

# CHILDREN'S HEALTH TASK FORCE

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## **1.0 BACKGROUND**

### **1.1 CHILDREN’S HEALTH TASK FORCE**

The CHTF is a group of community leaders from the public, private, and nonprofit sectors, appointed to study and make recommendations on improving children's health, particularly that of children from 5 - 12 living in poverty in the Greater Saint John area. It has reviewed relevant research and has benefited from consultations with a range of local experts. In presenting its report, the Task Force is offering recommendations on an age group that has not been included in earlier studies, which have had as their focus children 0 - 5 and 13 - 18. Worthy of note is that with few exceptions all children in this age group are in school, unlike those in the other groups previously studied.

The Community Health Centre, in conjunction with Vibrant Communities Saint John, formed the roundtable, which was provided administrative and research support by the Human Development Council. *(See Appendix 1 for a listing of the Task Force members)*

#### ***VISION***

The vision of the CHTF is healthier children in Greater Saint John.

#### ***MISSION***

The CHTF’s mission is to identify one to three actions that will improve the state of wellness of children 5 to 12 years of age who live in poverty in Greater Saint John.

#### ***GOALS***

The goals of the CHTF are improved fitness, improved nutrition and improved academic achievement in the target population.

#### ***PRINCIPLES***

In beginning its work and reviewing the available literature, the CHTF agreed on four guiding principles. It would be: 1) accessible to the community; 2) rooted in the community; 3) guided by research; and 4) focused on measurable outcomes.

### **1.2 DEFINITIONS**

#### ***HEALTH***

The CHTF adopted a broad definition of health, namely: “the capacity of people to adapt to, respond to, or control life’s challenges and changes.” This notion of health—a population health approach—recognizes the range of social, economic and physical environmental factors that contribute to health.

## ***POVERTY***

The Task Force acknowledges that poverty can be defined in a number of ways, often reflecting the values we hold for society. Yet virtually all definitions have approached poverty as a concept focused on income inadequacy. Accordingly, the CHTF has adopted Statistics Canada's Low Income Cut-Off (LICO) figures—which have been compiled for over thirty years—to benchmark poverty in the community and to measure any changes.

## **1.3 DETERMINANTS OF HEALTH**

A population health approach reflects the overwhelming evidence that factors outside the health care system significantly affect health. It considers the entire range of individual and collective factors and conditions—and their interactions—that have been shown to be correlated with health status. The CHTF added nutrition to the list that is commonly referred to as the determinants of health, which includes: 1) income and social status, 2) social support networks and social environment, 3) education, 4) employment/working conditions, 5) mass media and technology, 6) physical environments, 7) personal health practices and coping skills, 8) healthy child development, 9) biology and genetic factors, 10) health services, 11) gender, 12) culture, and 13) nutrition. (*See Appendix 1 for definitions*)

The CHTF then narrowed the list by ranking the top four determinants that, in its opinion, most influenced the health of Saint John's children living in poverty. The group applied the backgrounds and experiences of its members, together with information provided by key informants and the literature review, in concluding that the health of the city's children aged 5 and 12 living in poverty was most affected by: 1) healthy child development, 2) education, 3) nutrition, and 4) social support networks and social environment.

## **1.4 WORD ABOUT DATA**

The Task Force benefited from the comments and contributions of its members and key community informants. Anecdotal and experiential evidence suggested serious issues related to children's health. Many of the personal accounts and stories were revealing. A major frustration was the lack of quantitative data that could support or refute the picture of children's health that was painted by individuals with personal knowledge. Although several national surveys collect data on children's health, serious gaps remain.

## **1.5 THE IMPORTANCE OF PLACE**

In recent years, place-based development and public policy have received growing attention in research reports and academic literature. This reflects a growing understanding of the significance of community settings—localities where diverse factors come together to generate either positive or negative effects.

Place-based policies are those that build on the unique characteristics and opportunities of a community. While people-based programs target individuals or households, place-based ones target particular areas like neighbourhoods. A place-based approach considers local issues, circumstances and characteristics and tailors interventions to suit.

