Summary of Expert Presentations

from the

Promoting Healthy Weights Workshop

May 9, 2006, Delta St. John's Hotel, St. John's, Newfoundland

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EXECUTIVE SUMMARY

On May 9, 2006, the Canadian Population Health Institute (CPHI)[1] and the Chronic Disease Prevention Alliance of Canada (CDPAC) co-sponsored the Promoting Healthy Weights Workshop at the Delta hotel in St. John's, Newfoundland. The keynote presentation introduced *Improving the Health of Canadians: Promoting Healthy Weights*, a new CPHI report which focuses on the link between our structural and social environments and obesity. The workshop also featured expert presentations highlighting current knowledge and action on the link between healthy weights and specific environments. The workshop emphasized that there are many opportunities to promote healthy weights at the population level within the settings where we live, learn, work and play.

This executive summary is organized by environment. Each section begins with the relevant findings from *Improving the Health of Canadians: Promoting Healthy Weights* report, as described in the keynote presentation, followed by additional points from the expert presentations. The main body of this report contains the summaries of the workshop presentations and participants' discussions. PDF versions of all presentations are available on the CDPAC website (www.cdpac.ca).

Home and Family Environments

According to *Improving the Health of Canadians: Promoting Healthy Weights*, there are a number of features of home and family life linked to healthy weights. These include: whether or not infants are exclusively breastfed, what parents eat and how active they are, and the amount of time children spend in front of the TV or computer. Those who live in the urban core report are more likely to report lower BMIs.

Although parents play a critical role in influencing children's obesity and physical activity levels, there may be a "disconnect" between parents' health beliefs, the extent to which they actually encourage children's physical activity, and how much they know about their children's actual activity levels. Parents need to: 1) provide children with opportunities and support for physical activities (without exerting undue pressure and without causing other family members' to be sedentary), and 2) regulate children's screen time, without replacing screen time with other sedentary activities.

There are efforts in Canada to restrict food advertising aimed at children. In 1980, Quebec set a world precedent by passing legislation that imposed a comprehensive ban on this type of television advertising. In February 2006, CDPAC's Obesity Policy Project held a think tank to explore the pros and cons of five options for restrictions on advertising in Canada (see *CDPAC backgrounder*): 1) full ban, 2) comprehensive ban, 3) partial ban, 4) corporate bans/disincentives, and 5) social marketing. There is strong public opinion support in Canada for restricting food advertising aimed at children. Making this happen, however, will require a long-term effort.

[1] The Canadian Population Health Institute is part of the Canadian Institute for Health Information (CIHI).

Schools

Improving the Health of Canadians: Promoting Healthy Weights found that coordinated school health initiatives that look at nutrition, physical activity and other factors are more likely to be effective.

Schools are an important vehicle for reaching children, parents, and the significant proportion of the workforce working in or near schools. The evidence shows that comprehensive approaches involving schools connected to communities have an impact, as do specific interventions, such as: Breakfast for Learning, school meal programs, media literacy programs, lifetime-oriented physical education and skills-oriented nutrition education. The fact that schools are an important part of both national and provincial level healthy living initiatives is a good start, but it will be important to develop enduring policies and interventions that link physical activity, nutrition, mental health and other issues, such as stress, boredom and work-life stress. The Joint Consortium on School Health is an intergovernmental pathway that is working to: develop and coordinate education and health policy, develop formal knowledge transfer mechanisms, improve the evidence base, and develop practical pan-Canadian strategies for action.

At this time, school health promotion research includes, for example, the work being done by the Comprehensive School Health Research team and the School Health Research Network. A number of valuable tools and resources have been developed to date, but more financial, human and material resources are needed to develop research partnerships with schools, and to conduct in-depth intervention research and evaluation that addresses the needs of schools, students, families and communities.

Workplace

According to *Improving the Health of Canadians: Promoting Healthy Weights*, working conditions are linked to obesity. Although research has shown that interventions combining nutrition and physical activity can be effective, employers face barriers to implementing programs, such as space and cost.

For health to become a long-term initiative in most corporations it must be linked through human resource management (HRM), and the notion of health will have to be expanded to include a full range of meanings, including organizational health. Achieving real change involves creating healthy cultures in organizations and healthy work environments, which in turn can support individual health promotion efforts and initiatives (i.e. a comprehensive approach). Better intervention designs and stronger workplace interventions that address multiple risk factors are needed. The Canadian Council on Integrated Healthcare has called for policies, such as tax incentives, to encourage and support employers in developing higher levels of workplace health and for supporting individual health promotion in the workplace.

There is an ongoing need for national leadership in policy development and knowledge exchange in this area. Current initiatives include work being done by a number of national level organizations and agencies, as well as valuable resources and tools that have been produced at the provincial/territorial level. In addition, several leading workplaces are implementing initiatives.

Built Environments

Improving the Health of Canadians: Promoting Healthy Weights found that some community-based interventions, such as Saskatoon *In Motion*, have been evaluated and shown to increase physical activity. Neighbourhood characteristics, such as "walkability," are linked to engagement in physical activity and active transportation. Active transportation choices are influenced by factors such as health benefits and distance to work. Those who live in neighbourhoods where a number of residents bike or take public transit to work are more likely to report a BMI less than 25.

CDPAC's Advocacy Working Group is supporting stakeholder efforts to improve built environments (i.e., land use patterns, transportation systems and design features). CDPAC's forthcoming (June 2006) scan of the key research findings and current NGO and federal government initiatives in this area indicates that, although key organizations are providing leadership in this area, they are not connected to each other, nor are they resourced. The scan calls for action and improvements in a number of key areas. In addition, built environments will be one of the streams at CDPAC's national conference in the fall of 2006.

Nutrition Environment

According to *Improving the Health of Canadians: Promoting Healthy Weights*, food-related issues such as food insecurity are another important component of understanding healthy weights. Features of the nutrition environment include: living in the Territories; living in single-mother or low-income households; the cost of food and access to food; the energy-density of food; and the number of residents per fast-food restaurant. Adults in the highest-income households have higher fruit and vegetable consumption than those in lower-income households.

Although the most recent statistics no longer show that lower income groups have the highest rates of obesity, this may reveal that, in fact, "overlapping epidemics" are occurring among different groups in Canadian society. Evidence shows that low income still has a negative impact on dietary intake, and there are links between food insecurity and body weight and healthy eating. Research-based models suggest that there would be substantial nutritional gains if food-insecure families could afford to eat the healthy foods they usually eat on a more regular basis. Achieving healthy eating and healthy weights for low-income and, in particular, food-insecure Canadians begins with *income being available to improve the nutrition environment*.

Fostering Knowledge Development, Knowledge Transfer and Action on Healthy Weights

CPHI and CDPAC share a longstanding commitment to promoting healthy weights for Canadians. CPHI plays a crucial role in knowledge development and knowledge transfer, while CDPAC is committed to capacity building, advocacy, and development of an integrated chronic disease prevention system in Canada. In addition, at the provincial/territorial level, there are now nine formal organizations/networks involved in this work, including the Alberta Healthy Living Network.

