

Protecting Our Gifts and Securing Our Future

First Nations Children and Obesity:
A Growing Epidemic

Prepared for:
The Assembly of First Nations

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Executive Summary

Over half of First Nations children are either overweight or obese. Rapid social and lifestyle changes are responsible for the increase in prevalence of both obesity and chronic diseases such as diabetes, cardiovascular disease and cancer in this segment of the population which represents over one third of First Nations people in Canada.

There are many determinants influencing health which make-up the social, economic and physical landscape where children live, learn and play. The *First Nations Regional Longitudinal Health Survey 2002-03* was an initiative conducted in 238 First Nations on-reserve and other communities between August 2002 and November 2003, with more than 22,000 participants involved. The survey showed clearly that the high rates of obesity are linked to physical activity and the diet that children 3-11 years of age are consuming.

Walking was the most frequently reported physical activity which boys and girls both participated in. Although over half of First Nations children are reported as eating a nutritious balanced diet, children who are never active are more likely to consume soft drinks, fast foods, baked goods and high fat snack foods. Obese children are more likely to be less active, come from lower income households and are more likely to live in larger communities. Children who are active on a daily basis and who eat a balanced diet are more likely to say that they are in excellent health.

A First Nations-specific approach to identifying effective health promotion strategies is needed. The AFN's First Nations Wholistic Policy and Planning Model provides a framework which looks at the determinants of health that are most relevant to First Nations peoples in promoting positive health outcomes.

A comprehensive community development approach is needed to address the multi-factorial nature of obesity in First Nations children. Eight recommendations for change are put forward in marking a path to health and wellness for First Nations children. To action these recommendations will require alignment of funding with population growth, aging and inflation. The AFN projects a shortfall of close to \$2 billion in federal health funding for First Nations over the next five years if these gaps are not addressed.

Protecting Our Gifts and Our Future

First Nations Children and Obesity: A Growing Epidemic

INTRODUCTION

The Assembly of First Nations

The National Indian Brotherhood was founded in 1968 and became the Assembly of First Nations (AFN) in 1982. The AFN is the national representative organization of more than 630 First Nations in Canada. Historically, First Nations have a unique and special relationship with the Crown and the people of Canada, as manifested in Treaties and other historical documents and the Canadian Constitution. This special relationship is one of negotiated agreement with a view toward peaceful coexistence based on equitable sharing of lands and resources, and ultimately on respect, recognition and enforcement of the right to govern First Nations peoples. As the national lobby organization working to support the efforts of First Nations leaders, the AFN exists to promote the “restoration and enhancement” of this relationship and to ensure that it is beneficial to First Nations, including health care for First Nations peoples in Canada.

A Profile of Aboriginal Children

As a result of colonization, the health of First Nations people has been drastically impacted by changes including:

- ◆ A movement away from traditional foods to more processed foods;
- ◆ Restrictions to hunting, fishing and gathering of foods;
- ◆ Reduced access to safe and secure food supplies;
- ◆ Poor understanding of nutrition and nutritious food choices as a result of Indian Residential School experiences; and,
- ◆ Depression, addictions and other mental health issues, also as a result of poverty and intergenerational impacts of residential schools.

These social and lifestyle changes have rapidly given rise to the appearance of chronic diseases in First Nations communities (Young TK et al, 2000). First Nations children have not been immune. Currently, half of First Nations children are either overweight (22.3%) or obese (36.2%). The

future looks bleak for First Nations peoples, as it is likely that chronic diseases such as diabetes, cardiovascular disease and cancer will be perpetuated by our children who represent 35% of the First Nations people in Canada (Canadian Institute of Health Information, 2004).

“A First Nations specific process is required to address the impact that historical factors have played and continue to play on the physical, mental, emotional and spiritual health and well being of Aboriginal people in Canada”

-- Assembly of First Nations

A Wholistic Approach to Health

The factors influencing health include a myriad of determinants which make-up the social, economic and physical environments where children live, learn and play. In 2005, federal, provincial, territorial and First Nations governments endorsed a First Nations Wholistic Health Strategy at the First Ministers Meeting on Aboriginal issues. A First Nations Wholistic Policy and Planning Model (Figure 1) has been proposed by AFN which addresses the determinants of health that are most relevant to First Nations and which emphasizes the significance of self-government in looking at potential new investments and partnerships in promoting positive health outcomes (AFN, 2005).

