CANADIAN PUBLIC HEALTH ASSOCIATION 2000 RESOLUTIONS & MOTIONS

One position paper, eight resolutions and three motions were presented to and voted on by the members of the Canadian Public Health Association at the Annual General Meeting (AGM) in Ottawa, Ontario on Wednesday 25 October 2000. The results of the deliberations of the Annual General Meeting are presented below.

2000 CPHA RESOLUTION NO. 1
Position Paper on Gambling Expansion in Canada: An Emerging Public Health Issue

THEREFORE BE IT RESOLVED THAT the Canadian Public Health Association adopt the Position Paper entitled *Gambling Expansion in Canada: An Emerging Public Health Issue*.

CARRIED

2000 CPHA RESOLUTION NO. 2
Reducing Poverty and Its Negative Effects on Health

WHEREAS 20% of Canadian children, 15% of Canadians in families, and more than one-third (36%) of unattached Canadians all lived in poverty* in 1997 (the most recent year for which data are available)[1] despite economic growth, declining unemployment rates, and Canada's number one human development ranking among all countries in the world since the early 1990s,[1-3]

WHEREAS poverty, whether conceptualized and measured as absolute or relative in nature,[4] negatively affects the health of individuals, communities, and society as a whole,[5-12]

WHEREAS the most effective way to reduce the negative health consequences of poverty is, first and foremost, to reduce the rate and depth of poverty in Canada,[13] and also to reduce economic burden and barriers to health experienced by people in poverty,

WHEREAS poverty is a complex phenomenon that is rooted in a network of social, economic, and political factors and conditions, some of which include changing labour market conditions[14] as well as social assistance benefits and minimum wages that are insufficient to meet basic needs and allow meaningful participation in society,[4]

WHEREAS it is highly improbable that poverty and the economic burden and barriers to health experienced by people in poverty will decline in the absence of social and economic policies and programs that specifically aim to reduce the rate and depth of poverty and aim to reduce the economic burden and barriers to health experienced by people in poverty,

WHEREAS the federal, provincial, and territorial governments in Canada have implemented some policies and programs that aim to reduce the negative health consequences of poverty (e.g., pre- and post-natal and early intervention programs)[15-18] and aim to reduce the economic burden (e.g., child tax benefit) and barriers to health (e.g., comprehensive health benefits for children in working poor families) experienced by some people in poverty,[19] but Canada does not have a comprehensive coordinated network of social and economic policies and programs, the specific purposes of which are to reduce the rate and depth of poverty and to reduce the economic burden and barriers to health experienced by people in poverty, and

WHEREAS the Canadian Public Health Association (CPHA) has gone on record acknowledging the negative health consequences of social and economic inequities such as poverty,[20-22] acknowledging its commitment to reducing such inequities,[23-26] and purporting the responsibility of public health professionals to the reduction of health inequities,[26]

THEREFORE BE IT RESOLVED THAT the Canadian Public Health Association (CPHA) reconfirm its commitment to the reduction of social and economic inequities by working in partnership with health, social, and anti-poverty organizations and coalitions (e.g., Canadian Council on Social Development, Canadian Centre for Policy Alternatives, Canadian Nurses Association, National Anti-Poverty Organization, Campaign 2000, Child and Family Canada) to influence the federal, provincial, and territorial governments to develop and implement a comprehensive coordinated network of policies and programs that aim to reduce the rate and depth of poverty and aim to reduce economic burden and barriers to health experienced by people in poverty,

AND FURTHER BE IT RESOLVED THAT CPHA develop and implement a social marketing campaign to educate and promote dialogue with the public about the persistence of poverty in the midst of economic growth and declining unemployment rates, the negative effects that poverty has on the health of individuals, families, communities, and society as a whole, and solutions/strategies for reducing poverty and its negative health consequences.

* Poverty is defined here as the relative deprivation of income that is necessary to meet basic needs and a standard of living that is consistent with the norms of the society within which one lives.[4,27]

CARRIED

References

1. National Council of Welfare. *Poverty Profile 1997*. Ottawa: Minister of Public Works and Government Services Canada, 1999.
2. Statistics Canada. *Economic Indicators – Canada*. (On line: http://www.statcan.ca).
3. United Nations Development Program. *Human Development Report – 1999*. (On line: http://www.undp.org).