Preventing and treating obesity is complex. Many factors and settings play a role. There are many initiatives underway, but there are very few published evaluations. The Promoting Healthy Weights Workshop provided participants with information about many different perspectives and policy options. Although there are challenges within each environment and some limitations on the current body of knowledge, there are also many new directions that could be pursued. According to public opinion data, more than half of Canadians think obesity is very important to the overall health of Canadians. It will be very important to continue this dialogue, and to include those from outside the health sector who are interested in building healthier communities.

INTRODUCTION

On May 9, 2006, the Canadian Population Health Institute (CPHI)[2] and the Chronic Disease Prevention Alliance of Canada (CDPAC) co-sponsored the Promoting Healthy Weights Workshop at the Delta hotel in St. John's, Newfoundland. The keynote presentation introduced *Improving the Health of Canadians: Promoting Healthy Weights*, a new CPHI report which focuses on the link between our structural and social environments and obesity. The workshop also featured expert presentations highlighting current knowledge and action on the link between healthy weights and specific environments. The workshop emphasized that there are many opportunities to promote healthy weights at the population level within the settings where we live, learn, work and play.

This report provides summaries of the workshop presentations and participants' discussions.[3]

OBJECTIVES

The objectives of the workshop were to:

- Share some of the current research on the factors influencing the ability of Canadians to maintain healthy weights, including findings from the Canadian Population Health Institute's (CPHI) new report, *Improving the Health of Canadians: Promoting Healthy Weights.*
- Share current CDPAC and partner actions in the area of healthy weights
- Facilitate knowledge exchange and transfer, and
- Discuss implications and explore directions for policy development related to the promotion of healthy weights.

The workshop agenda is included in Appendix A.

PARTICIPANTS

Workshop invitees included: members of CDPAC; members of the Expert Advisory Committee for CPHI's new report, *Improving the Health of Canadians: Promoting Healthy Weights*; and representatives from policy-making agencies across Canada. The Participant List is included in Appendix B.

[2] The Canadian Population Health Institute is part of the Canadian Institute for Health Information (CIHI).
[3] The views expressed in this report are not necessarily those of CIHI, CDPAC or the experts who presented at the workshop.

WELCOME AND INTRODUCTIONS

Dr. Catherine Donovan[4], Regional Medical Officer of Health, Eastern Regional Integrated Health Authority, moderated the workshop.

Dr. Donovan opened the workshop by welcoming participants and explaining that the co-sponsoring organizations, CPHI and CDPAC, share a longstanding commitment to promoting healthy weights for Canadians. CPHI plays a crucial role in knowledge development and knowledge transfer, while CDPAC is committed to capacity building, advocacy and the development of an integrated chronic disease prevention system in Canada.

PART 1: STATE OF RESEARCH ON HEALTHY WEIGHTS

The first half of the workshop focused on the current state of research on promoting healthy weights. In the keynote presentation, Ms. Elizabeth Gyorfi-Dyke, Director, CPHI, outlined the findings of CPHI's new report, *Improving the Health of Canadians: Promoting Healthy Weights*. Then a panel of four researchers shared their insights and expertise on research related to promoting healthy weights in key environments, including: schools, the nutrition environment, the home and family environment, and workplaces. Summaries of the presentations and discussions follow. PDF versions of the presentations are available at www.cdpac.ca.

1.1 CPHI

1.1.1 Summary of *Improving the Health of Canadians: Promoting Healthy Weights*, Keynote presentation by Elizabeth Gyorfi-Dyke, Director, Canadian Population Health Initiative (CIHI-CPHI)

Ms. Gyorfi-Dyke provided an overview of the recent CPHI report, *Improving the Health of Canadians: Promoting Healthy Weights*. The Canadian Population Health Initiative (CPHI) is part of the Canadian Institute for Health Information (CIHI). CIHI provides Canadians with essential statistics and analysis about their health and their health care system. CIHI is a source of information for those seeking answers to critical questions around the performance of the Canadian health system, the delivery of health care, and the status of Canadians' health. Within CIHI, CPHI focuses on the determinants of health, looking at what makes us healthy.

CPHI's four strategic functions include: knowledge generation, policy synthesis, knowledge transfer and knowledge exchange. Currently, CPHI is focusing on three key themes: healthy transitions to adulthood, place and health (e.g., rural and urban), and healthy weights. The new CPHI report, *Improving the Health of Canadians: Promoting Healthy Weights*, is the second in a series of three reports. It explores how our

[4] Dr. Donovan is also Chair of the Newfoundland Wellness Coalition, a member of the CDPAC Steering Committee, and a previous member of the CPHI Advisory Committee.

environments either help or hinder us in achieving healthy weights. The report synthesizes the research on healthy weights, reviews existing programs and policies on healthy weights, analyzes new data, and presents public opinion data on policy options.

The obesity rates in Canada are increasing. The new CPHI report focuses on the link between our structural and social environments and obesity.

1) Where we live:
- There are features of the home and family that are linked to healthy weights, such as whether infants are exclusively breastfed, what parents eat and how active they are, and the amount of time children spend in front of the TV or computer.
- Those who live in the urban core are more likely to report lower BMIs.

2) Where we learn:
- Coordinated school initiatives that look at nutrition, physical activity and other factors are more likely to be effective.

3) Where we work:
- Working conditions are linked to obesity, and although research has shown that interventions combining nutrition and physical activity can be effective, employers face barriers to implementing programs, including space and cost restraints.

4) How we get to work and where we play:
- There are some community-based interventions (e.g., Saskatoon *in Motion*) that have been evaluated and shown to increase physical activity.
- Neighbourhood characteristics such as "walkability" are linked to engagement in physical activity and active transportation.
- Active transportation choices are influenced by factors such as health benefits and distance to work.
- Those who live in neighborhoods where a number of residents bike or take public transit to work are more likely to report a BMI less than 25.

5) The broader nutrition environment:
- Food-related issues such as food insecurity are another important component of understanding healthy weights. Features of the nutrition environment include: living in the Territories; living in single-mother or low-income households; the cost of food and access to food; the energy-density of food; and the number of residents per fast-food restaurant
- Adults in the highest-income households have higher fruit and vegetable consumption than those in lower-income households.

There is another side to this discussion. Thirty-seven percent (37%) of females aged 12-17 who report being a normal weight also report trying to lose weight.

Public opinion data indicates that more than half of Canadians think obesity is very important to the overall health of Canadians. Almost three quarters believe individuals have the most responsibility for reducing obesity. The intent of the report is to look at issues beyond individuals – to the social and structural environment that may influence the choices we make.