THE IMPACT

Defining the Issue

Body Mass Index (BMI) is a reliable method of measuring adiposity and related health risk (He M and Beynon C, 2006) but it has been difficult to compare the results of studies that differ on definitions of overweight and obesity in children. In the absence of Canadian BMIs, the Dietitians of Canada (DC), Canadian Pediatric Society, College of Family Physicians of Canada and Community Health Nurses Association of Canada (Dietitians of Canada et al, 2004) have endorsed two methods for comparing the BMI of individuals and groups, respectively:

- ◆ **Centre for Disease Control (CDC) BMI Reference Values** use five national health examination surveys in the United States from 1963-1994 in defining the cut off for "obese" (Kuczmarski RJ et al, 2000). In Canada, CDC weight categories have been altered to identify children with a BMI above the 95th percentile as obese.
- ◆ **International reference values** for obesity have been developed by Cole et al based on pooled international data for BMI using the common adult obesity cut off point of 30 kg/m² (Cole TJ et al, 2000). This reference is used by the 2002/03 RHS to define obesity in children.

Although these measures are an improvement in providing a common yardstick with which to identify children, it is important to realize that culturally-appropriate reference charts will be required to properly identify BMI reference values for Aboriginal children (Ball GDC et al, 2005).

Weighing In

Older children (9-11 years) are twice as likely (28.8% vs 13.1%) to be overweight than younger children (3-5 years) but less likely to be obese (26.4% vs 48.7%) (RHS, 2005). It appears that the pattern of obesity may be well established even in early childhood as obese children tend to become obese adults (Serdula M et al, 1993) carrying with them many of the conditions associated with adult obesity including: high blood pressure, high levels of fat and insulin, increased blood clotting, joint problems and breathing difficulties (Willows N, 2005). Psychosocial factors such as poor self-esteem, self-image, weight dissatisfaction and eating disorders have also been shown to weigh heavily on the health and well being of the obese child (Dietz WH, 1998; Story M, 1994).

The causes of obesity are multi-factorial and link to many of the determinants of health including: gender, genetic make-up, socioeconomic status, level of physical activity and nutrition. The First Nations regional Longitudinal Health Survey (RHS) is a First Nations initiative, led by First Nations, conducted with more than 22,000 participants (6, 657 of whom were children) in 238 First Nations on-reserve and other communities across Canada in identifying the factors affecting the health of First Nations children. A snapshot of what we know about childhood obesity and health and wellness from this study follows in Table 1. It is important to note that the parent/guardian reported the answers and that the children did not answer the questions.

Table 1
RHS 2002/03 Children's Survey
Select Highlights Related to Obesity and Determinants of Health

Active Living	<ul style="list-style-type: none"> ◆ Younger children (3-5 years) are more likely to participate in physical activity everyday compared to older children (9-11 years) (50.3% vs 37.3%) ◆ Walking is the most frequently reported physical activity in which First Nations boys and girls participated in (86.9%) ◆ Boys spend more time playing video games than girls (7.3h/wk vs 4.2h/wk) ◆ Older children spend more time using a computer and assisting with chores than younger children ◆ Children who participate in physical activity every day are more likely to eat a balanced and nutritious diet compared to those who are active <1x/wk (60.9% vs 45.5%) ◆ Children who are never active are more likely to consume soft drinks, fast foods, baked goods and high fat snack foods but are less likely to consume traditional foods
Nutrition	<ul style="list-style-type: none"> ◆ Over one half (55.4%) of First Nations children are eating a nutritious balanced diet ◆ Older children are more likely to consume soft drinks a few times a week than younger children (51% vs 42.4%) ◆ Children who watch fewer hours of TV are more likely to consume a nutritious balanced diet ◆ Overweight and obese children reported having similar nutritional or dietary practice patterns but were more likely to participate <1x/wk in physical activity as compared with normal weight children (7.9% and 8% vs 2.95%)