4. Williamson DL, Reutter L. Defining and measuring poverty: Implications for the health of Canadians. *Health Promotion International* 1999;14(4):355-64.
5. Shaw M, Dorling D, Davey Smith G. Poverty, social exclusion, and minorities. In: Marmot J & Wilkinson RG (Eds.), *Social Determinants of Health*. New York: Oxford University Press, 1999; 211-39.
6. Reutter L. Socioeconomic determinants of health. In: Stewart MJ (Ed.), *Community Nursing: Promoting Canadians' Health,* 2nd edition. Toronto: W.B. Saunders, 2000; 174-93.
7. Kaplan GA, Pamuk E, Lynch JW, Cohen RD, Balfour JL. Income inequality and mortality in the United States. *British Medical Journal* 1996;312:999-1003.
8. Kennedy BP, Kawachi I, Prothrow-Stith D. Income distribution and mortality: Cross-sectional study of the Robin Hood Index in the United States. *British Medical Journal* 1996;312:1004-07.
9. Kennedy BP, Kawachi I, Glass R, Prothrow-Stith D. Income distribution, socioeconomic status, and self rated health in the United States: Multilevel analysis. *British Medical Journal* 1998;317:917-21.
10. Lynch JW, Kaplan GA, Pamuk ER, Cohen RD, Heck KE, Balfour JL, Yen IH. Income inequality and mortality in metropolitan areas of the United States. *Am J Public Health* 1998;88:1074-80.
11. Wilkinson R. *Unhealthy Societies*. London: Routledge, 1996.
12. Wolfson MC, Kaplan G, Lynch J, Ross NA, Backlund E. The relationship between income inequality and mortality is not a statistical artefact: An empirical assessment. *Br Med J* 1999; 319: 953-957.
13. Link BG, Phelan J. Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior* 1995; Extra issue: 80-94.
14. Jackson A, Robinson D. *Falling Behind: The State of Working Canada 2000*. Ottawa: Canadian Centre for Policy Alternatives, 2000.
15. Health Canada. *Canada Prenatal Nutrition Program*. (On line: http://www.hc-sc.gc.ca/hppb/ childhood-youth/cbp/cpnp)
16. Health Canada. *Community Action Program for Children (CAPC)*. (On line: http://www.hc-sc.gc.ca/hppb/childhood-youth/cbp/capc)
17. Ontario Ministry of Health and Long-Term Care. *Healthy Babies, Healthy Children Program*. (On line: http://www.gov.on.ca/health/english/program/child/child).
18. Manitoba Children and Youth Secretariat. *Manitoba Children and Youth Status Report*. Winnipeg: Author, 1999.
19. Government of Canada. *National Child Benefit Progress Report 1999*. (On line: http://social_union.gc.ca/NCB-99/toceng.html).
20. Canadian Public Health Association. *Health Impacts of Social and Economic Conditions: Implications for Public Policy*. Ottawa: Author, 1997.
21. Canadian Public Health Association. *Reducing Inequities in Health – CPHA Position Paper II*. Ottawa: Author, 1993.
22. Canadian Public Health Association. *1997 Position Paper on Homelessness and Health*. Ottawa: Author, 1997.
23. Canadian Public Health Association. *1993 Resolution No. 12 – Position Paper on Reducing Inequities in Health*. Ottawa: Author, 1993.
24. Canadian Public Health Association. *1993 Resolution No. 13 – Association Actions on Reducing Inequities*. Ottawa: Author, 1993.
25. Canadian Public Health Association. *1989 Resolution #1 – Healthy Public Policy: A Framework*. Ottawa: Author, 1989.
26. Canadian Public Health Association. *Action Statement for Health Promotion in Canada*. Ottawa: Author, 1996.
27. Reitsma-Street M, Townsend P. Peter Townsend: An international scholar of poverty. *Canadian Review of Sociology* 1996;38:101-106.

2000 CPHA RESOLUTION NO. 3
Gas Flaring

WHEREAS gas flaring is regulated by provincial/territorial and federal governments,

WHEREAS flaring produces incomplete combustion with the release of over 250 identified toxins including carcinogens such as benzopyrene, benzene, carbon di-sulphide and toluene, and sour gas with H_2S and SO_2,

WHEREAS flaring contributes to greenhouse gases,

WHEREAS there is mounting research evidence of direct damage from this pollution to plant and animal life (particularly cattle),

WHEREAS there is a lack of research on the health effects on human populations of low level, chronic exposure, and

WHEREAS there is an urgent need for exposure and health-effects research,

THEREFORE BE IT RESOLVED THAT the Canadian Public Health Association (CPHA) ask the Provincial and Territorial Branches and Associations to work together with CPHA to urge provincial/territorial and federal energy regulatory bodies, ministries of health and environment protection bodies to move quickly to:

- provide resources for increased research on measurement of emissions and the effects of gas flaring on human health;
- establish targets for reductions of flaring; and
- support the efforts of industry to reduce flaring.

