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Chair

Mr. Rob Merrifield

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● (1530)

[*English*]

The Chair (Mr. Rob Merrifield (Yellowhead, CPC)): I call the meeting to order.

We have a very large panel in front of us. We want to thank each of you for coming in and presenting to this very important session on childhood obesity, which can lead to childhood diabetes and many other things. We have had a very interesting study up to now, and we thank you for being able to contribute to it.

We'll start with witnesses from Indian and Northern Affairs Canada, Robert Eyahpaise, and Fred Hill.

The floor is yours.

Mr. Robert Eyahpaise (Director, Social Services and Justice, Social Policy and Programs Branch, Indian and Northern Affairs Canada): Thank you, Mr. Chair.

Our department is responsible for the funding and administration of programs and services for first nations communities and its members through our various programs. As part of this responsibility we aim to ensure that the wellbeing of women, children, and families is addressed. In this respect, INAC is committed to taking concrete action in advancing the interests of aboriginal children and families and enhancing their wellbeing by providing the necessary supports to enable positive outcomes.

INAC's social policies are based on the principles of reasonable comparability and on-reserve residency-based service delivery, with the requirement to follow provincial-territorial rates and standards. INAC currently provides funding for the delivery of five programs. These include first nations child and family services, income assistance, assisted living, the family violence prevention program, and the national child benefit reinvestment program.

When it comes to the health of first nations and Inuit children, the lead is with Health Canada's First Nations and Inuit Health Branch. However, Indian and Northern Affairs Canada plays a support role through the funding of programs that impact on the social determinants of health.

The criteria and guidelines for many of our programs are set according to the relevant provincial or territorial guidelines. Where these guidelines allow, INAC's income assistance program provides financial support to the extent permitted for people requiring special diets for conditions such as diabetes or celiac disease.

We try to ensure that the health interests of first nations and Inuit children are addressed through the food mail program, also known as the northern air stage program. It pays part of the cost of shipping nutritious perishable food by air to isolated communities. Anyone, including retailers and individuals, can receive food mail if suppliers in the south have a food mail account with Canada Post. INAC funding to Canada Post helps keep the cost of shipping food down. Foods of little nutritional value, such as soft drinks and potato chips, are not funded.

About 140 communities—roughly 90,000 people—are eligible for the program. Most of these are aboriginal communities located in the three territories, Labrador, Quebec, Ontario, Manitoba, Saskatchewan, and Alberta.

The examples I have provided so far address the financial aspect of healthy eating. A prime example of a program designed to improve the quality of food is INAC's northern contaminants program. It was established in 1991 in response to concerns about human exposure to elevated levels of contaminants in wildlife species that are important to the traditional diets of northern aboriginal peoples.

Early studies indicated that there was a wide spectrum of substances—persistent organic pollutants, heavy metals, and radionuclides—many of which had no Arctic or Canadian source, but were nonetheless reaching unexpectedly high levels in the Arctic ecosystem.

The program's key objective is to work towards reducing and, where possible, eliminating contaminants in traditional country foods, while providing information that assists individuals and communities in making informed decisions about their food use.

● (1535)

INAC tries to avoid the overregulation of its programs, and this allows for the creativity of services and service deliverers to create initiatives that benefit their specific populations.

Some first nations schools have taken the lead in helping their students develop healthy lifestyles. These include, for example, Eel Ground First Nation, which was one of the first schools in New Brunswick to adopt a healthy eating program by eliminating junk foods and by providing walking programs and similar initiatives that were intended to get students active. Eel Ground was recognized provincially in the media for its work in this area.

A St. Mary's First Nation school is part of the BOOST program, in partnership with the University of New Brunswick. The program concentrates on daily activity and a healthy diet.

The Mi'kmaq Kina'matnewey, or Mi'kmaq Education Authority, is another interesting example. A sports animator position was developed by the province of Nova Scotia and works out of the MK office. The sports animator works in band-operated schools and develops and promotes healthy living programs for students. Students have designated exercise time every day, have started walking clubs, and have initiated competitions between schools for students to log the greatest number of steps on pedometers that were given to them. The MK is also working towards entering a provincial track and field event for first nations students in the summer of 2007.

Unfortunately, there are not only positive stories to share with you. For many of our programs, the need is great, and there are insufficient resources to meet the needs. For example, we have seen instances when first nations women's shelters have had limited access to appropriate supplies of food, which has incurred additional hardship for them.

Although INAC's role is not specifically to address health issues, we do attempt to make our program guidelines flexible enough to permit first nations and Inuit to address the specific needs of their communities. There are many examples of first nations and Inuit showing initiative in finding ways to help their kids lead healthy, active lives.

INAC is committed to continuing to work with Health Canada and other partners to help first nation and northern communities find ways to develop and maintain healthy lifestyles. Very often, the real solutions come at the grassroots level, and we embrace this creativity and initiative towards building healthy communities.

With that, Mr. Chair, I thank you for giving me the opportunity to make this presentation at this time.

● (1540)

The Chair: Thank you for your presentation.

We'll now move to the Assembly of First Nations. We have Chief Katherine Whitecloud, regional chief, and Valerie Gideon, senior director, Assembly of First Nations Health and Social Secretariat. The floor is yours.

Ms. Katherine Whitecloud (Regional Chief, Assembly of First Nations): Good afternoon, ladies and gentlemen, and thank you very much for the opportunity to make a presentation to you today.

I'm going to be referring to a document that was provided for you. It's called “Protecting our Gifts and Securing our Future—First Nations Childhood and Obesity: A Growing Epidemic”, and it's a slide presentation that was prepared for you today.

Thank you, Mr. Merrifield and members of the committee. We appreciate the opportunity to provide you with a briefing on the state of first nations childhood obesity and recommendations on how to secure the future of our first nations children.

My name is Katherine Whitecloud. I'm the regional chief of Manitoba, and I'm a member of the Assembly of First Nations executive committee. I am also chair of the AFN chiefs committee on health and chair of the AFN chiefs committee on education. The two are connected.

With me today is Dr. Valerie Gideon, who is the senior director of health and social at the Assembly of First Nations.

I wish to begin by expressing regrets from the national chief, Phil Fontaine, who is unable to attend today.

The Assembly of First Nations is the national political organization representing 750,000 first nations peoples in Canada, regardless of age, gender, or place of residence. The federal government has a distinct fiduciary obligation to first nations peoples, stemming from our treaties and our inherent rights. Today we will provide you with a brief overview of the childhood obesity that is affecting our first nations children. We will then conclude our presentation by offering the AFN's perspective on the solutions that are required to address this very important issue.

On slide 2, we address the legacy of colonization. First nations people have been drastically impacted by colonization and its most shameful forms, such as residential schools. The health and well-being of our people have suffered. Forced relocation from our lands has severely limited our access to traditional foods and our hunting, fishing, and gathering of these foods. High rates of poverty and residential school experiences have resulted in depression, addictions, and other mental health issues that influence nutrition and physical activity practices in our communities.

On slide 3 is the growing epidemic. There is a growing epidemic of obesity among first nations children. Currently, more than half, or 58.5%, of first nations children are either overweight or obese. Only four out of ten first nations children sometimes eat a nutritious and balanced diet.

Broken down further, younger first nations children are more likely to be obese, with older children more likely to be overweight. This finding is interesting when you consider that younger first nations children are more likely to participate daily in physical activity.

On poverty among first nations children, on slide 5, our own national first nations health survey can point to several correlations between nutrition and physical activities levels among children and indicators of poverty in their home environment, such as overcrowding.

It is critical to recognize that one out of four first nations children lives below the poverty line. Children in higher-income brackets are twice as likely to participate in physical activity. You'll know this from your own experience.

It is also clear that to improve the overall health and well-being of first nations children, we must adopt a comprehensive community development approach that reinforces the capacity of our governments to take charge of this epidemic.

On the health and social fiscal imbalance, first nations governments have not been empowered over the past decade to invest the necessary resources to meet the needs of their children in health, social, education, housing, and many other sectors. Arbitrary caps of between 2% and 3% have been imposed on community budgets for over ten years. We have estimated that these caps have resulted in a 13% decrease in those budgets, or a total loss of close to $14 billion nationally. Meanwhile, provinces and territories are receiving a 6.6% annual increase in Canada health and social transfers, which allows them to respond to inflation and population growth.

Here I'd just like to raise a quick point that although our first nations statistics are used in the Canada health and social transfers, those funds do not necessarily reach our communities or our children, for whom they are intended. It is therefore clear that there is currently in place a practice of systemic discrimination against first nations in Canada's health and social and safety net.

With these staggering statistics, a bleak future awaits first nation children. Despite being the fastest-growing population in Canada, which we all are aware of, first nations will inevitably face higher rates of chronic diseases, such as diabetes, high blood pressure, cardiovascular diseases, joint problems, breathing difficulties, and cancer, as well as social and emotional problems.

● (1545)

The effects of these health problems will place an immense strain on the Canadian health care system, not to mention causing a loss of opportunity and productivity in the Canadian economy. The Royal Commission on Aboriginal Peoples determined in 1996 that $11 billion would be lost to Canada if the status quo was perpetuated until 2016.

In developing a strategy to target the rising epidemic of first nations childhood obesity, we must consider physical activity, nutrition, and breastfeeding, as well as other non-medical determinants. Trends in current physical activity show a link with access to traditional foods, the need to invest efforts in children nine to eleven years old, and also activities that will interest and engage first nations girls. Thankfully, breastfeeding prevalence is increasing among first nations infants, but is still below the Canadian average. Lastly, nutrition trends show greater access to traditional foods in smaller communities, and this access is related to lower obesity rates found in these communities.