Socio-Economic	<ul style="list-style-type: none"> ◆ A majority of children (83%) live with two or more adults ◆ Median income of households with children is higher (\$27,970) than for those without children (\$19,716) ◆ Over one third of households with children are crowded ◆ Children in lower income households (<\$10K) are more likely to never participate in physical activity as compared to higher income homes (≥50K) (10% vs 4.2%) ◆ Mother's level of education, total household income or community health transfer status was not found to be related to a child's diet
Emotional Well being	<ul style="list-style-type: none"> ◆ Children active on a daily basis are more likely to have excellent health than children who are active only 1x/wk (46.2% vs 26.7%) ◆ Children engaged in physical activity 4-6x/week are less likely than those who never participate to get along well with their family ◆ Children who eat a balanced diet are more likely have their parent/guardian report they are in excellent health than those who only sometimes do (47.4% vs 32.1%) ◆ Children who eat a balanced diet are more likely to get along with their family well than those who do not (56% vs 36.3%)
Community	<ul style="list-style-type: none"> ◆ Children living in small communities (<300 people) are less likely than larger communities (≥1500 people) to be obese ◆ Children living in small communities are twice as likely to consume traditional protein-based products (44.8% vs 23.3% and traditional berries and wild vegetation (33.7% vs 17.8%) than larger communities
Education	<ul style="list-style-type: none"> ◆ Children who are obese are less likely than normal weight children to be seen as above average in their performance at school (13.5% vs 25.1%) ◆ Half of mothers and fathers had graduated from high school and half of those from post-graduate education
Early Health	<ul style="list-style-type: none"> ◆ More infants of high birth weight (>4kg) are born to First Nations mothers compared to the general Canadian population (21% vs 13.1%) ◆ Over 60% of First Nations infants are breastfed with 43.3% breastfed for >6 months. Breastfeeding is known to be related to maternal level of schooling, family income and the nature of the community which she lives in ◆ High birth weight infants are more likely to be overweight or at risk of being overweight

Culture	<ul style="list-style-type: none"> ◆ Parents who believe learning their language was very important were more likely to have children participating in traditional activities 4 or more times a week ◆ Children's understanding of their culture was dependent on whether mothers had completed post-secondary education ◆ Remote and isolated communities support learning of a First Nations language and traditional culture than non-isolated communities
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Health and Social Fiscal Imbalance

“Funding for First Nations programs has increased in recent years, but not at a rate equal to population growth. Indian and Northern Affairs Canada’s funding increased by only 1.6 percent, excluding inflation, in the five years from 1999-2004, while Canada’s Status Indian population, according to the Department, increased by 11.2 percent.”

--Auditor General of Canada 2006

Since 1997-98, the Government of Canada has maintained an arbitrary 2% cap on spending increases for core services which includes all social programming provided to First Nations communities. Similarly, in 1996-97, the Indian Health Envelope, containing all core programs of the First Nations and Inuit Health Branch (FNIHB) of Health Canada has been generally capped at 3% annually. These caps ignore basic cost drivers such as population growth, aging, and inflation. These caps also represent less than one-third of the average 6.6% increase that most Canadians will enjoy through the Canada Health and Social Transfers in each of the next five years. When adjusted for inflation and population growth over time, the total budget for INAC has decreased by 3.5% since 1999-2000. Core program budgets, such as social development and capital facilities and maintenance, have decreased by almost 13% since 1999-2000.

This health and social fiscal imbalance has resulted in a gradual impoverishment of community budgets. If communities had been funded in alignment with population growth and inflation, their budgets would be 45.5% higher than they are today. The AFN projects a shortfall of close to \$2 billion in federal health funding for First Nations over the next five years. This translates to an average gap for individual First Nations communities

of 9% in 2006/07 and 14% in 2007/08. Furthermore, despite development by the AFN of a preliminary strategy for First Nations Healthy Living in 2005, no First Nations-specific strategy or approach has been supported by the Pan-Canadian Healthy Living Strategy, which was funded at the level of \$300 million.

WHERE CHILDREN LIVE, LEARN AND PLAY

What We Know

Table 2 summarizes the significant findings of the RHS related to physical activity, nutrition and body mass according to the RHS Cultural Framework in considering the total person and total environment.

Table 2
Relationship of Key Indicators with Physical Activity, Diet and BMI

	Physical Activity	Diet	BMI
Individual Factors			
Age	3	3	3
Gender	(sports) ₃	X	X
Income	3	X	X
Health Factors			
General health status	3	3	3
Sedentary activity	X	3	X
Participation in physical activity or sports	n/a	3	3
BMI	3	X	n/a
Balanced and nutritious diet	3	n/a	X
Mental health factors			
Emotional or behavioral problems	X	X	X
Societal Factors			
Community size	X	3 (trad)	3

Comparison to other children in grade	3	X	3
Skipped a grade due to academic achievement	X	X	X
Repeated a grade	3	X	X
Societal Factors			
Interaction with family	3	3	X

