrastructure funds for social infrastructure (parks, community recreation centres, swimming pools, hockey rinks, tennis courts etc) and active transportation projects (bike trails/paths, walking trails/paths and sidewalks) that facilitate active living. These funds can be obtained from existing federal infrastructure funds, such as the Municipal Rural Infrastructure Fund, the Canada Strategic Infrastructure Fund, the Gas Tax Fund, the Public Transit Fund and the Building Canada Fund.

Several organizations have recommended that at least 7% of transportation-related infrastructure funding be dedicated for and allocated to active transportation infrastructure. This figure is believed to be a reasonable interim target nationally, given that in most major cities at least 7% of commuters use active transportation. In the US, 10% of transportation infrastructure spending is allocated to facilitate walking and cycling.

The House of Commons Standing Committee on Health in March 2007, in its report on childhood obesity entitled, "Healthy Weights and Healthy Children", among other things, called upon the federal government to provide new and dedicated infrastructure funding to facilitate access to varied options for children with respect to quality physical activity. Canadians agree with this approach. The vast majority (87%) of Canadians agree that governments in Canada should build more parks, walking and biking trails in cities, towns and communities so that Canadians can be more physically active in order to reduce obesity and become healthier[29].

PRIORITY AREA 2: Building a Strong Public Health Response to Chronic Diseases

An important chronic disease prevention responsibility for the federal government is improving Canada's ability to intervene effectively to improve the health of Canadians. This requires a strong population health evidence base, chronic disease surveillance system (including risk factors and conditions), and coordinating mechanisms to enable intersectoral collaboration. These areas are seriously underdeveloped in Canada and need sustained and targeted federal investment and leadership.

Strategy a. Supporting high quality research on population level interventions

Canada needs evidence informed solutions to reduce the economic, social, and health consequences of obesity, tobacco use, inadequate physical activity, and other modifiable factors that give rise to cancer, cardiovascular disease, diabetes, and other illnesses. However only about 0.4% of research is relevant to public health interventions[30]. Furthermore, many of population level interventions now underway lack an explicit research and evaluation component. Resources must be allocated to developing the evidence base in these areas if we

are to learn from current efforts, and systematically apply this knowledge to inform future policy and practice.

CDPAC recommends allocation a greater proportion of resources to increasing the quantity and quality of population and public health intervention studies, and the use of this evidence by policy makers and practitioners.

A key mechanism to commence work in this area has already been created, namely the Population Health Intervention Research Initiative for Canada (PHIRIC) with partners including the Canadian Institutes of Health Research, Public Health Agency of Canada, Canadian Population Health Initiative, and the Centre for Behavioural Research and Program Evaluation. It is important that these efforts be continued and increased so that we have the knowledge we need for future progress in addressing chronic disease.

Strategy b. Funding a country-wide birth cohort

CDPAC recommends the federal government fund a country-wide birth cohort study as part of the Canadian Lifelong Health Initiative (CLHI) of the Canadian Institutes of Health Research (CIHR). Canada is one of the few developed countries without such a cohort – which would enable tracking and monitoring the determinants of health over the lifecourse and provide invaluable knowledge for primary prevention for future generations. The CLHI is a groundbreaking set of large cohort studies that will track the health of thousands of Canadians over many years and generate new knowledge of how key factors impact on health and disease outcomes. The study is greatly needed to increase our understanding of chronic disease and how environmental, social, life-style, genetic and behavioural factors affect health across the lifespan.

Strategy c. Building Canada's chronic disease surveillance system

The federal government is responsible for monitoring chronic disease in Canada through rigourous surveillance. However, Canada's chronic disease surveillance system is currently inadequate, with significant data gaps and insufficient integration and coordination. Existing surveillance systems need to continue to develop and grow. At the same time, we need to create a coordinated chronic disease surveillance system that builds on and links with existing data systems like those for cancer, diabetes and physical activity without slowing down the momentum of existing successes.

Collecting and coordinating the data that is directly relevant to all chronic diseases (including data on determinants, risk factors and co-morbidities), will better enable the selection of future investments in public policies, research or support programs that will maximize effectiveness and the return on public investment.

Strategy d: Supporting intersectoral collaboration

Because the major determinants of chronic disease burden lie outside of the health sector, intersectoral action is necessary at all stages of policy formulation and implementation (WHO, Preventing Chronic Diseases: a vital investment, 2005). Efforts need to be coordinated across sectors (agriculture, environment, transportation and health) and across jurisdictions (federal, provincial, regional and municipal) both within and outside of government. This will not happen naturally and solid federal leadership is required to purposefully create structures that will allow

this collaboration to take place without slowing down momentum in disease-specific and risk factor areas of work.

