Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Submission to the Healthy Kids Panel by the Registered Nurses' Association of Ontario

Building a More Inclusive and Vibrant Ontario to Support Children's Health

November 26, 2012

Registered Nurses' Association of Ontario L'Association des infirmières et infirmiers autorisés de l'Ontario
158 Pearl Street, Toronto, ON M5H 1L3 - Toll-free 1 800 268 7199 - Fax 416 599 1926 ~ www.RNAO.ca

1. Introduction and Background

The Registered Nurses' Association of Ontario (RNAO) is the professional voice for nursing in Ontario. Our mandate of *Speaking Out for Nursing, Speaking Out for Nursing and Speaking Out for Health* has positioned our organization as a key player in shaping health care and nursing provincially, nationally, and internationally. RNAO has taken this mandate with utmost seriousness as reflected in the myriad of evidence-based policy and practice programs, communications and advocacy work. Nurses believe that health is a resource for everyday living and that access to the conditions that permit health is a universal human right.[1]

Three recent ground breaking reports exemplify RNAO's influential work: *Primary Solutions for Primary Care; Enhancing Community Care for Ontarians (ECCO): A Three* Year Plan; and RNAO's Submission to the Government of Ontario's Senior Care Strategy. The three, are central pillars to improve health system integration and ensure Ontario becomes a high-performing health system that achieves the 'triple aims' of improved patient experiences, enhanced population outcomes, and health system cost-effectiveness. The focus of these work is on locating care coordination and system navigation within primary care, with a strong emphasis on health promotion, disease prevention, chronic disease prevention and management, and mental health – resulting in a system that is upstream and more responsive to the public's needs.

Equally vital in our quest to advance quality care, and improve population and system outcomes, is RNAO's Best Practice Guidelines Program. Launched in 1999 and funded by the Ministry of Health and Long-Term Care, the program has evolved into an internationally acclaimed one that is influencing nursing practice and policy in Ontario, Canada and abroad.

RNAO has long advocated for healthy children as cornerstone to building healthy and vibrant communities. RNAO is the voice of the public in shaping healthy public policy, strengthening our publicly funded and not for profit health care system, and providing evidence-based unbiased facts that inform discussion and deliberations. It is in this context, that the articles and opinions that appear on the HealthyDebate website are important additions to the public discourse about health care in Ontario.

A signature program of the RNAO is the ***International Affairs and Best Practice Guidelines Program*** (IABPG), which is focused on the development, dissemination, implementation and evaluation of clinical and healthy work environment best practice guidelines (BPGs). The program was launched in 1999 with multi-year funding from the Ontario Ministry of Health and Long Term Care. To date, RNAO has developed thirty-nine clinical practice guidelines, nine guidelines focused on healthy work environments, a tool kit[2] to aid in the implementation of the guidelines in practice settings, an educator's resource[3] to facilitate guideline implementation in the nursing curriculum and education programs, and numerous other evidence-based education and implementation resources (*see Appendix A for a list of BPGs and other resources*).

The published guidelines, many of which address child, youth and maternal health, are disseminated and uptake is supported using a multi-pronged approach that includes a focus on individual capacity development, through the Best Practice Champion Network®[4] and RNAO Institutes; and organizational/system implementation through the Best Practice Spotlight Organization®[5] (BPSO®) designation. The BPSO designation is a formal process

wherein institutions apply for a three formal partnership with RNAO, to implement multiple BPGs and evaluate their impact on clinical and organizational outcomes.

The BPGs are actively implemented provincially, nationally and internationally, and the impact on clinical practice and client outcomes has been profound. Through a focus on individual practitioners and organizations, there have been significant enhancements made in developing evidence-based cultures that support using the best evidence in ongoing daily practice. The guidelines, related resources, and implementation projects are freely available on the RNAO web site at www.rnao.org/bestpractices.

The RNAO appreciates this opportunity to provide a submission to the Healthy Kids Panel on how to improve the health of children and reduce childhood obesity in Ontario.