This model has been embraced by Vibrant Communities Saint John because local research demonstrated that poverty in Saint John tends to be concentrated in specific inner city neighbourhoods. A place-based focus also utilizes the expertise of the community and ensures local ownership and grassroots responses. The Task Force supported this reasoning, and so smaller units where poverty is concentrated—neighbourhoods and schools—determined the focus of its recommendations.

## 2.0 FINDINGS

The Task Force members agreed from the start that three specific indicators should be used to measure child wellbeing: academic achievement, fitness, and nutrition. For each, a summary of relevant literature explored by the CHTF is offered, followed by highlights from community informants. While most of the informants work in the field, the CHTF also had the benefit of hearing from a group living the experience: the Crescent Valley participants (parents from a low-income neighbourhood who are working with Vibrant Communities Saint John).

### 2.1 CHILD POVERTY

#### *THE RESEARCH TELLS US...*

*New Brunswick's Child and Family Poverty Report Card* states that one in every six children in New Brunswick (24,550 in total) live in poverty, and that the child poverty rate for female lone-parent families is very high at 58 percent. The report outlines the considerable gap between the rich and poor families in the province: for every one dollar earned by the poorest 10 percent of families with children, the richest 10 percent earn 15 dollars.<sup>1</sup>

On a local level, Vibrant Communities' report *Poverty and Plenty* found that over 60 percent of lone-parent families fall below Statistics Canada's LICO measure in the Saint John Census Metropolitan Area (CMA). This number has seen little change over twenty years, and the rate of poverty among lone-parent families is nearly the only indicator related to poverty where Saint John led the country over this time period. Overall, roughly 22 percent of children in the Saint John CMA fall below LICO, a number that is seeing an upward trend.<sup>2</sup>

The CHTF awaits the results of the 2006 Census—income and earnings figures are expected this time next year—which will paint a timelier picture of child poverty locally.<sup>3</sup> Of particular interest will be whether the downward trend in Saint John's poverty rate continues, evidenced by the dip from 27 percent in 1996, to 24.5 percent in 2001.

#### *THE KEY INFORMANTS TELL US...*

The CHTF consulted with a number of individuals and groups that were considered to be key informants in this area. They included residents of Crescent Valley, literacy experts and government officials. Our key informants have relayed that living in poverty affects

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<sup>1</sup> Hatfield and Sterniczuk, *Child and Family Poverty Report Card*, 1.

<sup>2</sup> Peacock, *Poverty and Plenty*, 11.

<sup>3</sup> Statistics Canada, 2006 Census.

the academic achievement, fitness, and nutrition of children in Saint John. As mentioned, these three areas were adopted as the health indicators for the CHTF and are explored in detail below.

## **2.2 ACADEMIC ACHIEVEMENT**

### *THE RESEARCH TELLS US...*

On a provincial level, the Pan-Canadian Education Indicators Program has found that New Brunswick has scored below the Canadian average in reading, mathematics, and science.<sup>4</sup> On a local level, the Canadian Council on Learning has granted Saint John 66 of a possible 100 points—in contrast to Fredericton’s 68, Moncton’s 72, and the national average of 76—in this year’s Composite Learning Index, which ranks performance in a number of areas related to lifelong learning.<sup>5</sup>

A study examining educational outcomes and reading ability found that at age 15, reading proficiency plays a role in high school graduation and postsecondary participation. Without effective literacy skills and education credentials young people are at an increased risk of facing barriers to employment, reduced financial security, and poorer social outcomes.<sup>6</sup>

The major finding of the Ontario Public Health Association’s research study—the most extensive Canadian research study exploring the connection between health and literacy—was that:

Low literacy levels have a major negative impact on health. In fact, literacy is one of the major influences of health status. However health is defined or measured, people with limited literacy skills are worse off than others with higher literacy skills. Literacy is a major factor underlying most other determinants of health.<sup>7</sup>

### *THE KEY INFORMANTS TELL US...*

The Crescent Valley participants stressed to the Task Force that parents need to be involved in their children’s education and that they need to feel that their contribution is valued and invited. High expectations should be set for all children regardless of background.