PRIORITY AREA 3: Protecting Canadians from tobacco exposure

Strategy a. Banning all tobacco advertising and promotion

CDPAC urges the strengthening of federal tobacco legislation to ban all tobacco advertising and promotion, consistent with the standard in the new international tobacco treaty. The effect will be to reduce tobacco use, among adults and kids, and consequently reduce tobacco-related disease and deaths.

Canada does not have a tobacco advertising ban. Pursuant to existing federal legislation, the 1997 *Tobacco Act*, tobacco advertising is restricted, but is still permitted in:

- publications with at least 85% adult (18+) readership (virtually all newspapers/magazines in Canada);
- direct mail to identified adults;
- bars.

Tobacco advertising increases overall consumption by encouraging initiation, discouraging quitting, and enticing ex-smokers to relapse. Tobacco advertising adversely affects smoking rates among both adults and kids. This is confirmed by a vast body of evidence.

In 1997, tobacco companies challenged the constitutional validity of the advertising restrictions in the *Tobacco Act*, and refrained from advertising pending the outcome of the court case. On June 28, 2007, the Supreme Court of Canada unanimously (9:0) upheld all provisions in the *Tobacco Act*. But with the court case now over and the Act permitting advertising, the tobacco companies are expected to resume advertising soon. This will surprise Canadians as they have not seen direct cigarette advertising in 10 years.

Canada has fallen behind international standards. Many countries have banned tobacco advertising, instead of the mere partial restrictions found in Canada, including: Australia, New Zealand, the U.K., France, Ireland, Belgium, Sweden, Norway, Finland, Iceland, Denmark, Portugal, Italy, Thailand, Malaysia, Singapore, India and South Africa. If these countries can ban tobacco ads, then Canada should also be able to do so.

The new international tobacco treaty, the *WHO Framework Convention on Tobacco Control* (FCTC), contains an obligation for Parties to implement, within 5 years, a comprehensive ban on tobacco advertising and promotion. This treaty, which came into force in 2005, applies to tobacco in a way similar to the Kyoto Protocol applying to climate change. Canada ratified the FCTC in 2004, and is now one of 150 Parties.

The FCTC does exempt Parties where implementing an advertising ban is constitutionally impossible. But this exemption applies to very few countries. Given the totality of evidence that exists today concerning the impact of tobacco advertising, and given the new international standard, health organizations believe that a total advertising ban would be justified today in Canada under the Charter.

Strategy b. Requiring plain packaging for tobacco products

We recommend implementing regulations under the federal Tobacco Act to require plain packaging, implementing the 1994 conclusion of the House of Commons Standing Committee on Health. Plain packaging would reduce tobacco use, especially among kids, and consequently tobacco-related disease.

Plain packaging would prohibit brand logos and colours on packages, require a standard colour (e.g. brown) on packages of all brands, prohibit slogans and "puffery" on the package, and require the brand name to appear in a standard font size and style on a specified place on the package. Plain packaging would also standardize the shape and format of packages to eliminate special tins, 8-sided octagonal packages, etc.

Plain packaging would reduce tobacco use and has been recommended by the House of Commons Standing Committee on Health (1994) and by the World Conference on Tobacco or Health (1994). The evidence in support of plain packaging includes studies, reports, expert opinion, testimony of industry representatives, and industry documents.

The package is a mini-billboard that walks around the home, walks around the schoolyard, and walks around our communities. The package is at the core of the brand and tobacco marketing. There cannot be a true advertising ban without plain packaging.

Plain packaging would strip the package of its alluring lifestyle brand imagery, such as masculinity, femininity, sophistication, status, slimness, youthfulness, freedom, independence, rebelliousness, and even health. The creation of such intangible brand imagery for an addictive, lethal product should not be allowed.

The demonstrated need for plain packaging is newly emphasized following the ban on the misleading descriptors "light" and "mild". Tobacco companies have responded in a number of ways, including the deceptive use of increasing amounts of white on packaging, as well as lighter colour variations for different brand extensions, to suggest a "lighter" or "safer" product (many consumers associate white/light colours with purity).

A Supreme Court of Canada Judgment has opened the door to plain packaging. On June 28, 2007, the Supreme Court of Canada unanimously (9:0) upheld the partial advertising restrictions in the *Tobacco Act*. In doing so, the Court stated that the only thing that companies could do under the Act was to convey "hard, factual data directed to confirmed smokers" (para. 111). This conclusion is a strong indication that plain packaging would also be justified, given that brand colours, logos and slogans have nothing to do with "hard, factual data".