CARRIED

Background to 2000 Resolution No. 3
Gas Flaring

The flaring of natural gas occurs by releasing emissions into the atmosphere when the gas cannot be processed or sold. Flaring of natural gas involves hydrogen sulphide (H_2S) and other water gas contaminants. Most gas flaring arises from solution gas, which is the natural gas contained in crude oil. Similar to the bubbles arising from carbonation when a soft drink is opened, solution gas bubbles to the surface of the oil when oil reserves are brought to the surface.[1-3]

There have been over 250 identified toxins released from flaring including carcinogens such as benzopyrene, benzene, carbon di-sulphide (CS_2), carbonyl sulphide (COS) and toluene; metals such as mercury, arsenic and chromium; sour gas with H_2S and SO_2; nitrogen oxides (NO_x); carbon dioxide (CO_2); and methane (CH_4) which contributes to the greenhouse gases. Improper combustion of natural gas, as witnessed by visible smoke from a flare stack, contributes to increased hazardous chemicals being released into the environment including volatile organic compounds. The 1986 Southwestern Alberta Medical Diagnostic Review is the only major population-based study on flaring. While there are little data on the effects of flaring on health, the effects of air pollutants have been identified. These include non-specific effects such as chills, fever, myalgia, respiratory irritation, nausea, vomiting and headaches. Systemic effects include renal failure, central nervous system depression, cardio-vascular failure and altered neurobehavioural function in addition to multiple airway and lung injury such as cancer, alveolar damage, emphysema and chronic bronchitis. Environmental contaminants have also been related to endocrine dysfunction, immune dysfunction, reproductive disorders and autoimmune rheumatic diseases.[4,5]

While one must recognize that flaring is also an important safety measure in natural gas facilities in cases of emergencies, equipment and power failures, reductions in flaring amounts can be achieved. Not only does a reduction in flaring make environmental sense and reduce climate change and acid deposition, but it reduces waste of a potentially valuable product.[1,3]

The methods by which flaring can be reduced include conservation through re-injection of the solution gas back into reservoir; operational changes in procedures and equipment; use of new well-testing methods which reduce the duration of the flare; and power generation whereby mini-turbines are used to produce electricity from the gas. Flaring emissions can be reduced through efficiently designed flare systems whose heating value is monitored frequently. In Alberta, the Clean Air Strategic Alliance's goal is to work towards the elimination

of routine solution gas flaring and has achieved a targeted provincial flaring reduction of 50% by the year 2003.[1-3]

References

1. Petroleum Communication Foundation (2000). *Flaring: Questions + Answers*.
2. Frank George, P.Eng of the Canadian Association of Petroleum Producers. *Flaring: Presentation to the Alberta Public Health Association,* March 16, 2000.
3. Kim Eastlick, P.Eng of the Alberta Energy and Utilities Board. *Alberta Upstream Petroleum Industry Flaring Requirements: Current Status and Future Directions,* March 16, 2000.
4. Petroleum Communication Foundation (2000). *Sour Gas: Questions + Answers*.
5. Dr. Stephan Gabos of Alberta Health and Wellness. *Solution Gas Flaring and Public Health,* March 16, 2000.

2000 CPHA RESOLUTION NO. 4
Travelling in the Back of a Pickup Truck

WHEREAS research demonstrates that people riding unrestrained in the back of a pickup truck are at a much higher risk of serious injury and death than those riding in the cab,[1,2]

WHEREAS injuries to passengers riding in the back of pickup trucks frequently occur in non-crash events, and ejections leading to death or serious injury can easily occur at speeds of 40km/h or less,[1-3]

WHEREAS the head is the most frequently injured body region following a fall or ejection from the back of a pickup truck, and the direct average cost of care during the first year following severe brain injury can be as high as $300,000 with a lifetime care cost ranging from $2.5 to $5.5 million dollars,[3]

WHEREAS numerous provinces prohibit unrestrained passengers from riding in the back of pickup trucks and the penalties range from $29 to more than $84,[4] and

WHEREAS British Columbia, New Brunswick, Northwest Territories, Nova Scotia, Quebec and Alberta have some form of legislation making riding in the back of pickup trucks illegal,[5]

THEREFORE BE IT RESOLVED THAT the Canadian Public Health Association (CPHA) approach the Provincial and Territorial Branches and Associations (PTBAs) in Ontario, Prince Edward Island, Saskatchewan, Manitoba, Yukon, Newfoundland and Nunavut to urge their governments to take immediate action to make it illegal for passengers to ride in the back of pickup trucks,

AND FURTHER BE IT RESOLVED THAT CPHA approach the PTBAs in Ontario, Prince Edward Island, Saskatchewan, Manitoba, Yukon, Newfoundland and Nunavut to request that their governments take action to educate the public about the benefits of the legislation and about how to comply with the legislation.

