

**Raising Healthy Children: Re-interpreting Moral and Political Responsibility for  
Childhood Obesity and Chronic Disease**

By

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B.A. (Hons), University of British Columbia, 2006

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In the Department of Political Science

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**Supervisory Committee**

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(Departments of Philosophy, Political Science, and Law)

Dr. Avigail Eisenberg, Departmental Member  
(Department of Political Science)

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(Department of Political Science)

## Abstract

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Childhood obesity and chronic disease rates have reached epidemic proportions, but policy responses remain focused on individual health promotion rather than environmental change. This paper reveals the limitations of the current response, the Minimal Public Health (MPH) approach, due to its moral and political foundations. The foundations of the MPH rest upon the problematic liberal public/private divide. Furthermore, the MPH neglects to recognize the legal obligations and implications of the *UN Convention on the Rights of the Child*. Additionally, children's entitlements to care extend beyond the provision of basic necessities and demand high standards of nutrition and physical activity to ensure equal and just developmental outcomes. Finally, obesity and chronic disease may limit children's ability to participate in practices of meaningful citizenship. As a result of its foundations, the MPH is inherently flawed and an alternative public health paradigm must be developed to effectively address childhood obesity and chronic disease.

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## **Dedication**

To my parents, Ken and Barb, for nurturing my health and happiness, and for providing me with the best of opportunities

*In health there is freedom. Health is the first of all liberties.*  
-- Henri-Frederic Amiel

*The old notion that children are the private property of parents dies very slowly. In reality, no parent raises a child alone...common sense and necessity are beginning to erode old notions of the private invasion of family life, because so many families are in trouble.* -- Marian Wright Edelman, Founder of the Children's Defense Fund

## **Introduction**

For many North American children, dinner is served from a bag, while rushing between organized activities or sitting in front of a television. The meal is typically accompanied by a toy; a cheap piece of plastic that will soon be forgotten despite its original desirability. The latest athlete, movie character or celebrity has been promoting the meal and its toy, inspiring many children to beg and cry to obtain it. Busy parents, struggling to keep life organized, comply because it is easier than arguing. The meal itself is composed of two pieces of white bun, bearing little resemblance to its origins in the wheat field, with a thin, rubbery beef patty in between. Most of the burger's substance seems to be composed of the condiments, and the thin slices of pickle and colorless iceberg lettuce. On the side, salty French fries full of dangerous saturated and trans fats complete the meal. To wash it all down, a soft drink sweetened with high fructose corn syrup (HFCS) ensures that the children will soon be experiencing yet another 'sugar high.' After eating, children across North America return to their regular activities on the computer or in front of the television, already looking forward to the next bag of chips and pop for snack.

Although many parents know that such meals are unhealthy, they are struggling in a "toxic environment" with little support or recognition for the challenges of raising children in such a world. About \$10 billion per year is spent on advertising to children, and one study of Australian children ages nine and ten indicated that more than half believe that Ronald McDonald knows best what children should eat (Brownell & Horgen, 2004). Not surprisingly, children themselves have little opportunity to develop a 'taste' for healthy, wholesome food when they are targeted by the big business of the food

industry, and unhealthy choices surround them. Alarming, “children have become conduits from the consumer marketplace into the household, the link between advertisers and the family purse” (Schor, 2004, p. 11). While not all components of the food industry are harmful, those selling ‘unhealthy’ choices are dedicated to convincing children to ‘eat more’ regardless of the known health consequences (Nestle, 2002).

Children of colour, living in poor neighborhoods or in single parent families have a greater chance of experiencing such patterns, with limited access to healthy food, and a proliferation of cheap, energy-dense, low nutrient food (Brownell & Horgen, 2004). In a 1988 British study, a shopping cart of healthy food cost 18 percent more than a cart of unhealthy food, but by 1995, the difference was 51 percent (2004). As a result, the researchers concluded that many low-income families were “priced out of a healthy diet” (2004). In British Columbia, a family of four living on income assistance would spend 42% of its net income on healthy food, while a family of four on an average income would spend only 17% of its income purchasing healthy food (Dietitians of Canada, 2007). Moreover, when neighborhoods are more dangerous and lack safe places to play, children are often restricted to playing indoors, thereby increasing their time spent in sedentary activity. Economic and social inequality between families translates into unequal access to healthy food and physical activity for many children, which affects learning and developmental outcomes.

The consequences of unhealthy eating and limited activity within a “toxic environment” have resulted in biological imbalance. The energy (calories) consumed does not match the energy expended in many children (Maziak, Ward, & Stockton, 2008). Thus, the energy is stored for times of future scarcity, which tend not to occur in

the highly regulated world of modern agriculture, particularly for developed states (Brownell & Horgen, 2004). Children's bodies are growing in an environment of artificial abundance, fueled with energy dense, low-nutrient food, compounded by insufficient physical activity, which for many children results in weight gain (Nestle, 2002). The 'epidemic' of overweight and obesity<sup>1</sup> is a natural response to the current environment, but it has serious consequences for children. Chronic diseases, typically found in the adult population, such as Type 2 diabetes, heart disease, some cancers, and orthopedic problems are becoming common in children (Canadian Paediatric Society, 2002). Perhaps more disturbing is that many overweight children face daily humiliation and discrimination from their peers, as well as adults, including their own health care providers for being 'fat' (Latner & Schwartz, 2005, p. 59). A child is often considered 'sloppy', 'lazy', or 'ugly' for being overweight, yet the environmental structures are the source of the problem, not personal "failure" or irresponsibility, as is commonly believed (2005, p. 59).

In this thesis, I argue that socio-ecological change is necessary to address the rapidly rising rates of childhood obesity and chronic disease; however the current public health approach is inadequate due to its conceptual foundations. Current responses to obesity are minimal and individualistic because obesity is understood primarily as a lifestyle issue arising out of private choices people make, rather than as a serious public health threat. As a result, 'health promotion' strategies are limited by the boundaries of the political context, even when strategies claim to be ecologically focused. Thus, most health promotion strategies for obesity continue to rely on very modest community

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<sup>1</sup> For purposes of brevity, I use overweight and obesity interchangeably, as related conditions, although they represent different BMI and weight classifications.

mobilization initiatives and public education to encourage the self-regulation of ‘private’ choices. While these initiatives may be promising practices, they are often ineffectual and short-lived. Strategies of individualist health promotion (IHP) for obesity are known to be less than successful, but continue to receive support because of the prevailing power dynamics of neo-liberalism, which distances government from direct involvement in change (Share & Strain, 2008, p. 239). Thus, minimal regulation is implemented to manage marketing, industry or the structures of the built environment, which are fundamental to influencing weights (Swinburn, Egger, & Razza, 1999).

Essentially, the current public health approach, which I term a Minimal Public Health (MPH) approach, is concerned with supporting only the most basic health and nutrition needs of children, which results in wide variation of health outcomes and prospects for different children. Fundamentally, the MPH regards eating and physical activity (PA) as the personal choices of citizens, and protects parental autonomy with regard to children’s eating and PA. Through emphasis on parental responsibility and consumer sovereignty, the MPH allows and encourages the food industry to have nearly unregulated access to children, as well as to employ insidious strategies to sell products, regardless of the consequences. Enabled by this approach, “corporations have infiltrated the core activities and institutions of childhood, with virtually no resistance from governments or parents,” which consequently “places a lower priority on teaching...children how to thrive socially, intellectually, even spiritually, than it does on training them to consume” (Schor, 2004,p. 13). Therefore, I assert that the MPH is incapable of systemic, effective change that would reduce the incidence of childhood obesity and chronic disease because it is restricted by the way in which childhood obesity

is *implicitly* framed. The implicit assumptions about the role of the state in relation to children and families are illustrated through the current public health approach to obesity, but these remain largely unquestioned.

In order to understand the limitations of the MPH and how childhood obesity may be better addressed, I will problematize the underlying assumptions of the MPH and reveal how it is ineffective. The primary assumption that underpins the MPH is the liberal conception of the public/private divide, which limits political action for preventing and treating childhood obesity and chronic disease because children are understood as the responsibility of the private realm. Moreover, the limited abilities and opportunities for children to voice their own rights and entitlements results in continued injustices within the private sphere. As a result of the powerful public/private distinction, other consequences arise, including the inability of the MPH to recognize the moral and legal rights of children as expressed in the *United Nations Convention on the Rights of the Child*. Furthermore, the MPH fails to respond adequately to demands of egalitarian justice for children, and it also fails to recognize the significance of obesity as a potential obstacle to meaningful citizenship.

Before critiquing the implications of the MPH, I will first examine the scope of the obesity epidemic and the resulting health impacts for children. Chapter One discusses the complex causal factors related to overweight, obesity and chronic disease, including the biological, social and environmental influences. It also examines the physical, social, and psychological consequences of obesity, which are often devastating, long-term, and thereby warrant immediate action. Chapter Two is concerned with exploring the current policies and programs designed to address the obesity epidemic, from government

regulation to community-based initiatives. Although I scan international policies and programs, the primary focus of the chapter is on British Columbia. While many initiatives are modestly effective, the limitations of the current approach emerge throughout the discussion, and it is clear that more comprehensive, aggressive action is necessary to reduce the incidence of childhood obesity. In particular, the food industry has often erected barriers to change, but the priorities of public health and the vulnerability of children demands that commercial interests not remain the dominant concern for government. The first two chapters frame the health issues and draw upon scientific sources, as well as current policies and programs in Canada to contextualize the problem. These chapters illustrate the types of actions possible under the current public health (MPH) framework, and demonstrate where it is failing to protect children's interests.

In Chapter Three, I address the theoretical inadequacies of the MPH approach to childhood obesity and chronic disease, and I demonstrate how this approach continuously fails to address childhood obesity because it is inhibited by its implicit understanding of the role of the state in the private decisions of families. Therefore, I strive to identify the underlying obstacles preventing more assertive and appropriate policy that reflects the severity of childhood obesity, and the value of children's entitlements to healthy development. It is insufficient to settle for partially protecting children's health, as long as it does not interfere with commercial interests or require direct action from governments. Preventing childhood obesity must be a political priority, which requires a reassessment of our approach to the issue.

## Children and Childhood

Before I begin to examine the problem of childhood overweight, obesity, and chronic disease, I will expand upon my understanding of the child. In recent years, the study of children and children's rights has evolved to better recognize the distinct status of children, politically and sociologically. According to the state, children are persons under the age of eighteen or the age of minority (*Convention*, Article 1). However, childhood is more than a phase of life; it is also a social status with accompanying social and political expectations, which vary culturally and temporally. There has been increasing recognition of children's rights and respect for children as (developing) moral agents, which suggest that children *should* have more influence over their environments and choices (Mayall, 2002, p. 2). Thus, the studies of children and childhood have often grappled with whether children are "individual, almost-adults with inalienable rights", or "relational, dependent beings who are primarily influenced by their immediate environments." I argue that children are *both* rights-bearing individuals, upheld through the *Convention on the Rights of the Child* and the state; as well as relational beings, deeply embedded within the family and the immediate web of relationships, which provide care and attachment.

In studying the experience of childhood it becomes clear that while children are social actors, participating in the family, community, or school; the child's agency is "understood within the parameters of childhood's minority status" (Mayall, 2002, p. 21). This implies that people who "inhabit childhood differ from adults in that childhood is understood as a period when people require protection, since they know less, have less maturity and less strength, compared to older people; protection implies also provision;

and it implies unequal power relationships” (2002, p. 21). While I will not be exploring the extent to which children should be enabled to structure their environments or make choices independently of adults, these issues will arise in the exploration of childhood overweight and obesity. Primarily, I am concerned with the role of adults in constructing the obeseogenic<sup>2</sup> environment, while struggling to protect and provide for children. Due to unequal power relationships, children may be at risk for obesity when parents and other adults do not provide quality care through healthy food, physical activity and a supportive environment. As a result, parental autonomy or adult authority may conflict with the needs of children for healthy development. Since obesity has the potential to harm children, it may be understood as neglectful of parents or other adults to enable it. Thus, questions of intervention, harm, and parental rights must be considered in relation to the child’s rights. In the third chapter, I explore how these competing rights and responsibilities should be negotiated to provide children with the best possibilities for healthy development. However, I will first explore the scope of the childhood obesity issue to better contextualize the appropriate responses.

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<sup>2</sup> Obeseogenic is widely used in health promotion literature to describe the construction and interaction of complex factors that lead to rising overweight and obesity in the population.

## **Chapter One ~ Causes and Consequences of Childhood Overweight and Obesity**

To understand the rise of childhood overweight and obesity over the past thirty years, one may simply examine changes in diet and physical activity, which are the key determinants of weight gain. An imbalance between energy intake (i.e. diet) and energy expenditure (i.e. physical activity) has been firmly implicated in the production of excess weight, and especially, excess fat storage (Krueger, Williams, Kaminsky, & McLean, 2007). In turn, one's behaviour with regard to eating and physical activity (PA) is shaped by the political, social, and structural contexts, which have dramatically changed in the past thirty to fifty years. Furthermore, adult practices and beliefs shape the behaviours of children within the family, school, and other public spaces, affecting children's quality of life, as well as their future health. Most Canadian adults fail to provide a sufficiently healthy example or environment for optimal child development. As the health of North American children deteriorates due to unhealthy eating and limited PA, this generation of children is the first who may not outlive their parents (Olshansky, Douglas, Hershov, Layden, Carnes, Brody, et al., 2005).

In Canada, the rate of childhood overweight has more than doubled, while obesity has tripled in the past twenty-five years (Shields, 2005). Governments and citizens are becoming increasingly aware of the need for change, but they are often resistant to implementing changes that may be considered 'interventionist'. In many ways it is easier to delegate sole responsibility to parents or children themselves for making poor lifestyle choices, but the evidence suggests that the environment is one of the most significant contributing factors (Swinburn et al., 1999). Accepting social and political responsibility for childhood obesity would require making significant changes to the obesogenic

environment and practices within families and schools. Environmental and practical changes would potentially limit adult liberty or hinder the big business of the food industry, which appear politically unviable to more conservative governments. As a result, the rates of childhood obesity continue to rise despite modest prevention and treatment efforts that strive to change individual behaviour (Share & Strain, 2008).

The rise of childhood obesity is frequently described as an “emergency”, “epidemic” or “crisis”, and action against the trend is often termed a “war” or “battle” (Schwartz & Brownell, 2007). Critical understanding of what can be done to improve the health of children in Canada is necessary, but our responses must reflect the complexity of the issue. The complex factors contributing to the rise of childhood obesity provide insight into the appropriate responses required, as well as the political consequences.

As the public becomes more aware of the issue of childhood obesity, it is also more difficult to sort through the myriad of causes leading to the problem. The trends in childhood obesity are a reflection of many factors, from biological to cultural. While most studies on childhood obesity tend to focus on single causal factors, often ignoring the more elusive indicators, such as emotional and cultural connections with food, I argue that we must consider the entire context of the issue. Moreover, it is essential to address the problem with empathy, in order to be attentive to the vulnerability of children and sensitive to the challenges faced by caregivers. In addition, it is crucial to recognize that individuals develop in all shapes and sizes, and that the definition of a healthy weight is often controversial. However, the practices of eating healthy and exercising regularly in a supportive environment are key concerns for supporting healthy child development.

Since it is not always clear how each causal factor may be affecting a child's health, I shall explore the currently identified factors, with the understanding that they are operating in tandem with one another within a particular cultural and political context. These causal factors have been identified through a number of studies, and are widely recognized as contributing to the rise in obesity rates in different ways. To begin, I will examine the biological components of obesity, including genetic factors and maintaining the energy (caloric) balance. Second, I shall explore the more complicated social factors that shape children's behaviours, resulting in obesity. Finally, I will discuss the factors that have structured the 'obesogenic' environment in which children are being raised. Each component cannot be approached without recognizing how they are exacerbated or enabled by other components, as I shall demonstrate. Thus, any attempts to address childhood obesity must account for the complexity and interdependency of the various influences on children's health.

Following the exploration of the causal factors leading to childhood overweight and obesity, I will examine the consequences for the individual child, the adult she becomes, and for society. The health and social consequences have been well documented, and demonstrate the need for urgent action to reverse trends of obesity. Obesity affects the physical body, emotional and psychological development, the abilities to socialize and contribute to society, as well as places an enormous, long-term burden on the health care system. These consequences are typically viewed in terms of medical dangers for the individual or monetary costs of society; however, the consequences must also be understood empathetically to appreciate the struggles with obesity that many children are facing, and to prevent other eating disorders, such as anorexia nervosa or

bulimia, from becoming more prevalent. Supporting children in leading healthy, active lifestyles is the most basic and essential expression of caregiving that will enable them to experience a healthy childhood, as well as optimal future opportunities.

### ***The Causes and Influencing Factors of Childhood Obesity***

Through most of history, food scarcity has been the main threat to children's survival, and has shaped the eating behaviours and child feeding practices that continue today (Savage, Fisher, & Birch, 2007). Since the early twentieth century, children's health concerns have been bolstered by the public health agenda in Canada, which has supported families in protecting children's health. Prior to this attention, many children died from the complications of infectious diseases aggravated by diets limited in calories and nutrients (Nestle, 2002). As scientists learned more about how nutrition could protect against disease, measures were introduced that virtually eliminated severe under-nutrition among North American children, such as increasing the available calories and food fortification (2002). Today, only children who are ill for other reasons or very poor demonstrate the health consequences of under-nutrition. The most common nutritional problems children are facing, from all socio-economic backgrounds, are eating too much of the wrong types of food, and "consuming too many calories in general" (2002). Children's eating habits are developing under unprecedented conditions of dietary abundance, in which inexpensive, calorie dense foods are easily available, yet parental feeding practices continue to reflect a scarcity context. The various physical, social and environmental factors resulting in the obesity epidemic compose the 'obesogenic environment'; the actual context in which children are developing.