Canadian leadership is needed. Canada was the first country in the world to require picture-based package health warnings, an innovation that quickly became an international model. Canada should again demonstrate leadership and move forward on plain packaging.

Strategy c. Curbing tobacco contraband

The federal government should urgently implement a series of available, effective measures to reduce tobacco contraband, which has grown to crisis levels. These anti-contraband measures will benefit public health and public revenue, and curb a serious crime and border security issue. Reducing the availability of cheap cigarettes will reduce smoking and consequently reduce tobacco-related disease and death.

Higher tobacco taxes are the most important available strategy to reduce smoking, especially among teenagers who are especially price-sensitive. There has not been a net federal tobacco tax increase since June 2002 (there was only a small modification in 2006 to adjust for the 1% GST decrease). Contraband is dissuading governments from increasing tobacco taxes.

In the last few years, there has been a dramatic increase in contraband levels, although by its nature contraband is difficult to measure. Contraband is highest in Ontario and Quebec, and is spreading to other provinces. Failure to act now will mean that contraband will grow even more, and will be even harder to get under control.

Given that Ontario and Quebec have the highest contraband levels, but the lowest tobacco tax rates, demonstrates that contraband is a problem of supply, and not a problem of price and demand.

The most significant source is from illegal operations on the St. Regis (i.e. American) side of Akwesasne, which straddles the Ontario, Quebec and New York States borders. Thus there is an important border security issue for both Canada and the U.S. Other sources are from illegal operations on Kahnawake (near Montreal), Tyendinaga (near Belleville, Ontario) and Six Nations (near Brantford, Ontario).

The key to preventing contraband is to eliminate the source of supply. Anti-contraband measures are available that do not require enforcement on First Nation reserves. Priorities for action by the federal government include:

1. persuading the U.S. federal government to shut down illegal manufacturing operations on the U.S. side of Akwesasne;
2. prohibiting the supply to unlicensed manufacturers of raw materials and equipment used in making tobacco products;
3. revoking federal licenses of manufacturers acting unlawfully;
4. introducing an effective package marking system known as 'tracking and tracing' to closely monitor tobacco shipments (the federal government is implementing more sophisticated package markings, but not a full ‘tracking and tracing’ system);
5. establishing a minimum bond of at least $5 million in order to obtain a federal tobacco manufacturing licence, instead of the current extremely low $5000.

Conclusion

CDPAC has identified these priorities and strategies through collaboration and consultation involving our extensive networks of organizations, alliances, researchers, policy makers and practitioners, all of whom are committed to improving the health of Canadians and addressing our chronic disease and risk factor epidemics. We appreciate the opportunity to share these priorities with the Leader of the Official Opposition, the Honourable Stéphane Dion, and look forward to the discussion and next steps.

ABOUT CDPAC

CDPAC is a network of voluntary, public and private sector organizations at the national, provincial/territorial and local level working to enhance chronic disease prevention in Canada. CDPAC’s vision is the prevention and reduction of chronic diseases through a comprehensive system of individual and coordinated strategies. We believe the greatest gains in the Canadian health system over the next few decades will be achieved by decreasing premature disease

through the reduction of risk factors such as obesity, unhealthy eating, physical inactivity, and smoking.

CDPAC has over 60 member organizations and alliances at the national and provincial/territorial levels. These organizations and alliances in turn represent hundreds of local, provincial/territorial and national organizations and networks. CDPAC utilizes and strengthens these linkages to facilitate consensus building and coordinated action on shared chronic disease prevention issues and priorities. CDPAC also works to support the alignment of primary prevention components of disease-specific strategies.

CDPAC is led by a Steering Committee made up of the following organizations:

- BC Healthy Living Alliance*
- Canadian Alliance for Mental Illness and Mental Health
- Canadian Cancer Society
- Canadian Council for Tobacco Control
- Canadian Diabetes Association
- Canadian Lung Association
- Canadian Public Health Association
- Coalition for Active Living
- Dietitians of Canada
- Heart and Stroke Foundation of Canada
- Kidney Foundation of Canada
- Public Health Agency of Canada (ex-officio)
- YMCA Canada
- Wellness Advisory Council of Newfoundland and Labrador*

