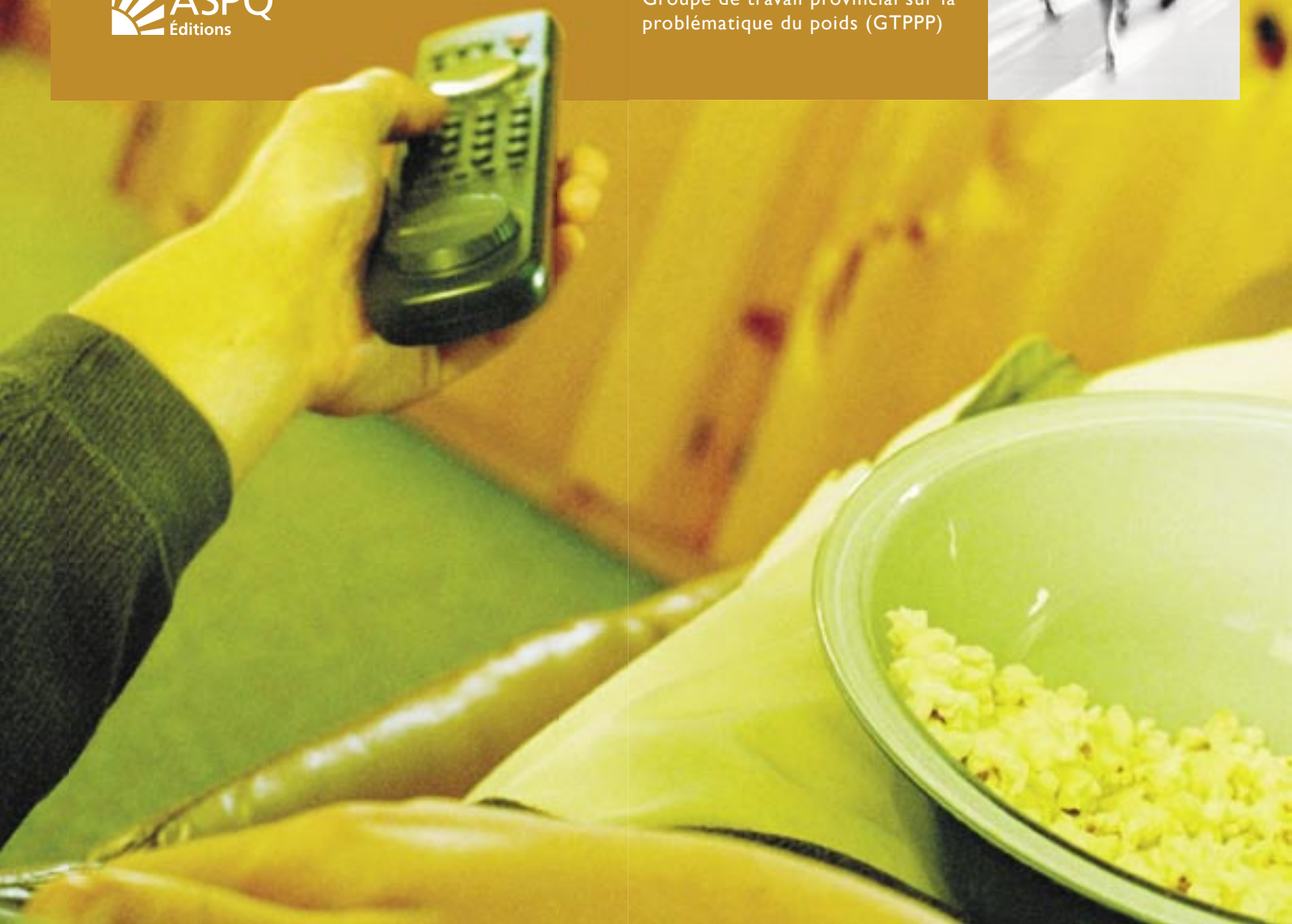


Weight

problems in Québec :
Getting mobilized



Groupe de travail provincial sur la
problématique du poids (GTPPP)



Preface

Initiated in 2000, by the Association pour la santé publique du Québec (AS PQ), the Groupe de travail provincial sur la problématique du poids (GTPPP) has for objective to develop a shared vision of weight-related problems and to propose an action plan. This document is the first milestone in the development of a more substantial action plan to come.

This document was developed by the GTPPP for its colleagues: decision-makers and professionals in the public health field. The document's goal is to describe weight-related problems in a broad and exhaustive perspective. The GTPPP proposes that innovative approaches are required since traditional approaches to weight-related problems have failed and have been shown to be harmful. Finally, it wishes, through dissemination of this document, to incite public health actors to participate and invest themselves in the face of this important emergent issued.

To this day, our public health network has deployed little resources for weight-related problems. Yet, everyday the media present the diverse facets of obesity and excessive preoccupation with weight as well as articles on food and physical activity. Every minute, people start a diet and talk about dieting. More and more persons see their health influenced by excess weight and at younger ages than before. The ubiquity of the topic reflects the public's interest. Yes, the population is greatly motivated by weight issues, physical activity and nutrition. They are eager to find solutions. The GTPPP believes that it would be judicious for the public health sector to take advantage of this interest.

Recently, the *Programme national de santé publique 2003-2012* (Québec Public Health Program 2003-2012) has changed the deal. This program which constitutes a national commitment towards prevention aims that "each Quebecer [should] be healthy, both physically and psychologically" (p.III). What better way to start reaching this objective than by working on weight! Thus, weight, body image, food and physical activity must be included in local regional and nation action plans that originate from the *Programme national de santé publique du Québec 2003-20012* (Québec Public Health Plan 2003-2012) and that will be put into place in the next few years.

Are we ready?

What will we do?

We wish that this document may inspire and stimulate you in starting this great task. It is the first significant information piece issue from the GTPPP. Others will follow, enriched by the abundant emerging knowledge, epidemiological data and results of evaluation of projects focused on weight issues. Thus, we invite you to carefully read this document and to reread it to appropriate yourself with its content. Then, to invite your colleagues, employees, superiors, partners in action and people around you to read it, because in the end weight-related problems concern us all.

Wishing you a good reading.

The GTPPP

Weight

problems in Québec :
Getting mobilized



Groupe de travail provincial sur la
problématique du poids (GTPPP)



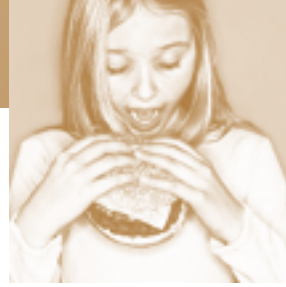
What are we going to do ?



Over the past thirty years, a legion of social changes have led people to adopt a more sedentary lifestyle and brought about major changes in eating habits.



In 1971, 80 % of children aged 7-8 walked to school. In 1999, this was the case for only 41 % of children this age.



It has been shown that when consumers are presented with "supersized" portions, they consume 30 % more calories.



Changing the eating environment means "making healthy choices easy and unhealthy ones more difficult".

One issue, two problems

In 1987, obesity^a affected 9 % of the Québec population 15 years of age and older^{1,2}. Eleven years later, in 1998, this number had risen to over 13 %. Although not as high as in the United States, this prevalence still represents an increase of 44 %. During the same period, the degree of overweight^b among Québécois between the ages of 20 and 64 increased from 19 % to 28 %, another increase of 44 %². There's no doubt about it: Québécois are also gaining weight.

But the similarities end there, as the weight distribution in Québécois differs in many ways from the distribution in other groups. While in many other populations women tend more often to be overweight, more men are affected in Québec (Figure 1). Moreover, in contrast with many other population groups, there is no significant relationship between excess weight and income in Québec. On the contrary, excess weight decreases as education increases².

Distribution of Weight Categories in the Québec Population

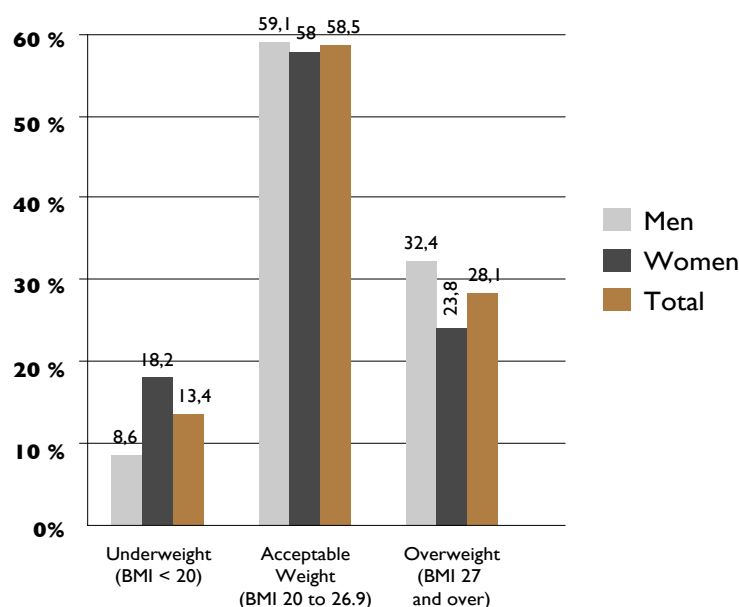


Figure 1: Distribution of weight categories by gender among the Québec population aged 20 to 64.

Source: Institut de la statistique du Québec, Santé Québec, 1998.²

Figure 1 illustrates another major difference between men and women: there are many more women who are underweight. Some of these women are naturally thin, but many others try to stay thin by various means. In 1998, one in two women in Québec in the healthy weight category wanted to lose weight². Here, as elsewhere, this dissatisfaction with weight and appearance is seen in youth: according to the *Enquête sociale et de santé* (Health and Social Survey) conducted among young Québécois in 1999, 35 % of girls

Across the planet, average weights are on the rise. The spread of Western culture has led to a new “obesogenic” lifestyle³⁻⁵.