Ultimately, we know that obesity is caused by many factors. Therefore, understanding the contributions of physical activity and nutrition to reducing the rate of obesity among our children requires a multifactorial approach. We must consider physiological, psychological, socio-cultural, and environmental factors.

In 2005 the AFN developed a first nations holistic policy and planning model, the intent of which was to lay out a population health approach to policy development. The model, if applied to a strategy targeting first nations childhood obesity, would require the consideration of the community's effective role, based on supporting its aspirations toward self-government in supporting the child throughout its lifespan in all contributing sectors.

With what we know from current research, and based on our model, we proposed a first nations holistic health strategy, which was unanimously endorsed by all first ministers and the national chief in 2005. Key principles to consider in rollout of the strategy are as follows: ensuring first nations ownership, adopting a community health approach, building on successes, promoting healthy living, securing adequate resources and infrastructure, and addressing non-medical determinants.

Within the broader strategy, targeted interventions for childhood obesity would be required, which we have proposed in our submission. These interventions focus primarily on improving food security, minimizing exposure to harmful food advertising, and supporting the home, family, and community environments.

Beginning on slide 13, we have proposed eight main recommendations, which echo the points raised over the course of our presentation today. We first recommend that opportunities be provided to first nations to develop comprehensive plans that address the health disparities they are currently facing, which have been caused by cycles of poverty and shameful social conditions. For this to be achieved, communities must be resourced to match needs and key cost drivers, taking into consideration community size and location. The fiscal imbalance, which is a true social injustice, must be urgently remedied. Existing programs such as aboriginal head start and another new one, maternal child health, which has been accepted by our communities, could then be leveraged and expanded. Despite the success of the maternal child health program, it is still not universally accessible to first nations communities.

Strategies need to be developed by first nations to address marketing to children of energy-dense foods that do not contribute to a nutritious and balanced intake of foods. A health human resource policy must be established to build nutrition capacity in first nations communities.

First-nations-driven research must be strengthened to identify appropriate measures of first nations children's health and to identify effective practices to attain and maintain health and well-being. Continued and increased funding of the first nations regional health survey is essential to monitor progress. Lastly, school environments must be targeted to implement healthy living practices that incorporate traditional approaches.

To conclude, evidence to date suggests that a comprehensive community development approach is needed to address the multi-factorial nature of obesity among our children. Failure to act will exact its toll on human, financial, and material resources. We urge the committee to consider these recommendations, which can best be achieved through collaboration between first nations and the federal government.

Thank you very much.

[*Witness speaks in her native language*]

● (1550)

The Chair: Thank you very much for a very interesting presentation. I appreciate your contribution.

We now have the National Aboriginal Health Organization. Mark Buell and Carole Lafontaine, the floor is yours.

Ms. Carole Lafontaine (Acting Chief Executive Officer, National Aboriginal Health Organization): Thank you, Mr. Chair.

Good afternoon, ladies and gentlemen. Thank you for the opportunity to appear before this committee today on behalf of the National Aboriginal Health Organization.

My name is Carole Lafontaine. I'm the acting chief executive director at NAHO. I'm also a member of the Métis Nation of Ontario. I am joined today by Mark Buell, our manager of policy and communications at NAHO.

We are pleased to join you today and share our knowledge on obesity in first nations and Inuit children. While NAHO recognizes that there are multiple contributing factors that lead to a high rate of obesity in aboriginal communities in Canada, we would like to focus our brief presentation on income and the cost of foods that shift away from a traditional diet, and the lack of opportunity for physical activities in many aboriginal communities. We would also like to recognize that obesity is a problem faced by all aboriginal people, including the urban population.

The importance of obtaining and analyzing aboriginal-specific data cannot be overstated. Appropriate data assist organizations and government to design and deliver programs that are responsive to the unique needs of target populations. Public policy formulations and fiscal allocations can be better informed by specific data that determine the scope and relevance of disease in first nations, Inuit, and Métis communities, and their needs.

The lower health and socio-economic status of aboriginal peoples in Canada is well known. The link between these factors and obesity is also well documented, so I will not be addressing this in detail today. The fact that the aboriginal population in Canada is younger and growing faster than the general Canadian population points to the urgency of addressing factors that contribute to a socio-economic and health disparity faced by first nations, Inuit, and Métis in Canada, but it also presents us with an opportunity for early intervention.

Clearly, the epidemic of obesity is more severe in aboriginal populations. Knowing that obesity is a problem brings us to the question: Why?

I would like to raise three points: income and the cost of food, the shift from traditional diet, and the transition from a physically active lifestyle to one that is more sedentary and spent indoors.

Income affects the ability to obtain nutritionally adequate and safe foods. Food costs remain higher in the north than in the south. This is of particular significance to first nations and Inuit, as many aboriginals live in the north and in remote communities.

Food-basket studies indicate that northerners pay far more than southerners for the same basket of food. For one week, for a family of four, the northern food basket in Kugaaruk, Nunavut, costs $327—double that of Edmonton. Given this fact, many families have insufficient income to cover the cost of a healthy diet and other necessary family costs. In the same study, in Kugaaruk, five out of six Inuit households were classified as being food-insecure. Over half of the households studied had experienced hunger in the previous year. According to a Thunder Bay health unit, the cost of local nutritious food baskets has risen by 19% since 1998. During the same time, minimum wage has only risen 13% and social assistance rates have seen net cuts.

● (1555)

Indigenous people in North America have experienced a rapid change in diet and lifestyle. Aboriginal youth and adults today have diets that are drastically different from that of their parents and grandparents. They choose higher levels of junk foods and decreased amounts of nutritious country food. When traditional food is lost but high-energy market food is substituted, the basis for developing obesity exists. This is coincident with additional circumstances of changing activity patterns and possible genetic predispositions.

Aboriginal people are adopting a diet high in saturated fat, sugar, and refined foods, and low in fibre, often termed the “western diet”. High costs associated with harvesting increasingly limit the ability of many first nations, Métis, and Inuit harvesters to continue their activities. The Nunavut harvesters support program estimates that it costs more than $200 in operating costs to conduct a weekend hunt. Unfortunately, this amount is too high for many families dependent on social assistance, and the inability to access country food forces them to continue their dependence upon store-bought and processed foods.

Next, I would like to discuss the transition from a physically active lifestyle to one that is more sedentary and spent indoors. This goes hand in hand with the transition in diet. There is less time spent hunting, trapping, and fishing, and that means less time being physically active. Also, a lack of community capacity to organize recreational programs and a lack of facilities means that for many children and youth, physical activity is very limited. This is particularly true in small and remote communities.

Much more research is needed on the factors that influence physical activity patterns of aboriginal children and youth. For example, there may be social and cultural values related to physical activity that should guide the development of policies, programs, and services. Empowerment is a social action process that promotes participation of people, organizations, and communities towards the goal of increased individual and community control, political efficacy, improved quality for community life, and social justice.

Health and social science research substantiates the role of powerlessness as a risk factor for disease and the control of empowerment as a health-enhancing strategy. In practice, this means that future initiatives must be driven by community participation.

The need for and impact of literacy skills cuts across all these determinants of health. The better a person's literacy skills, the more likely they are to have better education, housing, income, mental health, and so on—therefore, better health. The practice of educating parents and families about good nutrition needs to be augmented with programs that teach parents and caregivers the skills to prepare and plan nutritious meals. Investments here have proven effective in relation to nutritional improvement in families.

Additional upstream investment and expansions of maternal and child health programs could have a significant impact on child and youth health outcomes relating to obesity.

I thank you for your time and would like to refer you to our submission, where we highlight a number of recommendations for policies, programs, and service, as well as research.

Thank you again.

● (1600)

The Chair: Thank you very much for your presentation. We certainly appreciate it.

Now we'll move to the University of Alberta. We have with us Dr. Noreen Willows. We'll ask, Doctor, if you would take the floor.

Dr. Noreen Willows (Assistant Professor, Department of Agricultural, Food and Nutritional Science, University of Alberta): Thank you for inviting me to speak today.

I speak to you today as a nutritionist who does community-based research in first nations communities. My focus is maternal and child health. Today I will review the evidence for obesity in children in aboriginal populations, the gaps in knowledge about obesity, the requirements for continued research, and the need for aboriginal self-government in areas such as health.

It is clear that first nations children have a high prevalence of obesity. The first nations regional longitudinal health survey showed that 26% of children aged nine to eleven were obese. However, the study did not include children from all provinces or territories, and children's heights and weights were not measured but were reported by parents, so the prevalence of obesity may in fact have been underestimated.

Results from the Canadian community health survey showed that aboriginal children living off reserve had an obesity rate of 20%, which was two and a half times the national average for children, which was 8%. In the Arctic, research has found that 19% of Dene, Métis, and Yukon first nations children aged 10 to 12 were obese. High rates of obesity have also been reported for the Oji-Cree in northern Ontario and Mohawk children from Kahnawake in Quebec.

I have been very privileged to have done community-based research with the James Bay Cree in northern Quebec since 1997. The Cree live in nine communities: five are remote, located near James Bay and Hudson's Bay; one remote inland community; and three rural inland communities.

One community-based study I did showed that preschool children in James Bay as young as two years of age were obese. So this is a problem that begins very early in life. There cannot be delays in intervention strategies until children are older.

I've just completed a school-based study to understand the prevalence of obesity and the associated risk factors in Cree children in two communities. One community was rural; the other community was remote. A local steering committee called the study “the active kids project”, and named it in Cree. Over 200 children aged 10 to 12 years participated, with a participation rate in excess of 80%. One-third of children were obese in that study.