*representing CDPAC's Network of Provincial/Territorial Alliances

References

[1] World Health Organization. Preventing chronic diseases: A vital investment. October 5, 2005. Available at: http://www.who.int/chp/chronic_disease_report/en.
[2]Advisory Committee on Population Health. Advancing Integrated Prevention Strategies in Canada: An Approach to Reducing the Burden of Chronic Diseases, Discussion Paper, June 10, 2002.
[3] Advisory Committee on Population Health, 2002.
[4] World Health Organization. *Facing the Facts: the Impact of Chronic Disease in Canada.* 2005.
[5]Michael Tjepkema. Adult obesity in Canada: Measured height and weight. Nutrition: Findings from the Canadian Community Health Survey. Statistics Canada. 2005.
[6] Statistics Canada. Canadian Community Health Survey: Obesity among children and adults. The Daily. Wednesday, July 6, 2005
[7]Janssen I, Katzmarzyk PT, Boyce WF, Vereecken C, Mulvihill C, Roberts C, Currie C, Pickett W. Comparison of overweight and obesity prevalence in school-aged youth from 34 countries and their relationships with physical activity and dietary patterns. Obesity Reviews. 2005;6:123-132.
[8]Canada's report card on physical activity for children and youth – 2006. Active Healthy Kids Canada.
[9]Active Healthy Kids Canada. 2006.
[10] 2000/01 Canadian Community Health Survey.
[11] Craig CL, Cameron C, Russell SJ, Beaulieu A. Increasing physical activity: supporting children's participation. *2000 Physical Activity Monitor*. Canadian Fitness and Lifestyle Research Institute. 2001. Available from http://www.cflri.ca/pdf/e/2000pam.pdf
[12] Hastings, G. et al. (2003). *Review of Research on the Effects of Food Promotion to Children*. London: Food Standards Agency, pp 208.; McGinnis, J.M., Appleton Gootman, J., Kraak, V.I. (Eds) (2006). *Food Marketing to Children and Youth: Threat of Opportunity?* Washington D.C.: National Academies Press, pp536.; Shields, M (2006). Overweight and obesity among children and youth. *Health Reports*, 17, 3.
[13] Shields, M. (2005). Measured Obesity: Overweight Canadian children and adolescents. Ottawa: Statistics Canada.; Garriguet, D. Nutrition: Findings from the Canadian Community Health Survey: Overview of Canadians' Eating Habits. Ottawa: Statistics Canada.
[14] Canadian Association of Broadcasters et al. (2006). *Advertising to Children in Canada: A Reference Guide*.
[15] Irwin Toy v. Quebec (A.G.), [1989] 1 S.C.R. 927.
[16] Garriguet, D. *Nutrition: Findings from the Canadian Community Health Survey: Overview of Canadians' Eating Habits*. Ottawa: Statistics Canada; Lewin et al. (2006). Food industry promises to address childhood obesity: preliminary evaluation. *Journal of Public Health Policy*. 27, 327-348.
[17]Sheilds, M. & Tjepkema, M. (2006). Regional differences in obesity. Health Reports, 17, 3.
[18] Baylis, K. & T. Dhar. (2007). Effect of the Quebec Advertising Ban on Junk Food Expenditure.
[19]Health Canada. Canadian Community Health Survey, Cycle 2.2, Nutrition (2004) - Income-Related Household Food Security in Canada. 2007.
[20] McIntyre L and Tarasuk, V. Food Security as a Determinant of Health. Health Canada. Available at www.hc-sc.gc.ca/hppb/phdd/overview_implications?08_food.html
[21] Health Canada 2007.
[22]Social Planning Council of Winnipeg. Poverty Barometer. 2004. [Accessed 2007 18 Sept]. Available at: http://www.spcw.mb.ca/uploaded/File/food_security_poverty_barometer.pdf
[23] Power, E. Individual and Household Food Insecurity in Canada: Position of Dietitians of Canada. [Accessed 2007 18 Sept]. Available at http://www.dietitians.ca/news/highlights_positions.asp
[24] Canadian Labour Congress. Falling unemployment insurance protection for Canada's unemployed. 2003.
[25] Dietitians of Canada and Community Nutritionists Council of BC. The Cost of Eating in BC. 2003.
[26] Dietitians of Canada. Community Food Security. Position of Dietitians of Canada. 2007. [Accessed 2007 17 Sept]. Available at: http://www.dietitians.ca/news/highlights_positions.asp
[27] Nestle M. Safe food: Bacteria, biotechnology and bioterrorism. Berkeley, CA; University of California Press. 2003.
[28] Heart and Stroke Foundation of Canada (commissioned paper). Obesity Relationships with Community Design: A Review of the Current Evidence Base. September 8, 2005.
[29]Heart and stroke, 2006.
[30] Millward, L. M., Kelly, M. P., & Nutbeam, D. (2003). *Public health intervention research - the evidence*. London: Health Development Agency.