Ref: RHS 2005

3 significant association

X no association

n/a not applicable

The RHS and research studies to date support the framing of childhood obesity in First Nations communities within the context of a population health approach in improving community health and well being. The determinants of obesity are complex and include a myriad of factors that could positively influence BMI including:

- ◆ Opportunities to participate in physical activity including traditional activities and walking;
- ◆ Access to safe and minimal/no cost options to enable participation in physical activities;
- ◆ Encouraging nutritious foods during a child's critical growth period;
- ◆ Minimizing exposure to food advertising and marketing that targets children;
- ◆ Improving access to a safe, secure, inexpensive and nutritious food supply, including traditional foods;
- ◆ Enhancing healthy eating and physical activity within the context of the home and family environment; and,
- ◆ Reducing socio-economic disparities and improving community support in encouraging healthy lifestyle practices.

In circumventing the rise in numbers of preschool and elementary school children at risk, the following intervention strategies have been shown to be effective in addressing some of the factors above (Connolly, 2005):

Improving physical activity levels

- ◆ School-based and community-wide physical activity campaigns;
- ◆ School-based physical education;
- ◆ Improving walkability of neighborhoods;

- ◆ Increased access to natural environments which promote physical activity;
- ◆ Prioritization of pedestrian and bike facilities, transit service and connected street networks;
- ◆ Laws and regulations to improve access to physical activity opportunities;
- ◆ Reduce costs of participating in physical activity;
- ◆ Mass media strategies;
- ◆ Fiscal policies to facilitate healthy lifestyles; and,
- ◆ Incentives for intersectoral collaboration within government.

Encouraging healthy eating

- ◆ Encouraging breast-feeding from birth to a minimum of six months;
- ◆ School-based and community-wide healthy eating programs and campaigns;
- ◆ Point of purchase prompts;
- ◆ Mass media strategies;
- ◆ Laws and regulations to improve access to safe, economical and healthy food choices;
- ◆ Reducing the costs of food to individuals;
- ◆ Regulation of advertising and promotion of foods to children;
- ◆ Fiscal policies to facilitate healthy lifestyles; and,
- ◆ Incentives for intersectoral collaboration within government.

Looking to Community Success

Four key principles were identified by the AFN's environmental scan in identifying successful First Nations-specific health promotion programming (Seto C, 2005):

1. Programs which build capacity by enhancing the abilities of an individual, organization or community to address their health issues and concerns.
2. Strategies that help to effect a change in lifestyle in moving towards optimal health:
3. Policy development to create supportive environments; and, the
4. Promotion of health through physical activity and healthy eating initiatives.

"First Nations is the best place to grow up on as it is safe and small in numbers. The community becomes educated in a good way as well as to the needs of the children."

Several examples of successful community-based First Nations health promotion initiatives were shared in the development of this report:

- ◆ Engaging youth in the gathering of fish and berries while providing the skills and knowledge needed to learn about healthy active living through traditional practices.
- ◆ Recreation and Parks Association's (Yukon Region) *Active Schools Program* is a school-based initiative that integrates daily physical activity and healthy living through curriculum linked resources, support for organized events, information and programming and access to workshops and in-services training where children learn and play.
- ◆ Early Childhood Programs are paired with community kitchens to teach young parents how to shop, prepare and cook meals as a community. Building capacity through community involvement and decision-making is a fundamental part of this activity.
- ◆ The Daily Ten Minute Activity has been incorporated into one northern school where students and staff walk or run around the track after lunch each day in role modeling healthy active living where children live, learn and play.
- ◆ A radio contest show has been used in one community to promote diabetes prevention using incentives. This is one example of utilizing community-based media to disseminate information and deliver key healthy living messages to encourage community members to change their lifestyle habits.
- ◆ Kids camps utilize a wholistic approach to lifestyle teaching that incorporate traditional teaching in promoting healthy eating and regular physical activity.

Further examples of community best practices are given in Appendix 1.

“To make changes in your health you must take ownership of it. You must be a good role model for yourself and for your family. You must participate within your nation to have your voice heard. Until you can walk that talk and only then will you be able to measure your own healing.”

– Cathryn Mandoka

Recommendations

In Canada, obesity accounted for 2.4% or \$1.8 billion of the total health care expenditures for all diseases in 1997 (Laird Birmingham C et al, 1999). Identifying effective health promotion strategies specific for First Nations children becomes important if we are to stem the rising incidence of obesity in this age group and curb the costs of human, financial and material resources.