Carole Dilworth, former Director of Analysis and Evaluation for the Department of Health and currently a community evaluation consultant and researcher, spoke to the CHTF about her study on poverty in Saint John’s North End, which found that a lack of academic success early on continues in higher grades, and parents are often shy and cannot advocate for their children. She found that children’s literacy was often tied to that of their parents. Ms. Dilworth felt it would be beneficial to start an after-school program

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<sup>4</sup> Statistics Canada, Education Indicators in Canada.

<sup>5</sup> Canadian Council on Learning, Composite Learning Index.

<sup>6</sup> Knighton and Bussière, *Educational Outcomes at Age 19 Associated with Reading Ability at Age 15*, 18.

<sup>7</sup> Perrin, *How Does Literacy Affect the Health of Canadians?*

in the neighborhood where children could receive individual assistance with their school work, perhaps through a retired teachers association.<sup>8</sup>

Cheryl Brown, Children's Counselor and Community Literacy Worker, spoke to the Task Force about her involvement with Family Literacy Programming, Storytent, and Bookwagon. She said these programs have resulted in: a higher frequency of reading, improved reading skills, positive self-attitude in relation to reading, improved socialization skills, and improved access to books and borrowing.<sup>9</sup>

Sgt. Tanya LeBlanc with the Saint John Police Force said literacy is an issue and that she would like to see tutoring in the Old North End neighbourhood (ONE). She said that although some is happening in the community centre now, there is a need for more funding.<sup>10</sup>

Gary Sullivan, Principal of Lorne Middle School and President of ONE Change, noted that school-readiness is a concern. He said there are still a lot of children in school that cannot focus on their education because they have other worries, including not eating well, poor hygiene, and poor parenting.<sup>11</sup>

Dr. Anne Murphy, Developmental Pediatrician, discussed reasonable expectations for school age children. She explained to the Task Force that there is an increasing trend of children presenting at grade one without basics, such as not being able to identify their names on paper. She said this type of academic delay can result in a child falling further behind. Without addressing living/environmental difficulties this can lead to increasing problems with behavior such as aggression. Dr. Murphy explained that teachers and schools cannot compensate for families, but children with social/emotional problems benefit from increased contact with other children, thus they need to be in the school environment. We must support families within their community of origin and provide programs for the children to express different experiences ie. music or sports.<sup>12</sup>

Dr. Jean Craven, Manager of the Child and Adolescent Team, Mental Health Services, told the CHTF that a lot of time and energy may be spent on disruptive children in the classroom, to the detriment of other children. Those with mental health problems like anxiety and depression, in particular, may be less easily identified by teachers and may withdraw and even stop attending school altogether. These children may also be negatively affected by the behaviour of the disruptive and aggressive children.<sup>13</sup>

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<sup>8</sup> Carole Dilworth, Children's Health Task Force Meeting February 9, 2006, UNBSJ.

<sup>9</sup> Cheryl Brown, Children's Health Task Force Meeting February 9, 2006, UNBSJ.

<sup>10</sup> Sgt. Tanya LeBlanc, Children's Health Task Force Meeting, March 30, 2006, Prince Charles School.

<sup>11</sup> Gary Sullivan, Children's Health Task Force Meeting, February 23, 2006, UNBSJ.

<sup>12</sup> Dr. Anne Murphy, Children's Health Task Force Meeting April 27, 2006, School District 8 Office.

<sup>13</sup> Dr. Jean Craven, Children's Health Task Force Meeting, February 23, 2006, UNBSJ.

Debbie Cooper, Executive Director of the Boys and Girls Club, told the Task Force that there appears to be a lack of resources in the education system to accommodate children with special needs.<sup>14</sup>

Lynn Rector, Vice Principal of Prince Charles School (currently Acting Principal), explained the benefits of PALS which, she says, has a lot of programs for the children from the minute they come in at the beginning of the school day for breakfast until they leave the school after tutoring and sports. An after school program funded by RBC supplements programming at the school by supporting the After School Program which runs until six o'clock. She says these programs have made a difference in the life of the children, parents and community. An inner-city school that can provide nutrition and tutoring in a caring atmosphere promotes social growth in a community.<sup>15</sup>