Preventing and treating obesity is complex. Many factors and settings play a role. There are many initiatives underway, but there are very few published evaluations.

We have many opportunities to promote healthy weights at the population level within the settings where we live, learn, work and play.

Participants' Discussion

- Why is there no link between living in neighborhoods where residents walk to work and obesity?
    - We do not know why this may be. More research is needed to examine this.

- Was there no link between obesity and community size and ethnicity?
    - CPHI did not do this type of analysis for this report, but other work has been done.

- Why is there a lack of information on the Territories?
    - This is an ongoing challenge. CPHI over-sampled in the Territories for the public opinion survey it conducted for the report. CPHI continues to look for ways to include more information on the Territories.

- Importance of including waiting list data for bariatric surgeries?
    - In Quebec, there are 400 surgeries per year, but there are 2,500 on the waiting list, and these waiting lists have been increasing. This might be the case in other provinces as well.

- Use of the BMI?
    - The BMI is controversial. For example, higher BMIs are not necessarily bad, in some cases. It's important not to make people, especially youth, unduly concerned about BMIs.
    - The BMI is the measure that is most commonly used at the population health level. Researchers have the height and weight data so BMI can be calculated. Although some research has identified waist-hip ratios as a useful measure, this data is not currently collected.

- Impact of the critical work that has been done on "obesity"?
    - This report expands the discussion beyond the individual level. We need to stop blaming the individual and look at environmental and social structures.

- Impact of urban sprawl?
    - Families are driving to work and school and everywhere else. It is very hard to find or move to a walkable community in Canada, We need to work with those outside of health to address the built environment.
    - CPHI and others have begun to engage other sectors (e.g. urban development) to discuss the link with health.

- Importance of monitoring overall health?
    - We need a health reporting system that goes beyond the crisis-driven approach. We need to know what is happening to people overall, not just on one or two issues. For example, CPHI's report on children and youth and the report from Alberta are excellent.
    - There is a role for everyone to play in working together on this issue of healthy weights.

- Definition and use of term "healthy weights": does it mean being healthy at your weight?
    - CPHI uses the term "healthy weights" to encompass the fact that "healthy weight" is the weight at which you don't have a higher risk for a variety of diseases.

- In the discussion about weight, are we talking about health or beauty standards?
    - Healthy bodies come in all sizes, but beauty standards tend to drive the discussion about weight. Many women, and now men as well, are dissatisfied with their bodies. Unfortunately, focusing on healthy weight can create more unhealthy weight (through dieting).
    - Messages about body image are important, but so is the message about what we weigh. We all need to look at our surroundings and what we can do to make all of us healthy.

- Given the challenges with measures of healthy eating and physical activity, what are CPHI's recommendations regarding surveillance of nutritional intake and physical activity?
    - Statistics Canada is working on this, and there is ongoing discussion. The Canadian Community Health Survey (CCHS) food diary 2.2 will be available in the spring/summer and will give us better measures around food. The Canada Health Measures Survey will include physical tests, etc.

- "Obesity" and funding?
    - Using the term "obesity" is important to get funding.
    - Programs in the school context, however, may avoid this term and just focus on physical activity and affordability, etc.

- Is there information on treatment for obese children?

- Although it is difficult to find information on how to design programs for obese children with compromised longevity, it would seem very important to focus on unhealthy living (not actual weight) and also to promote having fun.
- Clinical practice guidelines for the management of obese children will be coming out soon, and Capital Health in Alberta is working on a program.

1.2 Schools

1.2.1 Summary of *Finding the Path for School Health Promotion/Research*, a presentation by Donna Murnaghan, Director of Programs and Partnership, Prince Edward Island Health Research Institute

Ms. Murnaghan focused on the ongoing task of finding the path for school health promotion/research in Canada. She began by providing a background on school health promotion in Canada and outlined the origins of school health and its ongoing evolution. She noted the impact on schools, in terms of demands from researchers and programmers, explained the rationale for focusing on school health promotion, and emphasized schools' capacity to influence children, families and communities. She described some of the key events, including the World Health Organization (WHO) guidelines, which set the stage for health-promoting schools in Canada.

Ms. Murnaghan focused on school health promotion research across Canada and in Atlantic Canada. She described the Comprehensive School Health Research team (CSHR) (www.upei.ca/cshr), and the School Health Research Network. She emphasized the need for theory-driven research, and outlined a number of potential models, including the Theory of Planned Behaviour. She emphasized the importance of understanding key mediating variables.

Ms. Murnaghan discussed some of the Network's current research projects and activities. She outlined some of the factors that will be needed to continue this work, and she described available tools and resources, including the use of a better practice model framework developed by Canadian Tobacco Research Initiative (CTRI), as well as other resources and a resource guide that are available on the CSHR website.

Ms. Murnaghan closed with a call for increased financial, human and material resources to conduct in-depth intervention research and evaluation that addresses the needs of schools, students, families and communities. She emphasized the need for research partnerships and clarification of the cost-benefits for all partners, including schools.

Participants' Discussion

- Engaging schools in the research process is key. We need to:
  - Recognize that many different groups approach the schools.
  - Have school/school board personnel on research committees or teams, and ensure that they are involved from the inception.
  - Establish dialogue mechanisms so schools and researchers can each identify their research needs and priorities, and find common ground.

- Provide reports back to schools so they can utilize the results. For example, provide them with comparisons to national averages.
- Provide schools with data and results in appropriate language. For example, recognize their need to produce school accountability plans, which must include health issues.

- The preparedness of teachers to talk about health issues, including nutrition, is important. We need to:
  - Examine the curriculum for teacher education.
  - Provide training for teachers as a key element in implementing research-based interventions. For example, teachers need training in carrying out surveys, as well as money for "release time," etc.

- What research is there on the effectiveness of reducing access to junk food in schools?
  - We need more evaluation in this area. Current data shows that if you make healthy choices available, young people will make healthy choices, but there are no efficacious measures, just diary and self-report.
  - There are only a couple of randomized controlled trials, and they have shown that you can reduce weights if you get sugar-sweetened beverages out of the schools, but the research does not extend to other foods.

1.3 Nutrition Environment

1.3.1 Summary of *The Nutrition Environment*, a presentation by Dr. Lynn McIntyre, Professor, Faculty of Health Professions, Dalhousie University

Dr. McIntyre's presentation focused on the topic of food insecurity, beginning with a review of the new data available on low income and healthy weights. Although the most recent statistics no longer show that lower income groups have the highest rates of obesity, this may reveal that, in fact, there are "overlapping epidemics" which have occurred first among Aboriginal peoples, then among the poor, then among children and youth, and now among the highest income groups. The evidence also shows that low income still has a negative impact on dietary intake. It is very expensive, in terms of proportion of income, for low-income households to eat healthily. Consumption of fruit, vegetables and milk goes up with level of income, and the consumption of "other" or calorie-dense foods goes down. Those with higher incomes are more likely to purchase lean meat, lower fat milk and breakfast cereal.