The proposed First Nations Wholistic Policy and Planning Model provides a conceptual overview of how health promotion should be thought about in addressing obesity and how strategies could be operational zed in communities across Canada. The Guiding Principles for AFN's action plan to address obesity are taken from the First Nations Wholistic Health Strategy (AFN, 2006) that characterizes strategies as:

- ◆ First Nations driven;
- ◆ Adopting a community health approach;
- ◆ Building on successes;
- ◆ Taking a wholistic approach to healthy living;
- ◆ Seeking adequate funding to support infrastructure, programs and resources in animating the strategy; and is,
- ◆ Being inclusive of solutions around determinant of health issues specific to First Nations.

Recommendations for addressing obesity in First Nations children include:

- ◆ A community-based, wholistic approach to First Nations children's obesity prevention programming involving the meaningful engagement of First Nations governments in related federal, provincial and territorial initiatives.
- ◆ Strategies focused at multiple levels to address significant health disparities due to non-medical determinants of health including poverty and social conditions including housing.
- ◆ Working within a First Nations Wholistic Health Strategy (see Appendix 2) engage communities to leverage existing successful programming such as Head Start and Comprehensive School Health Programs to bring programming to where children live, learn and play. The Aboriginal Head Start On-Reserve Program should be expanded as a universal program with its "Nutrition" component changed to "Nutrition and Physical Activity" to reflect the important role of both factors in supporting healthy growth and development. The Program's "Health and Promotion" component should be expanded as well.
- ◆ Develop strategies to address marketing of energy-dense foods to children that do not contribute to the nutritious and balanced intake of foods.

- ◆ Establish health human resource policy to address building nutrition capacity in First Nations communities to enable the counseling, teaching, policy development, health promotion and research work needed to help communities fight disease and promote health (Aboriginal Nutrition Network, 2005).
- ◆ Strengthen First Nations-driven research in addressing the appropriate measures of First Nations children's health and in identifying effective practices to attain and maintain health and well being.
- ◆ Develop policies and programs that contribute to creating supportive school environments that promote healthy eating and physical activity using a wholistic approach which incorporates traditional practice and values.
- ◆ Resource First Nations' health initiatives to match needs and key cost drivers taking into consideration community size and location.

Evidence to date suggests that a comprehensive community development approach is needed to address the multi-factorial nature of obesity in First Nations children. Unless marked improvement in reducing the incidence of obesity is seen, the consequences will exact its toll through human, financial and material resources. Effort must be made to engage a variety of sectors and levels of government to influence the health system in focusing strategies to address the physical activity and nutrition needs of First Nations children, their families and communities in a culturally appropriate way.

"The most effective cure for childhood obesity is prevention."

-- Anonymous

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Appendices

Appendix 1: Community Success Examples

Aboriginal Head Start

(http://www.hc-sc.gc.ca/fnih-spni/famil/develop/ahsor-papa_intro_e.html)

The Aboriginal Head Start Program is a comprehensive program for First Nations, Métis and Inuit children up to 6 years of age and their families, with a primary emphasis on preschoolers, 3-5 years of age. The Program provides a half-day preschool experience that prepares young Aboriginal children for their school years by meeting their spiritual, emotional, intellectual and physical needs in six core areas: education and school readiness, Aboriginal culture and language, parental involvement, health promotion, nutrition and social support. In 2004/05, there were 365 First Nations communities that were serving children through an Aboriginal Head Start Program.

Alberta Comprehensive School Health Model

(www.reachforhealth.ca/projects/publichealth/schoolhealth.html)

A Program of Alberta Heart Health involving an innovative partnership between the Calgary Health Region and the Calgary Board of Education, the Calgary Catholic School District and the Rocky View School District. In 2005, one third of Calgary's schools had enrolled in the program which puts healthy living into the school curriculum and partners with community, children and family to build capacity. The Project has transformed into a system-wide initiative called "Learning Through Health" in which more than 90 Calgary schools now participate.

Canada Prenatal Nutrition Program

(http://www.phac-aspc.gc.ca/dca-dea/programs-mes/cpnp_main_e.html)

CPNP funds community groups to develop or enhance programs for vulnerable pregnant women. Through a community development approach, the CPNP aims to reduce the incidence of unhealthy birth weights, improve the health of both infant and mother and encourage breastfeeding. The Program enhances access to services and strengthens intersectoral collaboration to support the needs of pregnant women facing conditions of risk including food supplementation, nutrition counseling, support, education, referral and counseling on health and lifestyle issues.