## 2.3 FITNESS

### *THE RESEARCH TELLS US...*

There are different theories on the connection between family income and the prevalence of childhood overweight and obesity. A study on socio-economic status and obesity in children found that children have a greater likelihood of being overweight or obese if they live in neighbourhoods with a lower socio-economic status, including those with lower average family incomes, higher unemployment rates, or fewer neighbours with post-secondary education. This may be a result of the trend of children in low socio-economic neighbourhoods to participate less in organized physical activities than children in higher socio-economic neighbourhoods. This in turn may point to a lack of opportunities to be physically active in these areas.<sup>16</sup>

Somewhat different observations were found in the 2004 Canadian Community Health Survey (CCHS), which showed that associations between lower socio-economic status and overweight/obesity are not as strong for children as for adults. The study found that while children in middle-income households were more likely to be overweight or obese than their counterparts in high-income households, the rates in low-income and high-income households were similar. The survey did however show a stronger trend for education: young people were more likely to be overweight/obese in households where no members had more than a high school diploma than those in households where the highest level of education was postsecondary graduation.<sup>17</sup>

An article on childhood overweight and obesity found that the risk of children being overweight or obese decreased for those who have physical education classes two or more times a week.<sup>18</sup>

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<sup>14</sup> Debbie Cooper, Children's Health Task Force Meeting February 9, 2006, UNBSJ.

<sup>15</sup> Lynn Rector, Children's Health Task Force Meeting, March 30, 2006, Prince Charles School.

<sup>16</sup> Statistics Canada, "Study: Socio-economic status and obesity in children."

<sup>17</sup> Shields, *Measured Obesity*, 5.

<sup>18</sup> Veugelers and Fitzgerald, "Prevalence of and risk factors for childhood overweight and obesity."

The CCHS showed that the likelihood of children aged 6 to 11 being overweight or obese increases with screen time: watching television, playing video games, or using a computer.<sup>19</sup> Over a third of children in this age group logged more than 2 hours of screen time a day. They were twice as likely to be overweight/obese as those who had one hour or less of screen time. Interestingly, physical activity levels were not associated with being overweight or obese for those in this age group, but for ages 12 to 17 such associations were considerable.<sup>20</sup>

#### *THE KEY INFORMANTS TELL US...*

The Crescent Valley participants told the Task Force that all children should have access to physical activities during and after school hours. The development and/or enhancement of sidewalks and pathways between the Crescent Valley neighbourhood and the local school was noted as one possible way to make programs more accessible. Access and participation could be improved with safer neighbourhoods, better street lighting and providing programs in school buildings beyond the traditional hours of operation<sup>21</sup>

Ms. Cooper explained to the Task Force that there is a lack of physical activity, which is often linked to sedentary activities such as computers and handheld games, and that poor physical health often accompanies poor mental health.<sup>22</sup>

Sgt. LeBlanc noted the importance of fitness. She told the Task Force she would like to start a running club for the Old North End, which she explained would be particularly appropriate for the area because there is no need for expensive equipment or facilities.<sup>23</sup>

## **2.4 NUTRITION**

#### *THE RESEARCH TELLS US...*

Proper nutrition lays an important foundation for the health and development of children—including better health, optimal weight, prevention of chronic disease, and stronger immune systems—and healthy children learn better and are more likely to be participating members of society.<sup>24</sup> However, overweight and obesity are on the rise in Canada—between 1979 and 2004 the rate among children almost doubled.<sup>25</sup> A RAND study has found that children in close-knit neighbourhoods, where social support is provided by adults, are at a decreased risk of being overweight.<sup>26</sup>

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<sup>19</sup> Shields, *Measured Obesity*, 2.

<sup>20</sup> *Ibid.*, 5.

<sup>21</sup> Crescent Valley Parents, Children's Health Task Force Meeting March 16, 2006, Hazen-White/St. Francis.

<sup>22</sup> Debbie Cooper, Children's Health Task Force Meeting February 9, 2006, UNBSJ.

<sup>23</sup> Sgt. Tanya LeBlanc, Children's Health Task Force Meeting, March 30, 2006, Prince Charles School.

<sup>24</sup> Canadian Council on Social Development, *Growing Up in North America*, 27.