There are links between food insecurity and body weight and healthy eating. Five studies from around the world have shown that, as a group, among those who experience food insecurity, it is white women who have higher rates of obesity. In addition, the Hungry Mothers study found that none of the low-income, lone mothers in the study had quality diets. These mothers, as well as the older children in their households, appear to support the somewhat better quality diets of the younger children in these families. There is also evidence that the "feast and famine" cycling in the diet of food insecure women could be

leading to weight gain, given the energy difference over the month, but not if one looks at total energy intake, which remains below recommended levels.

Dr. McIntyre described an ongoing research study that attempts to improve the nutritional status of food insecure families by increasing their access to their preferred healthy foods. The models based on this research suggest that there would be substantial nutritional gains if food insecure families could afford to eat the healthy foods they usually eat *on a more regular basis*.

Dr. McIntyre emphasized that achieving healthy eating and healthy weights for low-income, and in particular, food-insecure Canadians begins with *income being available to improve the nutrition environment*.

Participants' Discussion

- What are the potential policy implications for the "obesity" issue, given that new data indicates the highest risk is among the highest income men and middle-income women (i.e., the "reverse gradient")?
    - The 2004 data may have been skewed by response rates that differ by sex and income.
    - Messages about food insecurity and healthy eating have to focus on overall health, not just on unhealthy weights (although there is evidence of a predilection to unhealthy eating and overweight among poor populations).
    - There are still many other outcomes, including prevention of chronic disease, that are important.
    - We can still focus on the ability to promote healthy eating and reduce energy deficits.
    - The bottom line is that income matters. The minimum wage solution does not reach those not in the workforce so how do we get income to them? The federal income transfers have brought poverty rates down. Low-income earners have benefited, but provincial taxation policies don't allow people on fixed incomes to benefit. New Brunswick was the first province that allowed the child tax benefit to flow through to mothers on fixed incomes and the result, according to the Hungry Mothers' study, was one third the rate of both child and material hunger in New Brunswick compared with Nova Scotia. We have to let the money flow through!

- What could be driving this "reverse gradient" on obesity and overweight?
    - It may relate to large energy imbalances (i.e., high sedentary activity), work-related stresses (not income stresses), and lifestyle changes, such as long commutes.
    - Higher-income groups may also be able to carry their overweight longer, i.e. they can be overweight for 10 years whereas the lower-income groups may become obese within 10 years, which may mean something else is going on in terms of their weight maintenance.

- Lower-income men may be getting more physical activity in their work (manual labour phenomenon).
- There may be something wrong with the data, given the gradient on education: the lowest education group has the highest obesity rates.

- The issue of energy balance needs to be better addressed. For example, would it be better, instead of providing income, to provide milk, fruit and vegetables in schools? For example, there is a pilot project in B.C. providing fruit to schoolchildren three times per week.
    - This would not help the lone mothers who are the ones suffering the worst nutritional inadequacy.
    - We do need free low-fat school milk programs for children in all grades because there is a calcium and vitamin D problem, and the disparities are bigger in the older age groups.
    - For adults, we need to give income to households so they will buy healthier foods. If we require them to pick up food in the community, they may not pick it up. We need to give them income. Then, eventually, we can work with them on buying even healthier foods.

- Is there a link between smoking and the patterns of socio-economic status and obesity?
    - The obesity rates are not adjusted for smoking.
    - The groups that are most likely to be morbidly obese are also smoking.
    - Although Quebec has lower rates of obesity, that may be linked to European eating patterns rather than smoking because Quebec has dramatically reduced smoking rates.

1.4 Home and Family Environment

1.4.1 Summary of *Promoting Healthy Weights: Home and Family Environment*, a presentation by Ian Janssen, PhD, School of Physical & Health Education, Department of Community Health & Epidemiology, Centre for Obesity Research & Education (CORE), Queen's University

Dr. Janssen's presentation focused on how parents influence the physical activity level of both younger children and adolescents. He began by noting that parents are responsible for their children's physical and social environments. There is a large body of literature that demonstrates parental influence on obesity levels. Research also shows that parental support and help is more consistently related to physical activity levels in children and adolescents than is modeling by peers, teachers and coaches.

At the same time, survey data indicates most parents' actions are not consistent with their beliefs about health. For example, although they see being overweight as a serious health issue, relatively low proportions actually encourage children to do physical activity. Similarly, parents do not know how active their children are. Evidence suggests disparities between the activity levels parents think children are getting, and children's actual amount of physical activity. About 8 percent of children in Canada are obese, but

none of the 800 parents surveyed reported having an obese child. Parents seem more concerned about unsafe equipment, unsafe environments and danger from strangers, yet statistics indicate that assaults by strangers are relatively rare.

Parents need to provide children with opportunities and support for physical activity, but without exerting excessive pressure on children, and without other family members being overly sedentary during those activities. Parents also need to regulate children's screen time and ensure screen time is not replaced with sedentary behaviours.

Participants' Discussion

- What will be the impact of recent federal investments in this area?
  - The new federal tax credit for enrollment in sport or physical activity is a good start, but it is so small it will likely have only minimal impact. It isn't likely to encourage those who are not already enrolling in sports and physical activities, nor will it help lower-income people. It may increase disparities.
  - Investing one percent of the health budget in physical activity is significant, especially in a province like Ontario that spends half of the budget on health.
  - Incentives including tax credits can be helpful. We should tax unhealthy food and use the money to carry out initiatives.

- How can we better utilize physical education time, recess, and the before- and after-school periods?
  - Improving physical education at the elementary school level is key. The role of physical education coaches/teachers is still important.
  - In order to increase children's activity level during recess, we need to provide more supervision and organized activities. Saskatchewan *in Motion* is giving each class an activity bucket with ropes and balls, and teaching children the old games. In the Annapolis Valley, they are focusing on providing no-cost, low-organized, non-traditional (i.e. not basketball) games at recess and after school.
  - Perhaps we need to promote more un-organized activity versus organized activities?

- How much do parents influence adolescents?
  - Interviews with adolescents do not indicate that parents are an important influence. Interviews also indicate that these young people already know what they should be doing. They want school or peer-based initiatives, but they are critical of traditional physical education programs. Other obstacles relate to the gendered world, i.e. some girls don't want to participate in physical activity because they are plump, etc. In terms of sedentary lifestyles, other issues include: under-resourced schools, low-income parents, and cultural differences among new arrivals to Canada.
  - Parental influence on adolescents' physical activity is better revealed by using measures based on models of physical participation rather than self-report measures.

- We need to understand that interactions between parents and children work both ways:
    - We should avoid blaming individuals, including parents. There is important work on the interaction between parents and children, and the benefits of health activity overall. There is evidence that children may have a positive influence on their parents.