The study also found that the majority of children had abdominal obesity. This observation supports other research studies that obesity in aboriginal peoples is predominantly of the abdominal or upper body type—that is, fat patterning around the waist and the upper body, rather than on the thighs or the lower body. This type of upper body fat patterning places obese individuals and children at additional risk for metabolic syndrome—a constellation of factors such as high blood pressure, high triglycerides, and high levels of bad cholesterol—which increases risk of coronary heart disease, stroke, and type 2 diabetes.

The study also found that liquid calories comprised a major portion of children's energy intake: 9% of calories were from sweetened drinks such as pop, fruit punch, powdered drinks, and sport drinks. Snack foods such as potato chips were the major contributor to fat in the diet. In fact, children would reduce their fat intake by 20% if they did not eat snack foods or poutine. Many children ate restaurant or take-out meals.

It was encouraging to find that children ate traditional foods such as moose, goose, rabbit, duck, beaver, partridge, and whitefish. It is interesting to note that although children did not eat much traditional food, it made a very important contribution to children's diets. For example, children consuming traditional food had higher intakes of both iron and zinc.

We found that children had low levels of fitness and were not active enough for good health. In particular, girls were inactive.

● (1605)

More importantly, we found that children were not happy with the way they looked. Almost three-quarters of children wanted a smaller body size than their own; whereas almost half of children with normal weight wanted to be smaller, 100% of obese children desired a smaller body size. In addition, one quarter of normal-weight children, compared to almost three-quarters of obese children, did not like the way they looked.

It is clear from these results that many children were not happy with the way they looked and that obese children were most likely to prefer a smaller body size and be dissatisfied with their appearance.

This study that I presented to you on James Bay and other studies on first nations children indicate a high prevalence of obesity. We should be very concerned with these findings.

Obese first nations children are at a potentially increased risk for type-2 diabetes, particularly because they have abdominal obesity. We must also be aware that obese children may have mental health issues, such as depression, low self-esteem, and low self-worth. They probably pick up these ideas from mainstream society, media, and TV.

As a researcher, these are the gaps that I perceive in knowledge about obesity in aboriginal children. First nations and Inuit children have seldom been the focus of health research. Knowledge of rates of obesity in children is restricted to a few intensively studied communities. We have limited data about Inuit children.

Baseline data and trend data are essential to monitor and evaluate the effectiveness of programs designed to decrease obesity rates. Studies of obesity cannot be restricted to documenting dietary intake and activity levels of children.

We have limited information about community factors contributing to obesity. If communities in which aboriginal children live cause obesity, then understanding, measuring, and altering the environment is critical to reduce the rates of obesity. The environment is not only the physical environment, such as the layout of communities, but it's also the environment of economic and social organization and cultural values.

Given the need for high-quality obesity research, I recommend that the government ensure continued financial support for initiatives such as the aboriginal diabetes initiative, the Canadian Institutes of Health Research, and the Institute of Aboriginal Peoples' Health.

It is obvious that prevention strategies are required. Because the increasing prevalence of obesity is due to rapid social and cultural changes, obesity prevention cannot be focused solely on the individual. All children must be able to maintain a healthy body weight through physical activity and a healthy diet in the presence of a supportive environment.

For this reason, community-based interventions are required. Active living and affordable healthy foods must be made available and promoted at multiple levels, such as the family, child care centres, aboriginal head start, schools, and after-school programs. Healthy foods must be made the most economical choice.

Mr. Fred Hill will be speaking today about the food mail program. Is that correct?

Mr. Fred Hill (Manager, Northern Food Security, Northern Affairs Program, Indian and Northern Affairs Canada): I'm here to answer questions.

Dr. Noreen Willows: Okay, I'm sorry.

I would suggest that the postal subsidy for the food mail program be increased and that a nutritious food subsidy program also be offered to communities that have road access. The food mail program is currently only offered to communities that do not have year-round road access.

It is clear that traditional foods are important for nutrition and well-being. The harvesting of traditional foods also results in improved physical fitness. The environments that support traditional food species must therefore be protected. Carole Lafontaine has discussed other impediments to traditional food consumption today.

Research has shown that breastfeeding may offer aboriginal and other children protection from obesity and diabetes. First nations rates of breastfeeding are low. Breastfeeding must be promoted. The Canada prenatal nutrition program of FNIHB promotes breastfeeding in Inuit and on-reserve first nation communities. The government should ensure continued funding of this program.

Prenatal care for women must be emphasized. The data suggests that many first nations women begin pregnancy obese, gain excessive weight in pregnancy, and have high rates of diabetes in pregnancy called gestational diabetes mellitus. These conditions predispose unborn children to obesity and metabolic disorders such as diabetes later in life. Community environments must support adequate nutrition and activity so that young women of reproductive age can maintain healthy body weights. The focus cannot just be on children.

Jurisdictional gaps and overlaps in health care delivery need to be resolved.

I partner with the Cree Board of Health and Social Services of James Bay in all my research projects. I informed members of the board that I would make recommendations today about the federal government's roles and responsibilities in relation to childhood obesity in first nations communities. The perspective of board members was that the federal government should support aboriginal self-government in areas such as health.

The James Bay Cree of northern Quebec were the first on-reserve nation to have self-government and health care, following the James Bay agreement of 1975. Since that time, the James Bay Cree have been part of the provincial health system as a semi-autonomous health region of Quebec, with access to all new federal aboriginal program dollars. They were underfunded for decades. Since the settling of their outstanding treaty issues that established proper financing for their health services, the Cree are now implementing the most comprehensive system of services in the remote north, including a completely integrated public health system.

As is now happening in this region, self-government, with appropriate levels of financing, opens the possibility for northern regions to begin to work on improving the factors that determine the health of the population: social, economic, and environmental, including decreasing obesity prevalence in children.

Thank you for your time.

I will be submitting briefing notes, which add some additional information to what was presented today.

● (1610)

The Chair: Thank you very much.

We will move on to the Kahnawake Schools Diabetes Prevention Project. We have Sheila Wari Whitebean and Margaret Cargo and Treena Delormier.

The floor is yours.

Ms. Treena Delormier (Member, Community Advisory Board, Kahnawake Schools Diabetes Prevention Project): Thank you, Mr. Chair.

I am Treena Delormier from the Kanien'kéha:ka, the Mohawk Nation of Kahnawake. I'm also an academic trainee with the Kahnawake schools diabetes prevention program, pursuing a doctoral degree in public health, health promotion, at Université de Montréal.

I would like to thank you on behalf of the Kahnawake schools diabetes prevention project community advisory board. It's a group of community members who guide the research and intervention aspects of the project, of which I am an active member as well.

I will be sharing my presentation time with my colleague, Dr. Margaret Cargo.

The idea for the diabetes prevention project in Kahnawake was sparked after a presentation that was made to community members concerning the results of a research project that was done in the community. The research results documented high prevalence rates of type-2 diabetes in Kahnawake. Community members who had heard this presentation reacted by asking for something to be done to prevent diabetes.

That reaction was news to the two family physicians—Dr. Ann Macaulay, and the late Dr. Louis T. Montour—who had conducted the prevalence study. They were interested in pursuing research into complications. Needless to say, their efforts changed course on account of the community reaction to the information, and they pursued the idea of diabetes prevention.

This shows the power of sharing locally relevant and meaningful health information with the community. We see that the community was allowed to express their needs on a health issue, and it also sparked community mobilization for health toward diabetes prevention.

About eight years after that, the Kahnawake schools diabetes prevention project officially began when they received funding from a special initiative to address aboriginal diabetes through the national health research development program.

The intervention program focuses on primary school children in the community of Kahnawake. In the schools there is a health curriculum that addresses different aspects of health but focuses on nutrition, physical activity, and diabetes prevention from kindergarten to grade six. There is also a nutrition policy that has been adopted by the whole education system in Kahnawake. It promotes healthy food and bans junk food in the schools. As well as these interventions in the school, KSDPP staff do a number of additional activities with the schools throughout the school year.

The intervention activities also extend into the community. The activities are designed for families, organizations within the organization, and the community at large. The objectives of all these initiatives—community- and school-based—are to promote healthy eating and physical activity, and take a positive attitude and approach toward diabetes prevention.

Margaret is going to talk about some of the results of the evaluation of this intervention program that I just described.

● (1615)

Dr. Margaret Cargo (Researcher, Psychosocial Research Division, Douglas Hospital Research Centre, Kahnawake Schools Diabetes Prevention Project): Thanks, Treena.

I'm Margaret Cargo, I'm a researcher with the Douglas Hospital Research Centre, which is affiliated with McGill University. I'm just going to pick up where Treena left off.

The effectiveness of KSDPP intervention was evaluated in two ways: an impact evaluation assessed the short-term effects of the intervention and an outcome evaluation assessed the long-term effects. The impact evaluation assessed behaviour change in two specific areas, physical activity and dietary practices. We compared the health practices of elementary school children in 2004 to children in baseline in 1994. We found no change in children's physical activity levels. However, we did see a reduction in television watching during school days, which was good. We also saw an overall decrease in the consumption of soda, chips, and french fries and increased consumption of low-fat milk and whole-wheat bread.

However, these modest changes in behaviour did not translate to changes in anthropometric outcomes, which are measures of body composition. So despite the intervention efforts in the community that were ongoing for about ten years, mean body mass indexes changed from 1994 to 2004. Mean subscapular skinfold thicknesses also increased. In addition, the prevalence of those who were overweight and obese increased from 31% in 1994 to 47% in 2004.