Consequently, increases in childhood overweight and obesity and the resulting chronic disease and under-nutrition have become major public health concerns in Canada (Veugelers & Fitzgerald, 2005). A 'normal' weight range is defined as a body mass index (BMI) of 18.5-24.9, while the 'overweight' BMI is between 25 and 29.9, and the 'obese' BMI is over 30. The body mass index is a calculation of body fat; dividing weight (kg) by height squared ( $m^2$ ), and also accounts for age and growth in children (Basrur, 2004). More sophisticated techniques have been developed to measure 'obesity' in children, however, the BMI currently remains the standard. It is widely recognized that measuring childhood obesity is a complex process (Share & Strain, 2008).

According to the 2004 Canadian Community Health Survey, 26% of Canadian children and adolescents aged two to seventeen were overweight or obese; 8% were obese (Shields, 2005). The last time height and weight were measured in a nationally representative sample was during the Canada Health Survey in 1978/79, which revealed that 12% of two to seventeen year olds were overweight, and 3% were obese – a combined rate of 15%. Therefore, in the past twenty-five years, the overweight/obesity rate of this age group has more than doubled, and the obesity rate tripled (2005). Among Canadian aboriginal populations, the situation is even worse. Of the First Nations children living on reserve, 55% are overweight or obese, while 41% of aboriginal children living off the reserve are overweight or obese (Active Healthy Kids Canada, 2007). Using international standards, at least 10% of school-aged children worldwide are overweight or obese, with the Americas leading at 32%, followed by Europe at 20%, and then the Middle East at 16% (Maziak, et al., 2008).

Biological Factors Effecting Obesity and Chronic Disease

The causal factors resulting in these disturbing statistics are complex, including physical, social and environmental factors. Essentially, overweight and obesity is a calculation of energy (calories) intake versus energy output. When the energy intake is higher than the energy output, it results in weight gain over time (Maziak et al., 2008). The physiological processes that manage this energy consumption can be effected by various genetic, biological, and pharmacological factors that scientists continue to explore (Gilchrist & Zametkin, 2006; Newby, 2007; Maziak, et al., 2008). Genetically-speaking, we are programmed to survive scarcity by storing energy when it was available (Brownell & Horgen, 2004). Although our genetic compositions are different, and some people will have a “protective biology that keeps them from gaining weight despite what they eat” (2004, p. 7), most people are “exquisitely efficient calorie conserving machines” (2004, p. 6). Some ethnic groups, particularly First Nations, Hispanic and African American children, appear to be more predisposed to overweight and obesity, but usually under particular conditions (i.e. the obeseogenic environment) (Kimbrow, Brooks-Gunn & McLanahan, 2007). It has been found that between 25% and 40% of the variability in population body weight can be explained by genetics, leaving at least 60% of the influence attributed to the environment (Brownell & Horgen, 2004). Biology has an important role in “affecting food preferences, hunger, fullness after eating, metabolic rate, conversion of excess calories to fat, whether weight loss is easy or hard,” and thereby enables obesity under the right conditions (2004, p. 24).

However, the biological factors are the not the *cause* of obesity for most of the population. Although some genetic predispositions contribute to childhood obesity, its

rapid increase in genetically stable populations indicates the importance of social and environmental factors in causing the rapid rise in obesity (Maziak et al., 2008). Further, the different types of contributing factors operate in conjunction with one another, as particular social or environmental factors trigger a physiological response in the body. For example, infants are genetically predisposed to prefer sweet tastes and reject the sour or bitter tastes, which serve a protective function, particularly since breast milk is also sweet. Sweet foods tend to be energy-rich, while bitter or sour foods signal possible toxins (Savage et al., 2007). However, as the child develops, if they continue to be offered only sweet foods, they will often continue this preference throughout life, which also appears to restrict the child's natural ability to self-regulate caloric intake (2007). Thus, when these biological factors exist within a social environment full of readily available sweet foods, children are disadvantaged in choosing healthier options.

### *Social Factors Effecting Obesity and Chronic Disease*

Understanding the social factors that effect children's health is extremely complicated, often resulting in conflicting findings, depending on the child's context. The primary influence on children's eating behaviours and weights are parents and other caregivers (Savage et al., 2007). Even in the womb, children are influenced by the mother's food choices, as flavours are experienced through the amniotic fluid. After birth, this process continues through the breast milk, and ultimately in the food that is made available to the child throughout its life (2007). Breastfeeding is also a protective factor against obesity. One study showed that the prevalence of obesity in breastfed children was 2.8%, compared with 4.5% in non-breastfed children (Krueger et al., 2007).

Parents also influence the eating patterns of children, and this varies according to culture, socio-economic status, and other identity differences. The food and eating restrictions imposed by parents, such as requiring the child to eat all the food on her plate, or limiting the intake of certain foods, can affect the child's attitudes toward food. In many cases, excessive parental restriction of food as well as parental modeling of 'dieting' can lead to disordered eating in children and adolescents (Golan & Weizman, 2001). Parents also influence the manner in which food is eaten, whether at a dinner table with the family, in front of the television, or in the vehicle. Eating together in an appropriate social setting at regular intervals has a positive influence on children's eating behaviour (Newby, 2007). Also, frequency of family meals has been associated with healthier meals, including higher intakes of vegetables, fruit, and dairy products, as well as higher intakes of vitamins and minerals and a lower incidence of skipping breakfast (2007). In addition, family meals allow for positive support in providing "companionship, establishing a positive atmosphere, taking responsibility and serving both as a source of authority and a role model for the child" (Golan & Weizman, 2001, p. 103).

Parents need to become aware of their influence in shaping children's environments and behaviour, in order to protect children and promote their health. Some studies have indicated that overweight parents are more likely to establish an environment for themselves and their children that promote obesity (Styles, Meier, Sutherland, & Campbell, 2007). To compound this challenge, parents with overweight children may be less likely to recognize that their child is overweight (2007). Among low-income populations in particular, 70 to 80% of mothers perceive their overweight child to be of normal weight or even underweight (2007). The threat of scarcity may be

more tangible for low-income parents, thereby distorting their views of a “healthy weight”. Thus, one of the difficulties in exploring parental influence of and responsibility to their children’s weight is that they may not always realize when the child is at risk.

Parents also act as the “gatekeepers” to other social influences surrounding children’s eating, including access to the media, which structures children’s eating environments (Savage et al, 2007). However, if parents are unaware of their child’s health risk, then they may also neglect to monitor these outside influences. The personal food choices of parents also affect the health of their children, via role modeling. Thus, when parents eat a healthy diet and are physically active, children are more likely to be healthy (Active Healthy Kids Canada, 2007). However, requiring parents to make particular lifestyle choices is often perceived as restrictive of individual adult autonomy, even though parents are crucial in modeling healthy behaviour for their children.

In addition to shaping eating behaviours and the home environment, parents influence the types and frequency of PA in the child’s life, which is essential to maintaining healthy weights for children. Although nearly all parents report that their children are “very physically active,” in reality fewer than half of Canadian children and youth are active enough to ensure healthy growth and development (Active Healthy Kids Canada, 2007). However, findings indicate that parents who are physically active are more likely to financially support PA and volunteer their time to support their child’s sport or PA event (2007). Regular physical activity is a crucial component of achieving and maintaining healthy weights, so reducing screen time and encouraging active outdoor play for children is essential in their health and development (Kendall, 2005). Thus, any

effective strategy to address obesity must incorporate opportunities for physical activity as well as healthy eating, and account for barriers that have restricted children's access to activity, such as labour saving devices, time spent on computers or watching television, and parental safety concerns.

Beyond the influence of parental behaviours and knowledge, other caregivers also have a powerful impact on children's eating behaviours, since forty percent of meals are fed by caregivers other than parents, such as grandparents, babysitters or teachers. Thus, these individuals similarly affect the child's perceptions of eating, as well as the food they are consuming (Styles et al., 2007).

Teachers are key role models in influencing children's eating behaviour by providing nutrition education, physical education, classroom rules (e.g. only bring healthy snacks from home), and occasionally providing snacks or rewards for the children. Among pre-school aged children, it has been found that the consumption of vegetables is positively influenced by the observed eating behaviour of teachers (Savage et al., 2007). In British Columbia, the schools have been identified as "key community settings" in which changes can be made to support improved health for children, partly through the practices of teachers, since children spend a considerable amount of time under their care (Kendall, 2003). Also, changes to curricular material, lunch programs, cafeterias, vending machines, educating parents and students, and organizing events which offer healthy food and physical activity, are some other key changes that will positively influence children's health (Krueger et al., 2007). Environmental changes have proven to be more effective in changing behaviour than educational programs alone (Krueger et al., 2007). Unfortunately, education remains the primary method for

encouraging students to “self-regulate” their behaviour, but this problematically assumes a ‘level-playing field’ for children in schools, and ignores how ‘material conditions in people’s lives influence the kinds of “choices” they are able to make’ (Share & Strain, 2008, p. 241). Thus, some children have access to more resources to eat healthy diets or participate in sports or other activities, which may widen the gap between children.

Additionally, teachers are important in monitoring the social interactions among children at school. They influence the development of children’s self-confidence and social skills, which may be challenging for overweight or obese children. In school, overweight children often face a significant amount of discrimination and teasing (Latner & Schwartz, 2005). Since weight and health are perceived as dependent upon personal responsibility, overweight individuals are subject to bias, teasing, and ridicule, and the resulting discriminatory actions of others (Schwartz & Brownell, 2007). As a result, overweight children are often at a disadvantage in school, potentially leading to increased drop-out rates or reduced academic achievement (Canadian Paediatric Society, 2002). While some argue that social stigmatization helps discourage obesity, the evidence strongly suggests that “the opposite is true; weight bias may exacerbate obesity through depression and binge eating” (Schwartz & Brownell, 2007, p. 81). The social and political emphasis upon individualism in North American society implies that obesity is controllable and that obese people must be responsible for their weight, which leads to increased prejudice. One study found that populations from traditionally collectivist cultures (Venezuela, India and Turkey) exhibited less prejudice against obese people than traditionally individualistic cultures (United States, Australia, and Poland) (2007, p. 81).

Thus, teachers have an important role in minimizing the negative experiences children may face, and promoting understanding and empathy among children.

The experience of weight bias that begins in school continues into adulthood for many people. These experiences not only affect school performance, but affect the possibilities of continuing on to post-secondary education and future participation in civil society. Obese individuals tend to earn lower wages (with equivalent qualifications) and are also at a distinct disadvantage in health care settings (Schwartz & Brownell, 2007). Adolescents are “particularly sensitive to weight-related mistreatment since identity formation is a major developmental task of adolescence and body image and self-esteem tend to be intertwined” (Neumark-Sztainer et al., 2002, p. 123). Since “bias may be one of the factors that links obesity with negative health consequences and hence health care costs,” the physiological responses to bias are increasingly being studied (Schwartz & Brownell, 2007, p. 81). This is also an area in which teachers, parents and caregivers must become aware of the experiences of overweight and obese children, and respond supportively. Engaging educational programs that reduce prejudice and bullying against overweight people are essential to improving understanding, as well as supporting healthy eating and PA.

In exploring the social factors involved with maintaining healthy weights for children, it becomes clear that the socialization process is more difficult for overweight or obese children, in the family, school and other social settings. The perception that the child is individually responsible for his weight is exacerbated by the overwhelming media information, which provides contradictory messaging. On the one hand, children and youth are encouraged to “eat more” of a plethora of unhealthy choices (sometimes

marketed as healthy), while on the other hand, they are expected to exhibit a particular and unrealistic body image, as demonstrated by supermodels, actors, and athletes. Boys and girls alike are targeted by these media messages, within an environment that does not encourage critical questioning of advertising. Part of the responsibility of parents, caregivers and teachers is to help children to critically interpret the media messaging to which they are exposed, although this is not always possible or convenient. Most Canadian provinces (except Quebec) have refused to regulate advertising to children, which leaves the responsibility for media monitoring with parents (see Chapter Two). Parents and children are left to navigate the ‘free choices’ available to them and make the ‘right choice’ as good, self-regulating citizens. However, the concept of choice in an obeseogenic environment also enables the ‘morally laden victim-blaming discourse to operate’ without critical interpretation of the dominant forces that shape the choices available (Share & Strain, 2008, p. 236).

### *Food Production and Consumption*

The food industry is composed of companies that produce, process, manufacture, sell and serve food and beverages, and works closely with the media to market their products, often specifically targeting children. Not only does the food industry structure the food choices available, but they influence the dietary advice and agricultural policies of government and experts (Nestle, 2002). The vast success of the industry has resulted in an abundance of food choices in competition for consumer purchases. Therefore, companies compete to attract buyers based on taste, cost, convenience and even public confusion (2002). Although expert nutritional advice has remained constant for half a century, the public is bombarded with so many advertising messages that the information

appears confusing (Nestle, 2002). The industry's main goal is to convince people to "eat more," which they achieve through increased portion sizes, astronomical spending on advertising, introducing new products, and gaining lifetime product loyalty by targeting children (Nestle, 2002).

Simultaneously, family eating practices have changed dramatically in the past thirty years. As women have increasingly moved into the workplace, the growing, gathering and preparing of food has become part of the "double day" routine, characterized by significant caring labour, limited time, and minimal recognition or value for that labour. Feminist theorists have identified the importance of caring work, particularly in the private sphere, but it continues to remain outside the dominant political discussion (Gilligan, 1995; Tronto, 1994). In addition, the "traditional" nuclear family is no longer the predominant family structure, and many single parents must struggle to work and provide care for their children (Tong, 1998). Consequently the preparation of healthy meals and opportunities for safe activity is not always readily available for children. Moreover, as the family division of labour has changed, so has the food industry, which has resulted in a "national eating disorder" (Pollan, 2006). Cheap and convenient foods reflect the needs of the changing family structures, despite the health consequences. Simultaneously, the task of "figuring out what to eat has come to require a remarkable amount of expert help," and the fact that a fifth of our meals are eaten in cars or that a third of children are fed at fast-food outlets every day, indicates a serious problem (Pollan, 2006, p. 3).

Farming has also changed dramatically in the past thirty to fifty years, which has affected where families are living, as well as the types of crops produced. In the early

twentieth century, one in every four families lived on a farm, with sufficient land and labour to feed the family and twelve others as well (Pollan, 2006). Canada lost two thirds of its farms between 1941 and 1961, and another 11% between 1996 and 2001 (Statistics Canada, *The Daily*, May 15, 2002). Costs have risen, while farm income has dropped dramatically, making small farms practically unviable. As a result, mass-producing agribusinesses have become the predominant producers, through the utilization of genetically modified crops, and petroleum dependent farming practices. The crops grown are largely determined by agricultural subsidies, which are in turn influenced by the political perspectives of the food industry. As a result, corn, wheat and other crops are cheaply produced to manufacture the many cheap, pre-packaged food and beverages that are so popular with consumers (Pollan, 2006).

Producing vast amounts of cheap food requires a system of mass production. The environmental impact of food production, especially highly processed foods and certain meats, require a considerable amount of energy. Pollan determined that 1071 liters of oil is used to bring a 570 kilogram steer to the table (Brownell, 2004). Energy is required to “produce the fertilizers, pesticides, and herbicides applied to feed-grain and corn; for the hormones injected into the cow to optimize its growth; to truck the meat to distant markets, and to keep it refrigerated” (2004, p. 167). Despite the economic and environmental costs, agricultural subsidies ensure that food remains affordable, however the subsidized crops, such as corn also ensure the consumption of subsidized products (e.g. soft drinks made with high fructose corn syrup) increases. This allows companies to increase portions “at virtually no cost, again making over-consumption more likely”

(Brownell, 2004, p. 168). Thus, in analyzing the dynamics of overweight and obesity, we must examine the entire food and production chain to grasp the complexity of the issue.

### *The Built Environment*

The dramatic changes in food production and manufacturing, combined with changes to social and political structures, have resulted in an ‘obesogenic’ environment that contributes to the rising rates of childhood obesity. In addition to these social changes, the “built environment” has also been recognized as contributing to the rise in obesity rates. The built environment is composed of all the physical structures engineered and built by people, including where we live, learn, work and play (Dearry, 2004, p. A600). These edifices include our home, workplace, schools, parks and transit arrangements, and the design and construction of these spaces has changed dramatically since earlier in the century (2004, p. A600). As a result, people walk less and drive more when the environment is conducive to driving. Also, when unhealthy food is available in a vending machine or cafeteria, individuals tend to make less healthy choices. Since the environment shapes behaviour, there has been an increasing effort to change elements of the built environment, including land use, road connectivity, and the food environment to influence physical activity and healthy eating (Maziak et al, 2008). Initial evidence from this area of research shows that “people who live in neighborhoods with traditional or walkable design are more physically active than those who live in ‘suburban’ type neighborhoods” (Maziak et al., 2008, p. 4). For children in particular, access to recreational facilities and schools, the presence of sidewalks and controlled intersections were found to be positively associated with physical activity, while traffic density/speed,

crime and area deprivation were negatively associated with physical activity among children (Maziak et al., 2008).