> **The inequities in how society is organized mean that the freedom to lead a flourishing life and to enjoy good health is unequally distributed between and within societies. This inequity is seen in the conditions of early childhood and schooling, the nature of employment and working conditions, the physical form of the built environment, and the quality of the natural environment in which people reside. Depending on the nature of these environments, different groups will have different experiences of material conditions, psychosocial support, and behavioural options, which make them more or less vulnerable to poor health. Social stratification likewise determines differential access to and utilization of health care, with consequences for the inequitable promotion of health and well-being, disease prevention, and illness recovery and survival.**
>
> **(Commission on the Social Determinants of Health, 2008:3)**

2. The Critical Importance of Social Determinants of Health for Health at All Ages

Consistent with the cumulative global evidence in the Final Report of the Commission on the Social Determinants of Health,[6] data from Ontario confirm that the burden of disease and premature death closely follow the social gradient. Ontarians of lower socioeconomic position experience much higher levels of chronic disease, disability, and premature death than more advantaged Ontarians.[7] If all Ontarians has the same health as Ontarians with higher income, an estimated 318,000 fewer people would be in fair or poor health, an estimated 231,000 fewer people would be disabled, and there would an estimated 3,373 fewer deaths per year among Ontarians living in metropolitan areas.[8]

3. Childhood Obesity and Social Determinants of Health

Although overweight children may be found at every socioeconomic level, it is important to note that the prevalence of overweight children and youth in Canada varies along a gradient by income. Children in the poorest neighbourhood had a 35 per cent overweigh prevalence compared with 30 per cent in the middle socioeconomic neighbourhood and 24 per cent overweight prevalence in the most affluent neighbourhood.[9] Of the 393,000 children living in poverty in Ontario in 2009, 7.3 per cent lived in deep poverty, as their family income was less than 40 per cent of median family income in the province.[10] “Children live in poverty

when their families live in poverty. In 2009, more than 1 in 3 children in female lone-parent families lived in poverty, compared to 1 in 9 children in two-parent families."[11] The health impacts of childhood poverty extend across the lifetime, even when material circumstances improve. In the United Kingdom, the death rate for adults between 26 and 55 years who grew up in poor socioeconomic conditions in childhood was double that of those living in the best conditions.[12] The death rate for those whose socioeconomic status disadvantage continued into early adulthood was between three and five times higher than those in the optimal conditions.[13] The British women's health and heart study found that belonging to the manual social classes in childhood and adulthood was independently associated with increased insulin resistance, dyslipidaemia, and obesity in older women.[14] Even if women moved into non-manual classes in adulthood, women who were in the manual social classes as children remained at increased risk for insulin resistance, dyslipidaemia, and obesity.[15]

Access to nutritious food to enable good health is severely compromised among low-income families in our communities.[16] One quarter of low-income adults in Ontario reported they did not have enough food to eat, worried about there not being enough to eat, or did not eat the quality or variety of foods they desired due to lack of money, according to the Canadian Community Health Survey.[17] According to nutrition researcher, Valerie Tarasuk, national and provincial averages hide the fact that within low-income communities, a very high percentage of people are experiencing hunger.[18] A sampling of 484 low-income families residing in high-poverty Toronto neighbourhoods found that two-thirds of the families were food insecure over the past twelve months and over one quarter were severely food insecure, indicative of food deprivation.[19]

With food bank use "at an all time high," "there is an undeniably high number in Ontario (who) live each and every day chronically hungry."[20] In March 2012, 412,998 Ontarians turned to food banks for assistance, a 31.4 per cent increase since the start of the economic downturn in 2008.[21] More than one-third (38.7 per cent) or 159,918 of these individuals were children.[22] This is an increase of 11,737 more children compared with March 2011.[23] In terms of other relevant characteristics of food bank users in Ontario, 27.3 per cent were on disability support, 42.8 per cent were on social assistance, and 64.5 per cent were rental market tenants.[24]