I want to put the findings of the KSDPP intervention in context, in that they are consistent with the majority of other evaluated interventions in childhood obesity prevention. Most studies result in modest changes in behaviour, but these changes in behaviour aren't sufficient to lead to changes in body composition. This was the basic finding of the most recent scientific review by the Cochrane Collaboration. That review included 22 studies, and only four studies had a positive effect on body composition, although the majority of those studies were successful in changing behaviour. One of the best-evaluated interventions was Pathways; it was implemented in several North American Indian communities in the United States, and their results were very similar to KSDPP.

We've learned a number of lessons from the KSDPP experience, and we'll share four of these lessons with you today. I'll talk about two, then Treena will talk about the other two.

The first lesson is that our most recent results suggest approximately half the children entering grade one are already overweight or obese. That suggests we need to refocus our intervention efforts on preschoolers, infants, families, and even pregnant moms, and that waiting until grade one may be too late. There's a parallel here to the smoking prevention interventions of the 1980s.

Also, if you want to see positive outcomes in healthy body weight, we need to consider the contextual factors influencing front-line workers who carry the responsibility for implementing a primary prevention mandate. Through a CIHR-funded study, we have interviewed over 35 front-line workers in aboriginal communities, first nations, Inuit, and even some Métis communities who have come to Kahnawake to receive training in the KSDPP model.

Many of these workers returned to their communities with the best of intentions, but they don't have enough time in their job to do the work. There are competing health issues, mental health issues in the community, and they don't have support within their organization, or even the political leadership, so it's very difficult for them to prevent childhood obesity or to implement their mandate.

We're short-sighted if we're looking at the outcome without looking at supporting the front-line workers and situating diabetes prevention, obesity prevention, in the context of competing community issues and putting conditions in place within their organizations to allow them to do their work.

Thank you.

● (1620)

Ms. Treena Delormier: I want to share what we learned about research findings. The research findings and data information that are relevant to the community and are meaningfully presented have potential for mobilizing communities toward action, particularly when these actions promote healthier children and when they are geared toward promoting healthier future generations. I think this was evident in our community responding with prevention objectives when they were asked to react to prevalence data.

Also, the continuous process of presenting research back to our community advisory board has fed back into what interventions we do, so the project is actually meaningfully owned by our community. There's a continued community commitment to do diabetes prevention. KSDP is continuing in spite of the information. It is this information that Margaret just presented that is stimulating further work and efforts toward diabetes prevention.

The last lesson would be that we need to continue diabetes prevention efforts in new ways that are mutually supportive to other community health efforts. We also need to work on community-level policies—that's something we learned as well—so that we're able to sustain these activities in the community, in addition to a diabetes prevention project.

If we're talking about policies in the community, we also need to think about policies at a broader level, policies at the national level, that promote healthy eating and physical activity for children and that promote environments to promote healthy eating and physical activity for all children in Canada. This would greatly support our community efforts, since our communities are not disconnected from the broader influence of society that impacts communities locally, including our aboriginal communities.

Nia:wen kowa.

Thank you.

The Chair: Thank you very much for explaining that study to us. I'm sure we'll have many questions for you on that.

We have one further individual. Kristy Sheppard is here. She is the representative of the National Inuit Committee on Health, from the ITK.

Thank you. The floor is yours.

Ms. Kristy Sheppard (Representative of the National Inuit Committee on Health, Inuit Tapiriit Kanatami): Thank you.

Thank you for the opportunity to speak here today on Inuit concerns regarding childhood obesity.

I will provide a brief background on Inuit Tapiriit Kanatami. ITK is the national Inuit organization in Canada representing Inuit from the four Inuit regions: Nunatsiavut, Labrador; Nunavik, northern Quebec; Nunavut; and the Inuvialuit settlement region in the Northwest Territories. ITK is primarily an advocacy organization to ensure Inuit rights and interests are protected and promoted.

ITK receives direction from the National Inuit Committee on Health, also termed NICOH, which provides technical guidance and recommendations related to national Inuit health, care review, reform, and policy development on health issues to the ITK board of directors. The committee ensures that Inuit land claim regions and the National Inuit Youth Council are informed and are in a position to make informed decisions on behalf of their members.

As a representative of NICOH, I would like to discuss the issue of childhood obesity in Inuit communities. Inuit childhood obesity is affected by many factors and determinants of health. Although there is a lack of Inuit-specific data, we do have anecdotal evidence indicating that childhood obesity is becoming an issue in Inuit communities. These contributions are exacerbated by the rapid change in the way of life brought on by colonization. An increase in sedentary activities combined with an increase in the amount of unhealthy junk food eaten by children and youth lead to devastating effects.

It is felt that children and youth are becoming addicted to pop. Junk foods are predominately displayed at stores and are readily accessible, in comparison to country foods. Generally, junk food is cheaper to buy with allowance money than fresh fruit, which is why children are purchasing so much. Often you can buy pop cheaper than milk. Statistically, in Iqaluit you can purchase a can of pop for $2 and a personal-sized carton of milk for $3.25 with tax. It must also be remembered that half the population of Inuit is under the age of 20. With such a large youth population who are becoming increasingly dependent on junk food, you can see the seriousness of it.

In relation to data, it is difficult to provide evidence for the extent of childhood obesity among Inuit children. Although many surveys provide data for all Canadian children, they do not provide data for Inuit children specifically. Most government surveys are not designed to provide data for Inuit regions. Both the biomass index and the waist-to-hip ratio are questionable, as there are uncertainties about whether national indicators accurately reflect Inuit stature. Inuit babies generally have higher birth weights, so this also may not be a relevant health indicator for Inuit.

We know the rate of obesity is affected by other determinants of health, which I would like to take this opportunity to touch on. To begin with, there is the issue of poverty. Median incomes for Inuit are much lower than those of non-Inuit. In 2001 the median income for Inuit was $13,637, in comparison to $22,136 for non-Inuit. This gap has widened significantly when you consider how much the cost of living in the north actually is.

Unemployment is three times higher for Inuit than non-Inuit and wages are lower than for non-Inuit. Families often end up purchasing the cheaper foods, which are higher in carbohydrates and low in protein, rather than fresh fruits and vegetables. They essentially get more worth for their money if they purchase the high-carbohydrate foods.

More frequently, both parents in Inuit households are working, which means that children are often responsible for preparing their own meals, and kids don't often make the healthiest choices. Junk foods are accepted in Inuit communities. An example would be in Hopedale, Nunatsiavut. They ran out of potato chips so they sent a plane to Nain, Nunatsiavut, to restock. One flight comes in every week for fresh vegetables, but not another one is sent out to get more. You can see the demand there is for potato chips and not fresh foods.

This feeds into the issue of food insecurity. The risks of dietary transition that include more market food and less traditional and country food are recognized to include risks of greater obesity and susceptibility to chronic diseases. The high cost associated with hunting means the traditional country food is also becoming more expensive. With lower incomes, you obviously can't purchase boats and skidoos, and the gas prices in the north are ridiculous.

● (1625)

The food security of Inuit is also affected by other factors, including climate change and contaminants. Climate change can cause changes in the availability of food plants and in migration patterns and breeding of animals that are often hunted in those regions. Regarding contaminants, there is decreased confidence in the safety of traditional and country foods due to the high contaminant level in many animals. In Nunavik, people spend up to 40% of their income on food. Over half the population, 56%, report food insecurity in Nunavut.

With regard to legislation, although country food has been shown to be healthier, day cares and schools in some Inuit regions cannot provide it to children. For example, in Nunatsiavut, food regulations won't allow them to put the food in the day cares as it's not been tested appropriately.

In many regions you are not allowed to sell country food, and there are also barriers to sharing food between Arctic regions. In regions where you can sell country food, there are some promising practices. In Nunavik the day cares are planning to provide 85% of the required nutrients per day, with 30% to 40% being filled by country food.

Through the Canada prenatal nutrition program, in some regions char and caribou are provided to pregnant women. This is done in Nunavik.

Regarding the topic of schools and recreation facilities, there is less time allocated to physical activity in schools, but in most northern communities there's also a lack of recreation facilities and activities outside of the school. Due to rising costs, many children do not have the opportunity to take part in traditional activities such as hunting and fishing, which have, in the past, kept Inuit healthy and active.

Considering the reality of high unemployment rates, low standards and high costs of living, and low wages, simply providing a tax credit to all Canadians will serve to increase the gap that already exists between Inuit and mainstream Canada. With obstacles such as funding, human resources, infrastructure, remoteness, elevated prices, etc., not being addressed, the children's fitness tax credit will not be an effective tool for increasing the physical fitness of Inuit children.

Underlying all of these issues is a need to continue to increase the human resources capacity of Inuit in these areas. We are in high need of recreation coordinators, dieticians, nutritionists, etc.

To conclude, these are the recommendations put forth by NICOH on the issues of childhood obesity in Inuit communities.

There is a need to develop baseline data for childhood obesity among Inuit and a need to develop an appropriate measure that works for all Inuit to fill the gaps. There is a need for Inuit engagement in program design and delivery in a continuum of services, which could decrease the effect of obesity on Inuit children.

These services must be a part of not only the health system, but must also reflect the changes needed in educational, economic, and environmental systems. This also means reviewing and providing Inuit input into proposed legislation and tax reforms, to ensure that the outcome that is expected does not negatively impact Inuit, but rather, ideally, positively impacts them.

There needs to be a review of the effectiveness and sustainability of existing programs and services aimed at childhood obesity.

Thank you.

We will also follow with briefing notes.

I appreciate the opportunity to provide the Inuit perspective here today.

● (1630)

The Chair: Thank you very much, and thank you to all your panel for your presentations.