<sup>25</sup> *Ibid.*, 28.

<sup>26</sup> RAND Corporation, "RAND Study Finds Close-Knit Neighborhoods May Help Prevent Children From Becoming Overweight."

An article on childhood overweight and obesity found that the risk of children being overweight or obese increased for those who bought lunch at school. A decreased risk was noted for those who ate supper with their family three or more times a week.<sup>27</sup> Another study has found that students from schools with nutrition programs that promote healthy eating had lower overweight and obesity rates and exercised more than students from schools without nutrition programs.<sup>28</sup>

According to the CCHS, in comparison to their counterparts in the rest of Canada, New Brunswick children 2 to 17 years experienced the very high overweight/obesity rate of 36 percent, which was 8 points higher than the national average.<sup>29</sup> The survey found children who eat fruit and vegetables five or more times a day were significantly less likely to be overweight or obese than those who eat these foods less often.<sup>30</sup> The study revealed that a relatively high proportion (79 percent) of children and adolescents in the Atlantic Provinces eat fewer than the minimum recommended five daily servings of fruit and vegetables.<sup>31</sup> In addition, over a quarter of Canadian children aged 4 to 8 do not eat the recommended daily minimum of 5 to 12 servings of grain products.<sup>32</sup> The study also found that Atlantic Canadians consume a significantly large percentage of their calories between meals. For children and adolescents in this region, 32 percent of their calories are snacks, compared with the national average of 28 percent.<sup>33</sup>

In addition, the CCHS study found that the food consumption patterns of children and adolescents are not as closely tied to household income as the patterns of adults.<sup>34</sup> However, as with adults, the likelihood that children and adolescents will eat food from a fast-food outlet increases with income.<sup>35</sup> Children are exposed to poor-quality food in their school neighborhoods as fast-food restaurants tend to concentrate within a short walking distance from schools.<sup>36</sup> Food advertisements viewed by children are dominated by convenience, fast foods, snack, and sweets. One study on the nutritional content of these foods found that they exceeded the recommended daily values of fat, saturated fat, and sodium, while failed to provide the recommended amount of fiber and certain vitamins and minerals.<sup>37</sup>

According to a report that examines child health and safety in Canada, the United States, and Mexico, there is a nutrition paradox in North America (which appears to be emerging worldwide) where obesity is an emerging issue for some children, while at the same time access to food and undernutrition plagues others. Overweight and obese children are at an

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<sup>27</sup> Veugelers and Fitzgerald, "Prevalence of and risk factors for childhood overweight and obesity."

<sup>28</sup> Veugelers, "Effectiveness of School Programs in the Prevention of Childhood Obesity."

<sup>29</sup> Shields, *Measured Obesity*, 3.

<sup>30</sup> *Ibid.*, 2.

<sup>31</sup> *Ibid.*, 9.

<sup>32</sup> *Ibid.*, 6.

<sup>33</sup> *Ibid.*, 9.

<sup>34</sup> *Ibid.*, 2.

<sup>35</sup> Garriguet, *Overview of Canadians' Eating Habits*, 10.

<sup>36</sup> Austin, et al, "Clustering of Fast-Food Restaurants Around Schools."

<sup>37</sup> Harrison and Marske, "Nutritional Content of Foods Advertised During the Television Programs Children Watch Most."

increased risk of a number of non-communicable diseases and long-term health problems.<sup>38</sup> They may suffer from lifelong impacts on their health and quality of life. Not only is this weight trend likely to continue into adulthood, these children are also more likely to develop related health problems such as arthritis, cancer, heart disease, hypertension, type 2 diabetes, and often lowered self-esteem, which can negatively impact academic achievement.<sup>39</sup>

On the other hand, undernourished children are more susceptible to infectious diseases.<sup>40</sup> In 2004, 9.3 percent of Canadian children under age 12 experienced some degree of food insecurity in being unable to afford the necessary food (whether with or without hunger). As is well-known, parents will go without to ensure that their children are not hungry. Food bank use among children is on the rise in Canada, and children accounted for about 40 percent of food bank users in 2004.<sup>41</sup> In Saint John food bank use has declined slightly since 2004, with over 9000 children served last year.