Despite the good intentions and hard work of many within the charitable food sector, the needs of many of those most severely in need continue to be unmet. Despite the high profile of food banks, only 20 to 30 per cent of those experiencing food insecurity seek charitable food assistance.[25] Across Canada, 55 per cent of the food banks have been forced to cut back the amount of food provided to each household due to scarcity.[26] During March 2012, 19.2 per cent of food banks ran out of nutritious food in our province.[27] These self-reported findings by the food banks have been confirmed by researchers who report that it is common for people accessing food banks and charitable meal programs to report still going hungry. This is due to the "extraordinary levels of vulnerability of those seeking food charity" and the limited assistance available from "a highly fragmented, resource-constrained system of food relief."[28] Federal and provincial programs that "comprise our 'social safety net' are failing to enable many Canadians to meet their basic food needs."[29]

Being poor means….praying for a miracle that you'll have enough money to buy food next week….It means bundling up your child to go out in a snowstorm to a Food Bank for a few canned goods. It means feeling ashamed…It means walking a long way to line up to get Christmas presents for your children so that they can believe that dreams can come true…It means never having dreams or aspirations.

A mother on social assistance (Campaign 2000 (2011: 6)

4. The Impact of health, education and policy interventions

Nurses and other professionals in health care across all sectors can be instrumental in influencing both the prevention and management of childhood obesity. It is clear that the simple formula to combating obesity through increasing activity and ensuring proper nutrition has numerous challenges, many of which are beyond the individual's control, and involve system and organizational change [30] [31] [32] [33] [34]. Recognizing this, the RNAO Best Practice Guideline on Primary Prevention of Childhood Obesity[35] utilized the best available evidence to determine recommendations built on a broad model entitled the Ecological Framework for the Prevention of Childhood Obesity. This framework utilizes concepts from Kumanyika et al[36] and Lobstein et al[37] and acknowledges the role of government, the corporate sector, community, school and family as well as the health care system in tackling childhood obesity.

Within that framework, there are key roles for nurses and other health care professionals which include: health promotion related to nutrition and activity when working directly with populations and children and families; advocacy for healthy public policy related to food marketing, communities (including built environments) and food and nutrition requirements; education, support and interventions when working with teachers and others in the school community; and regulation of food marketing[38].

RNAO is currently writing the second edition of the childhood obesity best practice guideline, to be released in 2013. Work to date related to the evidence review has identified more and stronger evidence to support the Ecological Framework and the direction of the recommendations in the first edition.

5. Taking Action on All Fronts

Recommendation 1: Improve health and decrease health inequities, including childhood obesity, by addressing social inequities through recommendations to provincial government on action such as:

A. Ensure that momentum and progress continues with Ontario's Poverty Reduction Strategy that is coming up for its legislated five-year review in 2013.
B. Transform the social assistance system with its dangerously low rates and confusing, punitive rules to a person-centred system, where the rates correspond to the actual cost of living.
C. Increase the minimum wage, which has been frozen since 2010, so that subsistence wages become living wages. Protect precarious workers against exploitation through enforcement of *Employment Standards Act* and ensure pay equity.

D. Work with other governments, including First Nations, to address the urgent need for affordable, healthy housing across the province.

In addition to robust action on these structural issues, there are a variety of other actions that must be implemented to address our current obesogenic environment. Governments at the federal, provincial, and territorial levels have identified a *Framework for Action to Promote Healthy Weights*[39] [40] as well as provided financial support for reports with multiple recommendations related to activity,[41] nutrition,[42] and built environments.[43]

When the Active Healthy Kids Canada 2012 report card, *Is Active Play Extinct?*[44] was released, a headline in the *Globe and Mail* focused on "Parental fear contributing to sedentary lifestyle of Canadian children."[45] The framing of blaming parents for "helicopter parenting" reinforced a focus on individual/family gaps in knowledge and poor choices. In a similar way, Participaction public service ads[46] that throw water or a ball at a mother for an incorrect answer on needed activity levels alienates some viewers as it normalizes physical violence, bullying, and disdain for women.