I just want to make mention to the committee, as well, that we have a representative from the Department of Health, Kathy Langlois. Thank you for coming back and being prepared to answer any of the questions that we might pose as we get into the question and answer period.

We'll move right to that. We will start with Mr. Merasty.

The floor is yours. You have ten minutes, I believe.

Mr. Gary Merasty (Desnethé—Missinippi—Churchill River, Lib.): Thank you.

Let me first thank each and every one of you for great presentations.

I'll try to go very quickly here, but three things immediately jumped out at me. One, there seems to be a very clear public policy conflict emerging; I'll explain that right away. Two, the lack of longitudinal research and how that has an impact on the community seems to come out as well. And three, that investment is needed now.

My first question is related to this demographic conflict. We know that a statement was made—I'm aware of this from past experience as well—that Canadian federal government departments try to fund aboriginal, first nations, Métis, and Inuit programs on the basis of reasonable comparability. Looking at that for a second, when we have the general public aging in Canada, going in one direction—the baby boomers are aging—and we have a very young aboriginal population coming up, public policy overall seems to focus on what Canada's greatest needs may be from a public policy health perspective. This is something I see every day. So when you have reasonable comparability as a guiding principle, we're going to have a conflict. I think we've seen some of this.

As my first question, do you feel that what I'm saying is fair, or maybe not fair? If some of the programs maybe don't fit some of the aboriginal communities' needs, what may they be?

My second question is with respect to what the AFN talked about. One of the things that RCAP, mentioned in your presentation, and then the Kelowna accord talked about is significant upfront investment, and that the payback to the aboriginal communities, to the government, to the people of Canada is quite significant even by the year 2016. You gave a specific example.

Within that, what do you think the cost of doing nothing, or the cost of not doing enough, will be in five years, in ten years, in fifteen years? I know that's a heavy question, but this jumped out at me fairly quickly.

I have a third question; I'm trying to spread it around here.

I liked your comment on the research you did in this corner. One of the things I've realized from my past experience is that when you share with the community the outcomes of some research, they really take hold of it. It empowers them. Being that there's a lack of R and D out there that actually comes from the community, this lack of empowerment means maybe less mobilization to respond to some of our issues.

Do you feel that more research and development is required, especially longitudinal studies on aboriginal communities—in this forum, of course, health? And how best do you think we could do that to empower the community as we go forward?

My final question concerns the food mail program. Just quickly, if the food mail program were improved and we got food in cheaper, how would we change the diet pattern in the community?

I'm done; anyone can answer.

● (1635)

The Chair: So we'll open it up to the panel. Anyone can take the first swing at that.

Go ahead, Katherine.

Ms. Katherine Whitecloud: Thank you very much for those questions.

I'd like to specifically respond to the questions you posed regarding our presentation, the significant upfront investment that is required, has been identified, and is pretty much known to everybody, and how the payback would be significant for Canadian society in general if you do something about it now versus waiting five, ten, or fifteen years. The costs of doing nothing are as follows.

Right now, from 1999 to 2004, over a five-year period, INAC funding increased by only 1.6%, excluding inflation, while the status first nations population, according to the department, increased by 11.2%

Since 2000 budgets have been impoverished by almost 13%. Had a 6% rate of growth been applied to account for inflation and population growth, equal to what has been granted to the Canada health and social transfer, the cumulative new dollars received over the ten-year period would have been $14,584,000,000, if the funds had been provided in the same way they're provided to the Canada health and social transfer. The amount of lost funds, the difference between the 2% rate received and the need, which is 6%, is over $10 billion.

“Gathering Strength”, the federal government's response to the Royal Commission on Aboriginal Peoples, has only provided $2,379,000,000, leaving a shortfall of $7,914,000,000.

For individual communities, the magnitude of lost funds in the 2006-2007 budget is 45.5% over existing funds and ranges from $1.5 million to $13.9 million per community.

That is the impact of the lack of funding provided to our communities, and it is only the actual costs right now. You also have to factor into that the cost of having people who are diabetic and the cost of people being in medical institutions because of the lack of health that we're seeing in our communities. All the other long-term effects will triple or quadruple that in the next five, ten, and fifteen years.

The Chair: Okay. Is there anyone else?

Ms. Treena Delormier: I'll speak to the third question, about research. Your question was on whether we felt more research and development are needed.

I think that yes, the question is easily answered. For certain populations, as was mentioned, a lot of baseline data doesn't even exist. How do we do that?

I think one of the reasons the data was so meaningful and people really took action was because the information was created in a partnership. The KSDPP continues to follow that model.

The community works with researchers in a participatory model where we share responsibilities around research, and we also make sure the information is useful and relevant to the community. Having the community continuously involved ensures that. It's that type of mechanism or model, where there's a partnership between the research expertise and the community, that makes the knowledge more relevant.

We currently have the Institute of Aboriginal Peoples' Health investing in research infrastructure and building capacity for researchers. We will have more aboriginal researchers and more researchers who are sensitive to the need for aboriginal health research.

We have more models of how partnerships can work, such as the KSDPP, the Sandy Lake School diabetes prevention program, and the Centre for Indigenous Peoples' Nutrition and Environment. We are slowly building this capacity, and I think those are models to look at for mechanisms on how to make partnerships for relevant research.

● (1640)

The Chair: Okay.

Yes, Fred.

Mr. Fred Hill: If you'd allow me to answer the food mail question, I'm not exactly sure what may have been meant by improvements to the food mail program. It could mean a number of things. But to the extent that it would mean further reducing the rate that is charged for shipping food into these communities, I can say without hesitation that the lower the rate that is charged for shipping the food, the lower priced those foods will be. We saw a lot of evidence of that when the rates were drastically reduced in the Baffin region of Nunavut in the early 1990s. In fact, food costs less in those communities now than it did in 1990.

More importantly, in three pilot communities where we have been conducting pilot projects over the last three or four years, we have further reduced the rate again for the most critical perishable foods—meaning, for the most part, fresh dairy products, fruit and vegetables, and frozen juice.

We have again seen the price of those foods come down. We have seen what I believe would be considered nutritionally significant increases in the volume of shipments of those foods. We've also seen improvements in the quality and variety of food.

We have not, however, assessed the actual impact of all of that on nutrient intake. But the intention was to provide evidence that ministers will need to make well-informed, long-term decisions about the future of this program.

The Chair: Thank you very much.

Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Thank you for your presentations and for providing details on obesity among aboriginal peoples. It was very informative. We take note of the problem. I believe you have a very good grasp of what is happening in each of these communities.

We are not sure what needs to be done exactly in order to take care of each community. You have not really proposed a direction for the government to take nor suggested a particular type of leadership. You speak of a global plan but it is not clear to me how the government can play a proactive role to better support you.

The problems have been clearly identified. Some programs lack longitudinal studies but what do we need to do? Until now, you have not seemed concerned by existing program issues.

Do you want the government to play a proactive role in implementing certain programs to address the problem of obesity among Aboriginals? I wonder if someone can speak to this issue. Ms. Lafontaine seems to be saying that the government should have a global plan and that more numbers are required. I would like someone to clarify this a little. You need to provide clearer ideas on what the global plan should be along with your presentation of the report.

[*English*]

Mr. Mark Buell (Manager, Policy and Communications, National Aboriginal Health Organization): I'll bring it back to an earlier statement that was made, which was about the lack of data. The data exists; you're right, there is a lot of research out there. What there isn't is comparable indicators nationally on things like diabetes and obesity. The Inuit provide a very good example. The National Diabetes Surveillance System collects data on diabetes rates for Inuit in the Northwest Territories and in Nunavut. Santé Quebec collects the data in Nunavik. In Labrador Nunatsiavut nothing is collected, so we don't know. We don't know what's going on within Inuit communities from east to west to know whether or not certain interventions are working.

The other thing is, yes, there are programs that exist and have been going for years. However, we need to have those programs evaluated. We need to evaluate the existing public health interventions that are related to diet and physical activity to know whether or not those would be promising practices that can be replicated in other communities across the country.

The other thing we need to keep in mind, if you want a specific recommendation from me, is that a one-size-fits-all solution isn't going to work. There is a strong need to have community-driven solutions that address.... We're talking about a million aboriginal people in Canada. There are 600 first nations. There are 52 Inuit communities, and there are one million individuals. Each community is different, and what works in one community may not work in another. So any programs, policies, or services that are developed need to be flexible enough to allow for community variability so that communities know they can do what works. And we need stable funding to ensure that happens.

● (1645)

[*Translation*]

Mrs. Valerie Gideon (Senior Director, Health and Social Secretariat, Assembly of First Nations): You have asked why we are not offering detailed definitions of the components in a holistic approach. Our document provides a framework that contains fundamental components. The framework is based on an evaluation of programs that have been the most successful in our communities.

It must be recognized that, at the community level, there are currently many administrative obstacles related to program management. There is a diabetes program, the Aboriginal Head Start Program, etc. There is little flexibility allowing for the transfer of resources, the identification of priorities or the determination of the need for recruiting additional skilled personnel. We don’t necessarily have the resources to accomplish these tasks. The bureaucratic system currently imposes many limits.

When provinces receive transfers to finance health programs, they do not face the same bureaucratic constraints we do. We must comply with a myriad of details and definitions, program by program, and produce reports for the government which take much time and restrict our ability to implement such a holistic approach. That is one of the recommendations we made when we met with the First Ministers. Governments want sufficient transfers, with a reasonable rate of growth, every year. We also want the required flexibility to identify our priorities and the strategies that will work in our communities. As Mark was saying, “one-size-fits-all” solutions don’t work.

In fact, we should be able to adopt a public health approach that is in better harmony with recommendations made by international organizations since the 1970s.