CARRIED

References

1. Agran P, Winn D, Anderson C. Injuries to occupants in cargo areas of pickup trucks. *Western Journal of Medicine* 1994;161(5):479-82.
2. Hamar GB, King W, Bolton A, Fine PR. Fatal incidents involving pickup trucks in Alabama. *Southern Medical Journal* 1991;84(3):349-54.
3. Bucklew PA, Osler TM, Eidson JJ, Clevenger FW, Olson SE, Demarest GB. Falls and ejections from pickup trucks. *Journal of Trauma-Injury Infection & Critical Care* 1992;32(4):468-72.
4. Motor Vehicle Act Regulations s.39.01; Injury Prevention Centre, Provincial/Territorial Motor Vehicle Legislation Review, 1997.
5. Personal communication, Alberta Centre for Injury Control and Research, Edmonton, AB Canada, 2000.

2000 CPHA RESOLUTION NO. 5
To Create an Aboriginal Health "Area of Interest"

WHEREAS there was a resolution No. 5 passed at the Annual General Meeting of the Canadian Public Health Association (CPHA) held in Halifax, Nova Scotia in June 1997 to explore the formation of an Aboriginal caucus or branch of the CPHA,

WHEREAS the Aboriginal Working Group has never been formally recognized as a group to provide a focus on Aboriginal public health issues,

WHEREAS the Aboriginal Working Group has identified that there is a strong need for an Aboriginal caucus or area of interest to give Aboriginal and non-Aboriginal members of CPHA an opportunity to discuss and vocalize their perspectives on Aboriginal health issues which would provide the Executive and Board with guidance on CPHA priorities, and

WHEREAS alarming statistics in the areas of diabetes, child health status and other areas of concern in Aboriginal communities show the importance of Aboriginal health as a Canadian public health concern,

THEREFORE BE IT RESOLVED THAT the Canadian Public Health Association (CPHA) form an Aboriginal Health Network within CPHA and revisit the formation of an Aboriginal caucus as noted in resolution No. 5, June 1997.

CARRIED AS AMENDED

2000 CPHA RESOLUTION NO. 6
Canadian Official* Development Assistance

WHEREAS the Canadian Government is committed to providing 0.7% of Gross National Product to Official Development Assistance,[1]

WHEREAS Canadian Official Development Assistance is at its lowest level since 1965,

WHEREAS Canadian Official Development Assistance is currently approximately 0.28% of Gross National Product and is anticipated to decline to 0.24% by 2002/03,[2]

WHEREAS Canadian Official Development Assistance has fallen in real terms by 37%, as compared to an overall federal program funding reduction of 11%, from 1991/92 to 1999/2000,[3]

WHEREAS the Canadian Government can rebuild Official Development Assistance to 0.35% of Gross National Product by 2005/06 while still being consistent with government priorities for the "fiscal dividend", and

WHEREAS the Canadian Government stated on October 13, 1999 that, "Our fiscal house is in order… Therefore, we will increase our international development assistance. And we will concentrate the growth in our assistance to enable Canada to work in innovative ways to help other less fortunate countries improve life for their citizens,"[4]

THEREFORE BE IT RESOLVED THAT the Canadian Public Health Association encourage the Government of Canada to initiate strategies to meet its financial commitment to Official Development Assistance by committing itself to allocate 0.7% of Gross National Product by 2005/06.

CARRIED AS AMENDED

* The original resolution incorrectly referred to "Overseas" Development Assistance; the correct terminology is as stated above.

References
1. Canada in the World – Canada's Foreign Policy Statement, 1999.
2. The Federal Budget Plan 2000, the Canadian Council for International Cooperation's Analysis of International Commitments, April 2000.
3. Renewing Canadian Aid: A CCIC/In Common Fact Sheet, Canadian Council for International Cooperation, October 1999.
4. Hansard, October 13, 1999, Prime Minister's Speech following the Speech from the Throne.