In contrast to these scolding approaches, there are resources available such as the British Columbia Healthy Living Alliance's healthy equity information sheet, *Everybody Active: Why Don't People Participate*[47] that help give insight into the challenges that people frequently experience.

I was in an abusive relationship and for a long time I was afraid to go out the front door. Once the kids and I were on our own, we had to move to a rough part of town where there are few sports facilities or programs. It is impossible to lug three kids and a stroller onto a bus to get across town where the good programs are and I would never go out at night.

Project Participant (BC Healthy Living Alliance Info 4:5)

Low or no-cost recreation programs, affordable public transit, publicly-funded, not-for-profit child care, and safe secure neighbourhoods where people are unafraid at night would have benefited this family. Less helpful are inequitable policy instruments, such as the Children's Fitness Tax Credit, which predominately benefits wealthier families[48] at a cost of $200 million to the public purse.[49] In a context of "austerity budgets," public goods such as parks, recreation, public transit, health care, child care, social safety nets, environmental protection, and social investments in high priority neighbourhoods are increasingly under threat at the same time that "innovative solutions" are sought from the private sector.

Recommendation 2: Encourage all levels of government to make public policy decisions based on public health science rather than ideology.

A. Implement the recommendations of the Office of the Chief Coroner for Ontario related to Accidental Drowning Deaths in Ontario.[50]
B. Implement the recommendations of the Office of the Chief Coroner for Ontario related to Cycling Death Review.[51]
C. Implement the recommendations of the Office of the Chief Coroner for Ontario related to Pedestrian Death Review.[52]

D. Model Ontario's approach to multi-faceted, complex health challenges on the approach taken by the Office of the Chief Coroner when reviewing Youth Suicides at the Pikangikum First Nation.[53]
E. If market forces are reluctant to change, use legislative powers to prohibit inappropriate advertising to children, restrict unhealthy content such as high levels of sodium or transfats, require nutritional information on restaurant menus, etc.

With all the best intentions, we have a history at government levels of recommending actions related to a myriad of specific "social catastrophies" that if implemented in a systematic way would begin to make a difference for broader health and social issues. Recommendation 2 presented clearly reflects this in identifying the need to implement recommendations related to accidental drowning, cycling deaths, pedestrian deaths and youth suicide. All these recommendations if implemented would lead to supporting and enabling increased safe participation in physical activity for youth and all Ontarians.

Recommendation 3: That the recommendations in the RNAO Primary Prevention of Childhood Obesity be embraced as key actions for nurses and other health care professionals, governments, corporations, communities and schools. Such recommendations include:

A. Advocating for healthy public policies related to activity and nutrition;
B. Promoting healthy eating and physical activity at the populations, community, family, and individual levels;
C. Supporting exclusive breastfeeding for infants until six months of age;
D. Promoting healthy eating using Canada's Food Guide and healthy eating patterns;
E. Promoting increased physical activity and decreased sedentary activities;
F. Working with school communities to implement school-based strategies;
G. Supporting a family-centred approach to promote healthy weights;
H. Regular Assessment of physical growth and development of children.

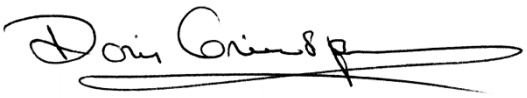
Recommendation 4: That a Champion Network modeled after RNAO's successful Champion Network be established to be led by nurses to work with teachers, students and others in the school system to begin to champion healthy lifestyles and healthy weights for children and families.