1.5 Workplace

1.5.1 Summary of *Promoting Healthy Weights in Canadian Workplaces: It won't be a Management Concern unless some things change!*, a presentation by Dr. John Yardley, Director, Workplace Health Research Unit, Brock University

Dr. Yardley began with an overview of the Workplace Health Research Laboratory (WHRL), including its organizational structure and vision and the measurement/data collection tools that WHRL has developed for use with business clients. WHRL is in the process of compiling a database that will eventually link key organizational and individual factors — including health — to productivity. Productivity is what WHRL's customers, the senior management of organizations (e.g. CEOs and CAOs), are interested in.

For health to become a long-term initiative in most corporations it must be linked through Human Resource Management (HRM), and the notion of health will have to be expanded to include a full range of meanings, including organizational health. Achieving real change involves creating healthy cultures in organizations and healthy work environments, which in turn can support individual health promotion efforts and initiatives. This comprehensive approach involves more than physical health issues (including obesity) and must be much more than small-scale health promotion initiatives, such as "lunch and learns," which are unlikely to have any sustained effects, organizationally or individually. In the first instance, the focus of an integrated HRM approach to health must target health factors with clear implications for work satisfaction and productivity, and one such factor that is growing in terms of momentum is the area of mental health. Additionally, all systems from the Senior Management down need to be engaged, otherwise the HRM programs, including health, will not receive sustained support, nor be seen as relevant.

The reality is, in the business model, CEOs and managers primarily focus on organizational outcomes or employee outcomes that impact on productivity, which translates into "services for the same or less dollars" in the public, not-for-profit sectors or "greater profitability" in profit-oriented sectors. Business leaders need a better understanding of how health affects those valued business outcomes. At this point, however, apart from rare leaders such as Dofasco, most Canadian businesses are not proactive about health, particularly at the individual level.

All of the things that make a workplace healthy — including HRM strategy, alignment and leadership; employment relationships; quality of jobs; quality of work life; health and E/FAP benefits; productivity management; occupational health and safety; and workplace

health promotion — are either linked to the way people are managed or are linked to the way people's health costs are managed, or health is promoted. But many senior managers still consider these elements as costs that either must be controlled or that need to be cut, especially in times of fiscal restraint. They are rarely viewed as "investments" in the human capital of an organization. There is a need for greater understanding of the links of those elements to productivity, profits, and performance, and that simply cutting costs in one area, e.g. drug benefits, is likely to merely shift it to another area, e.g. EAP usage, lost productivity, and higher presenteeism.

There are already many research studies that demonstrate positive clinical outcomes and the cost-effectiveness of workplace health promotion (see, for instance, Kessler's 2005 review article in the *Journal of Occupational and Environmental Medicine*). Rather than simply encouraging more research, we need to move toward better intervention designs and implement stronger workplace interventions that address multiple risk factors. For instance, we must encourage workplace-based, quasi-experimental designs (most likely using work units rather than individuals) to measure impacts of health and HRM interventions on outcomes relevant to management, e.g. changes in absences related to sickness or injury. In other words, health must become embedded within organizations' human resource management strategies, such as organizational development.

The Canadian Council on Integrated Healthcare (see www.ccih.ca) notes that employers pay almost one third of the health costs in Canada. CCIH calls for policies, such as tax incentives, to encourage and support employers in developing higher levels of workplace health and for supporting individual health promotion in the workplace. CCIH is currently planning a meeting of health policy experts and employers to be held in November 2006 to develop an agenda to move forward in this area.

Participants' Discussion

- How can we gain support for comprehensive workplace health policies?
  - Business leaders have to be engaged in order to create the strategic climate for developing Human Resource Management strategies.
  - Workplace health promotion has a much greater likelihood of gaining "traction" if senior management supports the broader notion of HRM.
  - Workplaces need to be comprehensive in their approach to workplace health.

- How would the HRM approach work in small businesses?
  - HRM is not limited to large work organizations. Small businesses can do this even without "programs." The focus is on how the small business owner relates to his or her staff and promotes healthy choices, even in small ways.

- What is the evidence base for the comprehensive approach?
  - While the vast majority of studies are based on relational data, there is strong evidence that quality of work-life factors (including management practices) combine to create positive psychosocial environment, which are moderately to strongly related to many valued business and work outcomes.

- The occupational health and safety literature provides evidence about healthy physical environments (beyond just toxic aspects of the work environment).
- Given costs related to many major changes to entire physical structures, it may be easier and less costly for companies to address health of employees, e.g. mental health through positive and engaging jobs..
- Anecdotal evidence indicates some low-cost physical changes can make a difference in work environments (e.g. a coat of fresh paint, the installation of a staff fridge).
- As in the Health Promoting Schools model, making a commitment to being health promoting involves changing both the psychosocial and physical environment. In England, schools were allowed to decide what they wanted to do to be healthier. Those schools with the highest levels of commitment and change had the highest impact on learning and social development.

PART 2: MOVING TO ACTION ON HEALTHY WEIGHTS

The second part of the workshop highlighted action underway on healthy weights across Canada. Ms. Bonnie Hostrawser, Executive Director, CDPAC, provided an update on CDPAC's work. A panel of five experts then provided overviews of action related to key environments, including: workplace, home and family environment, community and physical environment, schools, and provincial-territorial alliances. Summaries of these presentations and discussions follow. PDF versions of the presentations are available at www.cdpac.ca.

2.1 CDPAC

2.1.1 Summary of *An Update on CDPAC*, a presentation by Bonnie Hostrawser, Executive Director, Chronic Disease Prevention Alliance of Canada

Ms. Hostrawser provided an update on the Chronic Disease Prevention Alliance of Canada (CDPAC). CDPAC is an alliance of organizations that have a common focus on primary prevention of chronic diseases and health promotion. These organizations came together to form CDPAC in order to strengthen their collective voice. CDPAC builds on the earlier work of the Canadian Heart Health Initiative, the Canadian Diabetes Strategy, and the Canadian Strategy for Cancer Control, as well as on the successes that have been achieved in tobacco, nutrition and through the WHO CINDI (Country-wide Integrated Non-Communicable Disease Intervention) initiative. CDPAC seeks to reduce the burden of chronic disease in Canada by focusing on the common risk factors and determinants.

The current Canadian context for chronic disease prevention includes the new Public Health Agency of Canada (PHAC), which has just developed Public Health Networks that will focus on chronic disease prevention, injury prevention and health promotion. In October 2005, the federal government announced $300 million for an initiative on chronic disease prevention and healthy living. The current government has indicated it will honour this commitment. Several other departments have a role to play, including the Office of Nutrition Policy and Promotion and the Tobacco Control Programme within Heath Canada, as well as Infrastructure Canada, Agriculture and Agri-Food Canada, and others. Developing an integrated chronic disease system in Canada requires the involvement of many partners at all levels.