#### *THE KEY INFORMANTS TELL US...*

While the Crescent Valley participants acknowledge the importance of good nutrition for their children, they find it impossible to provide nutritious food on their incomes. In addition, they noted the difficulty of having fresh foods in the house all month, when grocery shopping generally coincides with a once-monthly cheque. They also related the challenge of providing healthy food for both school *and* home, and the need to ration what they send with their children to school.<sup>42</sup>

Martha MacLean, a nutritionist at the Community Health Centre, explained that too many children are overweight due to poor nutrition and a lack of physical activity, and that local rates of obesity have increased three fold since the late 1980s. She revealed the disturbing trend that parents may begin to outlive their children due to diabetes and heart disease. Many children, she said, have no exposure to fruits and vegetables, in contrast to an overexposure to “treat” foods. She referred to a 2003 Nova Scotia study, which found children who skip breakfast are 50 percent more likely to be overweight, while children who buy lunch are 46 percent more likely. Ms. Maclean noted that people living in poverty have a particularly difficult time. In 2004 it was estimated that a family of four would have to spend \$617/month to meet basic food needs. Those on low income face the additional challenge of access to reasonably priced food, and for many, the grocery bill is the only flexible monthly expense.<sup>43</sup>

Ms. Brown shared that through her work she sees children who are visibly in a poor state of health and who often eat breakfast and lunch at Storytent. She said there are some indications they are not familiar with fruits and vegetables—these children often do not

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<sup>38</sup> Canadian Council on Social Development, *Growing Up in North America*, 27.

<sup>39</sup> *Ibid.*, 27-28.

<sup>40</sup> *Ibid.*, 27.

<sup>41</sup> *Ibid.*, 30.

<sup>42</sup> Crescent Valley Parents, Children’s Health Task Force Meeting March 16, 2006, Hazen-White/St. Francis.

<sup>43</sup> Martha MacLean, Children’s Health Task Force Meeting April 27, 2006, School District 8 Office.

know what fruit looks like because they have not had exposure to it.<sup>44</sup> Ms. Cooper noted that the Boys and Girls Club feeds over 250 children per day. She explained that the cheapest food is often also the most unhealthy, which leads to poor nutrition and an unhealthy lifestyle for children.<sup>45</sup>

Ms. Dilworth's study in the city's North End revealed a poor understanding of nutrition among residents (which is linked to obesity), and no modeling in meal preparation, planning, budgeting, or understanding healthy food choices.<sup>46</sup> Sgt. LeBlanc also noted that nutritional needs are not being met (people are uninformed) in the North End.<sup>47</sup>

## 2.5 RECENT INITIATIVES

The Task Force is encouraged by the Provincial Government's commitment to engaging communities and partners in improving schools. As the government sees it, a community school:

creates a new alliance between the school and its community. Community schools use community resources – volunteer groups, parents, public services and recreational and cultural opportunities – to turn a school into a community centre of learning. A good school must be anchored in a supportive community. [...] The school uses community resources and assets to provide additional opportunities for classroom instruction and after-school programs. And teachers in a community school use those resources to provide more hands-on, interactive learning for children. Also, the building is often open for students and their families beyond traditional hours, offering community services.<sup>48</sup>

On June 2<sup>nd</sup> the Provincial Government unveiled a new education plan: *When Kids Come First*. Within the plan are eight priorities, which if fully implemented will significantly address many of the findings of the Task Force, particularly if schools in high poverty neighbourhoods are targeted. Phase 1 will: 1) Launch up to 30 new community school projects within the context of a new *Community Schools Policy*; 2) Work with the Department of Wellness, Culture and Sport to build on the success of the *School Communities in Action* program to provide after-school, early morning or lunch-time physical activities; 3) Work with the Department of Wellness, Culture and Sport to implement the *LINK* program in Grades 6–12 to promote safe school environments and use of community resources; 4) Ensure the new *Teachers' Virtual Resource Centre* includes information on community schools; 5) Explore innovative arrangements with community organizations, non-governmental organizations, municipalities and the private sector for activities which expand learning and teaching opportunities in

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<sup>44</sup> Cheryl Brown, Children's Health Task Force Meeting February 9, 2006, UNBSJ.