^a Obesity is defined by a Body Mass Index (BMI) ≥ 30 kg/m².

^b Overweight is defined, in this case, by a BMI ≥ 27 kg/m².

In Asia, cases of anorexia and bulimia have increased with the introduction of American television programs presenting extremely thin models of femininity⁷.

The World Health Organization is reporting that obesity will soon surpass infectious diseases as a world health threat, resulting in a significant financial burden on healthcare systems⁹.

aged 9 said they were trying to lose weight and 60 % of female adolescents 13 and 16 years of age, wanted a different bodily figure⁶. However, most children and adolescents are in the healthy weight category. As for boys, they wanted to be thin and muscular⁶.

Therefore, the weight of Québécois really consists of two related problems: obesity and excessive weight preoccupation. The word “diet” is on everyone’s lips... as shown by surveys indicating that people are very concerned about their weight and appearance^{2,8}. This is why the *Groupe de travail provincial sur la problématique du poids (GTPPP)* talks about “weight-related problems”, and not simply obesity.

Obesity: A price to pay

The burden of chronic disease is increasing rapidly throughout the world. In 2001, the World Health Organization estimated that chronic diseases such as diabetes, cardiovascular and respiratory diseases contributed to 60 % of the 56.5 million deaths reported in the world, as well as 46 % of illnesses⁹. Therefore, due to its impact on health, obesity contributes to the burden of chronic diseases. In 1999, it was estimated that in Canada, 50 % of type 2 diabetes cases, 30 % of hypertension cases and 25 % of endometrial cancer and pulmonary embolisms could be attributed to obesity¹⁰. In comparison with people in the healthy weight category, the *Canadian Heart Health Survey* reported that overweight people had a 23 % higher risk of developing diabetes, a 68 % higher risk of developing hypertension and a 50% higher risk of having high cholesterol¹¹. As a physical overload, obesity puts premature wear and tear on joints. In various countries, research has shown that obesity-related costs vary from 2 % - 7 % of healthcare costs¹². In Canada, in 1999, direct costs associated with overweight (BMI ≥ 27 kg/m²) were estimated at 1.8 billion dollars, i.e. 2.4 % of our total healthcare costs. These costs were calculated taking into account ten co-morbidities associated with obesity¹⁰.

Above and beyond the health problems and costs related to obesity, being or feeling “fat” in a thin world is a psychological and social burden. Obesity is the last bastion of prejudice. Our society is relatively tolerant of differences, but tends to be particularly harsh when it comes to excess weight. It is often said that heavy people are ugly, lazy, and unmotivated. In this way, chubby children, though they may receive more sympathy than obese adults, are more likely to be rejected by their peers and to be socially isolated¹³.

Weight loss efforts: A serious phenomenon

Excessive weight preoccupation can have physical, psychological and behavioural consequences, specifically due to the multiple attempts to lose weight^{2,15}. And yet, in general, commercially available weight-loss products and services are ineffective, and can even be dangerous^{12,14}. While they can sometimes lead to short-term significant weight loss, most often the weight is put back on^{16,17}. The use of weight-loss methods is associated with various physical symptoms which, even if minor, harm people's general functioning and productivity^{18,19,20}. Depending on the severity of dietary restrictions and the frequency of use²¹, these methods can have more serious consequences such as the development of anorexia and bulimia²², cardiac arrhythmia, electrolyte imbalances¹⁹, gallstones, or bone-density loss, which is often associated with osteoporosis^{23,24}. In the worst cases, death can be the outcome. In the 1970s, there were 58 deaths in the U.S. of women on extremely low-calorie diets (protein-modified fasts)²⁵. More recently, weight-loss drugs have caused numerous deaths and brought about serious health problems²⁶.

One of the most serious consequences of weight-loss methods, other than death, of course, is their impact on weight control. Paradoxically, while the goal is to lose weight, these strategies seem to promote obesity. Numerous recent studies involving adolescents and adult women have shown a significant average weight gain, as well as an increase in the proportion of obese persons among those who frequently try to lose weight, compared with those who do not²⁸⁻³⁶.

The dieting spiral

In reality, almost all traditional weight-loss methods are destined to fail in the long run. In spite of what we may be led to believe, these failures are not necessarily attributable to those trying to lose weight. On the contrary, the sacrifices made by these people are often enormous. A troubling and alarming fact is that these individuals risk falling into the vicious circle of dieting (Figure 2).

To sum up what's happening

- ❖ Muscle mass is a major determinant of basal metabolism; it acts as a sort of "body furnace" since it is a tissue that uses a lot of energy. Weight loss inevitably implies muscle loss. However, the greater the restriction or the more unbalanced the diet, the greater this loss will be.
- ❖ Muscle mass reduction leads to slower basal metabolism^{37,38}. Food is therefore more efficiently absorbed, to keep the body in its natural weight zone. The weight put back on after a diet, is mainly fat and not muscle, which can lower energy needs, thereby facilitating weight gain.
- ❖ Putting an end to the diet or suddenly relaxing strict dieting rules can lead people to eat compulsively and to overeat.

A working group of the Association pour la santé publique du Québec (ASPQ) analyzed more than 200 weight-loss products and services (WLPS) commercially available in Québec between October 2002 and February 2003.

One of the study's shocking results is that less than 1 % of the WLPS analyzed were based on an approach combining diet, physical activity and lifestyle changes, which is nevertheless the healthy way to lose weight¹⁴.

It is crucial to consider obesity and excessive weight preoccupation jointly, since both problems feed on each other. Continually trying to lose weight is ineffective, and more often than not leads to increased weight gain in the long term.

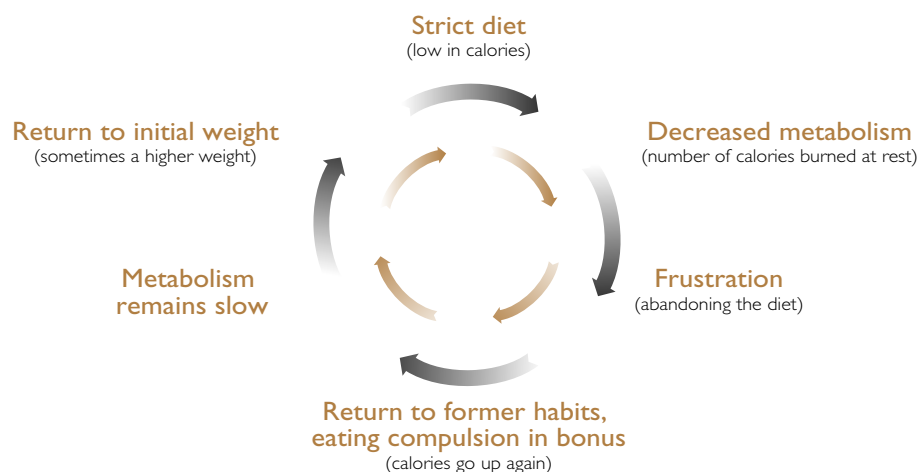


Figure 2: Vicious circle of dieting.
Source: Heart and Stroke Foundation of Québec³⁹

- ❖ Weight-loss methods affect people's natural food-regulation mechanisms. By relying on external dietary signals, they eat more with "their heads" than by listening to their bodies.
- ❖ The self-esteem and confidence that they can successfully control their weight diminish, and people are increasingly obsessed by weight and food.

Rather than questioning the quality and the efficacy of weight-loss methods and products, people often believe that failure to lose weight attests to their lack of willpower. They feel entirely responsible for the outcome. Constantly discouraged by their excess weight, they keep starting over and over, turning toward more radical treatments, involving more efforts, discouragement and major costs, all the while damaging their metabolism and weight-regulating mechanisms.



The GTPPP believes that the escalating use of various weight-loss methods is counterproductive. In addition to taking away from the pleasure of eating, these methods do not solve the problem but rather appear to contribute to it.

The current approach to "fighting obesity" often presents the problem simply as a matter of personal choice. Focusing on individual responsibility can lead to increased prejudice and discrimination towards heavy people.

In addition, this approach fosters the obsession with thinness, encourages the population to resort to miracle solutions and urges it to seek weight loss at any price, without regard for health. This is neither a responsible approach to the problem, nor feasible in a public health context.

The GTPPP proposes an alternative outlook on the problem. First, we must take a broader and more in depth look at issues related to weight, which are far more complex than they appear. In addition, we need to adopt a more realistic perspective regarding

solutions. While weight is a major determinant of health, it represents only one aspect of human beings. A more positive and promising approach is to take into account the complex dynamics of people and consider the interconnectedness between food, physical activity and self-image. Above all, the two aspects of the issue: obesity and excessive weight preoccupation must be considered as indissociable.

Why are weight-related problems on the rise?

The marked increase in weight-related problems seems to date back to the 1970s⁴⁰. This increase can be illustrated graphically by charting the population's weight distribution (Figure 3). The average weight has been moving to the right as the curve flattens out. Consequently, the number of individuals crossing the obesity threshold (illustrated by the vertical line at BMI = 30), as well as the number of persons approaching this threshold is increasing as the average weight in the population increases⁴¹.