Our document shows that there are links with housing and education but our budgets are not flexible enough for all sectors to really work hand in hand. Communities are structured like the federal government and we know that doesn't work. There is no communication between sectors. It would therefore be very important to recognize that fact and to facilitate a holistic approach. Of course, we must not be too rigid otherwise we will find ourselves in the same situation as we are now, i.e. being forced to dedicate our resources to one or two components of a program, in which case nothing would get done.

[*English*]

The Chair: I'm sorry, the time is gone. Thank you.

Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Mr. Chair,

Thank you, everyone, for your presentations.

I'm going to try to think outside the box, or outside our borders, for a moment and ask a question. What is done in other jurisdictions, such as Australia, New Zealand, and United States—and also in the case of the Inuit in Greenland and Alaska—to deal with this issue? I also understand that there are isolated, non-European populations in Siberia that may share some of the challenges we have in Canada. Also, there are populations in northern Scandinavia.

Can anyone on the panel comment on things they've done right or wrong in this area, or things we should include in our reports that would encompass what is known outside of Canada on this issue?

● (1650)

Dr. Noreen Willows: I can try to answer this and perhaps answer some of the questions that were raised by other members.

It's very difficult to give explicit examples to resolve this problem. As Dr. Cargo said, there have been reviews of studies of interventions in other populations in the United States that tried to reduce the prevalence of obesity in children. The majority of those have failed, if you look at modifying a child's body weight. They may have increased the knowledge, awareness, or self-efficacy that a child could make a change to improve diet or activity, but in general the results say that most interventions have not been effective, in terms of reducing the prevalence of obesity. It's an incredibly complex problem. We live in a society that makes it very easy to eat energy-dense foods and not move very much.

However, in Canada we have published examples of community-based diabetes prevention projects in first nations communities. Discussed here today was the Kahnawake school diabetes prevention project. In northern Ontario, there is also the Sandy Lake first nation school diabetes prevention program, and as Dr.Cargo mentioned, in the United States there was a National Institutes of Health study called "Pathways".

What is clear from the publications on these interventions in first nations communities is that interventions cannot be focused solely on the individual. That's one of the major messages.

Mr. Steven Fletcher: Do you have any comment on the international experience?

Dr. Noreen Willows: Well, there is the United States, if you consider that international. There are some projects in Australia with Australian Aborigines, but I'm not aware of the outcomes of those.

But what is clear is that interventions need to be participatory. That is, the communities have to be involved in the development of the form of the intervention. It may be frustrating, but nobody knows the solution to this problem yet.

Mr. Steven Fletcher: Health Canada, have we been in contact with any of our international friends?

Ms. Kathy Langlois (Director General, Community Programs Directorate, First Nations and Inuit Health Branch, Department of Health): The information I have in front of me is mostly related to diabetes in international examples. But the link to obesity is clear, because when you're looking at preventing diabetes, as my colleagues across the way have indicated, you're looking at healthy eating and physical activity.

Looking at what I have in front of me, if I look at Australia, it would appear that there is a national diabetes strategy in Australia. However, there's no specific strategy for aboriginal people in Australia.

In New Zealand, the Maori have an 8% rate of diabetes, compared with 3% among the non-Maori, so it's an issue there as well. There is a New Zealand health strategy and a Maori health strategy that does focus on diabetes. So there's perhaps something to be learned by delving into that more specifically.

Pathways, in the United States, was mentioned. I would note that American Indians and Alaska natives have the highest prevalence of type 2 diabetes in the world.

Mr. Steven Fletcher: Is 8% much lower than our prevalence?

Ms. Kathy Langlois: Our prevalence rate—I think we're saying three to five times—is about 15%. Yes, it's probably lower among the Maori. There are many different factors at play with the Maori. There is much more integration with New Zealand society. The culture is much more accepted.

There are a lot of different issues when you look at determinants of health.

Mr. Steven Fletcher: Sure. Thank you very much.

The Chair: Thank you very much.

Now we'll move to the NDP. We have Ms. Priddy for five minutes.

Ms. Penny Priddy (Surrey North, NDP): Thank you very much.

It's interesting. I think it was something Treena said, which keeps coming up at these sessions, which was about the ability to share information. You talked about how the community shared information, and you looked at what was happening in other places. It seems to be a recurrent theme in these sessions, our need to have a place where people can go for central information so that somebody can see what you are doing in another province or in another territory. It seems to be a recurring theme.

This is my first question. When body composition was looked at, it was acknowledged—I think by Dr. Cargo—that it changed behaviour, but it did not particularly change body composition. Is the body composition tool being used the regular BMI, or is it a BMI or body composition tool that has been adjusted for Inuit and first nations people? Because we have had some discussions about whether the regular BMI is suitable for first nations and Inuit people.

Second, I think Chief Whitecloud said earlier, at the very beginning, that there had been an increase in money, but it appeared to not always be getting to the community. I guess I'd like to know a little bit about what that means. I could perhaps guess, but I would not wish to do that.

I think that will probably take up the rest of the time, so I'll stop.

● (1655)

Dr. Margaret Cargo: To answer your first question, in our study the BMI was not adjusted for first nations and Inuit peoples, and I have not actually seen that available yet.

It might be something that Peter Katzmarzyk is working on.

The Chair: On behalf of the committee, just while you're on that, was that program designed by the first nations or the Inuit people, or did it come from somewhere else?

Dr. Margaret Cargo: The school curriculum was originally adapted from the "Know Your Body" curriculum in the United States and was culturally adapted by people in the community.

The Chair: Okay.

Ms. Whitecloud, did you have an answer?

Ms. Katherine Whitecloud: I'll do the best I can. Perhaps many of you already have the information close at hand, also.

I believe the question you're asking me is with regard to the Canada health and social transfer that I referenced. That's the reason Statistics Canada comes and knocks on all our doors and encourages us to fill out the forms: it provides the basis for providing the Canada health and social transfer dollars.

First nations people are included in the statistics for the Canada health and social transfer, but it goes to the provinces. The provinces' stand, as you realize, is that first nations people are the responsibility of the federal government—first nations people on first nations' land. Therefore, even though our peoples' statistics on reserve are included in Canada's stats for the transfer of the Canada health and social transfer, those funds do not come to our communities to benefit us.

The Chair: You have time for a little one, if you want.

Ms. Penny Priddy: Thank you.

Several people spoke to evaluation. Other than changes in the body mass index, what else are people specifically looking at in evaluation or in efficacy of the programs? I mean, is it self-esteem? Help me. In evaluation, although I know it's not about counting numbers, you have to look at something.

Dr. Margaret Cargo: If I look back to the studies that are included in the *Cochrane Review*, the psychosocial measures that are typically assessed are perceived self-efficacy for dietary practices and for physical activities, so they're behaviour-specific.

Other measures include mastery of the general control people perceive in their lives—that work is only starting to come out. Generally, in quotation marks, the "gold standard" for determining whether or not these studies are effective look at some measure of body composition or prevalence of overweight and obesity.

Ms. Penny Priddy: Thank you.

The other evaluations you gave would be pretty hard to get from a five-year-old.

Dr. Margaret Cargo: Well, you can't ask a certain—

Ms. Penny Priddy: I know that, yes.

The Chair: Thank you very much.

Mr. Batters, you have five minutes.

Mr. Dave Batters (Palliser, CPC): Thank you very much, Mr. Chair.

I want to thank every one of you for being here today and for your presentations on a crucial topic that some have called the next big epidemic. It's certainly a big problem that's going to face our first nations people. It's going to face all Canadians, but particularly first nations people because of the increased propensity for type 2 diabetes especially.

There have been discussions at this committee in recent meetings, though, affecting all Canadians. We need to work toward improving education in this realm, and I'm the first to step up and say boy, do I have a lot of work to do in terms of understanding food labelling. I think part of our report and part of what government needs to do here is to assist our communities and our first nations communities in terms of education and materials.

We've suggested a shortened or simpler version of the Canada food guide, maybe a two-page laminated document that's pretty easy to understand. Then Canadians can go and dig as far as they want in terms of examples that fit that food guide. Undoubtedly, there are many, many recipe books that conform to that.

I will direct my question toward Ms. Langlois, but I'd welcome input from anyone who'd like to tackle this.

I don't believe we're doing a good enough job in terms of the general practitioner's or nurse practitioner's offices when patients—be they first nations or frankly any Canadians—go in to see their doctors. Are they currently getting educational tools? Here's the issue: it's a big problem, and we need to push healthy eating and we need to push physical fitness and exercise. For our first nations communities, maybe these materials...well, I'd suggest they definitely need to be culturally sensitive and they definitely have to be in languages that everyone understands. These need to be translated documents that absolutely everyone can understand. I think we need to do a lot better in terms of promotion of healthy eating and physical fitness at the health care practitioner level. As well, I've talked about the Canada food guide, etc.

I'd like your opinion as to what kind of job we're doing right now. When families go in.... First nations is our focus today, so let's focus on that. First nations citizens going to see their doctor or their nurse practitioner, are they getting that information—healthy eating and physical fitness—and is that information in their first language?

● (1700)

Ms. Kathy Langlois: Thank you very much.

As you may be aware, the government has recently moved forward with the renewal of the aboriginal diabetes initiative. This is a strategy that puts resources into first nations on reserve and into Inuit communities and attempts to bring awareness and offer prevention strategies for diabetes. So in terms of putting information into the hands of communities, there will be resources there, and there are resources for communities to design programs that are meaningful to them, that are culturally relevant in the appropriate language, that bring the messages to the people in terms of healthy eating, physical activity, and so on. In fact, the Kahnawake project has benefited in the past, I think, from resources from that initiative.