CDPAC was established in 2001. A subsequent evaluation found that CDPAC plays two key roles: 1) CDPAC is the voice of influence for system changes to reduce chronic disease and improve health; and 2) CDPAC is a synergistic and dynamic network of intersectoral partners at all levels to share information and act together.

CDPAC's 65 organizational members include many national organizations as well as provincial and territorial alliances. The Alliance is guided by a Steering Committee. There are several CDPAC Working Groups, as well as a Secretariat. CDPAC has engaged stakeholders from many different communities of practice, which encompass numerous risk factors and locations.

CDPAC's three core functions include: enhancing capacity, collaborative leadership and advocacy. Specific activities have included:

- Hosting the national conference (scheduled for November 2006, the conference will have streams on: built environments, building equity, building partnerships, building healthy policies, and building and sharing knowledge).
- Providing a web resource centre/library which will soon move to the public area of the CDPAC website.
- Leading information exchange and capacity building for PHAC's Best Practices System.
- Producing briefing papers, background papers and scans on key areas, such as system changes, regulation of advertising, etc.
- Chairing and facilitating the Network of P/T Alliances for information exchange and collaborative action.
- Co-chairing the Integrated Healthy Living Network.
- Conducting the Obesity Policy Project (see below).
- Developing a Nutrition Mobilization Plan, and
- Advocacy. Although the federal government's $300 million is a good start, we need strong investment in: an integrated chronic disease surveillance system; a best practice system; and coordination of individual strategies across the country. In the area of healthy weights, CDPAC is doing work on: regulation, advertising and marketing of food to children; built environments; and tax incentives and disincentives (Heart and Stroke has done a great deal of work in this area).

CDPAC's Steering Committee has decided to increase its focus on obesity. An Advisory Committee for the Obesity Policy Project has developed policy recommendations in this area and evaluated those recommendations using a policy evaluation framework developed by Donald Nutbeam. The policy options include: development of a surveillance system; evaluation of the health impact of policies and programs; capacity building and implementation of comprehensive approaches; and government action on regulation, legislation and policies. CDPAC has produced a background paper on regulating and marketing to children. (See also: presentation by Manuel Arango in section 2.3.1 below.)

CDPAC has conducted a national scan of government and non-governmental action on built environments, and hosted a national roundtable of federal government representatives from all departments. (See also: presentation by Steve Grundy in section 2.4.1 below).

Participants' Discussion

- Where does financial support for CDPAC come from?
    - CDPAC has a collaborative funding model, in which funding comes from the NGOs, government (and one foundation). This collaborative model is key because CDPAC's mission includes advocacy, which is crucial to the NGOs, and government resources are not used for advocacy. Government

funding is through Grants and Contributions, and there is no government commitment to the core funding of CDPAC.

2.2 Workplace

2.2.1 Summary of *Workplaces*, a presentation by Nancy Dubois, Co-chair, Coalition for Active Living

Ms. Dubois' presentation described key examples of national, provincial/territorial and local level workplace initiatives and supports. Ms. Dubois began by noting that, as illustrated in the National Quality Institute's (NQI) Comprehensive Workplace Health Promotion model (and in other models with somewhat different terminology), lifestyle and obesity prevention/treatment programs are typically addressed as part of the "voluntary health practices" aspect of the model. The overall comprehensive approach is grounded in organizational change/culture and includes occupational health and safety as the third area.

At the national level, key initiatives include the work of:

- Environmental and Workplace Health section of Health Canada, including the Workplace Health System, the annual Healthy Work and Wellness Conference (www.healthworkandwellness.com), and Healthy Workplace Week (www.healthyworkplaceweek.ca)
- National Quality Institute, including leadership, training, modeling and national workplace wellness awards (www.nqi.com)
- The Public Health Agency of Canada's Active Living at Work initiative, including research, resources and tools for practitioners (www.phac-aspc.gc.ca/pau-uap/fitness/work/index.html), and
- The Canadian Centre for Occupational Health and Safety clearinghouse, which provides this services as the Canadian Health Network's Workplace Health Affiliate.

At the provincial/territorial level, there are valuable resources and tools available from:

- BC Active Living Workplaces (www.activecommunities.bc.ca)
- Ontario's Forum for the Advancement of Healthy Workplaces
- Heart and Stroke Foundation of Nova Scotia's HealthWorks Project
- Alberta Centre for Active Living's Workplace Physical Activity Audit tool, and
- The Health Communication Unit's Comprehensive Workplace Health Project.

There are important initiatives underway in some workplaces, including:

- Industrial Accident Prevention in Ontario
- City of Vancouver Incentive Program, and
- Dofasco

Ms. Dubois closed by emphasizing the need for national leadership in policy development and knowledge exchange in this area.

Participants' Discussion

- What is the key data that should be tracked?
    - Track indicators of economic impact, i.e. absenteeism, productivity, "presenteeism."
    - Tailor data collection to the needs of individual workplaces.
    - Access to information on individual employee health status is an issue.

- Given the importance of "cultural change," are specific health programs worthwhile?
    - Promoting a cultural change is critical, but specific health programs such as Heart and Stroke Lunch and Learns can serve as a "foot in the door."

- What are the most important evaluation measures?
    - The measures that should be used will depend on the starting point, but may include: pre- and post indicators related to tobacco, nutrition or other issues; a general audit of health status and outcomes; and/or indicators of employee satisfaction.
    - The key measures relate to employee performance: presenteeism, short-term absences, short-term disabilities, long-term disabilities, and exiting.

- Do we know anything about the impact of healthy workplaces on their community?
    - There may be some work at the healthy communities level that has indicated that healthy workplaces are stronger community citizens.

2.3 Home and Family Environment

2.3.1 Summary of *Home and Family Environment*, a presentation by Manuel Arango, Co-chair of CDPAC Advocacy Working Group & Assistant Director, Heart and Stroke Foundation of Canada

Mr. Arango focused on the work of CDPAC's Obesity Policy Project. He began by noting that CDPAC's Advocacy Working Group is focusing on restricting food advertising aimed at children. The objectives are: to describe the relationship between television advertising for junk food and obesity rates among children; to identify options to address the issue; and to conduct a feasibility analysis.

In the past 24 years there has been an increase in obesity among children. The evidence shows this increase is related to screen time exposure. Half of children watch two to four hours of television per day, and most food ads focus on energy dense (high fat, high sugar) foods. Children choose advertised versus non-advertised foods. A UK review of the evidence (by Hastings) concluded that, although the relationship is not one hundred percent causal, it is close. The Kaiser Foundation found that food ads are the most likely cause, and the WHO says they are the probable cause. CDPAC's review of the evidence indicates that ads are related to children's food choices, and are strongly implicated. Since the 1970s, the number of ads has doubled and spending by advertisers has

increased significantly (from $100 million to $150 million in 2004). McDonald's spends half a billion dollars each year on advertising. About 40 percent of advertising is targeted to children. In 1998, advertisers spent approximately $10 million in Canada.