### ***Consequences of Overweight and Obesity in Children***

Significant research continues to explore the consequences of overweight and obesity in children, and the evidence is disturbing. Overweight and obesity lead to serious physical, social, and psychological health complications for children and adolescents. Overweight and obese children are at increased risk for Type 2 diabetes, hypertension, respiratory disorders, cardiovascular disease, orthopedic problems and psychological problems during childhood and later in life (Canadian Paediatric Society, 2002). Juvenile obesity and overweight is associated with poor self-esteem, depression and social discrimination and teasing (2002). Obesity is also related to low reported quality of life, comparable to that of children with cancer (Schwimmer, Burwinkle & Varni, 2003) and impaired social recognition (Latner & Stunkard, 2003). Further, the psychological and emotional experiences of obesity and overweight are similar to other disordered eating (e.g. anorexia nervosa and bulimia), and many overweight/obese adolescents have reported binge eating behaviours (Golan & Weizman, 2001).

Childhood obesity frequently continues into adulthood, which can result in higher rates of morbidity and mortality from chronic diseases, such as diabetes (Canadian Paediatric Society, 2002). Further, being overweight increases the prevalence of kidney failure, gallbladder disease, hormonal and reproductive problems, sleep apnea, impaired immune function and blindness in adulthood (Krueger et al., 2007). When obesity continues into adulthood, individuals have a lower average income, lower marriage rates, fewer years of education and increased difficulties with daily life (e.g. movement)

(Warshawski, 2005). As a result of the many health risks, “obesity has become a leading cause of preventable morbidity and mortality worldwide (Maziak, et al., 2008, p. 1). In considering the many health consequences associated with obesity, I shall focus on four main areas of concern: Type 2 diabetes, cancer, cardiovascular disease and disordered eating.

In British Columbia, the health care costs related to overweight and obesity are overwhelming. Katzmarzyk and Janssen calculated that obesity was estimated to have cost the Canadian economy \$4.3 billion in 2001, which by 2004 cost about \$1624 per obese individual annually<sup>3</sup> (Krueger et al., 2007, p. 36). ActNow BC has projected that if health care spending continues on the current trajectory, then by 2017/2018 the entire provincial budget will be consumed by the Ministries of Health and Education (Kendall, 2005). Obviously this is an unacceptable outcome for the province, and the government is now implementing plans to prevent chronic disease and improve population health and wellness, which should result in decreased health care costs. Similar initiatives are occurring across Canada, and in other developed states. As a result, the issue of childhood overweight and obesity is central, since the costs of caring for overweight children throughout their adulthood are more severe if the children are pre-disposed for chronic disease.

Diabetes alone is an enormous cost, with 5.2% of British Columbians having diabetes; a number that is expected to rise exponentially (Kendall 2004). Across Canada, more than 1.8 million adults have Type 2 diabetes, which may result in the accelerated development of cardiovascular disease, end stage renal failure, loss of vision and limb

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<sup>3</sup> For methodology, see Katzmarzyk P. & Janssen, I. The economic costs associated with physical inactivity and obesity in Canada: an update. *Canadian Journal of Applied Physiology* 2004; 29 (1).

amputations (Canadian Paediatric Society, 2002). In the United States, diabetes has risen by more than 50% in the past thirty years, which is attributed to the rise in overweight and obesity (Krueger et al., 2007). The prevalence of Type 2 diabetes is rising among youth, with up to 45% of children with newly diagnosed diabetes having nonimmune-mediated disease (2007, p. 342). Moreover, obesity and overweight are attributed with diabetes, as 80% of those with Type 2 diabetes are overweight (Kendall, 2004). This is also true with children, as 85% of children diagnosed with Type 2 diabetes are overweight (Canadian Paediatric Society, 2002). In BC, the direct costs for caring for persons with diabetes was \$1.04 billion in 2003/04, including hospitalization, medical services plan and Pharmacare. The cost could rise to \$1.90 billion by 2015/16 if the prevalence of diabetes continues to rise at its current rate (Kendall, 2005).

Cancer is another potential risk associated with overweight and obesity, which has been established over the last couple of decades. In one of the largest prospective studies of more than 900,000 American adults over 16 years of age, increased body weight was associated with increased death rates from all cancers combined and from cancers at multiple specific sites.

For men and women, being overweight or obese significantly increased the risk of death from cancer of the esophagus, colon, rectum, liver, gallbladder, and kidney, as well as from non-Hodgkin's lymphoma and multiple myeloma. Overweight or obese women had a higher risk of death from cancer of the breast, cervix, uterus, and ovary, while overweight and obese men had a higher risk of death from stomach and prostate cancer. The authors estimated that the current patterns of obesity in the United States could account for 14% of all deaths from cancer in men and 20% of all deaths from cancer in women (Calle et al., 2003 cited in Kendall, 2005, p. 30).

A study by Hu et al. established that physical inactivity and increased weight are 'strong and independent predictors of death' (Krueger et al., 2007, p. 24). Thus, a person who is overweight, but physically active still has a significantly higher risk of death from all causes compared to a person who is a healthy weight and physically active (2007).

Even when obesity does not result in death, the chronic diseases can lead to a poor quality of life and increased social and health care costs.

Although it remains unclear how childhood diet affects the possibilities of cancer later in life, the theory remains that an unhealthy diet in the formative years may promote DNA damage that may emerge as cancerous mutations later in life (Willett, 2005). The increasing rates of obesity in children also raises concerns about the potential for an increase in cancer rates in future years, since obesity tends to track into adulthood and therefore will be exposed for a longer duration to potentially toxic compounds called adipokines that are secreted by fat (Kendall, 2005). A high-calorie intake in childhood has been associated with an increased risk of cancer in later life, even if the child obtains a normal weight as an adult (Frankel, Gunnell, Peters, Maynard, & Davey, 1998). These possibilities are disturbing and certainly inhibit a child's health opportunities.

Cardiovascular disease is another common problem linked with overweight and obesity. Deaths from cardiovascular disease are the second highest cause of death in BC, accounting for 1/5 of deaths in the province (Kendall, 2005). Cardiovascular disease includes a variety of disorders including coronary heart disease, myocardial infarction (heart attacks), angina, atherosclerosis (hardening of the arteries), stroke, transient ischemic attacks (mini strokes), hypertension (high blood pressure), and congestive heart failure (Kendall, 2005). Hypertension and diabetes increase the risk of coronary heart disease and stroke and are associated with dietary habits, particularly the high consumption of saturated fats, salt, and refined carbohydrates, and the low consumption of fruits and vegetables (WHO, 2003). It is estimated that 3 million American youths have high blood pressure, and obese children are particularly prone to hypertension

(Canadian Paediatric Society, 2002). Also, juvenile onset hypertension continues into adulthood unless weight concerns are treated, making it a significant public health concern.

Clearly the major health consequences of overweight and obesity are the chronic diseases which continue into adulthood and affect the lives of individuals, and the increased risk of death as a result. Diabetes, cancer, and cardiovascular disease are three major consequences of the problem. However, it is dangerous to focus solely on the problem of obesity and the resulting chronic disease. Obesity may also express an unhealthy relationship with food, whether fuelled by the 'toxic' environment, poor body image, or personal experiences, which sometimes expresses itself as other eating disorders, in the attempt to lose weight. Eating disorders are illnesses associated with severe distortion of body image and resulting obsession with weight (Krueger et al., 2007). Individuals facing teasing, peer pressure, media pressure and changing family dynamics can increase the likelihood of developing an eating disorder. It is important that campaigns to reduce obesity are sensitive to these risk factors, as they are different expressions of similar problems.

Anorexia nervosa and bulimia are also expressions of broader social issues affecting youth, similar to obesity, and should not be overlooked. "In North America, eating disorders are the third most common chronic health disorder among females between the ages of 15 and 19. These can lead to serious health problems such as heart irregularities, electrolyte imbalances, weakened bones, permanently damaged dental enamel, and other complications, including death" (Kendall, 2005, p. 44). Eating disorders usually begin in an attempt to control one's weight, and are often associated

with a fear of being obese, which may be aggravated by pressure from parents, at school or by health professionals. Anorexia involves restricting food to the point of extreme starvation, while bulimia is characterized by binge eating and purging the body through vomiting, laxative abuse and diuretic misuse (Kendall, 2005).

Obsessive dieting is another common problem, which prevents children and youth from developing healthy relationships with food. The 2003 McCreary Society Report found that 50% of girls of a normal weight were on a diet (McCreary Society, 2006). These behaviours are closely associated with the problematic relationships with food that are developing among North American youth and children. One of the concerns with focusing on childhood overweight and obesity as a public health issue is that it may result in increased disordered eating in the form of obsessive dieting, anorexia or bulimia. Therefore it is essential that any analysis of the causes of obesity also recognize the connection to other forms of disordered eating, which reflect the problematic food environment and social perceptions of weight. Moreover, prevention and treatment initiatives should avoid stigmatizing overweight and obesity, and focus instead on a healthy body image, behaviour and environment.

### ***Conclusion***

The causes of childhood overweight and obesity are complex and interdependent, with significant social, economic and political consequences, which require more research. Understanding the consequences of obesity for children will be important in exploring possible solutions to the problem. It is not always clear how the different facilitators are jointly enabling the continuation of the problem, but effective long-term treatment programs continue to be relatively ineffective, which may reflect an incomplete

understanding of the problem (Maziak et al., 2008), or it may reflect an inadequate political approach. The dominant treatment plans medicalize the issue and place the healthcare system as the first line of response to the obesity epidemic, yet the magnitude of the problem has already surpassed the ability of the healthcare system to cope with it (2008). As a result, prevention is the best method for addressing this growing problem, but it must occur through an integrated public health approach that can address the many agents and environmental factors contributing to the problem.

Policies must be sufficiently aggressive and target the traditionally protected commercial interests and change the structural barriers affecting childhood weight gain. As I discuss in the following chapters, the current public health approach is ineffective because it “problematizes the choices individuals are able to make. Making the ‘right’ choice – that is the rational choice – results from the process of self-problematization and the recognition of one’s self as a morally responsible subject or a morally responsible eater” (Coveney, 2006, p. 146). However, government manages to largely avoid addressing the “broader structural factors, embedded in the...system, and instrumental in the generation of inequalities, [which] remain unexamined” (Share & Strain, 2008, p. 236). In Chapter Two, I explore the current span of programs, policies and initiatives that are attempting to prevent and treat childhood obesity and chronic disease. As I discuss these initiatives, many of which are innovative and promising, it becomes clear that the political strategy for change incessantly falls short of adequately inciting or supporting effective change. It becomes clear that deeper assumptions about the role of the state, family and market underlie the health promotion techniques that currently strive to improve the state of childhood obesity in Canada.

## Chapter Two ~ Healthy Weights for Children: Programs, Policies, and Initiatives

Considering the scope of the obesity epidemic, particularly among children, very little has been invested to prevent and treat the problem. In the United States, the 5 A Day fruit and vegetable program from the National Cancer Institute had a maximum of \$2 million for promotion. This is one-fifth of the \$10 million used annually to advertise Altoid mints, which is “a speck compared to budgets for the big players - \$3 billion in 2001 for Coca Cola and PepsiCo combined in the US” (Brownell & Horgen, 2004, p. 6). It is a similar situation in Canada, as BC spends approximately 2 to 3% of its total health care budget (\$10.9 billion in 2004) on public health (approximately \$327 million) (BC Select Standing Committee, 2004). Comparatively, Ontario spends approximately \$367 million on health promotion programs alone, through its Ministry of Health Promotion. Public health is defined as the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society (2004), yet it receives a small portion of funds compared with acute care in all provinces.

While spending is gradually increasing to 6% in BC, public health remains a small priority in our system which is focused primarily on disease treatment, rather than prevention. Yet it is well known that prevention is cost-effective, particularly when it is targeted at children and youth. The European Commission evaluated the cost-effectiveness of health promotion programs for behaviour beginning in adolescence. They found that spending \$1 on preventing tobacco use saves \$19 in treatment costs and consequences of smoking<sup>4</sup> (BC Select, 2004). Similar findings exist for promoting healthy eating and physical activity behaviour, which are strongly established during

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<sup>4</sup> For methodology, see European Commission (1999) *The Evidence of Health Promotion Effectiveness: Shaping Public Health in a New Europe*. ECSC-EC-EAEC, Brussels.

childhood. Prevention offers “huge potential for greater efficiencies and effectiveness in how the [public health] money is spent. We can get, in essence, a better return for the money spent while reducing suffering” (BC Select Standing Committee, 2004, p. 19).

Although there is a shortage of spending and resources available for addressing the public health issues, including the obesity crisis, there are also some promising practices emerging. Programs to prevent or treat childhood overweight and obesity are developing in Canada and other countries that are facing the obesity epidemic. The research indicates that effective prevention or treatment initiatives must address the complexity of the problem, from the individual to the environment. Although many different initiatives have been developed to address the obesity crisis, little is known about the long-term effectiveness of many programs and policies, or how well they can be shared across jurisdictions (CIHI, 2004). Since all developed states are experiencing similar increases in childhood obesity rates, it is important that information sharing occur, but with the understanding that many different states are approaching the problem from different political perspectives.

In the past few years, several governmental reports have been released that explores the scope of childhood obesity and chronic disease in Canada, current programs and policies, and future recommendations for action. Although these reports offer insight into the state of prevention and treatment across Canada, the recommendations do not appropriately recognize the complexity of the issue. Furthermore, there is often a gap between the recommendations and the policies and programs that are later implemented. Government regulation is quite limited, while public education campaigns, community and school mobilization and capacity building initiatives are the most common methods

for addressing public health concerns. In addition, the governmental recommendations set forth in the reports tend to focus primarily on the individual responsibilities of direct care providers, (i.e. parents, teachers), while regulations limiting the food industry or advertising are scarce. Thus, like many other obesity reports, the Canadian versions “exhort people to assume individual responsibility and so help reduce the economic burden of obesity” (Share & Strain, 2008, p. 235).

In this chapter, I will explore some of the existing governmental regulations and policies attempting to address obesity. There are also an increasing number of capacity building initiatives (often funded by government), many of which are innovative. In addition, structural changes to the community, school and workplace environments are essential in supporting healthy children. While many of these policies, initiatives and public education campaigns are helpful, more must be done in order to effectively halt the obesity epidemic and support healthy child development. Thus, I will critically expand upon the recommendations provided in a number of influential obesity reports, and provide my own analysis of what programs and policies would be most effective in supporting healthy children. While it is encouraging to find that governments are beginning to recognize the problem of obesity and chronic disease, their recommendations are usually insufficient and ineffective. Policies and programs must consider care for children’s health as the “starting point” for restricting or facilitating particular actions among citizens, including corporations. In Canada, there are many unexplored options available for government and civil society to promote healthy behaviour in children and prevent chronic disease, but it will require challenging the fundamental political assumptions underpinning the public health framework.

### *Plans for Change*

Many provincial governments have developed frameworks for addressing the challenge of overweight and obesity, which are typically a collaboration of government and community organizations to implement change. In BC, the framework has been organized as ActNow BC and Healthy BC 2010, in Ontario it is called Active 2010, and the Framework for a Healthy Alberta offers another example. Similarly, the United Kingdom has implemented the comprehensive and inter-ministerial Health and Food Action Plan, and Ireland has formed a multidisciplinary taskforce to assess the issues (Share & Strain, 2008). In Canada, most of the child-focused policies and programs outlined in the frameworks were initiated following a number of recent key reports. In BC, the Public Health Officer's Report "An Ounce of Prevention" (2003) noted that "most risky behaviour and lifestyle choices begin in childhood and youth. Therefore, reaching children and youth in the captive school setting is one of the most effective ways to target both programs and funds" (BC Select Standing Committee, 2004, p. 18). This report was followed by the report of the Select Standing Committee on Health in 2004, titled "The Path to Health and Wellness," which provided a number of recommendations for health promotion, including making BC the healthiest jurisdiction to host the Olympic and Paralympic Games in 2010. Finally, in 2006 the BC Select Standing Committee on Health developed the "Strategy for Combating Childhood Obesity and Physical Inactivity in British Columbia," which provided more concrete recommendations for change.

A similar report was released in Ontario by the Chief Medical Officer of Health entitled "Healthy Weights, Healthy Lives" that also provided important recommendations

for addressing overweight, obesity and chronic disease. In 2005, “The Integrated Pan-Canadian Healthy Living Strategy” was released by the Inter-sectoral Healthy Living Network in partnership with the Federal/Provincial/Territorial (F/P/T) Healthy Living Task Group and F/P/T Advisory Committee on Population Health and Health Security. This national report recognized the targets and initiatives established by the provinces and recommended that federal funds and resources be available as support. In 2007, the House of Commons Standing Committee on Health released “Healthy Weights for Healthy Kids,” which provided more specific national recommendations for addressing the problem. Most recently, Dr. K. Kellie Leitch, the federal Advisor on Healthy Children and Youth released her report, “Reaching for the Top”, which emphasized the need for improved child health protection, as Canada is currently one of the lowest ranked OECD<sup>5</sup> countries in this regard.

Beyond government, other organizations have drawn attention to the challenges of obesity and chronic disease. The Canadian Institute for Health Information has developed several reports. Also, in 2003 the BC Healthy Living Alliance (BCHLA), a collaborative organization, joined with the 2010 LegaciesNow and the Provincial Health Officer to draft recommendations for action. This collaboration, called Healthy BC 2010, has developed a comprehensive vision of coordinated programs with diverse partners (BC Select Standing Committee, 2004). The BC government has provided \$22 million to fund the strategies for healthy eating, physical activity and tobacco reduction developed by the BCHLA.