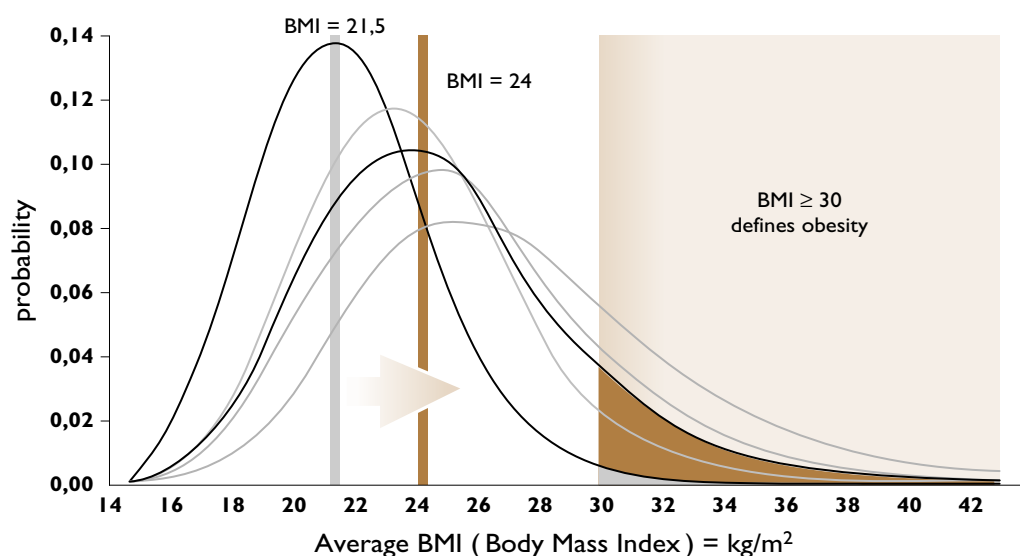


Figure 3: Illustrates the relationship between average BMI and the prevalence of obesity, where the shifting BMI and its effect on the proportion of obese people can be seen. Data from the Intersalt Study of men and women aged 20 to 59 in 52 population samples from 32 countries.

Source: WHO 2002¹²

What can explain the recent increase in weight-related problems? Various factors, including genes, can explain obesity in individuals. Genetic factors, however, cannot explain the recent significant weight gain across populations⁴². Genetic mutations are relatively rare, and their effects appear more gradually in the population. Actually, experts agree that the phenomenon is attributable to a synergy between biological and environment factors^{3,4,9,12,40,43-50}.

The simultaneous contributions of biology and environment to weight-related problems are summed up by Dr. Bray, Emeritus Researcher in obesity: "Genes load the gun, environment pulls the trigger⁵¹."



In 1971, 80 % of children aged 7-8 walked to school. By 1999, this figure had dropped to 41 %^{52,53}.

Over the past thirty years, numerous social changes have led people to have more sedentary lifestyles and have brought about profound changes in eating habits. In this way, above and beyond individual choices, behaviours are attributable to the society we have created.

We use less energy

Numerous mechanical and automated devices used at work, for transportation, in the home and for recreation have significantly reduced people's energy expenditure. Although multiple technological innovations, such as the car, industrial machinery, household appliances, computers may increase productivity, they simultaneously reduce energy expenditure^{3,13,40}. Added to this are leisure activities that also require little energy (televisions, computers, video games, and remote-controlled television, VCRs, etc.). Moreover, increased violence in certain areas fostering insecurity, coupled with shortcomings in urban planning which reduces green spaces and parks, are additional factors dissuading people from getting out and exercising^{12,40}.

The innovations of the second half of the 20th century and the work and lifestyle changes they have caused have considerably reduced the amount of physical energy required to accomplish daily tasks, and consequently to promote a positive energy balance.

We eat differently

With the rapid beat of modern day life, peaceful family dinners redolent with delicious aromas have almost become a thing of the past. Today, we eat anytime and anywhere, often alone, pre-prepared or restaurant meals, where the ingredients are unknown to us. The mission of the agri-food industry is no longer to ensure the survival of the population by providing basic food products, as was the case at the beginning of the last century. To satisfy its shareholders, it must produce a profit in a context of a free-market economy: fierce competition, consolidation and globalization. It now follows the same rationale as every other industry^{4,54,55}. It is faced with an aging and sedentary population whose numbers are not growing, and therefore has lower energy needs. What happens in our economic system when an industry can no longer rely on natural growth for its sales? The food industry is a typical example of a declining market.

The agri-food industry is therefore producing new types of food which meet the current needs of consumers who have little time to prepare meals, who do not know how to cook or who are simply not interested in it^{50,56}. These new ultra-refined foods, high in sugar and fat and low in fibre, have a high energy density. They can be found everywhere, even in unlikely areas: at the garage, in the streets, etc. In addition, people are eating more often outside of the home^{50,57}. Unfortunately, the food found in restaurants and cafeterias is generally higher in fat and above all, served in bigger portions⁶⁰. In the eyes of consumers, bigger portions means that they "get more for their money", even if, ultimately, these larger portions subconsciously encourage them to eat more.

A world of images and advertising

The cultural environment has also changed considerably. We are surrounded by advertising, and it has profoundly affected our relationships with our bodies, food, and many other things^{61,62}. For example, highly processed foods, created by the agri-food industry, are the subject of aggressive market launches and ubiquitous advertising campaigns⁵⁰.

Media, advertising, fashion and show-business never miss an opportunity to contribute to the creation of beauty norms. Pressured by a consumer society which showcases a thinner than ever female body^{13,63}, we now care for our bodies differently: we are more interested in form than function. Indeed, few people claim daily sustenance as their prime motivation for eating. We are more preoccupied by the effect of food on our weight and our appearance¹³. For example, in the 1990 *Enquête québécoise sur la nutrition* (Québec nutrition survey), 29 % of women in Québec said they were always concerned about their weight when eating⁸. This indeed shows that the motivations of the modern eater have profoundly changed. For many people, food is at the heart of a never-ending struggle: giving in to the numerous foods offered everywhere and having to look like the thin and eternally youthful models¹³.

The multi-causality of weight-related problems and the importance of macro-social factors are well illustrated in the causal web proposed by the International Obesity Task Force (Figure 4). From this causal web, it is easy to see that the combination of many factors has considerably changed the key determinants in humans' energy balance: a fast-paced lifestyle, challenges balancing life and work, a weak social support attributable to smaller, often single-parent families, ubiquitous advertising, an impressive array of all kinds of products, the mechanization of life, etc. Consequently, the biological mechanisms which have helped humans maintain a relatively stable weight for centuries seem threatened by all of these changes⁴².

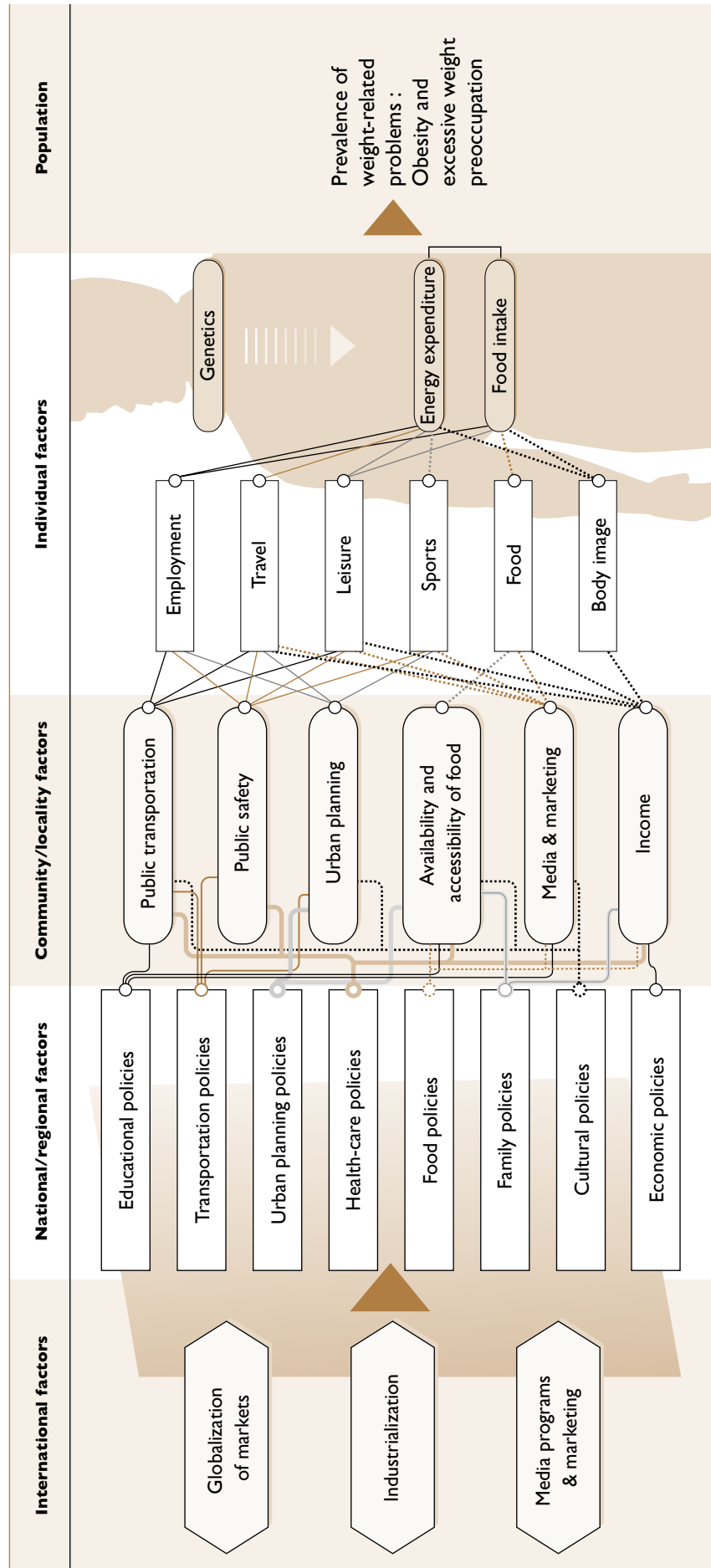


“Supersizing” is a way for the industry to add value, and thus overcome the economic challenge⁵⁸.