<sup>45</sup> Debbie Cooper, Children's Health Task Force Meeting February 9, 2006, UNBSJ.

<sup>46</sup> Carole Dilworth, Children's Health Task Force Meeting February 9, 2006, UNBSJ.

<sup>47</sup> Sgt. Tanya LeBlanc, Children's Health Task Force Meeting, March 30, 2006, Prince Charles School.

<sup>48</sup> Department of Education, *When Kids Come First*, 23.

community schools; and 6) Work with other government departments to provide relevant community services through community schools.

On June 7<sup>th</sup>, the Provincial Government announced funding support in the amount of \$900,000 over two years to help six schools in Saint John transform into community centres of learning. The Community Schools initiative is meant to encourage the community to become more active in the life of a school and in assisting children to learn. It plans to use community resources such as volunteer groups, parents, public services and recreational and cultural opportunities to turn a school into a centre of opportunity for children, youth, families and communities before, during and after school hours.

Among the first Anglophone sector schools to be designated under the new Community Schools initiative are Hazen White/St. Francis School, Centennial School and St. Patrick's School in School District 8, which will each receive funding from the Department of Education for personnel and resources to go along with community partnerships that have already been established at these schools. Three more Saint John schools will receive support beginning in the 2008 school year. They are Lorne School, Glen Falls School and St. John the Baptist/King Edward School.<sup>49</sup>

The newly appointed Community Schools Coordinator is working toward developing initiatives among other government departments and agencies whose mandate involves children and their families.

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<sup>49</sup> Communications New Brunswick, June 7, 2007.

## 3.0 CONCLUSIONS & RECOMMENDATIONS

### CONCLUSIONS

The Children’s Health Task Force concluded that children in poverty form a substantial population group in Saint John which does not have access to the right conditions for good health. They are at a greater risk for poor health today and throughout their lifetime. In Saint John, children who live in poverty tend to be concentrated in only a handful of neighbourhoods and these neighbourhoods are in serious states of neglect and decay. Lack of community investment in the basic conditions that determine good health – housing, healthy food, safety, and opportunities for positive self-development—means a lifetime sentence for these children, and then their children.

The findings of the Task Force also confirmed that no single program could sustainably address the health and wellbeing of children in poverty. The members agreed that multi-pronged interventions—offered from pre-conception through the teenage years—that recognized the diversity of health issues caused by poverty and their interrelationships were required.

The Task Force also found that some targeted investments are already being implemented in Saint John that aim to improve life conditions for children in poverty, for example: Boys and Girls Club, Family Resource Centre, FAST (Families and Schools Together), First Steps Housing Project, Food Purchasing Club, PALS (Partners Assisting Local Schools), P.R.O. Kids, StoryTent, TRC (The Resource Centre for Youth), neighbourhood recreation centres, and many in-school programs, including breakfast clubs, literacy help, and extra-curricular activities. Alone, each intervention is very likely not enough to alter health outcomes for the majority of these vulnerable children. However, these types of investments—if nurtured, better connected and built upon to address gaps—would most likely provide the health results that children in poverty need and that Saint John wants for its whole community.

Finally, the Task Force recognized that it takes *evidence*, *resources*, and *time* to scale-up new approaches and that community assistance would most likely occur if the Task Force initially called for a small-scale project to be piloted in one high-poverty neighbourhood in Saint John. The project should demonstrate a comprehensive, multi-pronged approach that would introduce a wide range of new opportunities, aimed at building child health.

### RECOMMENDATIONS

The Task Force endorses the Community Schools initiative and sees this education plan as one of the delivery agents for the below recommendations.

The Task Force recommends that a five year pilot project be undertaken in one high poverty neighbourhood and its elementary school.

The multi-pronged, neighbourhood-based pilot project should introduce *new* opportunities for children, with the common goal of improving their health and wellbeing through specific programs and measurable improvements in their academic achievement, fitness and nutrition.