Despite all the reports, strategies and recommendations that have been developed in the past five years, governments still hesitate to take necessary steps to curb the obesity

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<sup>5</sup> Organisation for Economic Cooperation and Development

epidemic. Even though health care costs are dramatically climbing, children are increasingly diagnosed with Type 2 diabetes (formerly known as adult-onset diabetes), and individuals face an obesogenic environment; governments are still relying largely on public education and individual responsibility to maintain public health. The research has indicated that public education has a minimal effect on individual behaviour, but the environmental factors are influential in affecting individual health (Maziak et al., 2008). For governments, however, changing the environment is far more difficult and costly than a public education campaign. It also requires restrictions upon agents that are powerful and often resistant to changes that could limit profit, such as the food industry. In addition, environmental change often requires cooperation between sectors, ministries and governments, which complicates the process. Yet if changes are not made, governments will be facing far more detrimental consequences, with an overweight and unhealthy population of citizens.

Programs and policies are clearly necessary to address the problem, and the evidence suggests that it must go beyond many of the recommendations sanctioned by current policy-makers. Further, interpreting the resistance to implement more aggressive, comprehensive policy in protecting children's health requires an examination of the implicit and underlying assumptions about children and the boundaries of the family and the state, which I will discuss in the next chapter. Before this theoretical discussion can occur, we must first understand the scope of the efforts currently underway to prevent and treat obesity and chronic disease, as well as the limitations of these approaches.

In Figure 1, I outline the areas for influencing healthy weights, which I will explore in this chapter. Some of these methods have been engaged, such as nutrition

labeling, while others are largely avoided, such as banning advertising to children. The table illustrates that a combination of methods is typically needed, including regulation, education and healthy environments. The options available for initiating change are listed in the table, not in order of significance, but to demonstrate the multiple combinations of potential action. First, I explore governmental regulations for influencing healthy behaviour, followed by environmental changes in schools and recreation facilities. In conclusion, I examine public health education campaigns and corporate policy opportunities for promoting health.

<b>Figure 1. Opportunities for Healthy Weight Promotion</b>		
<b>Regulation</b>	<b>Education</b>	<b>Healthy Environments</b>
Mandatory Nutritional Guidelines	National campaign (ParticipACTION)	Built (sidewalks, lighting, parks)
Mandatory Physical Activity and Education	Child-focused nutrition and physical activity	School
Municipal Zoning	Parent-focused nutrition and physical activity	Community (recreation, religious)
Food and Beverage Advertising	School-focused nutrition and physical education	Home
Nutrition Labeling	Health care provider-focused overweight and chronic disease management	Corporate (workplace, sponsorship, cooperation with healthy goals)
Obesity Treatment (funding, billing)		Health care (hospitals)
Taxation and Subsidization		Access to healthy affordable food close by

### ***Governmental Regulation***

#### *Nutritional and Physical Activity Guidelines*

In Canada, food regulation is primarily focused on the safety of products for human consumption according to national safety standards. However, the individual's food *choices* are considered a private matter in which the state should have minimal

interference, which aligns with neoliberal priorities to privatize risk as seen in individualized dietary strategies (Share & Strain, 2008). Thus, if an individual becomes overweight, it is considered the individual's fault for not making responsible choices (Brownell & Horgen, 2004). As a result, this strategy "not only massively extends the possibilities for individual choice, but introduces a technique by which government is able to 'manage' consumer behaviour in ways that distribute costs efficiently (Share & Strain, 2008, p. 236). However, if we recognize that the food environment is composed mainly of unhealthy choices, then individual responsibility for weight gain is more complex.

Changing the environment becomes the key to reducing weight gain, but it is often difficult to change adult eating environments, because change is perceived as a restriction of 'free' choice. On the other hand, significant action is beginning in children's public environments, particularly in schools. Some provinces have implemented initiatives to remove "junk food" and soft drinks from vending machines, cafeterias and concessions to support healthy child development. This has been a surprisingly difficult battle, and some provinces have achieved greater success than others. Many improvements remain controversial, particularly in terms of policy and regulation, so nutritional guidelines tend to be voluntary.

As with other neoliberal priorities, schools are typically under-funded by government and are often forced to fundraise to offer sport, music and art programs for students (Henry & Garcia, 2004). Fundraising may involve long-term exclusive arrangements or short term events. In many cases the fundraising methods generate between a few thousand dollars to hundreds of thousands of dollars.

Faced with limited resources and an increasing demand for improved academic performance, a growing number of schools in Canada and the U.S.A. have turned to businesses, including soft drink companies, for various resources (Consumer Union, 2003). In return, businesses receive benefits including exclusive “pouring rights” and vastly increased advertising spaces in school campuses (University of Oregon, 2003). This kind of contract typically provides an immediate transfer of funds (“signing bonus”) to school boards with subsequent assured revenues or incentives tied to sales that could go up as high as 30% or some guaranteed minimum for a certain period (Nestle 2000; Molnar and Reaves 2001) (2004).

As school budgets continue to shrink, many teachers contribute their own money for classroom supplies and often for food and drinks for the students. A survey in 2001 by the Canadian Teacher’s Federation found that more than 95% of teachers surveyed contributed more than \$593 of personal funds to school-related activities, with a large portion (52%) spent on food and drink (2004). This has led many schools to question whether they should be turning to business to support the school’s needs. Partnerships have formed between food and beverage corporations and schools, and in some schools, fast food chains have even been allowed to operate (Nestle, 2002).

Although data is unavailable on the number of school contracts in Canada and the revenue details, evidence suggests that such contracts exist, particularly in large urban school boards (Henry & Garcia, 2004). The Toronto School Board’s exclusive contract is confidential, but media reports “estimated that the three year arrangement was worth \$6 million” (2004, p. 109). The deal also resulted in the removal of all Pepsi machines, which were replaced with Coca-Cola machines. One school board official said, “if there are millions available from the sale of these products, do we leave it with corporations, or leave it in the school system for the benefit of children?” (2004, p. 109).

In comparison, Vancouver schools tend to be involved in smaller deals, but many still offer significant incentives. For example, Britannia Secondary School signed a three year deal with a vending company in 1999 that included a \$35 000 signing bonus upon installation of equipment and “35% of all sales paid as commission” (Vancouver vending

machine contracts summary, IUOE, 2002). Kitsilano Secondary signed with Coke for six years, which included a “35% of net revenue taken from each vendor for soft drinks and juices, and a four-installment signing bonus amounting to \$17 500” (Vancouver Summary, 2002). Magee Secondary signed with Pepsi for five years and received \$25 000 as an exclusivity benefit, with the total value of the contract at \$104 500 over five years. It was broken down as \$10 000 marketing fund, \$1250 scholarship, \$1000 recycling program, \$1000 Pepsi printout, \$2500 for under the can/bottle program, \$3750 for dry grad, and \$60 000 in projected commission revenue (Vancouver Summary, 2002).

While cooperating with businesses is not always a “bad” idea and may supplement the income of schools, most food and beverage companies offer unhealthy products and aim to target children as impressionable consumers. As a “captive” audience, children are especially vulnerable to the influences of industry advertising and the unhealthy products available. As Molnar (2002) argues, “corporate involvement in schools interferes with the ability of schools to provide a sound education, promote the best interests of children and foster democratic civic virtues” (Henry & Garcia, 2004, p. 108). Moreover, children lack the support to critically question the advertisements surrounding them, while the food products themselves are typically not nutritious, which also inhibits learning.

The rate of exclusive food and beverage contracts seems to be slowing as more schools begin to question the value of the agreements. For example, Philadelphia and Santa Fe turned down \$43 million and \$2.4 million deals with major beverage companies, respectively (Henry & Garcia, 2004). School districts are increasingly aware of the inconsistent message being sent to students by advertising on the one hand, and

nutrition and physical education on the other. Moreover, children should not be approached as consumers while at school, but as learners and citizens (2004).

With the rising obesity epidemic, schools are finally recognizing that perhaps children's health is not expendable or unimportant. Rather, when children receive healthy food and beverages and adequate physical activity, they are better able to focus and learn (Brownell & Horgen, 2004). In addition, the money being saved on schools through the food and beverage contracts is ultimately costing the state more in terms of obesity and chronic disease treatment. In BC, the *Guidelines for Food and Beverage Sales in BC Schools* were first established in 2005, and were to be fully implemented in all schools by 2009. However, as the scope of the obesity and chronic disease epidemic has continued to grow, the guidelines were revised in 2007, and all schools were required to implement them in 2008. The guidelines were created to assist schools to identify which foods are healthy for students and thus could be sold in the school environment. They are divided into four categories, aligned with the recommendations of *Canada's Food Guide*, including "choose most," "choose sometimes," "choose least," and "not recommended". According to the 2007 guidelines, "choose least" and "not recommended" foods must be eliminated from school sales, and at least 50% of foods must be from the "choose most" category. The guidelines have minor variations between elementary schools, middle schools and high schools. For example, artificial sweeteners and caffeine are not allowed for sale in elementary and middle schools. Yet all schools must eliminate soda pop, some juices, sports drinks, snacks and candy that are high in salt, fat and/or sodium. The guidelines were developed in recognition that "students, on an average school day, consume about one-third of their calories at school, and a

significant amount of that is purchased on site; good nutrition is important for healthy growth and development in childhood and can reduce the risk of health problems in later years; healthy children learn better; and schools can directly influence students' health" (*BC School Guidelines*, 2007, p. 1).

While government has implemented the policy and will monitor school compliance, it is the responsibility of the schools to work with stakeholders (i.e. parent advisories, vendors, cafeteria staff, etc.) to implement the changes. As a result, some schools have expressed resistance to the initiative, as it requires more time, effort and funding to offer healthy choices. Also, schools fear revenue loss as a result of product changes, but some schools manage to continue making a profit with healthy choices. Despite this resistance, government is enforcing the policy that ensures that student health is not for sale, and is providing resources for schools to support the change. However, the limited budget faced by many schools in operating "extra" programming (e.g. music, sports) is a serious issue. As a result, the opportunities for physical activity are sometimes limited, which is also harmful to children's health. In response, the BC government has also implemented guidelines for physical education. By September 2008, daily physical activity will be required in every school and for every student. Grades K-9 will do at least thirty minutes each day and 10-12 will do at least 150 minutes each week (*News Release 2007EDU0113-001978*). However, it remains to be seen whether teachers and administrators will be able to effectively implement the nutritional and physical activity policies, and whether government has provided sufficient support.

Schools are an important environment for influencing student health behaviour, particularly through a combination of regulations and programming. However, BC is one

of the only provinces to implement mandatory nutritional or physical activity guidelines for grades K-12. Ontario has recommended that schools offer students healthy food and beverage choices, however they have only implemented a policy for vending machines in elementary schools, leaving cafeterias and other food services to continue offering unhealthy choices (Ontario Policy/Program Memorandum No. 135). Everywhere else, healthy foods are only *recommended* to school districts. In Manitoba, nutritional guidelines have been developed, but they may be used however a school decides, and are not mandatory. In Prince Edward Island, three school districts interested in offering healthy choices worked together, along with other partners to develop policies limiting food sales in schools. Alberta also regulates food and beverage sales according to the policies of each school district. Although many schools across Canada are beginning to offer healthier choices, the comprehensive provincial policy, such as British Columbia's, appears to be the most effective in ensuring a healthy school environment. It also enables vendors and suppliers to transition to healthy choices consistently across the province.

As with schools, people spend a significant amount of time in the workplace. It is also a public space in which government can regulate the food environment and support healthy employees. As I discussed earlier, it is more difficult to change adult eating environments, due to the perceived "loss" of choice. However, in BC the changes are occurring in vending machines in all public buildings. The goal is to provide employees with better quality choices to support a healthier lifestyle overall. The *Guidelines for Vending Machines in BC Public Buildings* are gradually being implemented in all government leased or owned properties, and are structured like the School Guidelines. All public colleges and universities, health authorities, ministries, and crown corporations

will be expected to comply by renegotiating or renewing vending contracts as soon as possible (*Healthier Choices in BC Public Buildings Policy Paper*, 2008). It is also expected that the nutritional guidelines will be expanded in the future to incorporate other food services as well. This initiative is a unique example, but it is still in the early implementation phases. It is still unclear how the guidelines will be enforced, and whether building administrators will face penalties if they do not comply. Currently, the guidelines appear to be another voluntary resource, until they are effectively enforced. While these guidelines may be useful for organizations already interested in health, they have minimal impact more generally if they are unenforceable.

Clearly the BC nutritional guidelines have provided much needed direction for school districts, teachers, and employers in providing a healthy learning and working environments. Other jurisdictions offer a number of programs to promote healthy environments in schools and workplaces, but these are voluntary and not always as effective as policy. Enforceable policy must be implemented in order to enable consistent change in all areas where people learn and work. Environmental change is the most important component of changing behaviour, and children in particular must have the opportunity to eat healthy and be physically active. Nutritional and physical activity guidelines have the potential to create healthier contexts for children, but they must be followed and enforced.

### *Labeling for Nutrition*

Nutrition labeling is another area where government can regulate the information received by the consumer. In December 2007, the Canadian federal government made nutrition labeling mandatory on all pre-packaged foods. In addition, the nutrition facts

labels have been standardized to promote easier interpretation. The regulation also updates the requirements of over 40 nutrient content claims, and has allowed five health claims on diet-health relationships to be used on food labels or in advertisements (Health Canada, [http://www.hc-sc.gc.ca/fn-an/label-etiquet/nutrition/index\\_e.html](http://www.hc-sc.gc.ca/fn-an/label-etiquet/nutrition/index_e.html)). The allowable Health Claims refer to disease risk reduction based on evidence.<sup>6</sup> Labeling is an important component of consumer information, especially considering the amount of pre-packaged food consumed by the public, but it has also been a controversial subject of regulation. Moreover, labeling is generally not enforced in restaurants, where the consumer is often unaware of what she is consuming.

The report, “Healthy Weights for Healthy Kids” recommends implementing a “mandatory, standardized, simple, and front of package labeling requirement on pre-packaged foods for easy identification of nutritional value” (House of Commons Select Standing Committee, 2007, p. 22). In addition, the report recommends applying a “phased-in approach starting with foods advertised primarily to children” and to “promote the new labeling requirement to parents through an aggressive media campaign” (2007, p. 23). The front of package labeling will likely be useful for consumers who may already be inclined to read the nutrition label, and perhaps draw the attention of those who are less inclined. However, the fact that the report recommends addressing foods advertised to children first, by pressuring parents to read the labels, still leaves the onus on parents to resist the pressure of the media’s affect on their children’s

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<sup>6</sup> Acceptable Health Claims: 1) a healthy diet low in sodium and high in potassium and reduced risk of high blood pressure; 2) a healthy diet with adequate calcium and vitamin D and reduced risk of osteoporosis; 3) a healthy diet low in saturated and trans fat and reduced risk of heart disease; 4) a healthy diet rich in vegetables and fruit and reduced risk of some types of cancers; and 5) non-fermentable carbohydrates in gums and hard candies and reduction in dental caries (cavities).

preferences, rather than restricting the media. Moreover, the report completely neglects the issue of restaurant labeling.

The UK Food Standards Agency has implemented a front-of-package labeling system of “traffic lights” (see <http://www.food.gov.uk/foodlabelling/signposting/retailtraffic>). This system allows consumers to understand “at-a-glance” whether the food is a healthy choice or not. The label puts a traffic light next to each category of fat, saturated fat, sugar and salt. For example, a red light next to the fat category means it is high in fat, orange means that it contains some fat, and green means the food is low in fat. The four categories listed on the label are areas where many people want to limit their intake for better health. This system is relatively easy for consumers to use, but many continue to not use it. While many retailers and manufacturers in the UK have adopted the signposting, it does not apply to imported foods. Furthermore, nutritionists are often concerned that the signposting system may be inaccurate, or mask other nutritional benefits or risks associated with products. Also, since the signposting is optional, it is more difficult for consumers to compare products that do not include the labeling.

Another labeling option to promote healthier choices is to provide standard nutrition information for fresh fruits and vegetables, meats, seafood and other foods. This enables consumers to compare the dietary benefits of consuming fresh food, as opposed to packaged food. Greater exploration of effective labeling policies is needed to improve consumer education about reading and interpreting labels. Moreover, any labeling system must be consistent and mandatory, in order to be most effective. It is also essential to recognize that the provision of labeling is only one component of a larger

vision for change, and it is insufficient to provide consumers with information and expect them to make the ‘right choice,’ in spite of the current ‘toxic’ environment.

### *Tax Incentives and Disincentives*

Taxation is another regulatory method to encourage or discourage particular behaviour among citizens, although it continues to support consumer sovereignty. Food and beverage taxes, as well as physical activity tax credits compose the current means for affecting change. Every major health report on overweight and obesity has suggested that taxation be considered in various ways. The Canadian Institute for Health Information suggests that although the Canadian GST/HST currently functions as a “sin tax” because basic groceries are exempt (zero-rated), while foods prepared by eating establishments, catering and vending machines, as well as alcohol, soft drinks and snack foods are taxed, there has been minimal disincentive to purchase taxed products (CIHI, 2004, p. 54). However, if revenue from the GST/HST on foodstuffs were not returned to the general revenues, but was earmarked for health promotion, then this could be significantly beneficial if combined with environmental changes to support healthy behaviour. Some U.S. states, such as California, have implemented this type of system. About eighteen states and one major city have begun to levy special taxes on soft drinks, candy, and snacks, which has raised about \$1 billion annually to be used for health promotion programs (2004). Another option would be using taxes collected from “junk foods” to subsidize the cost of healthy choices, which also enables consumers to buy the more affordable healthy choices (Brownell & Horgen, 2004).