The renewal of the program—I guess it's into its second year now—was $190 million over five years. So this is a significant increase over what has been there in the past, and we anticipate moving forward with comprehensive strategies.

We work closely with the Assembly of First Nations and the Inuit Tapirit Kanatami to bring both programs into place, design program frameworks, and it may be that my colleagues from AFN and ITK may want to speak to that program.

Mr. Dave Batters: I'm anxious to hear how they're looking at this.

Ms. Kristy Sheppard: With the question posed, is that for Inuit as well, because I noticed you mentioned first nations three or four times without the inclusion of Inuit?

Mr. Dave Batters: And my apologies. First nations and Inuit people...yes, thank you for correcting me.

Ms. Kristy Sheppard: That's one of the primary points. We need to have an identity within that, because we often don't get program-specific dollars or materials due to the fact that we're lumped into one. So that's a good point to keep in mind there.

Mr. Dave Batters: That's a great point. Thank you.

I make my point: it's really for all Canadians. I'm focusing on—and thank you for pointing this out—first nations and Inuit people today, but really I think this is an issue for all Canadians. I don't think we do a good enough job in terms of educating people.

The focus, though, for first nations and Inuit people is we need to stress the importance because of the increased risk for diabetes. As all of you are well aware, it's a major deal of major importance to first nations and Inuit people.

I'd like to hear some other comments as to how we're doing at getting this material out. I've heard just from Ms. Langlois so far, Mr. Chair.

The Chair: That doesn't really matter; your time has gone, but we'll entertain a very short intervention.

● (1705)

Mrs. Valerie Gideon: I just want to make a quick comment. I think what needs to be understood is the overall context of health care in our communities. For instance, 30% of our communities are located more than 90 kilometres from a GP. The nursing shortage in our communities, although the nursing shortage in Canada is very severe, is much more severe. Nurses are facing a huge primary care burden. They're constantly pressured to evacuate people out of the communities for emergency care. They don't have the time to sit there and talk for fifteen minutes with people on how they should improve their children's nutritional habits.

We do not have school-based nutrition and activity promotion programs in our communities, unless the communities have found a way to resource those and found a way to implement them. We were left out of the healthy schools initiative. We were left out of the pan-Canadian healthy living strategy, the $300 million. None of it was dedicated to first nations or Inuit, despite the fact that we had been engaged in the development of that strategy.

So the recognition has not been there that our population is at greater risk. It may seem self-evident, but it has not been the case, generally, of federal government policy.

The Chair: Your time has gone twice now.

I'll ask for one more intervention by Ms. Willows.

Dr. Noreen Willows: I just want to say that the speaker had asked whether people get appropriate information from medical doctors and nurses. I would like to make people aware that the health care professionals who are most knowledgeable in nutrition are registered dieticians, not nurses or physicians, who get very little education with respect to nutrition. All health care teams should include a registered dietician, and yet very few first nations and Inuit communities have full-time registered dieticians available to help people understand things like food labels and the complex relationship between good health and nutrition.

So that should be actually one mandate to include, as in all health care teams in these communities, a registered dietician with the appropriate knowledge.

The Chair: Thank you.

Ms. Keeper, you have five minutes.

Ms. Tina Keeper (Churchill, Lib.): Thank you very much.

I'd like to thank all the presenters as well.

As has been mentioned, this is a critical issue. Throughout Canada, and especially in aboriginal communities, we have seen, and we have heard today, that there are significant numbers in terms of our youth.

One of the things I think I heard from every presenter today was that self-determination and empowerment are significant health determinants. We talk about chronic disease being on the rise; it was in the presentations. I'm sure everybody at this table is aware of how chronic disease is a critical issue in the first nations and Inuit communities.

We have program dollars that are being announced, and I know from the past Liberal government there were significant dollars announced. One of the things that has been mentioned, though, is that there's not a lot of first nations or Inuit access to those dollars, or control of those dollars.

We talk about children who are two years old, in kindergarten, and somebody mentioned that obesity levels are already recognized at those early ages. And we look at programs such as the maternal health program, where Vice-Chief Whitecloud mentioned there's not universal access to that program. It has also been discussed that there is not enough work between departments on these issues. You know, we have INAC and we have FNIHB.

I'm wondering what we need to take forward in terms of the communities. These are people right at the grassroots. This is their lives. They're aware that this is an issue, and obviously it's critical. What recommendations do we make, in terms of self-determination, program services delivery, research?

● (1710)

Mrs. Valerie Gideon: Certainly I think the point we've tried to bring forward to the committee is in the fact that we are facing a 3% cap on the overall health budget on April 1, 2007. There will be cutbacks and pressures, and budget resources will be oriented towards those critical services such as nursing and transportation, where if you don't provide them, people will die.

The emphasis on population health, health promotion, and disease prevention will be reduced even more significantly than it currently is. We would very much like the committee to recognize the need for that broader population health approach. We've developed a public health framework for first nations that includes a list of core and mandatory programs—which define public health with a big "P", so to speak—that would empower first nations governments to really address the root non-medical and medical determinants of diseases.

I think this type of approach would give them the flexibility to look at the school environment, as you just mentioned, and to really invest in a capacity to be able to deliver effective programs. If we continue to fund very specific programs that are highly targeted, there are some benefits, in that some materials can be provided and some standards can be developed. But at the same time, the limitations are that those programs are not made universally accessible to communities. For instance, the head start program is still a pilot program, and it was created almost ten years ago now. So is diabetes prevention. These are still pilot programs. Obviously there needs to be some real rethinking about how resources are invested and how the system overall is organized and structured. I think there needs to be that flexibility and an annual growth rate in transfers to first nations, so they can take greater control over how their programs and services are delivered.

You still need the economies-of-scale supports at the regional or sub-regional level to provide some broader population health capacity and expertise such as in the area of public health surveillance. That's still something that would be agreeable to first nations. But ultimately, that flexibility and that holistic approach needs to be fostered in first nations communities.

The Chair: Thank you.

Mrs. Davidson, you have five minutes.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Mr. Chairman, and thank you to the people who have come here to present to us today.

Certainly the presentations have been very informative, and I think we've run with a common thread through everybody's presentation. We've heard a lot of very difficult issues being discussed and we've heard about some solutions that have been put in place or that have been tried, but I'm not sure that they've been solutions.

I'm not sure where we go. We've heard the measures and the evaluations that have been done in the Kahnawake school project. You said you saw modest behavioural changes, yet the obesity increased drastically, if I remember correctly from the percentages that you gave. You learned some lessons about children being obese at a younger age; that there was a potential, from what you were doing, to motivate communities; and that you were seeing some community commitment. But I don't see where we have really gained from that.

Are there other areas? We've talked about different things, and other presenters have talked about things that we need. We need to have better data. I don't know how we get that data or whether we have a program that's going to give you that data.

You talked about continued financial support. Of course, everyone needs continued financial support to carry forth with other programming. You talked about promoting breastfeeding and active living. All of these things are common across all children in this country, and all of these things are ones we need to be promoting. Affordable, healthy food is a huge issue in all areas. I think it's more of an issue in first nation and Inuit areas because of the isolation in many cases, and the high costs.

You talked about promoting self-government in health. I'm not sure whether or not or how that fits in, and how that benefits.

I know those are a whole lot of things, but I just can't see a clear direction to take. If there are one or two things we could be working on, what would they be? I don't know who wants to comment on that.

● (1715)

The Chair: The floor is open. Do we have anyone who wants to try to answer this one?

Dr. Margaret Cargo: I can comment on that a little bit.

If you look at the interventions that were included or examined by the Cochrane review, it could be that the interventions weren't sufficiently intense for the changes in behaviour to lead to the changes in body composition that we would hope to achieve. If you look at the number of dollars that are invested in a lot of school-based interventions in the community, health promotion doesn't get a lot of money. If you look at the billions and billions of dollars that marketing companies have to market these foods to little children and parents, I think that's something we need to look at, because the local-level interventions need to be supported by broader-level policies that are supported by the government.

Also, we did see some changes in the Kahnawake schools diabetes prevention project, in increased physical activity around 1999. In 2004 we lost that effect, and it could be because the number of physical activity minutes in the schools dropped. So there are changes that could be made. While teachers and school administrators are trying to uphold academic standards, at the same time they have to address physical activity and health education. Changes could be made within the school system by mandating a minimum number of physical activity minutes.

The Chair: Ms. Sheppard.

Ms. Kristy Sheppard: When you're asking for a direction to go in, there is one thing that we require. A lot of programs that are in place now have amazing intentions and I'm sure they work in a lot of southern communities, towns, and provinces in Canada, but we require engagement that we don't receive. Many programs that are put out are modeled on southern communities but don't apply when they have to go in the north. But the only dollars we're getting are for the specific program that's modeled a specific way and has to be done like that.

Without appropriate Inuit engagement, you're not going to get the effective results, because they're not tailored to what the community needs. You're also not putting in appropriate evaluation tactics that go on what our Inuit communities would see as improvements. For example, if you used the BMI to measure someone before they got into a better eating program and then measured them again, they're probably still going to be overweight. They may have lost 25 pounds, but based on the standard BMI system, it doesn't apply.

So we need engagement in the development of projects, we need it in legislation, we need it in delivery, we need it period. We need engagement for aboriginal programs if they're going to apply and be successful in our communities.

The Chair: Thank you. Your time is gone.

We have Madame Demers.

[*Translation*]

Ms. Nicole Demers (Laval, BQ): Thank you, Mr. Chairman.