It has been shown that when presented with “supersized” portions, consumers will eat 30 % more calories⁵⁹.

In the United States, in 1997, food manufacturers, retailers and restaurants spent \$11 billion on advertising, which is second only to dollars spent for advertising by the automobile industry. In comparison, the United States Department of Agriculture (USDA) spent \$333.3 million over the same period on nutritional messages, i.e. 3 % of the amount spent by the agri-food industry⁵⁰.

Causal web of factors influencing weight-related problems*



Adapted from Ritenbaugh C., Kumanvika S., Morabia A., Jeffery R., and Antipatis V., IOTF website 1999.

Figure 4 - Political, socio-cultural, economic, and personal factors which directly or indirectly influence weight-related problems* (weight-related problems: obesity and excessive weight preoccupation)⁶⁴.

Understanding the causal web

Figure 4 illustrates the mechanisms leading to social changes which in turn influence weight. Take traveling, for example. The amount of energy people expend getting from one place to another is decreasing in the ever-growing presence of cars. This is largely due to urbanization, which has made car use necessary in many environments.

This perception of necessity, along with other perceptions associated with car driving such as pleasure, freedom and exhilaration, are promoted by advertising and marketing techniques. A new standard is created for car travel. Furthermore, transportation policies give people little incentive to use alternatives such as public transit, cycling and walking. Consequently, these means of transportation are expensive, poorly organized or inconvenient. Thus, they cannot overcome the perceived advantages of the car, and do not represent a competitive substitute. Finally, economic pressures, such as keeping factories open, creating or maintaining jobs, are exerted on governments by multinational car manufacturers. Accordingly, for various weight-related behaviours, individuals' responsibility to make healthy choices is subjected to very strong environmental pressures.

A public health problem

To qualify as a public health problem, a condition must be frequent and serious, be on the rise, have known risk factors, be established in various areas of society, and be preventable⁶⁵. As described here, weight-related problems are a perfect example of a public health problem... a societal problem.

Of course, the public health sector is already working, with varying intensity and in different ways, to improve eating habits and reduce sedentary lifestyle. However, since the WHO sounded the alarm in 1998, the obesity problem is increasingly perceived as serious, and the need to act imminent. Public health authorities from many countries, specifically the United States with a call to action from the *Surgeon General*⁶⁵, France⁶⁶, Australia⁶⁷, and the *European Association for the Study of Obesity*⁶⁸ have taken up the problem, produced action plans and, have in certain cases, mobilized resources. These action plans share several points in common.

An ounce of prevention

It is wiser to try and prevent weight gain than to try and eliminate it after the fact. Once the weight is on, it is difficult to permanently shed those extra pounds, as can be seen by the resounding failure of diets and various weight-loss methods.

Knowledge does not necessarily motivate change

Few obese people are unaware of the fact they are obese. The population is already extremely motivated to lose weight, as witnessed by the craze for various weight-loss methods. Merely telling individuals to eat well and to be more active is not of much help. A parallel can be drawn with smoking : every smoker knows that tobacco is bad for their health and many would like to quit. Yet knowledge and determination are not enough to

Changing our environments means we must “make healthy choices easy and unhealthy ones more difficult⁶⁹”.

succeed in making the change. There are other motivations and pressures at work that keep people smoking, as is the case for eating and exercise habits.

Environments must be changed

Environments include our physical, social and cultural environments, the rules and policies that govern us, and the social standards and dominant values of our society. Since the causes of weight-related problems can be found in these environments, changing them is a priority. Different players are responsible for these environments, and the role of public health is to mobilize the various players so as to work together on effective initiatives.

While epidemiology has generally focused on initiatives targeting at risk groups, public health has traditionally acted on environmental influences, with great success. It is helpful to recall, for example, that major health gains were achieved during the industrial revolution when public authorities decided to invest in the installation of running water, sewer systems and garbage collection⁷⁰. Other, more recent examples support the effectiveness of this strategy : anti-smoking laws for smoke-free environments, tobacco taxes and restricted access to alcohol have resulted in behaviour changes, even in the absence of education^{12,48,71}. Seat belts in cars prevent injuries regardless of how the cars are driven. Accordingly, major health problems can be solved not by healthcare or through personal action, but rather through adequate management of the environment.

Such is the challenge awaiting public health with respect to weight-related problems : to rely increasingly on initiatives which seek to modify the environment, i.e. to directly change life conditions which are at the root of certain behaviours. In this way, we influence behaviour without necessarily having to educate. By definition, this kind of initiative affects a large number of people, and since they are passively exposed, they benefit from preventive initiatives without a second thought.

This does not mean that people should be absolved of responsibility. They will continue to put food in their grocery carts, but supermarkets will contribute to making nutritious food choices easier. People will still have to choose between cars, public transit, cycling and walking, but better urban planning will make healthier choices easier. In fact, to reduce weight-related problems, we must rely on the idea of shared responsibility among individuals, communities and governments. Figure 5 illustrates this **shared responsibility** and the complementarity of actions.

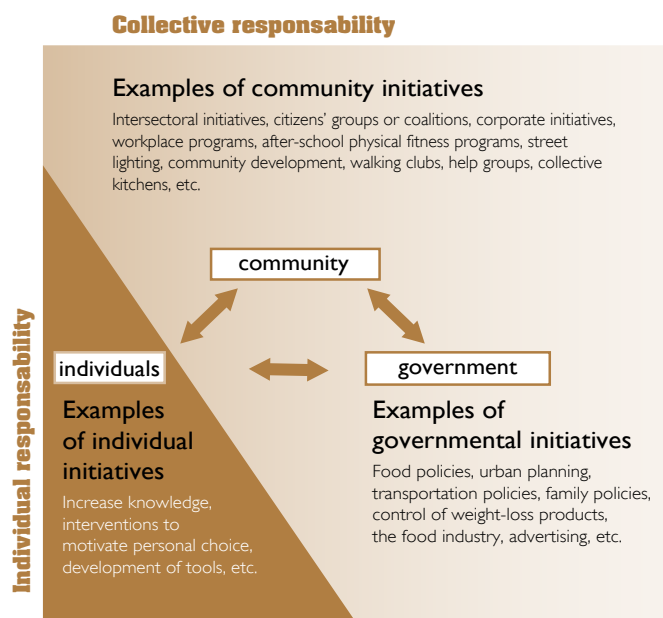


Figure 5: Shared responsibility and the complementarity of actions to reduce weight-related problems.

A framework for action

Within a health promotion context, programs designed to change the population's behaviour require that many strategies simultaneously work together⁷². The Ottawa Charter promotes the complementarity and synergy of interventions making it a judicious frame of reference for weight-related problems⁷³.

Based on the most significant health determinants, the Ottawa Charter proposes the following intervention axes :

- **Build Healthy Public Policy**
- **Create Supportive Environments**
- **Strengthen Community Action**
- **Develop Personal Skills**
- **Reorient Health Services**

The Ottawa Charter is widely known and used in public health in Québec, and is a frame of reference for two major Québec documents on public health : the *Politique de santé et bien-être* (Policy on Health and Well-being) of the Ministère de la Santé et des Services sociaux (Québec's Department of Health and Social Services)⁷⁴ and the *Programme national de santé publique 2003-2012* (Québec Public Health Program 2003-2012)⁷⁵. We acknowledge, however, that generally public health practice in Québec does not use the five axes equally. Development of personal skills remains the most heavily prioritized axis, while those of building healthy public policy and creating supportive environments

need more emphasis. Planning the interrelated use of several axes of the Ottawa Charter, particularly the first three, could help build an effective plan.

In accordance with the causal web (Figure 4), the GTPPP has identified three strategic areas in which initiatives on weight-related problems could be focused: the **agri-food**, **socio-cultural** and **manmade environment** sectors. Figure 6 illustrates these three sectors and their components.

The five intervention axes of the Ottawa Charter can be applied to each strategic sector. Examples of initiatives by sector, and the strategies to which they refer, are given below. Clearly, these types of initiatives could be implemented in each of the sectors and do not constitute an exhaustive list, nor a formal action plan. It is interesting to note that the same kind of initiatives can apply to more than one sector, e.g. support for a citizens' lobby group could apply to both food and to physical activities. Regions and neighborhoods must examine which combination of initiatives can best be put into place according to their respective needs and interests.

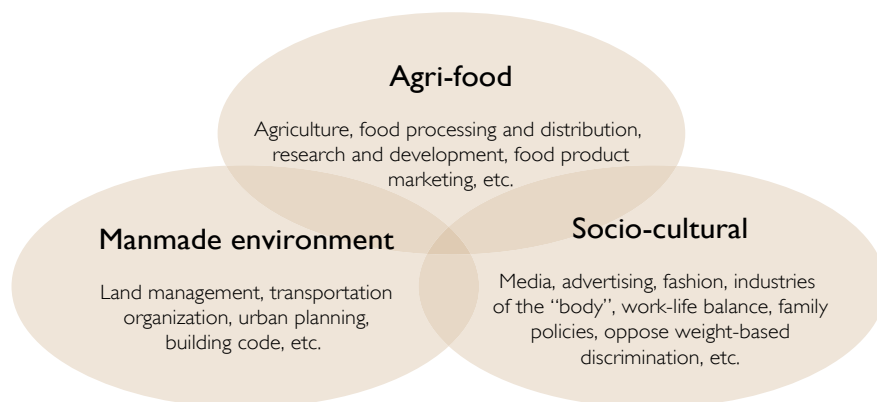


Figure 6: Illustration of the three sectors in which initiatives associated to weight-related problems could be focused.