It has also been suggested that the GST should be removed from health-enhancing products and activities, or that the sales tax from those items be funneled back into the

creation of programs and initiatives that enhance health (BC Select Standing Committee, 2004). The federal government has recently implemented the Children's Fitness Tax Credit, which applies up to \$500 per child for spending on fitness activities (House of Commons Select Standing Committee, 2007). However, this particular initiative will not be helpful to low-income families (2007).

In BC, applying the PST to snack foods such as chocolate bars and chips, as well as some "less healthy" restaurant foods such as french fries or pop was first recommended in 2004 (BC Select Standing Committee 2004). Since the BC tax branch already has a "clear delineation of items that are taxed or not taxed" it "could be asked to alter that structure" (2004, p. 63). In 2006, the Select Standing Committee on Health recommended that PST be applied to all "candy, confections and soft drinks" and that the government consider applying the tax to all foods that fall under the "not recommended" category of the *Guidelines for Food and Beverage Sales in BC Schools*. This recommendation is comparable to many other jurisdictions. For example, in Ontario the retail sales tax (RST) applies to snack foods and candy when sold for 21 cents or more, and most American states apply taxes to "junk food" (BC Select Standing Committee, 2006). Often the revenue from these taxes is significant, and should be used to support population health initiatives. As Brownell and Jacobson point out, "a campaign reaching about 200 000 people would cost about the same as one coronary by-pass operation" (2006, p. 857). Also, as more health promotion campaigns are conducted, the more health economists can evaluate their cost-effectiveness, and public health officials can measure the effectiveness of changing health behaviour (2006, p. 857). In conjunction

with a changing environment, taxation could be a useful means to influencing consumer and industry behaviour.

### Advertising to Children

For more than fifteen years researchers have associated a strong link between the amount of time spent watching television and the risk of obesity (Brownell & Horgen, 2004). Many studies have confirmed that TV time is “coupled with both obesity and poor food consumption in children and adults, males and females, and people across countries” (2004, p. 36). Although fewer children are watching more than 22 hours of TV per week, many are increasingly using computers, video games and other electronic devices that do not facilitate physical activity. Many families eat meals while watching television, and these families tend to eat fewer fruits and vegetables, consume more pizza, snack foods and soft drinks (2004). One study found that the metabolic rate declines in children while watching TV (Brownell & Horgen, 2004). However, time spent watching television is only part of the ‘screen time’ problem, as many children also spend time on computers and playing with other electronic and multimedia devices.

Coupled with the problems associated with frequent ‘screen time,’ the influence of food advertising on children also has a significant effect. Market researchers have defined the elements of advertising most likely to get boys or girls of varying ages to want to purchase products (Nestle, 2002). These researchers justify the results as a *public service*: “advertising to children...is nothing less than primary education in commercial life; the provision, in effect, of free and elementary instruction in social economics – a passport to street wisdom. Far from being further restricted, as many suggest, this education course should in fact be supported, encouraged and enlarged” (Stanbrook cited

in Nestle, 2002, p. 179). Many of the justifications for marketing to children are paradoxical, but clearly the marketing is effective; otherwise the spending would be significantly less.

Television advertising alone constitutes a significant amount of spending, with over \$1 billion per year spent in the United States (Nestle, 2002). Of the television commercials, 71% advertised foods and beverages of a “dubious nutritional value,” 61% were pre-sweetened breakfast cereals, candy, fast food, soda, cookies, chips (2002, p. 182). While television advertising seems to be declining, the numbers of ads in all media have continued to rise (e.g. internet), subjecting children to deceptive information and claims that prey upon the limited critical thinking abilities of children. “Food advertisers have become sophisticated anthropologists. Their ads build on basic social relationships and the connections of food to those relationships, and their power derives from these symbolic meanings” (Schor & Ford, 2007, p. 16). The sophisticated advertising methods are extremely effective in increasing spending, as well as gaining life-time brand loyalty. Part of the symbolic method of advertising is focusing on the child-adult distinction, and the construction of childhood itself (Schor & Ford, 2007). Allison James has argued that the “names, colours, sensations, textures and shapes” of children’s sweets makes these unpalatable for adults, who prefer not to eat foods that are neon-coloured or pop in the mouth (Schor & Ford, 2007, p. 17). Meanwhile, children exhibit strong preference for these sweets and reject the “meals” preferred by adults, a distinction which marketers capitalize upon. James argues that eating sweets is a means through which children define themselves, and resist the symbolic control of adults (2007). The marketing of

particular foods as part of “childhood” builds upon common perceptions of appropriate child behaviour and preferences that inform parental and public decision-making.

Governments have been reluctant to restrict food and beverage advertising, and have preferred to encourage responsible, corporate “self-regulation” of advertising directed at children (BC Select Standing Committee, 2006). According to the Centre for Science in the Public Interest, there is little evidence that self-regulation is effective. Self-regulation “usually means limited enforcement capabilities and softer penalties, such as publicly “shaming” the offending company through a press release or encouraging media companies to refuse future advertising space” (CSPI, Food Marketing Report). Moreover, self-regulation leaves parents and caregivers with the responsibility to monitor their child’s exposure to media, which is increasingly difficult.

However, a few jurisdictions have taken a strict stance on the issue. Quebec, Norway and Sweden have total bans on all television advertising during children’s television programming (CSPI, Food Marketing Report). Quebec’s law restricting almost all commercial advertising directed at children under thirteen was the first such law in the twentieth century (Jeffrey, 2006). *Irwin Toy Ltd. v. Quebec (Attorney General)* established that the “concern which prompted the enactment of the impugned legislation is pressing and substantial and that the purpose of the legislation is one of great importance. The concern is for the protection of a group which is particularly vulnerable to the techniques of seduction and manipulation abundant in advertising” ([1989] 1 S.C.R. 927). Furthermore, the Court recognized the “particular susceptibility of young children to media manipulation” and “their inability to differentiate between reality and fiction and to grasp the persuasive intention behind the message, and the secondary effects of exterior influences

on the family and parental authority” (p. 9). The Supreme Court decided that the evidence “sustains the reasonableness of the legislature's conclusion that a ban on commercial advertising directed to children was the minimal impairment of free expression consistent with the pressing and substantial goal of protecting children against manipulation through such advertising” (p. 9). As a result, Quebec has remained the only province in Canada to ban advertising to children, which is enforced by the Office of Consumer Protection (Jeffrey, 2006). It is noteworthy that Quebec’s obesity and soft drink consumption rates are the lowest in Canada, and the province is among the highest in terms of fruit and vegetable consumption since the enforcement of the ban (2006).

The rest of Canada has remained skeptical of advertising restrictions, despite evidence that suggests food and beverage advertising affects children’s perceptions and shapes life-long behaviour. In 2007, the New Democratic Party submitted a Private Member’s Bill that would have the rest of Canada restrict advertising to children under thirteen (see <http://www.ndp.ca/page/5046>). It has sparked debate among Canadians, but has not resulted in regulation. Other agencies have also called for reform, including the Canadian Institutes for Health Information, the Chief Medical Officer of Health for Ontario, the Heart and Stroke Foundation, and the Centre for Science in the Public Interest (Jeffrey, 2006). Recently, the Chronic Disease Prevention Alliance of Canada (CDPAC) has issued a statement to end unhealthy food and beverage marketing to children in Canada (see <http://www.cdpac.ca/media.php?mid=446>).

Advertising is one component of the obesogenic environment, and although regulating it will not single-handedly halt the rising rates of obesity and chronic disease, it has the potential to influence behaviour. Similar regulations exist for tobacco and

alcohol advertising to children and youth, which has helped reduce substance use. Although food is different from tobacco or alcohol because we all need to eat, some forms of food are similar and possibly addictive (Brownell & Horgen, 2004). Moreover, other states are taking action to restrict food and beverage advertising. The United Kingdom has recently decided that food and beverage advertising must be banned during children's programming, on children's channels, and for any show that appeals to a significant number of people under sixteen (Ofcom, 2007). This is an area for change that Canada should be pursuing by following Quebec's example, but thus far it has not been taken seriously.

#### Primary Health Care Funding and Billing

The Canadian health care system is primarily a disease treatment system, as I have previously discussed, with comparatively minimal investment in prevention. Despite this focus on medical treatment, overweight and obese patients, especially children, have few options when seeking medical treatment for their weight. In BC, only one childhood obesity treatment clinic exists; the Centre for Healthy Weights Shapedown BC Program at the BC Children's Hospital. Comparatively, the Ontario government has recently invested funds to support increased bariatric treatment, but the province still has only three obesity treatment centres, and one for children. In BC, experts have recommended that treatment be available at a community level within each health authority, and integrate with preventative programming (BC Select Standing Committee, 2006, Witness Testimony – Dr. Warshawski). Children's treatment is often different from the options available to adults and requires different expertise. One effective

model, the family-based Shapedown program, could effectively be applied at the community level if adequately resourced.

Shapedown was originally developed at the University of California, and involves family-based change with the support of experts, including physicians, dietitians, and psychologists. It is developmentally-sensitive and seeks to address the underlying factors leading to overeating (Shapedown BC, BC Children's Hospital). It has been successful in California and in BC, but it requires increased funding in order to be broadly effective. It is essential that the children struggling with obesity are not forgotten amongst the many prevention initiatives. Therefore, the establishment of more early-intervention and treatment facilities with a family-based "care" approach should be accessible in communities across Canada.

Another important area for change is the creation of clinical practice protocols for obesity management and treatment in children and adults. This would involve "evidence-based guidelines that provide medically sound advice to general practitioners about how to treat their obese patients" (BC Select Standing Committee 2004, p. 45). BC has a successful clinical protocols system, but it does not yet have a protocol for obesity, but it should be added (2004). The protocol should also include guidelines that are sensitive to the experiences and discrimination faced by overweight individuals, and it should recognize the complexity of the problem, beyond blaming the individual.

In addition, BC doctors do not have a billing code for providing weight loss counseling to patients. As a result, few doctors take the time to support patients or provide comprehensive advice, such as alternative "prescriptions" for exercise, dietetic counseling, or participating in acceptable weight loss programs (e.g. Weight Watchers).

Australia has already implemented many of these changes for doctors to enhance their ability to deal with obesity and lifestyle issues (BC Select Standing Committee, 2004). In the UK, the National Health Service now covers prescriptions for an overweight or obese patient to attend either Weight Watchers or Slimming World (both proven effective and safe) (2004). Many patients cannot afford these weight control programs, but research shows that it is more cost-effective for primary care trust to send obese patients to these programs than to treat the medical cost of obesity (2004). It is also beneficial to provide support from early childhood with six months coverage for qualified lactation consultants to encourage breast feeding, childhood and family dietitian services, and psychological services for at-risk children and adults. Early intervention may offer the most effective means for supporting healthy child development and preventing a long term struggle with overweight or chronic disease.

### ***Healthy Weight Promoting Environments***

#### ***The Built Environment***

Changing the built environment requires inter-governmental cooperation to regulate and improve planning and development that affects health. Child health and development is directly affected by the physical environment the child occupies. Evidence demonstrates that there is a “distinctive and astonishing relationship between the level of school readiness in children and the characteristics of the neighborhoods they live in – income level, affordability of housing, neighborhood crime rate, number of parks, playgrounds, libraries, and childcare options, and measure of social cohesion and social capital” (Hertzman cited in BC Select Standing, 2004, p. 56). Moreover, a child’s neighborhood determines his risk of becoming overweight or developing chronic disease.

The land use and layout of a community can contribute to the problem because it determines whether the community is “walkable,” whether it is safe for children to play outdoors, and whether healthy, fresh food is available. These issues are especially pertinent for local governments to address.

In the past thirty years, most urban centres in North America have experienced “urban sprawl” and many “community layouts now cater primarily to motorists, leaving walking or biking to destinations either precarious or altogether impossible” (Economos & Irish-Hauser, 2007, p. 132). While the emergence of large multi-purpose chain stores, fast food establishments and the roadways that connects them to suburban areas is convenient, there have been unforeseen health consequences (2007). Studies have demonstrated that communities with safe walking paths and affordable fruits and vegetables have healthier residents, while communities with high crime rates, numerous alcohol outlets, few outdoor spaces or limited fresh food, tend to be less healthy (2007).

Establishing safe, healthy communities should be a priority for governments, and there are a number of regulatory steps available to influence development, particularly through zoning. Local and provincial governments can be involved with transportation and urban planning by applying a public health lens to these areas, and considering the rising costs of obesity, take appropriate action. This would promote mixed land use and planning for active transportation (e.g. walking, cycling), as well as decrease the negative environmental effects of automobiles (CIHI, 2004). A number of legal changes could be made to zoning and developmental requirements to encourage “walkability” and support a healthy community. For example, large residential developments could be required to provide recreation amenities and include retail services and offices spaces, to ensure easy

access to healthy food and decreased automobile-dependence (Perdue, Stone, & Gostin, 2003). Furthermore, governments can regulate how roads are built, and whether they include bike lanes, sidewalks, and adequate lighting; it is essential that children have the space and opportunities to play and be active in their neighborhoods.

A promising example of community-based change in the built environment is the “Shape Up Somerville (SUS): Eat Smart, Play Hard” initiative conducted in Somerville, MA. It was an initiative designed to change the environment to prevent obesity in early elementary school aged children (Economos & Irish-Hauser, 2007). The intervention involved multi-level environmental change to prevent weight gain among young children. The specific changes involved before-, during- and after-school environments and focused on increased opportunities for activity and supported healthy eating (2007).

The initiative was designed to build community capacity to maintain healthy changes over time, which required adequate resources and support. Moreover, capacity building through community-based approaches can depend upon the community, as low-income areas, which are often characterized by high-crime rates, fear, lack of “social capital” and higher rates of obesity and chronic disease, are often less able to implement healthy community initiatives without significant support. Understanding a community’s capacity for change is crucial in providing sufficient resources, as well as in the planning and implementation process. As a result, leadership and resource allocation is often needed from governments, to be distributed and managed at the community level.

The positive results of the initiative in Somerville demonstrate the possibility for successfully reducing obesity through environmental community-based intervention. Prior to the intervention, 1/3 of the children in Somerville were at risk for becoming

overweight or were overweight, which was above the national average (Economos et al., 2007). About 1/4 were not involved in sports or physical activity in the past year (2007), and many children were not eating sufficient fruits and vegetables. Yet during the eight month intervention, the children at-risk for becoming overweight were prevented from gaining about a pound, compared with two control communities (2007).

Many of the changes were not expensive or complicated to implement. Simple steps, such as re-painting crosswalks, deploying school crossing guards, and providing safe walking maps for parents, resulted in about a 5% increase in children walking to schools. Other initiatives, such as giving out free pedometers and providing city employees with gym memberships all contributed to the change. Local business also joined in, with twenty-one restaurants becoming SUS approved by offering healthier foods and smaller portion sizes (Economos et al, 2007). In addition, the schools changed their menus and vending machines, and the curriculums were fortified with increased nutrition and physical education. Over the longer term, increased funding for recreation facilities and the construction of bike paths to nearby Boston were also implemented.

The cooperation of local government, researchers and community members resulted in modest, but significant changes in Somerville, and could be modeled elsewhere. The built environment is a key component of the obesity epidemic, but must be initiated through regulation; policy and funding are the primary methods for direct government action on the childhood obesity epidemic. However, most governments are unwilling to challenge the powerful agents of the food industry who affect the food environment. As the Somerville example demonstrates, it is crucial that the community, as well as business and industry become involved to support healthy choices, particularly

on a provincial or national level. However, it is also important to recognize the relevance of community support for achieving changes to the environment and ultimately behaviour. The most successful initiatives do not dwell on the “fat problem” of obesity, but rather seek to create spaces for people to live healthy lives in all ways.

### Healthy Schools

School settings have been a key space for changing the food environments of children, and in teaching healthy behaviour. Government policy concerning the nutritional guidelines has been important in structuring the food environment, but other educational programming, and school policies have also been important. As I have discussed earlier, schools have been targeted by companies seeking exclusive rights to sales, particularly for soft drinks. Although this has not been universally addressed with policy in Canada, many provinces and territories are beginning to recognize the importance of providing healthy food and beverages for children, as well as increased physical activity. The challenge is in ensuring that enough support is provided and that policies reinforce the initiatives. I will discuss some of the school-based programs and initiatives more closely to determine some of the key factors necessary for success.

Offering healthy food and beverages to children in schools is essential, and establishing mandatory nutritional guidelines supports this process. However, children have unequal access to healthy food at home, and therefore in lunches sent from home, depending on socio-economic status and other barriers. In terms of fruit and vegetable consumption, seven out of ten Canadian children aged four to eight do not meet the five-serving minimum per day (Statistics Canada, 2004), and some children are more vulnerable than others. In response to this issue, the School Fruit and Vegetable Snack

program was developed in BC to improve the food security of children and expose them to a variety of fresh food. In 2005, three provincial ministries (Health, Education, and Agriculture) came together with industry and non-government stakeholders to develop the program. The pilot test supplied ten elementary schools with BC grown fresh fruits and vegetables twice a week (Naylor & Bridgewater, 2006).

The initiative was welcomed by teachers, parental advisory committees, and the children, as well as BC producers and distributors. Initial evaluations of the program suggest that coordinating with parents, sufficient resources (e.g. fridges from BC Dairy), quality produce, and aligning with teacher values and approaches were essential to the successful implementation (Naylor & Bridgewater, 2006). The program has since expanded to 364 schools (57 000 students) as an inter-ministerial initiative, and a component of ActNow BC (*Press Release, 2007TSA0038-001101*).