### **ACADEMIC ACHIEVEMENT**

1. That community groups such as BCAPI, Vibrant Communities and other concerned interests lobby the provincial government to pursue the introduction of an Early Childhood Learning Centre, as a pilot project. The Centre would enable neighbourhood parents and their children, 0 to 5 years, to become full participants in early learning and quality childcare.

### **NUTRITION**

2. That all government departments responsible for health related issues be enlisted to offer, in conjunction with community organizations, nutritious breakfast and lunch programs for the school children.

### **FITNESS**

3. To inform the municipality, School District, Boys & Girls Club, PRO Kids and other community groups responsible for recreational activities in the region of the findings of this report and to further encourage them to find ways to provide for increased participation of children from vulnerable neighbourhoods in their respective programs.

### **THE 'OTHER' RECOMMENDATION**

4. As the Task Force drew to a close, it identified a fourth recommendation for inclusion in its report. It became evident through the course of the Task Force's work that the most basic health needs of some of our children are not being met. Accordingly, **the Task Force strongly recommends that nurses (Public Health or Community Health) be returned to schools**, especially where there are low income/high risk populations. Duties could include screening for hearing and vision, providing age appropriate sexual health services, making referrals to other health/community resources, training and supporting teachers in health promotion activities, and conducting workshops for students and their families. The nurse could tap into other health care professionals such as dietitians. The possibility of a partnership with the UNBSJ nursing department should be explored. The

neighbourhood has identified the need for neighbourhood-based primary health care services, and so a portion of the nurse's time could be spent in the neighbourhood.

***LEADERSHIP MODEL***

While the Task Force itself has come to its natural conclusion, it looks to its individual members and to the Vibrant Communities Saint John partners to move these recommendations forward.

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## APPENDIX 1: DETERMINANTS OF HEALTH

**Income and Social Status:** The more money you have, the more likely you are to be healthy. This is the single most important determinant of health. You are most likely to be healthy if you live in a place where there isn't a big gap between the rich and poor.

**Social Support Networks:** You are healthier and feel more in control of your life when you know you can count on friends and family for help in solving problems and handling hard times.

**Education:** The more education you have, the healthier you are likely to be. More education means you can get a better job with better pay and have more control over your life.

**Employment / Working Conditions:** You are healthier and live longer when you have more control over your work and less stress on the job.

**Social Environments:** You are more likely to be healthy when you live in a community, region, province or country that sticks together and works to find ways to help and support one another.

**Physical Environments:** The quality of the air, water, food and soil has an impact on your health. So do factors like housing, indoor air quality, workplace safety, and the way communities and transportation systems are designed.

**Personal Health Practices and Coping Skills:** The things you do to take care of yourself and the skills you use to deal with stress affect your health. Programs and policies that make it easier for you to make healthy choices and develop skills for coping with life's challenges are important influences on health.

**Healthy Child Development:** Things that you experience before birth and in early childhood affect your health, well-being, coping skills and competence throughout your life. A healthy start is important for a healthy adulthood.

**Biology and Genetic Endowment:** The biology of your body is a basic determinant of health. Each of us has a personal physical and genetic make-up that can make us more or less likely to develop particular diseases or health problems.

**Health Services:** Health services play a fairly small part in your state of health. Services that contribute most to health are those that help us to stay healthy or to regain our health after we've been sick or injured.

**Gender:** Whether you are male or female can affect your health. For example, women are more likely to face sexual or physical violence, low income and lone parenthood. Men are more likely to die young, from heart disease, injuries, cancer or suicide.

**Culture:** Culture can affect your health. You are less likely to be healthy if your culture is different from that of mainstream society, if you feel that your language and culture are not valued, or if you can't get health care and services that are appropriate for your culture.<sup>50</sup>

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<sup>50</sup> "The Determinants of Health," Public Health Agency of Canada, [http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Tool\\_kit/12\\_e.html](http://www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Tool_kit/12_e.html).

## **APPENDIX 2: TASK FORCE MEMBERS**

### **WORKING GROUP**

- Dawn-Marie Buck, Executive Director, St. Joseph's Community Health Centre
- Monica Chaperlin, Coordinator, Business Community Anti-Poverty Initiative
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### **MEMBERS**

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