Agri-food sector

- Develop and implement policies on food processing and distribution (*build healthy public policy*).
- Develop a nutrition policy (*build healthy public policy*).
- Implement and support food policies in schools and workplaces (*create supportive environments*).
- Support institutional food services (cafeterias and restaurants) in applying a code aimed at reducing portion sizes (*create supportive environments*).
- Make decision-makers from the agri-food industry aware of the importance of providing single-serving food items and appropriate beverages (*create supportive environments*).
- Help citizens' groups lobby the food industry for food products that meet the needs of the population (*strengthen community action*).



- Implement a campaign promoting the consumption of five fruits and vegetables per day (*develop personal skills*).
- Raise awareness in the population to the importance of listening to their bodies telling them when they are hungry or full, as a way to limit weight gain (*develop personal skills*).
- Provide first-line healthcare professionals with the tools to enable them to help people eat healthier foods, and listen to their bodies signals (*reorient health services*).

Socio-cultural sector

- Regulate the industry of weight-loss products, services, and methods industry (build healthy public policy).
- Strengthen regulations on advertising that targets children (build healthy public policy).
- Implement and support school programs that encourage youth to respect each other, regardless of body size, and that try to eliminate weight discrimination in the workplace (create supportive environments).
- Help citizens' groups lobby the fashion world for attractive clothes at a fair price in a wider range of sizes (strengthen community action).
- Help citizens' groups lobby the media for a magazine/newspaper code of ethics concerning representations of the body (messages and images) (strengthen community action).
- Start a campaign to change social standards leading to the population's understanding and integration of the idea of a "healthy body weight" (*develop personal skills*).
- Provide first-line healthcare professionals with the tools to help them better identify those trapped by excessive concern with weight, and to integrate respectful attitudes toward overweight and obese people into their practice (*reorient health services*).

Manmade environment sector

- Support the adoption of regulations aimed at increasing the number of hours of physical activity in schools (build healthy public policy).
- Adopt fiscal measures involving income tax deductions for fees related to participation in sports (build healthy public policy).
- Implement development plans that encourage the use of active transportation, the development of parks for families and sports facilities for adults (create supportive environments).
- Make local environments safer so that people are not afraid to walk or cycle (create supportive environments).
- Help communities set up baby-sitting services to make it easier for parents to make use of sports facilities or exercise (strengthen community action).
- Help start community programs for physical exercise and the adoption of realistic goals regarding weight and appearance (*develop personal skills*).
- Provide first-line healthcare professionals with tools to enable them to help people adopt a more active lifestyle (*reorient health services*).



Where do we start?

Under the *Programme national de santé publique 2003-2012* (Québec's Public Health Program 2003-2012), local and regional plans, as well as a provincial plan, have been developed and implemented⁷⁵. While the strategies proposed in the *Programme national de santé publique 2003-2012* (Québec Public Health Program 2003-2012) use different terms, they are in line with the Ottawa Charter and meet the challenges of the causal web of weight-related problems. According to the targets proposed by the program, initiatives can be considered at different intervention levels, with a main goal of complementing and strengthening each other. Here are a few examples :

• Promotion and application of policies, laws and regulations

(Ottawa Charter = Build healthy public policy)

Provincial level

Develop a food policy in schools.

Regional level

Develop and implement a training program for food services managers; support via the implementation of a comprehensive, coordinated program in schools; program evaluation.

Local level

Mobilize and support action taken in schools by principals, boards of governors and food services managers.

• Promotion and prevention to encourage healthy lifestyles

within communities

(Ottawa Charter = Create supportive environments, and strengthen community action)

Provincial level

Promote the creation of environments and situations for safe and accessible physical activities, which favour active lifestyles by implementing development plans.

Regional level

Have public health professionals participate in regional consultations on reviewing land management schemes and urban planning.

Local level

Set up and support local citizens' coalitions that encourage walking to help them lobby local decision-makers.

• Promote health and well-being in schools and prevent adjustment problems

(Ottawa Charter = Create supportive environments, strengthen community action and develop personal skills)

Provincial level

Develop and implement a comprehensive, coordinated program in schools to promote the health and well-being of children and adolescents.

Regional level

Train and support school staff on the topics of self-esteem, body image, respect for diversity, gender equality, healthy sexuality, etc.

Local level

Implement school and community activities that promote self-esteem, body image, respect for diversity, gender equality, and healthy sexuality.

Conditions for action

Certain conditions are required, however, to launch initiatives targeting weight-related problems. **Social and political will** are essential ingredients, since the allocation of human, material and financial resources is a prerequisite⁷⁶. Therefore, there must be a willingness among decisionmakers to build provincial, regional and local healthcare teams dedicated to chronic illnesses, including weight and body image. To obtain conclusive results, these teams must also have the necessary expertise and be concentrated in a critical mass. Finally, research and evaluation must accompany field work to increase our knowledge of the causes, consequences, priority targets and most effective actions. This way, formally-constituted healthcare teams provided with the right resources will be able to play their assigned role in this challenge:

- ❖ To influence and mobilize the players in various sectors involved in the issue.
- ❖ To partner with those involved with initiatives to transform environments, food products, etc.
- ❖ To raise awareness and support communities in intersectoral initiatives.
- ❖ To maintain a watch on new developments liable to further deteriorate life habits.
- ❖ To empower individuals by transferring knowledge and developing skills with a goal toward greater long-term community control over health issues.

Taking action today for a brighter tomorrow

The psychosocial consequences of obesity are immeasurable. If the “war against obesity” is conducted without consideration for its harmful effects, there is a risk that it may unintentionally turn into a “war against the obese”^{12,77,78}. Maligning obesity as a scourge on society adds to the already heavy burden of those suffering from it. The responsibility for the problem is transferred to individuals, while the problem itself is a social one. Pointing the finger at people with weight-related problems can only add to their stigmatization⁷⁹.

We must remember that the world is made up of a range of body types, and a certain amount of obesity will always be present in any population. This is the result of years of evolution and cannot be changed to any great extent. The problem that public health players should be more concerned with is the increasing prevalence of overweight and the excessive concern with weight which can be attributed to lifestyle. It is crucial to attack the right targets, which are deteriorating lifestyles and the pressures that initiate and maintain such deterioration.

The challenge in preventive interventions is therefore to reduce increased overweight in the population by attacking factors that can be changed, while not exacerbating the “fear of fatness”. The messages and initiatives must be prescribed with much forethought and delicacy if we want to prevent another epidemic: weight obsession⁷⁹.

We cannot wait

No matter how we approach the question, we are faced with a crisis. Let’s not fool ourselves: to wait would be a disaster. The cost of inaction will be very high. Not getting involved with weight interventions sends a message that the current weight-loss services are an appropriate solution to the epidemic. Is that really the case?

Soon, our children will suffer from our inaction. For example, type 2 diabetes, a condition found in adults, is slowly appearing in our children⁸⁰. Despite our as yet incomplete knowledge, we can understand enough about the problem to act. We know that the burden of control over this epidemic does not lie with the individual, but rather with our environment.

The population is motivated to fight this problem.

Let’s offer our support.