Quebec's 1980 legislation set a world precedent. Although this model has not yet been evaluated, data on soft drink consumption, fruit and vegetable consumption and obesity rates among children under 12 in Quebec suggest the legislation has had a positive effect. Sweden has a similar ban, and 32 other countries have restrictions. There is growing international momentum.

In February 2006, CDPAC held a think tank on its *public policy backgrounder* re: advertising restrictions. The think tank explored the pros and cons of five options: 1) full ban, 2) comprehensive ban, 3) partial ban, 4) corporate bans/disincentives, and 5) social marketing. A full ban on all advertising to children would be ideal, but would encompass more than just unhealthy food. As in Quebec, a comprehensive ban on TV ads is feasible, but would still allow the substitution of other types of advertising. A partial ban (only on TV food ads) could provide health benefits, but would be complicated to implement. Corporate taxation policies are less coercive, but require significant political will. Social marketing is key to a comprehensive approach, but it is expensive, and it's difficult to compete with industry advertising budgets.

There is strong public opinion support for restricting fast food advertising aimed at children. We need to invoke the precautionary principle and take action, but it will require a long-term effort!

Participants' Discussion

- How important is it to teach media literacy to children?
    - You can teach children to discriminate, but advertisers spend billions on advertising.
    - The main objectives of media literacy programs are empowerment, freedom of choice and personal responsibility.
    - Having more parental involvement in teaching children about ads is important, but it isn't the only factor.

- How should we address the fact that advertisers target parents as well as children?
    - Given that advertisers target parents as well as children, social marketing efforts need to reflect this focus.

- There are examples of recent action in British Columbia, including:
    - Voluntary withdrawals of sugar-sweetened drinks in schools (and such voluntary withdrawals are good, but they should not preclude bans).
    - The Premier is inviting Bill Clinton to help promote a healthy Olympics platform (including restricted advertising).

- What is the role of the CRTC?

- Advertising Standards of Canada uses a complaints-driven process. This type of process has inherent limitations. An amendment to the legislation may be more effective.
- We have very little data on the extent of advertising in Canada.

- How applicable is the Quebec model for the rest of Canada?
  - It's relatively easy to restrict ads on French language television, but it will not be possible to block U.S. TV ads aimed at an English-speaking audience.
  - Although Quebec is more insulated from the cross-border effect of U.S. ads, using similar types of ad bans could still have an impact in English-speaking Canada.
  - Children now watch television later at night than they used to. Although evening ads may be only indirectly aimed at children, the children are watching them.

- How can we define those foods that should be included in a partial ban?
  - Although this is not an easy task, it is do-able.
  - Heart and Stroke has defined healthy foods in its Heart Check program
  - Nutritionists have categorized food into three value levels: low, moderate and maximum
  - The UK has contemplated a colour-coded system for food.

2.4 Community and Physical Environment

2.4.1 Summary of *Built Environments: Actions required!*, a presentation by Stephen Grundy, CDPAC Advocacy Working Group & COO, Coalition for Active Living

Mr. Grundy's presentation outlined CDPAC's recent work on built environments. He began by noting that the CDPAC Steering Committee has identified the implementation of "regulations, legislation and policies that re-engineer community environments for active transportation and physical activity" as a key policy action area to solve the obesity epidemic. CDPAC's Advocacy Working Group is, therefore, supporting stakeholder efforts to improve built environments (i.e., land use patterns, transportation systems and design features) for improved health. To date, CDPAC activities have included a conference stream and a scan on built environments.

A recent research review by the Heart and Stroke Foundation of Canada found that the design of physical environments can make physical activity inconvenient, and individuals living in higher density areas tend to be more active.

CDPAC's scan (forthcoming, June 2006) provides an overview of the key findings from research compilations, as well as NGO and federal government initiatives in this area. The scan results indicate that key organizations are already providing leadership in this area, but they are not connected to each other and they are not resourced. At the governmental level, although there is an interdepartmental committee, no single federal government department has the lead. Unlike the U.S., Canada does not have a national

leadership program in place. Although some resources are available for community decision makers, they are not widely known. Research and best practice information is limited. Most policy strategies are linked to active transportation, and built environment investments are not being tracked.

The scan calls for: federal, provincial/territorial and municipal collaboration on land use, transportation and design policies; improved linkages between policy makers and expert organizations; multi-sectoral FPT forums; research in "living laboratory" communities; development of frameworks and allocation of resources to evaluate and share information about promising practices; development of indicators; and the coordination of existing surveillance data.

CDPAC leadership in this area will include hosting roundtables for key organizations, and including common policy platforms in CDPAC advocacy opportunities.

Participants' Discussion

- What's happening at the provincial/territorial level?
    - Active transportation is one of the priorities of the FPT Committee on Recreation and Physical Activity. PHAC is going to be sponsoring workshops this fall in order to bring health and non-health sector representatives together. The Advisory group includes Go for Green, Federation of Canadian Municipalities and other organizations.

- What's happening at the municipal level?
    - The "rubber hits the road" at the municipal level so it is very important to work with the Federation of Canadian Municipalities, Canadian Institute of Planners and other government networks to get politicians to focus on built environment.

2.5 Schools

2.5.1 Summary of *Working with Schools for Healthy Weights*, a presentation by Douglas McCall, Executive Director, Joint Consortium for School Health

Mr. McCall focused on current efforts to work with schools for healthy weights. He began by noting that, compared with a few years ago, there are now many different pathways that can be used to influence schools. In addition to the Joint Consortium for School Health (JCSH), which is the topic of this presentation, there are many other examples, including: the Canadian School Health Network, Canadian Public Health Association, Canadian Teachers' Association, Canadian School Health and the Canadian Council on Learning.

Schools are an important vehicle for reaching children, parents, and the significant proportion of the workforce working either in or near schools. The evidence shows that comprehensive approaches involving schools connected to communities have an impact. Evidence also shows that interventions such as Breakfast for Learning and school meal

programs, media literacy programs, lifetime-oriented physical education and skills-oriented nutrition education all have an impact.

At the provincial level, schools are embedded in the national Healthy Living Strategy, but we need to move from initiatives to strategies to programs and then to enduring policies. In addition to improving the physical education and family studies curriculums, we need to look at recess, longer lunch hours, and other areas beyond teaching time.

Nutrition and physical activity initiatives are being embedded in inter-ministry strategies on healthy living. We need, however, to link physical activity and nutrition and also mental health and other issues such as stress, boredom and work-life stress. We need to offer opportunities for dance and music as well as sports in the physical education curriculum, and we need to ensure that nutrition policy is accompanied by required elements such as nutrition education (i.e., not just the facts of the food guide).