Kahnawake School Diabetes Prevention Program (<http://www.ksdpp.org/index.html>)

The Kahnawake Schools Diabetes Prevention Project (KSDPP) was started in 1994 in response to the high incidence of diabetes and its complications in the community. In preventing type 2 diabetes in future generations, the KSDPP started out as a 3-year project funded by the NHRDP and was supported by Kahnawake organizations, private foundations, federal government and community funding. Guided by a Community Advisory Board, the KSDPP took a wholistic approach to preventing diabetes in communities in the development of health education curriculum for children about prevention of diabetes and its complications and in intervention activities in the community such as healthy breakfasts at school and healthy school snack policies. The Project was able to increase healthy eating and healthy lifestyle choices among children within the first few years of the initiative.

Pathways: a school-based research study for the prevention of obesity (Caballero B, 2003)

Pathways was a study involving 1704 children in 41 schools conducted over 3 years from 3rd to 5th grades in Arizona, New Mexico and South Dakota. It involved a multi-component intervention involving: changes in dietary intake; increases in physical activity; institution of a culturally-appropriate classroom curriculum focused on healthy eating and lifestyle; and, a family involvement program. Although the initiative did not effect a significant reduction in % body fat, significant reductions were observed in the percentage of energy from fat and the fat content of school menus. Knowledge, attitudes and behaviours have also been influenced by this intervention.

The Sandy Lake Health and Diabetes

(<http://www.sandylakediabetes.com/index.html>)

The SLHDP began in 1991 as a partnership between the Sandy Lake community and diabetes researchers. It is a model for community-based primary prevention programs in diabetes and incorporates the principles of participatory research. The original goals of the project were to determine the prevalence and risk factors for diabetes in the community and to develop a culturally appropriate strategy for primary and secondary prevention of diabetes and its complications. The project involves such community activities as weekly radio shows, community events, walking clubs and a school diabetes prevention program. The Program has helped to improve knowledge and psychosocial factors related to healthy eating (Saksvig BI et al, 2005)

Strategy for Nutrition and Activity Promotion (SNAP), FNIHB

SNAP was developed in response to escalating rates of obesity, diabetes and heart attack; lack of food security, poor nutritional status; and the role that physical activity and nutrition play in the overall health of FNs and Inuit communities. SNAP considers the determinants of healthy eating and physical activity across the life cycle and bases its work on existing programs and services. This Program is no longer an active initiative due to a lack of funding.

Appendix 2: Foundational Components of a First Nations Wholistic Health Strategy

<p>Key Principles:</p> <ul style="list-style-type: none"> ■ First Nations driven; ■ Adopts a community health approach; ■ Builds on best practices; ■ Takes a wholistic approach to healthy living; ■ Seeks adequate funding to support infrastructure, programs and resources in animating the strategy; and is, ■ Inclusive of solutions around determinant of health issues specific to First Nations. 	
<p><i>Building on Community Strengths</i></p> <ul style="list-style-type: none"> ■ First Nations jurisdiction founded on Treaty and Inherent Rights; ■ Success of existing programs despite limited funding available; ■ Initiatives that are community-based; and, ■ Knowledge that community members can contribute. 	<p><i>Addressing Gaps:</i></p> <ul style="list-style-type: none"> ■ Competition for limited resources; ■ Lack of inclusion of a mental health component in the Pan-Canadian Strategy and current FNIHB programs; ■ Need to develop intersectoral partnerships at the community level; ■ Lack of available, affordable foods; and, ■ Limitations imposed by current funders.
<p><i>Capitalizing on Opportunities:</i></p> <ul style="list-style-type: none"> ■ Blended health models incorporating both Traditional and Western medicine; practices; ■ Opportunity to utilize community knowledge; ■ Reciprocal accountability and transparency of governments; and, ■ Multi-year funding for national and regional First Nations organizations. 	<p><i>Need for Supportive Environments</i></p> <ul style="list-style-type: none"> ■ Competing priorities of governments, including First Nations governments; ■ Lack of capacity and respect of First Nations' data ownership and control in surveillance and research; ■ Governments' lack of recognition and respect of First Nations jurisdiction and culture.

Ref: AFN, 2006