While this initiative has had positive effects in bolstering children's fruit and vegetable intake, and increasing children exposure and experience with different fruits and vegetables, it is insufficient to meet the recommended intake of at least five servings per day. If schools want to support healthy eating among children, then at least one serving per day by the program should be the minimum standard. The problem with supplying daily fruits and vegetables through this program is that it relies on parental labour in distributing the product, and not all schools have access to the program due to limited resources. If children's nutrition were a priority for government, then *all* schools would be provided with staff and financial support to implement this crucial opportunity for supporting children's healthy development. Alternatively, a full healthy school meal program would ensure adequate daily intake among children, similar to the recent

changes in the British school meal program. While some funding is available to BC inner-city schools to provide meals for students, it is not a universal system (see CommunityLINK, BC Ministry of Education).

Britain has a long tradition of providing school breakfasts, lunches, snacks, and after-school programs, as well as vending machines and tuck shops. The mandatory national school guidelines are dramatically changing the school meals available to children in Britain; a movement that was championed by chef, Jamie Oliver (BBC News, Sept. 4, 2006). Moreover, all 4-6 year old children in infant, primary and special schools receive one piece of fruit or vegetable per day (UK Department of Health, 5 a Day Fruit and Vegetable Scheme). In comparison, school breakfast programs are managed by non-profit organizations in Canadian public schools. The Breakfast for Learning program has been supported by provincial governments, as well as corporations and volunteers, but it is not a national school meal program. Breakfast for Learning attempts to meet the needs of children who do not receive adequate nutrition to learn, but this leaves many children without opportunities for nutritious meals. Some schools with many vulnerable students have a subsidized hot lunch program, but this should be available to all students, since eating well is not only about accessing enough food, but accessing sufficient *healthy* food.

In terms of PA and education, the Action Schools! BC (ASBC) program has been successful in shaping the school environments, and has been funded jointly by the Ministries of Health and Education and 2010 Legacies Now. ASBC is a “best practices model designed to assist schools in creating individualized action plans to promote healthy living” (ASBC, [www.actionschoolsbc.ca](http://www.actionschoolsbc.ca)). The model has been provincially

disseminated and continues to be evaluated in changing school environments. It includes both physical activity and healthy eating components, and it is designed to include students, parents, teachers, administrators and community practitioners. ASBC has successfully increased the fruit and vegetable consumption of students, and facilitated increased physical activity ([www.actionschoolsbc.ca](http://www.actionschoolsbc.ca)). The program targets six areas for action including: school environment, scheduled physical education, classroom action, family and community, extracurricular, and school spirit. With more than 1200 schools currently registered in the program across BC, it is certainly affecting school environments and perspectives.

The problem with ASBC and similar programs is that they are still not reaching enough students in schools. Moreover, physical education is often the first class to be lost when other “academic” demands arise, particularly for youth in secondary and high schools. It is essential that teachers understand the importance of physical activity for students, and ensure that they are receiving sufficient opportunity. In addition, government must support the initiatives with financial and human resources, which are already in short supply for many schools. With sufficient resources, schools are able to implement healthy school programs and avoid the resources available through the sale of unhealthy food and beverages in vending or cafeterias. Overall, “what is required is a response premised upon the social, economic and material realities of schools, and an admission that neither individuals nor schools are the major players in confronting obesity” (Share & Strain, 2008, p. 241).

Although changes are occurring within environments where children spend time, not all schools are participating, and of those that do participate, the degree of success

depends on the dedication of its staff and students. Teachers and administrators are often caught up in “busywork,” rather than “actions that enable students to understand and question the economic, political and social realities that shape their lives” (Share & Strain, 2008, p. 241). While offering programs such as ASBC is crucial in supporting health, programs should include opportunities for students to become active participants in the policy-making arena, not subordinate partners in a consultation process or the ‘activity’ of programming (2008). Furthermore, school-based action should challenge the discrimination faced by overweight children, the dominance of adult priorities (economic, temporal), and provide opportunities for children’s voices to be heard.

#### *Healthy Choices in Recreation and the Community*

Recreation facilities are another important setting where children spend time, during out-of-school activities, child care, and sports. Despite the recreation industry’s mission to encourage healthy lifestyles, many facilities have been slow to offer healthy food and beverages to patrons. Like schools, many recreation facilities earn profits from vending and food services, and are reluctant to risk losing these funds. However, as other environments are changing, recreation is also facing pressure to change its food products. The BC Healthy Living Alliance (in coordination with the BC Recreation and Parks Association and Union of BC Municipalities) is addressing this issue through its *Healthy Eating Strategy*, which has a component for Food and Beverage Sales in Recreation Facilities and Local Government Buildings (BCHLA, 2007). They will be working with facilities across BC to implement the *Nutritional Guidelines for Vending Machines in BC Public Buildings*, as well as providing resources (e.g. toolkit) and incentives.

Recreation and sport have also been at the forefront of many community-based physical activity initiatives. Some examples include Active Communities, which is organized by the BC Recreation and Parks Association; Healthy Eating and Active Living (HEAL) in Ontario; or Saskatoon In Motion, a city-wide PA initiative. Working with health regions and community partners enables recreation and sport to promote active lifestyle choices within the community. Often the recreation programs involve public education campaigns to gain public support and participation.

In addition, smaller community initiatives can also make an important impact. For example, community gardens and farmer's markets offer a means for increasing access to affordable fresh food, connecting more closely with local agriculture, and building cooperation within a community. Community gardens can also work with schools and recreation centers, as well as provide children with learning opportunities, particularly when paired with cooking classes. Changing the health of a community can be achieved even with minimal resources, but it should be supported by governments, particularly within the current context of rising childhood obesity rates and chronic disease.

### ***Public Education***

Public education campaigns help raise awareness and knowledge of health issues, recommendations, and ideas, but when used without significant structural and environmental change, they are ineffective in changing behaviour. Campaigns can reach a large audience within a fairly small budget, and an effective campaign will remain memorable and consistent for years. In Canada, the most effective population health campaign for healthy eating and physical activity was ParticipACTION, which was created in 1971 and operated for thirty years. In late 2006 the campaign received renewed

government support from Sport Canada and the new Public Health Agency, and was revitalized in February 2007 ([www.participaction.com](http://www.participaction.com)). As a private non-profit organization, ParticipACTION is a “catalyst for communications,” but it is not involved in direct programming or program delivery. It partners with other organizations, including the private sector, to facilitate communication, and support ongoing programs, such as Winter Active. ParticipACTION was successful for over thirty years because it was a hybrid of health communication and social marketing (Ontario Health Promotion Bulletin, August 2004). It emerged at a time before health communications was a field of study, and set a powerful example for future initiatives. It managed to create simple and recognizable messages that influenced public perceptions about healthy living (2004).

Other campaigns that have been established include Health Canada’s VITALITY and ActNow BC, which also initiate health communications, but these other campaigns also provide programming and resources. Many initiatives are not only public education campaigns, but also implement programs, which can be useful for enabling community leaders to use existing resources. For example, ActNow BC provides information and promotes the idea that “every move is a good move.” It also acts as a policy framework for other programs and initiatives, including healthy school initiatives.

It is important to recognize that public education campaigns also perpetuate the problematic distribution of responsibility for health onto the individual. Some types of campaigns promote the message that it is the individual’s responsibility to make the ‘right choice’, without recognition of the barriers to healthy behaviour. However, when used in an educational manner, campaigns may counteract some of the negative influence of unhealthy marketing and pressure governments into taking further action. Although

public education campaigns can successfully influence opinions, they do not typically change behaviour (Maziak et al., 2008). Changing the environment remains the main method for achieving healthy behaviour; however, nutrition and physical activity education is an important component of supporting healthy bodies. In Australia, the Simply Active Every Day campaign managed to “greatly increase [people’s] knowledge and intention – they wanted to exercise – but it did not increase the actual rates of exercise” (BC Select Standing, 2004, p. 44). Ideally, campaigns should address the barriers and discrimination that people face as a result of weight issues, and strive to increase understanding of the complex factors involved, rather than focus on individual responsibility for choices. In addition, the ParticipACTION model is especially useful in achieving health communication, as well as public marketing. Campaigns like ParticipACTION tend to promote simple steps for healthy behaviour in the home, such as packing healthy lunches for children, promoting breast feeding, limiting ‘screen’ time, eating together, and being active. In successful campaigns, the ideas are usually easy to understand and avoid blaming, in order to encourage positive reception by the public.

Despite the widespread popularity of health promotion campaigns as a means for addressing obesity or chronic disease, it must be emphasized that these techniques reflect the individualist health promotion (IHP) methods, which are known to be “less than successful” (Share & Strain, 2008, p. 239). When public education is the primary means for government response to a health crisis, such as obesity, it is remarkably insufficient. It allows governments to maintain their distance from direct involvement, and places the responsibility on the individual. However, the structural barriers to healthy weights for children require government involvement (e.g. built environment, industry). Public

education alone is terribly inadequate for addressing childhood obesity, no matter how memorable or interesting the campaign may be.

### ***Corporate Policy***

Some members of the food industry have recognized the changing context of food and beverage selection, and the increased awareness of health problems associated with unhealthy eating and sedentary behaviour. As a result, some companies have begun offering different foods, healthier formulations (e.g. reducing sugar or trans fats), and work with partners to promote healthier lifestyles. For example, Kellogg's has pledged to reduce the sugar content in cereals targeted at children (CBC News, June 14, 2007), and also joined with Canada on the Move, a physical activity program, to provide pedometers to participants ([www.canadaonthemove.ca](http://www.canadaonthemove.ca)). While it is beneficial for community and government initiatives to coordinate with industry, it also important that the companies involved not attempt to diminish the goals of the program for their own benefit. Moreover, the public health organizations should be wary of some of the techniques that industry has used to divert attention from the issue or shift the responsibility (Brownell & Horgen, 2004).

Some public health organizations and initiatives have partnered with food industry in order to sponsor health initiatives. While this is often necessary for financial reasons, such partnerships may compromise the initiative. For example, ParticipACTION's newly revised campaign has partnered with Coca-Cola (\$5 million) to offer the 2010 Olympic Torch Leadership Program, which will promote physical activity (Media Release, [www.participaction.com](http://www.participaction.com)). It is common for food companies, especially soft drink companies, to focus on physical activity rather than healthy eating because it places

the responsibility on the individual's behaviour, rather than the food product. It is short-sighted of a health education program to partner with an organization that manufactures unhealthy products. It is comparable to partnering with a tobacco company, which is no longer considered acceptable. Alternative partners could include athletic clothing or equipment companies, or other business that are not related to food.

Brownell and Horgen outline a number of tactics employed by the food industry to promote their products and circumvent critics (2004). Many of the biggest food companies are owned by tobacco corporations that have extensive legal and political experience with resisting product limitations or restrictions. For example, Kraft owns Nabisco, Post Cereals, Oscar Meyer, Jell-O, Kool-Aid, and others, but Kraft itself is owned by Phillip Morris (2004). The tactics of resistance include claiming to be committed to public health, even though the company's behaviour may not correspond. For example, some companies have agreed to self-regulate by reducing the amount of sugar in products, such as Kellogg's cereals. Similarly, the Vice President of Social Responsibility and Communications at McDonald's stated, "McDonald's has sponsored physical fitness programs and nutrition education for decades. McDonald's takes nutrition very seriously" (Brownell & Horgen, 2004, p. 259). Meanwhile, McDonald's continues to market its products to children, and primarily offers unhealthy choices. Industry directly influences public policy through lobbying and hiring nutrition experts to support their interests or in the United States by making contributions to political campaigns (2004). For example, the Canadian Sugar Association has hired a nutritional expert whom was also on the expert panel revising the *Canada Food Guide* (CSPI

Presentation, Jeffrey). Other conflicts of interests emerge with regard to the food industry and government nutritional recommendations in Canada and the United States.

Another tactic is to divert attention from food by focusing on physical activity. For example the National Soft Drink Association in the US claims that obesity is “about the couch and not the can” (Brownell & Horgen, 2004), even though the scientific evidence indicates that “soft drink consumption may be an important contributor to the epidemic of obesity, in part through the larger portion sizes of those beverages and from the increase intake of fructose from HFCS and sucrose” (Bray, Nielson, & Popkin cited in Brownell, p. 177). Also, industry claims that nutrition information is confusing to consumers, as a result of the “food police,” yet as Nestle points out, nutrition advice has remained fairly constant for the past fifty years (Nestle, 2002, p. 20). Industry also “decries the demonization of a food or the food industry” as they claim that no one food is responsible for the epidemic of obesity (Brownell & Horgen, 2004, p. 262). A Burger King spokesperson demonstrates this denial when he states that “dumping the obesity issue on fast food is completely missing the issue” (2004, p. 263).

While fast food, soft drink and snack companies are not entirely responsible for the obesity epidemic, it is inaccurate for the industry to claim they are free of responsibility. If they wish to maintain a positive public image and not meet a fate similar to tobacco companies, they may wish to consider becoming part of the solution. Many food and beverage companies argue that no food is “good” or “bad”, which is partly true, but evidence demonstrates that some foods are better than others for promoting health. Industry also posits that restricting access to some foods will only backfire, because people will desire those foods more (Brownell & Horgen, 2004). If this

were the case, it would seem that restrictions would actually increase sales, rather than be negative for industry.

One of the most politically relevant tactics is when the food industry argues that restrictions on food violate personal freedom of choice. In the US, the Centre for Consumer Freedom represent many restaurants, tobacco and food companies, and strongly lobbies against any restrictions affecting these industries. They claim that “consumption of food is one of the most fundamental liberties people can enjoy” (Brownell & Horgen, 2004, p. 265). Further, they argue that children should be taught by parents to become good consumers, and be fully exposed to advertising, despite the scientific evidence that children cannot discern the deceptive nature of advertising. It is also the responsibility of parents to ensure that their children eat a healthy diet, and engages in adequate physical activity, thereby, eliminating responsibility at the industry level. Similar arguments were also employed against the public health campaigns to limit tobacco, and although food is different in that we all need it, it presents some interesting parallels.

Brownell & Horgen argue that the food industry must decide whether it is going to approach the obesity crisis as the tobacco industry approached its health crisis, through denial and avoiding responsibility. The other choice is to approach the issue with responsibility and sincerity, thereby potentially avoiding the negative outcomes that tobacco has since faced (2004). Building consumer trust must be achieved first, which Dr. Ludwig from the Harvard Medical School and Boston’s Children’s Hospital argues can be achieved when the industry:

- 1) suspends all food advertising and marketing campaigns directed at children; 2) removes sugar-sweetened soft drinks and snack foods from vending machines in schools; 3) ends sponsorship of scholastic activities and professional nutrition organization linked to product promotion; and 4)

refrains from political contributions that might influence national nutritional policy (Brownell & Horgen, 2004, p. 279).

The industry faces a paradox because they have a vested interest in the continuation of product sales, whether products are healthy or not, as these products result in enormous revenue. Yet, they are also making claims that public health is a priority for corporate social responsibility (Brownell & Horgen, 2004). Options are available for industry to make positive changes, by offering healthier foods, changing product formulations, restricting certain ingredients (e.g. high fructose corn syrup, trans fats), not marketing to children, funding health initiatives, or regulating healthier and more sustainable farming and manufacturing practices. Revenue loss may occur initially, but food will always be necessary and the health of citizens, especially children, must prevail over profits. Even if industry does not self-regulate its actions responsibly, then government should be managing these changes. It is not unexpected for business to act out of self-interest, but “governmental failure to correct the situation, or worse yet, collusion in ways that damage public health” is especially troubling (Brownell, 2004, p. 178).

### ***Conclusion***

Opportunities for changing the environment and supporting healthy behaviour exist. However, many areas have not been pursued or may be considered unviable because they are perceived as threatening to some agents, particularly industry. Considering the scope of the obesity epidemic, and the burden of costs and suffering associated with it, decisive action is necessary. Many of the initiatives, programs and policies currently underway are promising and innovative, but they consistently fall short of the actions required for substantive and comprehensive change. These limitations

become clear when a school fruit and vegetable snack program for students is only able to offer students a snack twice a week, rather than everyday. Worse still, when children are aggressively targeted by multi-billion dollar food and beverage corporations, which governments and citizens accept and even facilitate. It is not enough to settle for partially protecting children's health, as long as it does not interfere with commercial interests or require direct action from governments. Preventing childhood obesity must be a political priority, which demands a reassessment of our approach to the issue. This chapter has attempted to illustrate both the promising practices that have emerged, as well as where fundamental change is possible.

In reflecting upon the limitations of the current public health approach (MPH) and why it is unable to adequately address childhood obesity and chronic disease, we must question its foundations. What does the problem of childhood obesity reveal about our implicit conceptions of children, family, the state and commercial interests? What are the obstacles to implementing appropriate and effective policy to genuinely prevent and treat obesity? In the next chapter I will explore these questions, and reveal how the current approach (MPH) is failing children. As a result, a new public health paradigm must be asserted to recognize children's rights and justice-based entitlements to high standards of nutrition and physical activity in the public and private spheres. Dynamic political action is needed to ensure that children have the best possible opportunities for healthy development, of which promoting healthy weights is an essential element.