JCSH is an intergovernmental pathway that is supported by First Ministers, Education Ministers and Health Ministers in all provinces/territories. Experts and NGOs provide input through the working groups. The focus is on changing 26 education and health systems by developing and coordinating education and health policy, and developing formal knowledge transfer mechanisms.

To improve the evidence base, JCSH is working to make surveillance and monitoring more coherent, and to develop knowledge summaries in key issue areas. Next year, the working groups will start to explore and develop practical pan-Canadian strategies for action. There have been a number of forums, and there will be a national conference on school health in Vancouver May 23-27, 2006.

Participants' Discussion

- Importance of having a comprehensive strategy:
    - Policy-only approaches are not useful in nutrition or physical activity or any other area; everything has to work together. A comprehensive strategy is required.

- Monitoring and data collection is key: would it be possible to emulate UK's approach re: taking height and weight measurements in schools?
    - We don't have the capacity for public health in the schools, never mind surveillance and monitoring. Our public health system needs more resources to invest in working in schools. Many other countries have nurses and doctors in the schools and, in the past, we used to have nurses in schools. There are cost studies on this in the areas of sexual health, tobacco and so on.
    - JCSH is working to produce a report on what data is being gathered now, and there will also be work done on what the data is being used for. Once we have that information, JCSH will look at a long-term strategy for planning surveys and producing reports.

2.6 Context for the Provincial-Territorial Alliances

2.6.1 Summary of *The Alberta Healthy Living Network and Framework: An Integrated Approach*, a presentation by Cynthia Smith, Manager, Alberta Healthy Living Network (AHLN)

Ms. Smith's presentation described the Alberta Healthy Living Network (AHLN) as one example of the many healthy living networks now in place across the country. According to CDPAC's *Making it Work* report, there are now nine formal organizations involved in this work at the provincial/territorial level.

Many champions worked together to develop the AHLN. Most were part of the Alberta Heart Health Project Dissemination Phase (1999-2005). That project studied the capacity for heart health, health promotion and chronic disease prevention at the health region level and found that there were limited resources for prevention, and limited collaboration among the regions.

In 2002, after a consensus-building workshop, stakeholders came together to form the AHLN, articulate its mission and conduct community-focused strategic planning. AHLN has a 25-member, multisectoral Coordinating Committee, and many content-based coalitions belong to the Network. The Network is linked to CDPAC, the Pan Canadian Healthy Living Strategy and the Intersectoral Healthy Living Network. In 2003, the WHO designated AHLN as a CINDI demonstration site.

To date, AHLN's work has included: a report on the Costs of Chronic Disease; network mapping to demonstrate levels of integration; support (through PHAC) for local and regional coalitions to focus on the social determinants of health and evaluation; development and promotion of best practices and common messages for physical activity and healthy eating; the development of the Alberta Healthy Living Framework; the establishment of working groups; and the development of an evaluation framework. The Alberta Healthy Communities project is modeled on the Framework and focuses on doing an intensive evaluation of the integrated collaborative approach in three Alberta communities.

Participants' Discussion

- We need to be inclusive of obese children:
    - Five percent of children are already obese. We need to plan physical activities that are inclusive of children of all sizes so we can reduce their long-term medical risks.
    - Health promotion is for the whole continuum. One of the coalitions that AHLN collaborates with is in the childhood treatment area. Those involved in primary health care are very concerned about this issue.

- We need to develop strategies for those who are hard to reach:
    - The AHLN social determinants of health project helps stakeholders use an inclusion "lens" and learn to work on these issues with other populations.

CLOSING REMARKS

In her closing remarks, Dr. Donovan noted that the workshop provided information about many different perspectives and policy options. Although there are challenges within each environment and some limitations on our current knowledge, there are also many new directions that we can pursue. It is very important to continue this dialogue, and include colleagues from outside the health sector who are interested in building healthier communities.

APPENDIX A – AGENDA

Promoting Healthy Weights Workshop

Delta St. John's Hotel
120 New Gower Street
St. John's Newfoundland

Tuesday May 9, 2006

Objectives

- Share some of the current research on the factors influencing the ability of Canadians to maintain healthy weights, including findings from the new CPHI report *"Improving the Health of Canadians: Promoting Healthy Weights,"*
- Share current CDPAC and partner action in the area of healthy weights,
- Facilitate knowledge exchange and transfer, and
- Discuss implications and explore directions for policy development related to the promotion of healthy weights.

Workshop Agenda

Morning Welcome

8:00 – 8:30 Registration and Breakfast

8:30 – 8:45 Welcome and Introductions
- Catherine Donovan: Newfoundland Wellness Coalition

Part 1 State of Research on Healthy Weights

8:45 – 9:15 Keynote Presentation on *"Improving the Health of Canadians: Promoting Healthy Weights"*
- Elizabeth Gyorfi-Dyke: Director, Canadian Population Health Initiative (CIHI-CPHI)

9:15 – 9:30 Discussion Period

9:30 – 9:45 Break

9:45 – 12:00 Research Panel Presentations
- Moderator: Catherine Donovan

- Schools:
  Donna Murnaghan: Director of Programs and Partnership, Prince Edward Island Health Research Institute (Presentation)

- Nutrition Environment:
  Lynn McIntyre: Professor, Faculty of Health Professions, Dalhousie University (Presentation)

- Home and Family Environment:
  Ian Janssen: Assistant Professor, School of Physical & Health Education, and Department of Community Health & Epidemiology, Queen's University (Presentation)

- Workplace:
  John Yardley: Director, Workplace Health Research Unit, Brock University (Presentation)

12:00 – 1:00 Lunch
- Please feel free to browse the resource and publications tables

Part 2: Moving to Action on Healthy Weights

1:00 – 1:30 An Update on CDPAC
- Bonnie Hostrawser: Executive Director, Chronic Disease Prevention Alliance of Canada (Presentation)

1:30 – 1:45 Discussion Period

1:45 – 2:00 Break

2:00 – 3:30 Action Panel Overview

- Moderator: Catherine Donovan

- Workplace:
  Nancy Dubois: Health Promotion & Planning Consultant, Coalition for Active Living (Presentation)

- Home and Family Environment:
  Manuel Arango: Co-chair of CDPAC Advocacy Working Group (Assistant Director, Heart and Stroke Foundation of Canada) (Presentation)

- Community and Physical Environment:
  Steve Grundy: Member of the CDPAC Advocacy Working Group (Chief Operating Officer, Coalition for Active Living) (Presentation)

- Schools:
  Douglas McCall: Executive Director, Joint Consortium for School Health (Presentation)

- Context for the Provincial-Territorial Alliance:
  Cynthia Smith: Manager, Alberta Healthy Living Network (P/T Alliance) (Presentation)

3:30 – 4:15 Panel Discussion

4:15 – 4:30 Closing and Workshop Evaluation
- Catherine Donovan

APPENDIX B – PARTICIPANT LIST*

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* The following is a list of selected participants who consented to be included on the participant list for the workshop.

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