References

- 1 - Therrien L (1995) Poids corporel. In: *Et la santé, ça va en 1992-1993? Rapport de l'Enquête sociale et de santé 1992-1993*. Ministère de la Santé et des Services sociaux: Québec, Chap. 7. Pg. 109-123.
- 2 - Ledoux M, Rivard M (2000) Poids corporel. In: *Enquête sociale et de santé 1998*. Institut de la statistique du Québec: Québec, Chap. 8. Pg. 185-199.
- 3 - Brownell K (2002) The environment and obesity. In: *Eating disorders and obesity. A comprehensive handbook*. Fairburn CG, Brownell KD (Eds). The Guilford Press: New York, Chap. 78. Pg. 433-438.
- 4 - Brownell KD, Battle Horgen K (2004) *Food fight. The inside story of the food industry, America's obesity crisis and what we can do about it*. Contemporary Books: Chicago, 356 p.
- 5 - Critser G (2003) *Fat land. How Americans became the fattest people in the world*. Houghton Mifflin Company: New York, 232 p.
- 6 - Ledoux M, Mongeau L, Rivard M (2002) Poids et image corporelle. In: *Enquête sociale et de santé auprès des enfants et des adolescents québécois 1999*. Institut de la statistique du Québec: Québec, Chap. 14. Pg. 311-344.
- 7 - Tsai G (2000) Eating disorders in the Far East. *Eating and Weight Disorders*. 5(4): 183-197.
- 8 - Santé Québec, Bertrand L (sous la direction de) (1995) *Les Québécois et les Québécoises mangent-ils mieux? Rapport de l'Enquête sur la nutrition*, 1990. Ministère de la Santé et des Services sociaux: Montréal, 317 p.
- 9 - WHO (2003) *Diet, nutrition and the prevention of chronic diseases*. Report of a Joint WHO/FAO Expert Consultation. WHO technical reports series No 916. World Health Organization: Geneva, 149 p.
- 10 - Birmingham CL, Muller JL, Palepu A, Spinelli JJ, Anis AH (1999) The costs of obesity in Canada. *Canadian Medical Association Journal*. 160(4): 483-488.
- 11 - Ledoux M, Lambert J, Reeder BA, Després JP (1997) Correlation between cardiovascular disease risk factors and simple anthropometric measures. *Canadian Medical Association Journal*. 157 (S1): S46-S53.
- 12 - WHO (2000) *Obesity, preventing and managing the global epidemic. Report of a WHO consultation*. Technical report series No. 894. World Health Organization: Geneva, 252 p.
- 13 - Fischler C (2001) *L'Homnivore*. Éditions Odile Jacob: Paris, 440 p.
- 14 - ASPQ (Association pour la santé publique du Québec) (2003) *Produits, services et moyens amaigrissants offerts au Québec: des promesses trop souvent irréalistes*. Press release May 6 2003. [Online] [<http://www.aspq.org/news/index3.htm>] (September 7, 2003).
- 15 - Green KL, Cameron R, Polivy J, Cooper K, Liu L, Leiter L, Heatherton T (1997) Weight dissatisfaction and weight loss attempts among Canadian adults. Canadian Heart Healthy Surveys Research Group. *Canadian Medical Association Journal*. 157(S1): S17-S25.
- 16 - Anderson JW, Konz EC, Frederich RC, Wood CL (2001) Long-term weight-loss maintenance: A meta-analysis of US studies. *American Journal Clinical Nutrition*. 74(5): 579-587.
- 17 - Ayyad C, Anderson T (2000) Long-term efficacy of dietary treatment of obesity: A systematic review of studies published between 1931 and 1999. *Obesity Reviews*. 1(2): 113-119.
- 18 - Petersmark K, Smith P (1989) *Toward safe weight loss recommendations for adult weight loss programs in Michigan*. Michigan Health Council. Michigan department of Public Health: Lansing MI.
- 19 - Rasio E (1970) Répercussions métaboliques du jeûne. *Revue Médicale de Bruxelles*. 26(10): 569-579.
- 20 - Berg FM (1999) Health risks associated with weight loss and obesity treatment programs. *Journal of Social Issues*. 55(2): 277-297.
- 21 - Gegg EW, Williamson DF (2002) The relationship of intentional weight loss to disease incidence and mortality. In: *Handbook of obesity treatment*. Wadden TA, Stunkard AJ (Eds), The Guilford Press: New York, Chap. 7. Pg. 125-143.
- 22 - Polivy J, Herman CP (1985) Dieting and bingeing: A causal analysis. *American Psychology*. 40(2): 193-201.
- 23 - Langlois JA, Mussolino ME, Visser M, Looker AC, Harris T, Madans J (2001) Weight loss from maximum body weight among middle-aged and older white women and the risk of hip fracture: the NHANES I epidemiologic follow-up study. *Osteoporosis International*. 12(9): 763-8.
- 24 - Felson DT, Zhang Y, Hannan MT, Anderson JJ (1993) Effects of weight and body mass index on bone mineral density in men and women: The Framingham study. *Journal of Bone and Mineral Research*. 8(5): 567-73.
- 25 - Wadden TA, Van Itallie TB, Blackburn GL (1990) Responsible and irresponsible use of very-low-calorie diets in the treatment of obesity. *Journal of the American Medical Association*. 263(1): 83-85.
- 26 - Mundy A (2001) *Dispensing with the truth: The victims, the drug companies and the dramatic story behind the battle over fen-phen*. St-Martin's Press: New York, 400 p.
- 27 - Irving LM, Neumark-Sztainer D (2002) Integrating the prevention of eating disorders and obesity: Feasible or futile? *Preventive Medicine*. 34(3): 299-309.
- 28 - Field AE, Austin SB, Berkley CS, Rockett HR, Colditz GA (2000) *Frequent dieting predicts the development of obesity among preadolescent and adolescent girls and boys*. Annual Conference NAASO 2000, Long Beach, California.
- 29 - Stice ERP, Cameron RP, Killen JD, Hayward C, Taylor CB (1999) Naturalistic weight-reduction efforts prospectively predict growth in relative weight and onset of obesity among female adolescents. *Journal of Consulting and Clinical Psychology*. 67(6): 967-974.
- 30 - Coakley EH, Rimm EB, Colditz G, Kawachi L, Willett W (1998) Predictors of weight change in men: Results from the Health Professionals Follow-up Study. *International Journal of Obesity*. 22(2): 89-96.
- 31 - Korkeila M, Rissanen A, Kaprio J, Sorensen TI, Kosjenvuo M (1999) Weight-loss attempts and risk of major weight gain: A prospective study in Finnish adults. *American Journal of Clinical Nutrition*. 70(6): 965-975.
- 32 - Field AE, Austin SB, Taylor CB, Malspeis S, Rosner B, Rockett HR, Gillman MW, Colditz GA (2003) Relation between dieting and weight change among preadolescents and adolescents. *Pediatrics*. 112(4): 900-906.
- 33 - French SA, Jeffery RW (1994) Consequences of dieting to lose weight: Effects on physical and mental health. *Health Psychology*. 13(3): 195-212.
- 34 - French SA, Jeffery RW, Folsom AR, Williamson DF, Byers T (1995) Relation of weight variability and intentionality of weight loss to disease history and health-related variables in a population-based sample of women aged 55-69 years. *American Journal Epidemiology*. 142(12): 1306-14.
- 35 - Kroke A, Liese AD, Schulz M, Bergmann MM, Klipstein-Grobusch K, Hoffman K, Boeing H (2002) Recent weight changes and weight cycling as predictors of subsequent two year weight change in a middle-aged cohort. *International Journal of Obesity*. 26(3): 403-9.
- 36 - Pasman WJ, Saris WH, Westterp-Plantenga MS (1999) Predictors of weight maintenance. *Obesity Research*. 7(1): 43-50.
- 37 - Keys A, Brozek J, Henschel A, Mickelsen F, Taylor HF (1950) *The biology of human starvation*. University of Minnesota Press, Minneapolis, 1385 p.
- 38 - Leibel RL, Rosenbaum M, Hirsch J (1995) Changes in energy expenditure resulting from altered body weight. *New England Journal of Medicine*. 332(10): 621-628.
- 39 - Fondation des maladies du cœur du Québec (2000) *Du fond du Cœur*. Pamphlet May 2000.
- 40 - James WPT (1995) A public health approach to the problem of obesity. *International Journal of Obesity*. 19(Suppl 3): S37-S45.