## Chapter Three ~ Re-conceptualizing Responses to Childhood Obesity

### *A Discouraging Diagnosis*

In the first two chapters, I have demonstrated the extent to which childhood obesity and chronic disease are serious public health concerns, as well as the limitations in responding to the issue. Clearly, the existing public health approach is ineffective, as it is not reducing the rates of childhood obesity; in fact the numbers continue to climb (Shields, 2005). Individualist health promotion is failing to effectively ensure healthy weights for children because it seeks to “distance government in direct involvement in change” due to the prevailing power dynamics (Share & Strain, 2008, p. 239). Although health promotion initiatives are often rhetorically embraced by policy makers and the media, in practice they “fall far short of the high hopes invested in them” (Callahan, 2000, ix). A different approach is needed to address the limitations of the current public health perspective (MPH), and ultimately protect children from obesity and preventable chronic disease. Health promotion and disease prevention are not only educational and technical challenges, but they “raise profound questions about the role of the state in trying to change health-related behaviour, and the freedom and responsibility of those of us who, as citizens, will be the target of such efforts” (2000, ix). These profound questions are complicated further when addressing the health of children. As vulnerable, dependent and impressionable young people, children’s unique entitlements cannot be met under the current public health approach.

In this chapter I will first explore the current approach to childhood obesity, the Minimal Public Health (MPH) approach. The MPH is the conceptual framework informing public policy and programming responses to childhood obesity and chronic

disease in North America. Repeatedly, initiatives under the MPH attempt to address components of the obesity issue, but cannot achieve the desired outcome. As a result, I question the barriers to effective change, and explore the implicit conceptions disabling the MPH. Through this exploration, I hypothesize that the MPH responses to childhood obesity are embedded with a number of problematic conceptions that not only impede effective policy, but also raise normative concerns. The foundational premises of the MPH include its problematic interpretation of the public/private divide, its failure to recognize children's rights, and its inability to recognize the significance of children's justice-based entitlements to high standards of care. In addition, a secondary concern with the MPH arises due to its disregard for children as 'developing' citizens.

In exploring the MPH framework, it becomes clear that an alternative political conception of childhood obesity is necessary. An alternative conception of the issue must ensure children's claims are recognized as the responsibility of the public and private spheres. Although I do not fully explore the alternative approach, I suggest that it could address children's health through a model of rights and entitlements, which also recognizes the context and importance of interdependency, family and care. In re-conceptualizing children's claims through an alternative approach, the resulting policy and programs would sufficiently protect children's wellbeing and provide increased support for caregivers; directly and environmentally. Thus, the public/private divide emerges as a more nuanced division of care and responsibility, while the healthy development of children is considered fundamental to rights, citizenship and social cohesiveness. Outcomes would include drastic changes to funding and human resources for schools and child care providers to offer healthy meals, as well as changes to

municipal zoning regulations that control the built environment (e.g. restrict the development of fast food restaurants near schools). Moreover, the strict regulation of food and beverage advertising to children would restrict market's access to vulnerable children. According to the current understanding of appropriate public and private interventions, these would be difficult changes to achieve. However, through a revised understanding of shared responsibility for children and the recognition of their rights and entitlements, these types of changes are essential.

### ***The Minimal Public Health Approach***

The Minimal Public Health approach is the term I use to describe the current public health initiatives in Canada. This framework is broadly characterized by the belief that individuals should be 'free' to choose what they eat and how often they exercise, and parents are responsible for their children's behaviour. As a result, the MPH places the onus on parents to protect their children's health, despite the broader environmental limitations, with little direct action by public officials to enforce higher standards of provision and protection for children. The MPH is concerned with supporting only the most basic nutrition needs of children, which leads to developmental inequalities among different children. This is further problematized when "policy approaches that emphasize health education" are implemented, as they "have the capacity to *widen* health inequalities for low-income groups lacking the means or resources to act positively on health information (Branka, Nikogosian, & Lobstein, 2007). Furthermore, the MPH enforces only minimal regulation of marketing, industry or the built environment to influence obesity and inequalities among groups, as this involves more direct government

action. Thus, industry and marketers are ‘free’ to target vulnerable children, shape their life-long brand loyalties and eating behaviour, without restriction from governments.

According to the MPH, childhood obesity is conceived as a private, medicalized and individual health concern. In response, the MPH tends to implement modest educational initiatives to ‘encourage’ individuals to make the ‘right’ choices, without addressing the structural barriers to change in the built environment. This is further demonstrated through the low prioritization of preventative health, which is reflected in government spending (3-6% of the health care budget in BC), and which continuously results in limited funding and resources for programming (BC Select Standing Committee, 2006). In addition, initiatives under the MPH often reflect inconsistencies, such as the recent ParticipACTION campaign accepting “more than \$5 million in sponsorship from Coca-Cola” (see <http://www.participaction.com/whatsnew/pAction.cfm>).

Since the MPH understands children as the responsibility of parents in the private sphere, it also ignores children’s voices in examining the issue of obesity. As a result, children’s interests and experiences are usually not taken seriously, and policies affecting them tend to be more concerned with other factors (e.g. health care costs or commercial interests). The MPH claims to provide ‘freedom of choice’ and consumer sovereignty to adults and children, by maintaining practices of minimal interference; in reality the approach enables much more insidious methods of manipulation and self-regulation of children’s behaviour through the unrestricted access of commercial marketing. As a result of the disturbing characteristics of the MPH, halting the obesity epidemic from the current perspective will be impossible. Some individualized changes may be successful, but overall it cannot make a significant impact at the population level. The inadequacies

of the MPH and the negative implications for children's health demand that we question the implicit barriers to change and re-evaluate the appropriate responses.

*Limitations of the Public/Private Divide*

The MPH implicitly rests upon a particular normative conception of the public/private divide and children's status within the family, which acts as a significant barrier to effective change. According to the modern liberal imagination, the "family is a private and autonomous institution that nonetheless works hand-in-hand with the state: the welfare and stability of the family is essential to the welfare and stability of the political order" (Hearst, 1997, p. 200). The family (especially the nuclear family) serves to "convert the needs of the dependents into a private, rather than a public, responsibility, while at the same time imbuing its members, particularly children, with those values essential to operating successfully in the social and political worlds outside the home" (1997, p. 200). Thus, the public/private distinction represents an idealized conception of children as the responsibility of the private sphere.

Within the private sphere, the claims of children are, in many cases, not considered on an equal basis as adult interests. Furthermore, as feminists have often argued, privacy masks injustices, which are not subject to the same standards of justice found in the public sphere. Thus, children's interests are primarily mediated through the family structure, rather than as direct claims of justice. As a result, children's best interests are not always upheld, particularly when parents are operating in an unhealthy environment. In the current 'obesogenic' environment, the wide-spread availability of high-calorie, low-nutrient food that children are taught to desire from a young age means that parents are often struggling to resist the demands of children to purchase 'unhealthy'

products. Moreover, children often have fewer opportunities for physical activities, such as walking to school, due to safety concerns or limitations of the ‘built environment’ (e.g. no crosswalks). Parents have a responsibility to support the healthy development of their children, but this responsibility should be shared with and supported by the agents of the public sphere, including the state and commercial interests.

Feminists have long drawn attention to the injustices of the public/private divide, which has often restricted women to domestic roles in the private sphere. Even with improved status for women in the public sphere, they continue to perform the majority of housework and care work in the private realm (Tong, 1998). The division of labour is also characterized by a division of power between these two spheres. Domestic labour is not valued as legitimate work and remains unpaid and of low status for many women, which is distinctly unfair, according to many feminists (1998). Considering that the provision of care and housework are foundational to upholding the public sphere, it seems logical to ensure justice in the private sphere. However, as Kymlicka points out, “mainstream theorists have been wary of confronting family relations and judging them in light of standards of justice” (2002, p. 386). Traditionally, the family has been governed privately in terms of “natural instinct or sympathy” rather than principles of justice (2002, p. 386). It appears that the “failure to confront gender inequalities in the family can be seen as a betrayal of liberal principles of autonomy and equal opportunity” (2002, p. 388). Yet, even though the private sphere is unjust, many liberals are committed to maintaining the public/private divide, and assert that the protection of privacy is of high importance.

As with women, children occupy the private realm with little opportunity to assert claims of justice. The work and resources involved with child development are largely considered matters of “biological instinct rather than conscious intentions or cultural knowledge” (Held cited in Kymlicka, 2002, p. 391). Moreover, parental authority is considered the natural arbiter of justice over children in the family. Parents are considered best able to determine the child’s “best interests” and take appropriate action, which is acceptable in many cases. However, some parents may be unable or unwilling to provide high standards of care for their children. For example, when a child is overweight and at risk for chronic disease due to the provision of poor nutrition and limited activity, there is no mechanism for either supporting parents or holding them accountable. This mechanism does not exist (except in extreme cases) because according to liberalism, the child’s interests are implicitly less important than parental autonomy and family privacy.

Since children (especially very young children) are “vulnerable, impressionable, and dependent on adults,” they are fundamentally influenced by their parents’ choices (Macleod, 1997, p. 118). The child’s developmental capacities may be permanently damaged by neglect of the child’s health and nutritional needs; moreover, the child cannot be expected to meet his own needs, which is the responsibility of mature adults (1997, p. 119). As a result, the family is an essential institution for creating healthy citizens, but the experiences of childhood and the resulting developmental capacities of children are far from egalitarian. Many children do not receive optimal care, often lacking the basic necessities and opportunities for healthy development. In the case of childhood obesity, children are at risk for chronic disease and other related challenges,

which disadvantages them in terms of their future opportunities and quality of life. Despite the apparent inequalities, the principles of justice are usually not applied to the private sphere, in order to preserve the intimate nature of the family and the dominance of parental authority.

While it is important to recognize the intimate nature of the family, it is unacceptable to use it as a mask for injustice. Historically, the private and intimate nature of family life has de-valued the work and contributions of women and children. The ethic of care literature in recent feminist theory has drawn attention to the importance of interdependency and care work that takes place in the private sphere (Gilligan, Tronto). The care performed in the private sphere is fundamental to child development, and must not be hidden because of its intimate and sentimental character. Claims of justice can be sensitive to the realities of care, intimacy and interdependence when addressing children's needs, as applications of justice are not necessarily coercive. The relationship between the public and private becomes crucial to attentive justice in the family. As feminists have argued, "the private is not private – it intersects with the public. What happens to women and children at home is structured by public theories and policies; and what happens in the private domain affects the public domain" (Mayall, 2001, p. 247).

Recognition of women's equality has improved as a result of feminist theories and demands for justice in the public and private spheres. Children's claims are more complicated, however, since children are developing and may lack the capacities necessary for making claims of justice. In the public and private spheres, children are considered inferior to adults (partly due to their dependency), which limits their abilities

to make claims of justice or speak for their own rights (Mayall, 2001). The powerful body of knowledge on child development and socialization overwhelms the opportunities for children's claims to be heard and further separates the social groups of adults and non-adults (2001). Children are embedded in the family where they are believed to be protected from the dangers and stressors of the public sphere. However, this belief is an inaccurate reflection of the experience of childhood. In terms of their health, children are fully exposed and at the mercy of the media, food industry and Minimal Public Health initiatives. Children's status is further de-valued when parents and other adult citizens do not fulfill their responsibilities for supporting healthy child development.

The privacy of the family and the dominance of parental authority limit the possibilities for assessing the quality of care children receive, including nutrition and physical activity. Unless a child's basic needs are denied or the child is in immediate risk of harm, intervention and support are unacceptable under the current understanding of the public and private spheres. While I am not advocating for the removal of children from their families or the elimination of privacy and intimacy, I am asserting that some mechanism for assessing children's health rights be engaged and that children's claims be considered as equal in status to adult claims to autonomy and authority. The health risks associated with poor nutrition and limited exercise, are comparable to other physical dangers that children should be protected against, and are fundamental to their development. I recognize that not all of children's claims may be as essential to their healthy development. Moreover, children's opinions may not always reflect their "best interests," and parents are ultimately responsible for many decisions. However, parents need to recognize that their choices are affecting these developing citizens, and that

children have rights to protection from preventable harms, even when it limits parental authority. In addition, health is not only a private concern; it is deeply affected by public and commercial interests, which must be managed and regulated to prevent harm to children and support families. If children's health claims continue to be ignored or manipulated, the long term consequences will have serious implications for their lives in the public and private spheres.

### Public Intervention

Although the liberal ideal purports a clear public/private distinction, in reality the state is often involved in the family and the lives of children. Education and health are two main components of child development for which parents are not solely responsible in the private sphere. Education is typically handled by public institutions, while health care (disease treatment) is handled through family doctors, public health nurses, and in hospitals. Simultaneously, the privacy of "the family has been carefully molded: the state has had considerable input in defining who could claim status as a family, what rights, privileges and liabilities attached to that status, and in defining relationships within the family" (Hearst, 1997, p. 201). Through this understanding of the public/private divide, the parameters of the family and child development remain based on the image of autonomous, rational individuals. However, this is "particularly unsuited to understanding how the family might be regulated" (1997, p. 202), as well as how agents in the public sphere might be responsible for children's healthy development. In reality, children are 'developing' individuals, embedded in a web of relationships based on care in *both* the public and private spheres. Through children's access to public institutions,

such as schools, they develop their identities and capacities. Moreover, the state has influenced the structures and definitions of family relations, which affects children.

Perhaps most importantly, the public sphere's unmediated access to children enables it to shape their beliefs and behaviour, often in sophisticated and insidious ways. Whether through the state or market, public access to children is often ignored under the sharp public/private distinction, which asserts that children's development is almost entirely private. However, commercial and political interests have a great deal of power over children's development, including their weight through various mechanisms. This power is applied directly, through advertising or public education campaigns, as well as indirectly, by prioritizing particular issues, such as reducing funding to schools and expecting them to supplement budgets through vending machines sales. The most significant public influence on children, however, has been the shift toward understanding children as consumers.

The commercialization of childhood has been particularly driven by the corporate interests of the food industry who possess remarkable power to encourage overeating in general, and in particular, the "tasty" foods that are high in sugar, sodium and fat (Nestle, 2002). More than one third of children's overall spending, which in 2002 was estimated at \$30 billion in the US, is spent on "sweets, snacks, and beverages" (Schor & Ford, 2007, p. 10). Furthermore, advertising has become more symbolic and sophisticated, and many approaches "place food brands at the centre of themes such as finding an identity, and feeling powerful and in control" (2007, p. 19). Thus, children are particularly vulnerable to the deceptive messages of advertising and the appeal of 'unhealthy' food

products, which demonstrates how unregulated commercial access to children is problematic to protecting health.

Under the MPH, few regulations manage the food environment or support the healthy development of children in public or private spaces. Meanwhile, the existing regulations typically reflect the state's deference to corporate and commercial interests, rather than a commitment to public health or the entitlements of children. It is essential to question why commercial interests seem to trump children's health interests, and why governments are willing to enable such blatant irresponsibility for children. In addition, the MPH approach makes it seem acceptable to leave responsibility with parents, while enabling commercial interests to maximize access to children, despite their vulnerability.

The public/private distinction, and the invisibility of children as public, rights-bearing people, allows for the continued inattention to children's entitlements (high standards of nutrition and activity), and the unchecked liberty of commercial food and beverage powers. Martha Minow reveals that "locating children within the larger legal system [yields] the conclusion that children simply are not the real focus of the varied laws that affect them" (1996, p. 45). Furthermore, she asserts that the "inconsistent legal treatment of children stems in some measure from societal neglect of children. The needs and interests of children, difficult enough to address when highlighted, are too often submerged below other societal interests" (1996, p. 45). This is true of the laws and regulations that emerge from the MPH framework, which imply that if health information has been provided, then it is the responsibility of parents to choose what they feed their children and the state should not be further involved.

This implication is rooted in the basic legal framework governing children, based on the sharp distinction between public and private, which assigns child development as the responsibility of parents, and thereby avoids public responsibility for children (Minow, 1996, p. 46). Most people accept this approach and its limitations for promoting children's optimal development, even though public neglect could have negative long term consequences. Public power becomes relevant only in exceptional circumstances, when parents default and fail to provide the minimum standards of care, which "essentially authorizes public neglect of children while assigning duties to parents" (1996, p. 46). As a result, families are operating in an environment that actually constructs the development of "unhealthy" citizens, yet most people are unwilling to challenge this problematic division.

#### *Re-interpreting the Public/Private Divide*

Since children's health claims are fundamental to their protection from harm and the maximization of future opportunities, principles of justice should be applied to their assessment. When children are at risk for becoming overweight and developing chronic disease, they should have sufficient support and high quality care to ensure that they are receiving optimal nutrition and physical activity. If parents or other caregivers fail to provide the nutrition, exercise and other medical attention necessary for maintaining healthy weights, then parents are acting negligently, whether intentionally or not. Although state intervention in the family is often problematic, potentially resulting in traumatic and unhealthy experiences for children, a family-based approach to health management need not be coercive in nature. Rather, using a family-based intervention model such as Shapedown, children and their families could be supported in their

lifestyle and behaviour changes. Recognizing that many parents are doing their best to meet the needs of their children, but are operating in a hostile environment, interventions should not attack parents, but support them.

Children and youth should have the opportunity to voice their health concerns, so a representative or commissioner should be established to monitor the quality of care (nutrition and PA) children receive in the family and in public institutions. Although this already exists for children experiencing violence or other forms of abuse (e.g. BC Representative for Children and Youth), it is reasonable to establish a representative for children's health, as health issues have a significant affect on the child's quality of life and development. Recently, the temporary Canadian Advisor on Healthy Children and Youth suggested the implementation of a permanent national representative for child and youth health, as well as a Centre of Excellence for Childhood Obesity, which would help give voice to children's health concerns at the political level (Leitch, 2008). The representative should have political access and power in order to effectively protect and promote children's entitlements, but should be accessible to children and youth. Moreover, teachers, health care providers and other caregivers have a responsibility to refer children and families to health representatives that will assist them in making positive changes. Should parents resist intervention or refuse to protect their child's health, then the principles of justice would demand that the child's interests be protected by the state. Obviously this is not an ideal situation, but children's claims to health are fundamental to their wellbeing.