The RNAO Best Practice Champion Network, consists of a set of workshops, and an ongoing Champion Knowledge Exchange Network, that is used by RNAO and now many others, to advance guideline uptake, and initial and sustained evidence based practice change. RNAO would be prepared to target some of our Champion workshops to focus on obesity prevention and offer such workshops to nurses in all relevant sectors as well as to teachers and others who are leaders and mentors for children and youth, as well as youth groups themselves. The Champion model in this case can be very successful, as it utilizes a peer to peer strategy to share a good health, good feeling, good to do message.

6. Conclusion

RNAO strongly believes that Childhood obesity can be successfully addressed. We do have the evidence to direct actions at all levels. We urge the Healthy Kids Panel to utilize all the resources to recommend involvement of all stakeholders to take an integrated approach to development and implementation of healthy public policy. Finally we need to ensure consistency in healthy policy uptake in all levels of government, our corporations, communities, and schools such that families and individuals can find it easier to engage in healthy behaviours especially those that impact healthy weights.

With warm regards,



Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer, Registered Nurses' Association of Ontario

Appendix A

RNAO Clinical and Healthy Work Environment Best Practice Guidelines

Clinical Best Practice Guidelines (39)

- Adult Asthma Care Guidelines for Nurses: Promoting Control of Asthma
- Assessment and Care of Adults at Risk for Suicidal Ideation and Behavior
- Assessment and Device Selection for Vascular Access
- Assessment and Management of Pain
- Assessment and Management of Stage I to IV Pressure Ulcers
- Assessment and Management of Venous Leg Ulcers
- Assessment and Management of Foot Ulcers for People with Diabetes
- Best Practice Guideline for the Subcutaneous Administration of Insulin in Adults with Type 2 Diabetes
- Breastfeeding Best Practice Guidelines for Nurses
- Caregiving Strategies for Older Adults with Delirium, Dementia and Depression
- Care and Maintenance to Reduce Vascular Access Complications
- Chronic Kidney Disease
- Client Centred Care
- Crisis Intervention
- Decision Support for Adults Living with Chronic Kidney Disease
- End of Life Care During the Last Days and Hours
- Enhancing Healthy Adolescent Development
- Establishing Therapeutic Relationships
- Facilitating Client Centred Learning
- Integrating Smoking Cessation into Daily Nursing Practice
- Interventions for Postpartum Depression
- Nursing Care of Dyspnea: The 6th Vital Sign in Individuals with Chronic Obstructive Pulmonary Disease (COPD)
- Nursing Management of Hypertension
- Oral Health: Nursing Assessment and Interventions
- Ostomy Care & Management
- Primary Prevention of Childhood Obesity
- Prevention of Constipation in the Older Adult Population
- Prevention of Falls and Fall Injuries in the Older Adult
- Promoting Asthma Control in Children
- Promoting Continence Using Prompted Voiding
- Promoting Safety: Alternative Approaches to Use of Restraints
- Reducing Foot Complications for People with Diabetes
- Risk Assessment and Prevention of Pressure Ulcers
- Screening for Delirium, Dementia and Depression in Older Adults
- Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients
- Stroke Assessment Across the Continuum of Care
- Suicidal Ideation and Behaviour
- Supporting Clients on Methadone Maintenance Treatment
- Supporting and Strengthening Families through Expected & Unexpected Life Events
- Woman Abuse : Screening, Identification and Initial Response

Healthy Work Environment Best Practice Guidelines (8)

- Collaborative Practice Among Nursing Teams
- Developing and Sustaining Effective Staffing and Workload Practices
- Developing and Sustaining Nursing Leadership
- Embracing Cultural Diversity in Health Care: Developing Cultural Competence
- Managing and Mitigating conflict in Health Care Teams
- Preventing and Managing Violence in the Workplace
- Preventing and Mitigating Nurse Fatigue in Health Care
- Professionalism in Nursing
- Workplace Health, Safety and Well-Being of the Nurse

Additional Resources:

- Educator's Resource: Integration of Best Practice Guidelines
- Toolkit : Implementation of Clinical Practice Guidelines

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