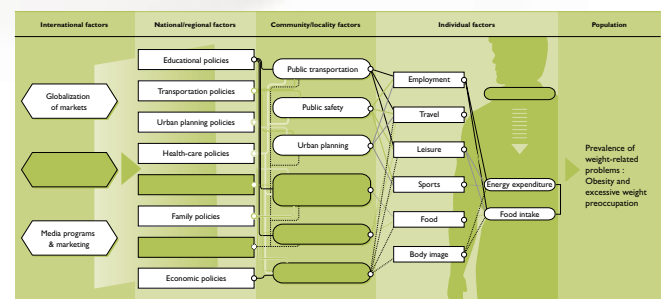
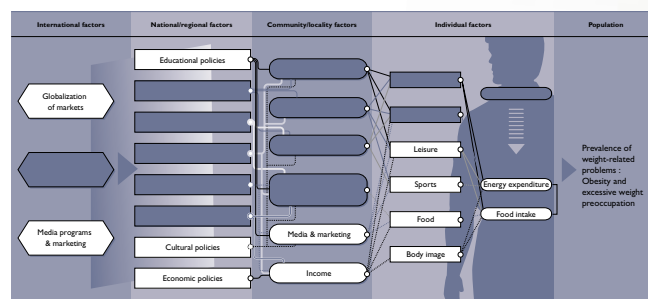
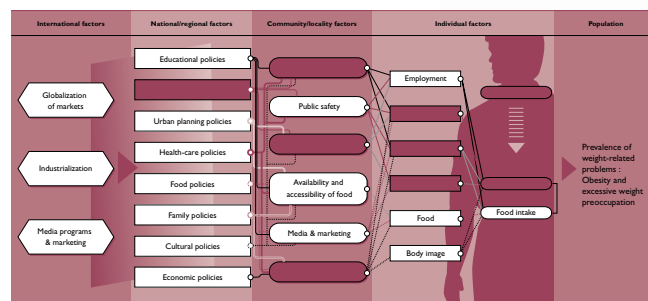
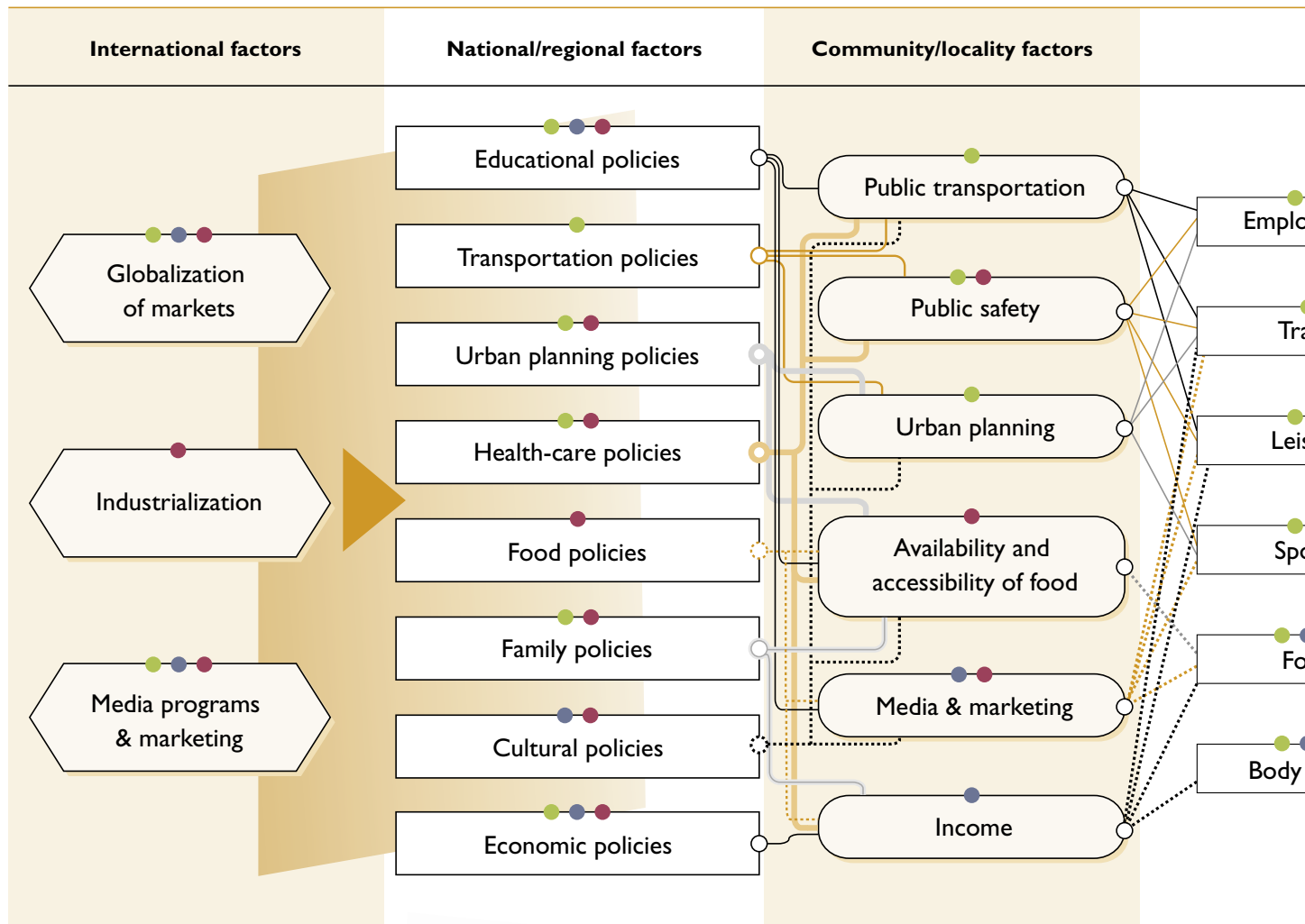
- 41 - Rose G (1992) *The strategy of preventive medicine*. Oxford University Press: New York, 138 p.
- 42 - Hill JO (2002) An overview of the etiology of obesity. In: *Eating disorders and obesity. A comprehensive handbook*. Fairburn CG, Brownell KD (Eds). 2nd ed. The Guilford press: New York. Chap. 83. Pg. 460-466.
- 43 - Kumanyika SK (2001) Minisymposium on obesity: Overview and some strategic considerations. *Annual Review of Public Health*. 22: 293-308.
- 44 - Kumanyika S, Jeffery RW, Morabia A, Ritenbaugh C, Antipatis VJ, Public Health Approaches to the Prevention of Obesity (PHAPO). Working Group of the International Obesity Task Force (IOTF) (2002) Obesity prevention: The case for action. *International Journal of Obesity*. 26(3): 425-436.
- 45 - USDHHS (U.S. Department of Health and Human Services) (2001) *The Surgeon General's call to action to prevent and decrease overweight and obesity*. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General: Washington. [Online] [<http://www.surgeongeneral.gov/topics/obesity/calltoaction/cover.htm#citation>] (February 13 2002).
- 46 - IOTF (International Obesity Task Force), EASO (European Association for the Study of Obesity) (2002) *Obesity in Europe. The case for action*. IOTF: London, 22 p. [Online] [<http://www.iotf.org/media/euobesity.pdf>] (February 25, 2003).
- 47 - Booth SL, Sallis JF, Ritenbaugh C, Hill JO, Birch LL, Frank LD, Glanz K, Himmelgreen DA, Mudd M, Popkin BM, Rickard KA, St Jeor S, Hays NP (2001) Environmental and societal factors affect food choice and physical activity: Rationale, influences and leverage points. *Nutrition Reviews*. 59(3 Pt 2): S21-S39.
- 48 - Swinburn B, Egger G, Raza F (1999) Dissection obesogenic environments: The development and application of a framework for identifying and prioritizing environmental interventions for obesity. *Preventive Medicine*. 29(6 Pt 1): 563-70.
- 49 - Nestle M, Jacobson MF (2000) Halting the obesity epidemic: A public health policy approach. *Public Health Reports*. 115(1): 12-24.
- 50 - French SA, Story M, Jeffery RW (2001) Environmental influences on eating and physical activity. *Annual Review of Public Health*. 22: 309-335.
- 51 - Wadden TA, Phelan S (2002) Behavioural assessment of the obese patient. In: *Handbook of obesity treatment*. Wadden TA, Stunkard AJ (Eds). The Guilford Press: New York, Chap. 10. Pg. 186-226
- 52 - Chevalier R (2003) *Comment faire bouger nos enfants*. Revue Capital Santé, March 2003.
- 53 - Mayer M, Roberge D (2002) Perception de l'environnement social: quartier ou voisinage. In: *Enquête sociale et de santé auprès des enfants et des adolescents québécois 1999*. Chap. 5. Institut de la statistique de Québec, Gouvernement du Québec, pg. 137-152.
- 54 - James WPT (2003) *The food chain and obesity prevention*. Prevention of obesity - the global approach. Berzelius Symposium 62. May 26-28/2003, Stockholm, Sweden.
- 55 - Nestle M (2002) *Food politics. How the food industry influences nutrition and health*. University of California Press: Berkeley, CA, 457 p.
- 56 - Seidell JC (1999) Prevention of obesity: The role of the food industry. *Nutrition Metabolism and Cardiovascular Diseases*. 9(1): 45-50.
- 57 - Statistique Canada (2000) Concurrence dans les services de restauration durant les années 1990. *Le Quotidien*, Le vendredi 14 avril 2000. [Online] [<http://www.statcan.ca/daily/Francais/000414/q000414a.htm>] (August 18 2003).
- 58 - Young LR, Nestle M (2002) The contribution of expanding portion sizes to the US obesity epidemic. *American Journal of Public Health*. 92(2): 246-9.
- 59 - Orlet Fisher J, Rolls BJ, Birch LL (2003) Children's bite size and intake of an entrée are greater with large portions than with age-appropriate or self-selected portions. *American Journal of Clinical Nutrition*. 77(5): 1164-70.
- 60 - Jeffery RW, French SA (1998) Epidemic obesity in the United States: Are fast foods and television viewing contributing? *American Journal of Public Health*. 88(2): 277-80.
- 61 - Cossette C (2003) *Les envahisseurs d'espaces publics*. Le devoir, August 17 2003.
- 62 - Klein N (2001) *No Logo*. Leméac/Actes sud: Arles, 574 p.
- 63 - Stearns PN (1997) *Fat history. Bodies and beauty in the Modern West*. University Press: New York, 294 p.
- 64 - Ritenbaugh C, Kumanyika S, Morabia A, Jeffery R, Antipatis V (1999) *The causal web*. [Online] [<http://www.iotf.org/graphics/causalweb.tif>] (September 20, 2000).
- 65 - Donnan S. (2001) Ethics in public health. In: *Oxford handbook of public health practice*. Pencheon D, Guest C, Melzer D, Muir Gray JA (Eds). Oxford University Press: New York, Chap. 28, pg. 118-124.
- 66 - Secrétariat d'État à la santé et aux handicapés (2000) *Pour une politique nutritionnelle de santé publique en France: enjeux et recommandation*. [Online] [<http://www.sante.gouv.fr/htm/actu/nutri2000/sommaire.htm>] (June 15, 2002).
- 67 - NHMRC (National Health and Medical Research Council) (1997) *Acting on Australia's weight: A strategic plan for the prevention of overweight and obesity*. Australian Government Publishing Service: Canberra, 229 p.
- 68 - IOTF (International Obesity Task Force), EASO (European Association for the Study of Obesity) (2002) *Obesity in Europe. The case for action*. IOTF: London, 22 p. [Online] [<http://www.iotf.org/media/euobesity.pdf>] (February 25, 2003).
- 69 - Milio N (1981) *Promoting health through public policy*. FA Davis Pub, Philadelphia, 359 p.
- 70 - Rosen G (1993) *A history of public health*. The John Hopkins University Press: Baltimore, 535 p.
- 71 - Cohen DA, Scribner RA, Farley TA (2000) A structural model of health behaviour: A pragmatic approach to explain and influence health behaviours at the population level. *Preventive Medicine*. 30(2): 146-54.
- 72 - Sallis JF, Owen N (2002) Ecological models of health behaviour. In: *Health behaviour and health education. Theory, research and practice*. Glanz D, Rimer BK, Marcus Lewis F (Eds). Jossey-Bass: San Francisco, Chap. 20, 462-484.
- 73 - Epp J (1986) *La santé pour tous: plan d'ensemble pour la promotion de la santé*. Santé et Bien-être social Canada: Ottawa.
- 74 - MSSS (Ministère de la Santé et des Services sociaux) (1992) *La politique de la santé et du bien-être*. Ministère de la Santé et des Services sociaux. Gouvernement de Québec, 192 p.
- 75 - MSSS (Ministère de la Santé et des Services sociaux) (2003) *Programme national de santé publique 2003-2012*. Direction générale de la santé publique de ministère de la Santé et des Services sociaux. Direction des communications du ministère de la Santé et des Services sociaux. Gouvernement du Québec: Québec, 126 p.
- 76 - Atwood K, Colditz GA, Kawachi I (1997) From public health science to prevention policy: Placing science in its social and political contexts. *American Journal of Public Health*. 87(10): 1603-1606.
- 77 - Friedman JM (2003) A war to obesity, not the obese. *Science*. 29(5608): 856-858.
- 78 - Hawks SR, Gast J (1998) Weight loss management: A path lit darkly. *Health Education & Behaviour*. 25(3): 371-382.
- 79 - Schaefer C, Mongeau L (2000) *L'obésité et la préoccupation excessive à l'égard du poids. Éléments d'une problématique et réflexions pour l'action*. Collectif action alternative en obésité: Montréal, 87 p.
- 80 - Eisenmann JC (2003) Secular trends in variables associated with the metabolic syndrome of North American children and adolescents: A review and synthesis. *American Journal Human Biology*. 15(6): 786-794.