Applying theories of justice to the private sphere also challenges children's status within the family. Through this perspective, children are recognized as morally equal

human beings with social rights, even though children do not have equal political and civic rights as adults. Children also possess special protections due to their vulnerability and dependence, which must also be recognized. First they have the right to equal opportunity for optimal development, which is determined largely by the environment and provision of particular needs (e.g. nutrition, socialization, education). Second, their fundamental claims (e.g. health and nutrition) must be considered equal in relation to adult claims. Moreover, children have the right to express their interests, which is often first mediated through the family. In regards to fundamental claims, however, children (or their representatives) should have the opportunity to seek independent mediation. In addition, the uninhibited commercialization of childhood must be challenged to reveal the inability of children to act as discerning ‘consumers,’ which requires that the state intervene to protect children from potential harms. Ultimately, by challenging the perspectives of the MPH and revealing the traditional public/private distinction, it is possible to demonstrate how these spheres are intersecting, interdependent and not as rigidly defined as traditional liberalism would have us believe.

### *Neglecting Children’s Rights*

Due to the rigid public/private distinction, the MPH has traditionally neglected engaging with children’s rights in its efforts to address childhood obesity, which enables it to prioritize other interests over the interests of children. However, the *Convention on the Rights of the Child* provides a legal foundation for understanding children’s basic human rights, and the special protections needed to address their particular vulnerabilities. In order for the Convention to be effective, however, children must be educated on their rights and given the opportunity to voice their perspectives. In

addition, the state's legal structures must integrate children's rights into their processes. Canada, along with nearly every other country in the world has ratified the Convention, with the exception of the United States and Somalia (Howe & Covell, 2005). Yet in most states the Convention remains a "nice sentiment" rather than effective legal instrument for protecting and promoting children's interests.

If we take rights seriously, however, then the factors leading to wide-spread childhood obesity and chronic disease clearly violate the rights of children, according to the Convention. In particular, providing children with poor nutrition and limited PA in an 'obesogenic' environment does not uphold the "best interests" principle<sup>7</sup> for children. Moreover, considering the consequences of obesity, it is not in the best interests of a child to be at risk for unhealthy weight gain. The Convention states that the "best interests of the child shall be the primary consideration" for parents and states (Article 3.1). Moreover, "state parties shall undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, guardians or others legally responsible for him or her" (Article 3.2). Therefore, adults have a responsibility to protect children and provide care to ensure that they develop at a healthy weight. In addition, the priorities and actions of governments, industry and other citizens should also reflect the legal obligations to implement children's "best interests". Upholding children's rights is necessary to meet the legally binding agreement of the Convention. Children's fundamental rights to grow up in a family, be protected from harm, and be provided with the best possible means for healthy

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<sup>7</sup> Article 3 of the Convention states that "in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration."

development dictate that children's claims are equally as important as adult claims of autonomy and authority.

At first glance it seems universally desirable to uphold children's rights, and argue for the protection of their health from this perspective. However, there is often reluctance to engage with the Convention, even among those concerned for children's health. Applying the Convention is often perceived as a threat by family values organizations, traditional conservative politicians, and some parents' groups, who argue that if children become aware of their human rights, it will undermine the family and adult authority (Howe & Covell, 2005). Such reluctance re-enforces the power of the public/private distinction discussed earlier. Moreover, it neglects to acknowledge the benefits of children understanding the rights and duties of belonging to a community from an early age, and the possibilities for gaining insights into the experience of childhood through children's own expressions.

In 1999, child elections were held across Canada to celebrate the tenth anniversary of the United Nations adoption of the Convention. Children in schools were educated about their rights and given the opportunity to vote on the rights most important to them. The vote caused significant outcry among administrators, parents and politicians who believed that children should not participate. One school trustee in Abbotsford, BC stated that the vote "undermines the integrity of the family and involves children in a political undertaking. There is a gradual erosion of parental authority and this is one more step in that direction" (Howe & Covell, 2005, p. 3). Many feared that children would "become overly demanding and would give priority to their own personal freedoms" (2005, p. 4).

Interestingly, the vote revealed that what Canadian children value most is the right to grow up in a family (Howe & Covell, 2005, p. 4). This was followed closely by the right to food and shelter and the right to health care (2005). Since the adoption of the Convention, no reports have emerged demonstrating that the awareness of rights has led to children defying the authority of their parents, religious leaders or teachers (2005). Children's rights are meant to be tools for improving the quality of children's lives in many contexts. Teaching children about their rights also enables them to respect the rights of others, learn about social responsibility, and to support principles of justice and equality (2005). In addition, it helps children learn to respect one another, and potentially develop a sense of empathy for other children who may be struggling with weight.

Since the factors leading to wide-spread childhood obesity and chronic disease violate the rights of children according to the Convention, we must re-evaluate these factors to determine how children's rights can be upheld. Furthermore, obesity is difficult to treat, so prevention is an obvious priority (Brownell & Horgen, 2004). Changing children's nutrition and PA is necessary, as well as changing the broader environment to support children's rights. The legal obligations of the Convention dictate that parents, government, industry and other citizens each have a responsibility to ensure that children are provided with conditions of living for healthy development. The fact that Canadian children most value their opportunities for family, food and shelter, and health demonstrates the importance of protecting and supporting these areas. Considering the scope of the obesity and chronic disease epidemic, we are not meeting the rights most valued by children in the current public health context. Moreover, many opportunities exist to improve the provision of care to children within the family, and through public

policy. To achieve those changes, it will be necessary to continue challenging the traditional public/private distinction and engaging with children's rights, which means acknowledging children as part of the public sphere.

*Justice as Egalitarian Provision and Protection from Harm*

While the Convention establishes a legal framework for interpreting the equal claims of children to their fundamental rights, it does not clearly indicate the extent to which those rights must be met. Are children entitled only to the minimum provision of their basic necessities, such as food and shelter? For many children around the world, even these basic needs are not met. However, for children to have the best opportunities for healthy development they require more than the minimum provision of care in terms of nutrition, physical activity, education, socialization and other developmental necessities. Thus, if parents are to ensure the child's wellbeing, then they must seek to provide a high quality of care, but how is this measured? Further, what if parents are unequally capable of providing high quality care? In the case of childhood overweight and chronic disease, parents may be disadvantaged for socio-economic reasons, or may lack the knowledge and capacity to provide healthy food and safe physical activity.

According to the Egalitarian Provision Thesis (EPT), children are entitled to the provision of their needs that provide them with an equality of opportunity that corresponds to the ideal of liberal equality defended by various influential theorists (Macleod, 2007). The EPT demands provision for children beyond the Minimal Provision Thesis (MPT), which requires that children be provided with their basic needs to lead a minimally decent life (2007). The EPT can be further distinguished between the moderate and the strong version. The moderate version enables a basic equality of

opportunity for children, while the strong version seeks to “equally indemnify persons against all morally arbitrary sources of disadvantage that impair their overall life prospects” (Macleod, 2007, p. 7). While the strong egalitarian approach may be unrealistic, it recognizes the importance of ensuring children have the best opportunities for healthy development. Moreover, it acknowledges that many children face inequalities that are due to pre-existing conditions into which they are born.

Preventing or treating childhood overweight or obesity may fall under both of the egalitarian provision theses. Under the moderate approach, children within a healthy weight range would likely have an equal opportunity for a healthy childhood and adulthood. Yet, the strong egalitarian provision thesis would expand upon the importance of being a healthy weight, to ensure that “all children have an entitlement to an upbringing that ensures that their welfare and development interests are equally well served (relative to their generational cohort) and that they enjoy an equal opportunity among their generational cohort to lead a good life” (Macleod, 2007, p. 7). The strong EPT requires that children be a healthy weight, in addition to meeting their other nutritional and fitness needs, developing skills to remain healthy throughout life, and generally having a positive physical and emotional experience with their health. In many ways, the EPT is an expression of good quality care, and meeting the entitlements involved in this process is determined through theories of justice and fairness.

In analyzing children’s entitlements to care through the paradigms of justice, the importance of intimacy and emotional attachment are sometimes lost. Thus, it is valuable to reassert the arguments of feminists who draw attention to the blind spots in theories of justice, particularly in relation to the family. Feminist theory has

demonstrated the importance of interdependency and webs of relationships that inform decision making and conceptions of justice (Tronto, 1994). Furthermore, the disembodied or disembodied self that is theoretically engaged in interpreting justice is an inaccurate reflection of the family (Kymlicka, 2002), especially for children who require care. Any application of the principles of justice in the family must address the inherent inequalities or injustices, as well as recognize the integral relationships. Often children do not possess the capacities, voice or opportunities to challenge injustices; therefore the emotional attachment of caregivers to children offers the primary means for ensuring children's rights are upheld. Parents and caregivers who deeply love their children want to see them grow into healthy, happy adults.

Unfortunately, many parents cannot fulfill their desires due to broader inequalities of resources and opportunities. Therefore, justice for children requires the equal distribution of resources and opportunities across both the public and private spheres. In preventing obesity and chronic disease, this also requires a healthful environment in which to access resources and opportunities. When parents cannot meet their responsibilities to their children, then the state has a responsibility to support their efforts by changing the environments where children spend time, re-distributing resources or regulating built-in disadvantages. Creating healthful environments may sometimes require drastic action by the state, through regulations or re-constructing the built environment, but this is necessary to address the injustices caused by such factors. With regard to family intervention; however, it is only when parents refuse to meet their responsibilities that legal structures of justice must intervene to protect children.

Parents do not own their children, and cannot “subvert the development of autonomy in their child or raise children in such a fashion that they will impose substantial burdens on other members of the community” (Macleod, 2007, p. 14). Moreover, parents cannot violate the rights of their children as laid out in the Convention, or the protective laws of the state. While obesity and chronic disease may not seem as immediately threatening as domestic violence or other legal violations, over the long term, the consequences can be deadly (Brownell & Horgen, 2004). Most parents are probably willing to change behaviour and improve the opportunities for their child when given sufficient support and a healthy environment. However, for parents who refuse to comply with health interventions or recommendations, their children are at considerable risk.

When children are at risk for being harmed, the state has a responsibility to intervene; initially through increased supports for the family, but with the primary goal of protecting the child. In the Millian liberal view, “the guarantee of noninterference is conditional rather than absolute: autonomy and privacy rights are subject to the standard constraints imposed by Mill’s harm principle” (Lotz, 2004, p. 292). When applied to the family, the harm principle stipulates that parental autonomy and privacy is justifiably restrained by state interference only where a child has been harmed or is in immediate and real danger of being harmed (2004). Risks associated with obesity are real dangers to the child, and some of the consequences will be immediate (e.g. low self-esteem), while others will be longer term (e.g. Type 2 diabetes). Should parents refuse to protect their children, then intervention may be justified. However, as I have asserted earlier, family interventions should be supportive and care-based to the maximum extent

possible, and the children's interests should be understood through the value of the existing familial relationships.

### *Becoming Citizens*

Since children possess rights and are entitled to equal resources and opportunities for healthy development, it is also important to recognize children as 'developing' citizens. Although the creation of healthy citizens is important for the state, this concern is secondary to the significance of the legal, moral and political responsibilities for protecting and caring for children. Children do not yet possess all the capacities for legal and political citizenship that adults possess, but children are developing these capacities. As citizens, children are integral to the 'national' community in which they will participate as full legal citizens later in life. During childhood, they are entitled to the rights outlined in the Convention, and protection against any inequalities or injustices that undermine the ties of citizenship. I am not arguing that obese children could not contribute in meaningful ways as adults, rather that their quality of life, health and opportunities for development are potentially more limited. As the evidence illustrates, persons with chronic disease suffer more in terms of education, income and other factors, as well as experience physical suffering and discrimination (Warshawski Presentation, 2005). It is reasonable to strive to minimize the preventable harms to children and ensure the best possible outcomes for their childhoods and adult lives.

In many ways, understanding children as citizens is an extension of the interpretation of principles of justice and care. Recognizing children's rights, their status, and equal entitlements are foundational conditions for citizenship. The benefit of recognizing children's status as "citizens-in-development" is that it highlights their

importance for the public sphere. Children are no longer the responsibility of their parents alone, but also represent the nation's future. Moreover, society will either benefit or suffer, depending on how future generations are prepared for their role as citizens.

Citizenship “articulates the terms of belonging in a society by defining the entitlements and obligations that accompany full membership” (Kershaw, 2005). The rights and responsibilities that shape membership are partly determined by constitutional and legal frameworks, as well as civic participation and social cohesiveness. The Convention already outlines children's rights as citizens, and the principles of egalitarian provision articulate the extension of those rights. However, we must also question the assignment of responsibilities for upholding children's rights. Rights cannot be enforced unless they are recognized and respected by other citizens, namely adult citizens.

Civic responsibility is traditionally expressed in terms of political participation and virtue, but to what extent is the promotion and protection of health a civic responsibility? Clearly health is not always within control of the individual, and adult citizens have the capacities and autonomy to make decisions about whether to protect or promote their own health, and to what extent. Preventing childhood obesity, however, may be interpreted as a civic responsibility, which lies with parents as well as other citizens. Obviously not all adults have an equal responsibility to the protection of individual children; however, the construction of children's public environments lies within the realm of responsible civic duty. Schools, recreation facilities, industry, marketers and others have a moral and civic duty to protect children, not exploit their vulnerabilities for profit. The common ties developed through citizenship cannot be maintained if some members are sabotaging the efforts and development of other

members. Children must be protected and supported in their development, with the hope that they will become healthy, politically and socially engaged, and economically productive citizens.

Finally, understanding children as a shared responsibility among citizens also facilitates empathy and altruism for children who may be overweight, rather than blaming or disgust (Schwartz & Brownell, 2007). This allows “people to put themselves in another person’s shoes,” which is especially important for meeting the needs of children (2007, p. 85). For example, school districts that decide to ban peanuts from the school environment for the sake of a few allergic children demonstrate how “collective empathy for the vulnerable children allows the protective policy” (2007, p. 85). Unfortunately, with obese children and their parents “empathy is in short supply,” and many argue that the state has no place in regulating the food environment because parents should just be more responsible for their children’s weight (2007, p. 85). The evidence has demonstrated the complexity and importance of the environment, and psychological and biological factors involved with obesity. It is not caused by a lack of self-discipline, and cannot be resolved with ridicule or stigmatization. Rather, increased empathy and altruism and a shared sense of responsibility as citizens allows for better support in addressing weight-related challenges. Drawing attention to the human suffering involved can help illuminate the insensitivities that permeate the media and perpetuate public misperceptions.

### ***Conclusion ~ Moving Beyond the MPH to Address Childhood Obesity***

This thesis has demonstrated the scope of childhood obesity and chronic disease, and the need for re-interpreted responses to protect and promote children’s health. The

foundations of the MPH approach are flawed and problematic, which prevent it from effectively addressing childhood obesity. The rigid limitations of the public/private distinction, the inattentiveness to children's rights, the inability to address children's justice-based entitlements and the neglect of children as 'developing' citizens disables the MPH as a framework. These problematic foundations are reflected in the policy and program responses to childhood obesity, which are proving ineffective. Moreover, the current responses claim to allow for 'more freedom' and less government intervention, however, they enable more harmful and subtle means for manipulating children through food and beverage marketing and the 'obesogenic' environment.

Currently, Canada is managing the childhood obesity poorly when compared with similar states. Canada ranks 27<sup>th</sup> out of 29 OECD countries for childhood obesity, and it ranks 21<sup>st</sup> in childhood well-being, including mental health (Leitch, 2008). Under the MPH framework, children's well-being is simply not a significant priority, despite the legal obligations established in the Convention. Children's entitlements to high standards of nutrition, PA and health education are not recognized as fundamental to their development. Clearly we cannot continue on the current path by allowing the obesity and chronic disease rates to rise.

While this paper has not provided a comprehensive treatment plan for childhood obesity and chronic disease, it has demonstrated the problematic underpinnings of the current approach, and suggested how we may re-interpret children's claims to higher standards for health. There are many possibilities for change, which I have proposed throughout the paper, but which require further investigation in terms of an alternative public health approach. However, some requirements for a new paradigm are clear,

including the need to re-conceptualize children as the responsibility of the public and private spheres, which does not threaten the family, but simply recognizes the existing influence of the state and commercial interests on childhood obesity. In particular, the application of an *effective* framework requires changes to regulatory standards, and would demand more rigorous attention to re-structuring the built environment and aggressively restricting commercial access to children, particularly in schools and other public spaces. In addition, it would require the establishment of political health representatives for children, to ensure that their voices are heard and needs addressed.

Essentially, the individualist health promotion strategies would be re-evaluated in addressing obesity, and replaced or supplemented with effective government action that may be openly and critically evaluated by citizens. While the full exploration of more comprehensive initiatives is beyond the scope of this paper, it is possible to envision how they could unfold to support the development of healthier children. Re-evaluating responses to childhood obesity and chronic disease enables political action, but there must be a stimulus to change. As Brownell and Horgen argue:

that stimulus is now beginning to take shape. It is concern, even outrage, over the human suffering caused by this environment, especially in children. Suffering is least defensible when children are affected, and children are the most startling victims of the toxic environment (2004, p. 18).

As a result, citizens of all ages must begin to challenge the acceptability of the current situation and become active political participants in changing the MPH framework and its inherent inequalities, rather than remaining victims of an ‘obesogenic’ social and political context.

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