Chief Whitecloud, Dr. Gideon, my first question is for you. I browsed your website to better understand the issues you face. I noticed that financing allocated to the health of the First Nations had been cut by $269 million. I presume that has had a serious impact on your work. I want to say that I believe wholeheartedly in your holistic approach. I believe that it is a very intelligent way to tackle problems.

I wonder whether Health Canada consults with you before deciding to implement new programs in your communities. Do they consult you? For example, were you consulted on the preparation of the new *Canada Food Guide*? Did you participate in the development of those programs and guides so that they might fully satisfy your needs?

Mrs. Valerie Gideon: I will begin with the question of the $269 million. Yes, the impact of those cuts will be felt more deeply over the next fiscal year. These reductions were announced in the 2005 budget. They therefore do not include the budget cuts in the Smoking Cessation Program that have just been announced. Those will be added to that amount. The effect will be mostly felt on non-insured services. The E-Health Program will be completely eliminated. We will therefore forgo new technologies in the communities.

In 2004, we were not consulted when $700 million in new investments were announced, which notably included the renewal of the Aboriginal Diabetes Initiative. On the other hand, we participated in the evaluation of the Aboriginal Diabetes Initiative and we insisted that it be renewed. The amount of money allocated is much higher than before but we were not consulted on how the $700 million would be used. We are dissatisfied with the way in which communities have access to financing. For example, the First Nations communities will have access to only 4% of the $100 million allocated for human resources in the health sector over the four years of the Initiative. The budget is over four years because it was difficult to have it approved. We are quite dissatisfied with this.

With regard to the new *Canada Health Guide*, we are part of a small working group that the First Nations and Inuit Health Branch created with the Inuit. However, we were not really consulted on the contents of the *Canada Health Guide* but rather only on its presentation so as to ensure that the recommendations would be appropriate to the needs of the populations. We should really consider this issue. In-depth research would, however, be required to ensure that the recommendations are adequate rather than to presume that the rate of...

● (1720)

Ms. Nicole Demers: Excuse me, are you saying you were consulted on the packaging rather than on the contents?

Mrs. Valerie Gideon: Exactly.

[*English*]

The Chair: Very short.

[*Translation*]

Ms. Nicole Demers: Mr. Eyahpaise, I would like to know what the permissible limit is for special food requirements. You touched on this earlier. Please explain your thought and what these would imply.

Mr. Robert Eyahpaise: I'm sorry, Madam, I did not mention any limits.

[*English*]

Ms. Nicole Demers: What is the extent permitted for special dietary needs? You talked about allowing certain dietary needs to the extent permitted for diabetes, for special diseases. I want to know what the extent is.

Mr. Robert Eyahpaise: The extent permitted for people requiring special diet conditions. I just don't have those amounts with me right now, because they're variable, but I can get the details for you.

The Chair: If you can get those to the committee, I think on behalf of all, that would be great.

Mr. Lunney, five minutes or less.

Mr. James Lunney (Nanaimo—Alberni, CPC): Great.

I've been following this discussion with a lot of interest. I think it's interesting that by the time these children hit grade one, they're already overweight. One of you mentioned that. Somebody mentioned that breastfeeding may provide protection.

Then, I see, we get into discussion here. My colleague Dave Batters brought up the question of what kind of education is taking place. We heard responses about dietitians and the lack of access to professionals to really explain and make sure that people are getting adequate nutrition.

I'm looking back at some of the information provided by our researchers here, that traditionally, with hunting and gathering, there used to be a lot of access to berries and seaweed in northern communities, and many of the wildlife that were consumed were rich in nutrients, and so on. Perhaps, of course, as traditional foods are less a part of many aboriginal diets, we're missing a lot of nutrients, vitamins and minerals, that should be important there.

With such a large group around this table, representing researchers and people with a lot of experience about this, has anybody done a simple study with basic vitamins and mineral supplements for children to find out whether this might make a big difference in their handling of blood sugars? For example, we know that chromium is essential for blood sugar metabolism. Can anybody tell me, has such a simple study been done, just with basic vitamins and minerals, for our young people?

I would just make this comment: we know that physiological efficiency has a big role in physical activity. When the body is physiologically functioning well, you simply feel like doing more.

The Chair: Okay, it's a simple question. Is anyone aware?

Ms. Whitecloud.

Ms. Katherine Whitecloud: If we had simple answers, we wouldn't be here.

My children are all grown up. I'm a grandmother. But I know there used to be provision for vitamins for children when you went to healthy-baby clinics in the communities. I'm not sure if that's still available or not.

Many children now—those who can—go to a pediatrician instead and are provided with vitamins, and such, there. But it's not available to everybody or for every community, especially in the north. It's not available, because we have critical nursing shortages and physician shortages. They don't even have the staffing to be able to provide that unless a community health representative does.

Ms. Langlois may be able to answer that.

● (1725)

The Chair: Okay, but time is very tight.

Ms. Kathy Langlois: Certainly the Canada prenatal nutrition program is very much concerned with the nutritional adequacy of mothers. So there is encouragement around breastfeeding; there is the provision of food. We had mentioned the example in Nunavik; char and caribou are provided to mothers through that program.

I'm looking to my staff in terms of the specific answer around vitamins. We are concerned about the issues of vitamins and supplementation. We work with the Canadian Paediatric Society, particularly around vitamin D supplementation.

I think the sense is that we do, through that program, provide access to supplements, but a broader intervention is required than simply that.

Mr. James Lunney: Yes, but you're not saying there's no specific multivitamin and mineral program to make sure we're covering all the bases that a young child might need in developing. It seems to me a good basic place to start.

The Chair: We have a researcher who wants to speak on this.

Ms. Willows.

Dr. Noreen Willows: At least in James Bay communities, I know that babies are given Tri-Vi-Sol, which is a vitamin supplement, and mothers are given Materna. Not all individuals take those supplements or give them to their children. But I think it's really important to remain food-focused and not nutrient-focused, because individuals eat food, not nutrients.

In the United States, there has been the horrible thought of adding vitamins and minerals to pop because that's what children are drinking, which is a hideous notion. SunnyD markets itself that way. It's sugar water, with a few vitamins thrown in. It's mostly sugar.

I can't see that the increasing prevalence of obesity over the last few decades has to do with rampant vitamin and mineral deficiencies in children. I don't think the diet has changed enough to allow for that hypothesis. So I don't know any research specifically that has looked at whether supplementing children would reduce rates of obesity. I doubt it. And again, I think it's very important not to move away from food, because individuals eat food, not nutrients.

The Chair: Thank you very much.

I think that answers it. The answer is no or that it probably won't help. That's my interpretation.

Ms. Dhalla, you have three minutes.

Ms. Ruby Dhalla (Brampton—Springdale, Lib.): Thank you very much, Mr. Chair.

I want to echo my colleagues in saying that your presentations were extremely interesting. We thank you for taking the time and putting in the effort to provide us with information.

It was also great to see so many women come as witnesses and take a leadership role in what is now a very big issue, not only for the first nations and Inuit communities but also for all Canadian children across the country.

I was actually interested in hearing from Chief Whitecloud, along with Valerie. One of the concerns I've heard from many of the witnesses around the table is the frustration—I think Kristy put it best—with the fact that the programs being designed and developed are not actually being tailored to the needs of the community.

Looking back at last year, there was a tremendous amount of consultation done with people from the aboriginal community in regard to developing the Kelowna accord. Consultations with all levels of government and a variety of stakeholders took place over 18 months, and I think it was quite historic that everyone sat down and actually reached an agreement that was put into place.

In your presentation, Chief Whitecloud, you spoke about the holistic health strategy that had been endorsed at that particular meeting of first ministers. Unfortunately, things have taken a turn, I would say, for the worse. The Kelowna accord hasn't been endorsed by our government to date.

What type of impact has that had relative to implementing your holistic health strategy at the moment, and what types of challenges do you see, moving forward, in addressing the issue of healthy programs for our children to ensure there is promotion of obesity prevention within the population of the aboriginal, first nations, and Inuit communities?

● (1730)

Mrs. Valerie Gideon: Chief Whitecloud has asked me to respond.

The impact has been that the $1.3 billion that had been announced in funding—which included funding to stabilize the envelope but also included a $445-million envelope, I believe, for transformative change in the system, which would have facilitated the changes required to allow communities the flexibility to implement that particular strategy—is gone.

We've also lost, as I mentioned, other investments around early learning and child care, which would also have contributed to improved nutrition that would have been accessible to children. So there are other resources there.

The other impact, of course, is the fact that we are facing a 3% cap as of April 1, 2007, with no alternative plan for how that will be addressed. Our communities are in an emergency situation. They are focusing strictly on how they will mange within these cutbacks instead of thinking about how they could approach things in a more innovative way and how they could address the determinants of health in their communities.

The Chair: Thank you.

Our time is gone, but if the committee will allow, I have one quick question.

I've heard an awful lot about the funding and a lot about studies, and so on. Have any of you actually been approached by the federal level of government and asked for a solution that you could see coming out of your own specific communities and actually engaged in some of the solutions? There were some questions that were leading that way, but I never did hear whether you were actually engaged and asked for a first nations or Inuit approach to this problem.

Ms. Katherine Whitecloud: We in Manitoba are meeting with the minister, in fact, on Thursday morning to present to him a plan for how we want to take care of the health concerns of our people in Manitoba. It's specific to Manitoba.

The Chair: That's fine.

I'm speaking specifically about childhood obesity, because it is a major problem throughout all society, but in your community particularly. If you're not engaged in whatever solution we come up with here as a committee, it will not work. That's a challenge for you to think about.

Our time is gone. Thank you very much.

The meeting is adjourned.

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