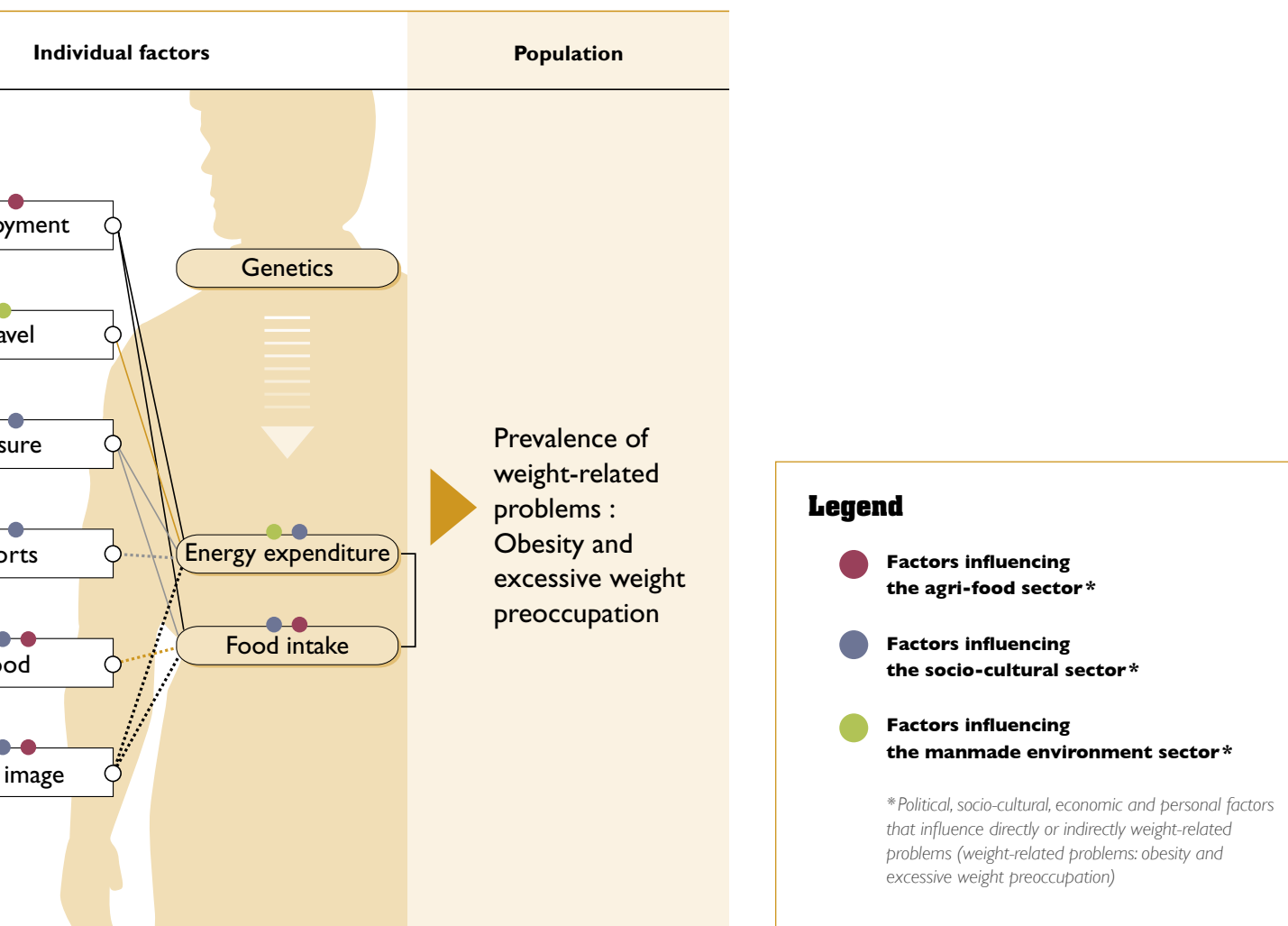
Get mobilized!

Let's act **now**.

www.aspq.org

Interrelationships among selected environmental actions identified for each strategic sector, the five intervention axes of the Ottawa Charter, and the causal web of factors influencing weight-related problems.





Agri-food sector

- Develop and implement policies on food processing and distribution (build healthy public policy).
- Develop a nutrition policy (build healthy public policy).
- Implement and support food policies in schools and workplaces (create supportive environments).
- Support institutional food services (cafeterias and restaurants) in applying a code aimed at reducing portion sizes (create supportive environments).
- Make decision-makers from the agri-food industry aware of the importance of providing single-serving food items and appropriate beverages (create supportive environments).

See the complete list of actions on page 16-17

Socio-cultural sector

- Regulate the industry of weight-loss products, services, and methods industry (build healthy public policy).
- Strengthen regulations on advertising that targets children (build healthy public policy).
- Implement and support school programs that encourage youth to respect each other, regardless of body size, and that try to eliminate weight discrimination in the workplace (create supportive environments).
- Help citizens' groups lobby the fashion world for attractive clothes at a fair price in a wider range of sizes (strengthen community action).

See the complete list of actions on page 17

Manmade environment sector

- Support the adoption of regulations aimed at increasing the number of hours of physical activity in schools (build healthy public policy).
- Adopt fiscal measures involving income tax deductions for fees related to participation in sports (build healthy public policy).
- Implement development plans that encourage the use of active transportation, the development of parks for families and sports facilities for adults (create supportive environments).
- Make local environments safer so that people are not afraid to walk or cycle (create supportive environments).

See the complete list of actions on page 17

The Association pour la santé publique du Québec (ASPQ)

was founded in 1943 by physicians, nurses and hygienists who worked in the sanitary units of Québec. It is an independent multidisciplinary non-profit group who contributes to the **promotion, development** and **maintenance** of the **health** and **well-being** of the Québec population. Also, it networks with the canadian and international public health community.

The ASPQ is primarily a forum that brings together public health actors, from institutions, professionals as well as community, to help them strengthen public action on current important public health issues, to develop alliances, coalitions, and collaborations.

The Groupe de travail provincial sur la problématique du poids (GTPPP) was established by the ASPQ as a result of its growing interest in weight-related issues.



the members of the GTPPP are :

Diane Boudreault <i>Kino-Québec, ministère des Affaires municipales, du Sport et du Loisir</i>	Marie-Paule Leblanc <i>direction générale de la santé publique, Régie régionale de la Montérégie</i>
Roxane Guindon <i>Fondation des maladies du coeur du Québec</i>	Simone Lemieux <i>Chaire de recherche sur l'obésité Donald B. Brown, Université Laval</i>
Fannie Dagenais <i>Équilibre - Groupe d'action sur le poids</i>	Johanne Laguë Lyne Mongeau Marie-Claude Paquette <i>Institut national de santé publique du Québec</i>
Suzanne Laberge <i>département de kinésiologie, Université de Montréal</i>	
Brigitte Lachance <i>direction générale de la santé publique du ministère de la Santé et des Services sociaux</i>	
	Valérie Blain <i>Chargée de projet de l'ASPQ</i>

At the time of the first edition of the document in December 2003, Anne Jubinville (Collectif action alternative en obésité) and Dominique Lesage (DSP Régie régionale Montréal-Centre) were members of the GTPPP.

ASPQ

GTPPP¹

- 2000 Development of a common vision of weight-related problems
- 2001 Participation to the development of the Québec Public Health Program 2003-2012
- 2002 **2 Projects :**
 - *Creating enabling environments^{1,2,3}*
 - *Education to healthy weight control practices as a strategy for promoting healthy living³*
- 2003 Development of the document : *Weight problems in Québec : Getting mobilized*
- 2004 Development of an action plan

¹ The Direction générale de la santé publique du ministère de la Santé et des Services sociaux du Québec financially contributes to the project.

² The Office of Nutrition Policy and Promotion financially contributes to the project.

³ Financial contribution of the projects by Health Canada within the Prevention and Promotion Program of the Canadian Diabetes Strategy.

This document's reprint has been possible thanks to the financial contribution of Health Canada within the Prevention and Promotion Program of the Canadian Diabetes Strategy. The views herein expressed do not necessarily reflect Health Canada's official position.

ASPQ

4126, rue St-Denis, bureau 200 Montréal (Qc) H2W 2M5

Téléphone : (514) 528-5811

Télécopieur : (514) 528-5590

info@aspq.org

**Come visit our web site at
www.aspq.org**

Cataloguing data prior to publication

Dialogue paper

Weight problems in Québec : A call to arms

1. Body weight
2. Obesity
3. Excessive weight preoccupation
4. Public health
5. Environments

ISBN: 2-920202-43-X

Legal deposit 4th trimester 2004
Bibliothèque nationale du Québec
Library and Archives Canada

This document can be reproduced
when citing the source.
October 2004

ASPQ
Éditions