2000 CPHA RESOLUTION NO. 7
Increasing the Portion of Official* Development Assistance to Provide Basic Human Needs

WHEREAS the Canadian Government is committed to providing 0.7% of Gross National Product to Official Development Assistance,[1] and

WHEREAS the current allocation of 19.4% of total Canadian Official Development Assistance to Basic Human Needs is an improvement from the 13% in the early 1990s,[2] it still falls far short of the NGO community recommended target of 30% and of the Government of Canada's own commitment to 25%,[1]

THEREFORE BE IT RESOLVED THAT the Canadian Public Health Association (CPHA) urge the Canadian International Development Agency to demonstrate leadership and commitment to the principle of allocating 30% of its resources to Basic Human Needs,

AND FURTHER BE IT RESOLVED THAT CPHA express appreciation to the Canadian International Development Agency for its progress in increasing the proportion of assistance provided to Basic Human Needs.

CARRIED

* The original resolution incorrectly referred to "Overseas" Development Assistance; the correct terminology is as stated above.

References
1. Canada in the World – Canada's Foreign Policy Statement, 1999.
2. Renewing Canadian Aid: A CCIC/In Common Fact Sheet, Canadian Council for International Cooperation, October 1999.

2000 CPHA RESOLUTION NO. 8
The Need for a National Approach to Intensive Livestock Operation Regulation

WHEREAS the intensive livestock industry in Canada has the potential for rapid growth in the next twenty years,

WHEREAS without adequate regulation, it has the potential to affect the wellbeing and public health of Canadian citizens from coast to coast,

WHEREAS the incidence of pathogenic zoonotic infections related to the intensive livestock industry is increasing as demonstrated by the recent E.Coli outbreak in Walkerton, Ontario, and

WHEREAS the negative effects of such outbreaks may affect international trade with our principal trading partners in the United States and Europe,

THEREFORE BE IT RESOLVED THAT the Canadian Public Health Association (CPHA):

1. Encourage federal departments to take leadership in developing and promoting the harmonization of provincial legislation/regulation affecting intensive livestock farming development and operation.
2. Request that Provincial/Territorial Branches/Associations (PTBAs) join CPHA in urging the provinces to enact legislation that protects the public's health from the negative impacts of intensive livestock operations.
3. Urge federal and provincial agencies to promote research into:
   a) the cumulative impact of the growth of the intensive livestock industry,
   b) environmental impact assessment protocols for intensive livestock siting, and
   c) the assessment of waterborne, airborne and foodborne human health risks associated with the intensive livestock industry.
4. Take action to inform CPHA members regarding the issues related to the intensive livestock industry and to its role and effect on the health and on the environment of Canadians.

CARRIED

Background to 2000 Resolution No. 8
The Need for a National Approach to Intensive Livestock Operation Regulation

The human population of the globe is forecast to increase by 33% over the next 20 years[1] and consequently the demand for food will increase along with it. Theoretically, current food supply should be able to meet the global demand but inequalities in income distribution, increasing urbanization and changing eating patterns, including the increasing demand for meat, milk and eggs, along with changing environmental conditions are affecting the ability of local populations to meet local food demands. The global demand for meat is predicted to be 63% greater in 2020 than in 1993. Eighty-eight percent of this increase will be in developing countries.[1] The large increase in demand for food of animal origin is for pork, poultry and beef and these animals are being raised in large (factory) farms.

The traditional family farm/ranch operation that raised several hundred head of livestock on its own land is fast disappearing. The demand for high productivity and profit is resulting in factory-type operations with upwards of 55,000 animals contained in pens or lots on a relatively small quantity of land. In the case of hogs, the animals are raised and contained in enclosed buildings from birth to slaughter. In the case of cattle, the animals are shipped to the "feedlots" for fattening about six months prior to slaughter. The high concentration of animals would naturally result in increased illness and transference of infectious agents such as E.Coli and salmonella. Animals are often provided with quantities of preventive antibiotics and other food and growth supplements which would not have been needed had the animals been raised under traditional conditions.

Globalization of industry, market pressures, increasing free-trade zones and the lack of available arable land in the third world has resulted and will continue to result in increased pressure in North America, including the Canadian provinces, for the accommodation of large animal production operations. Global agricultural industries will welcome these opportunities and have already brought pressure to bear on governments to take advantage of the economic opportunities without imposing the necessary constraints and legislation to ensure a sustainable and safe environment. The issues surrounding intensive livestock

operations can be classified as environmental, economic, and socio-political.[1]

Environmental issues relate to water quality and air quality and land stewardship.[2] The potential exists for contamination of ground and surface water by pathogens, nitrogen and growth supplements which may be harmful to human health and have detrimental effects on living conditions of populations in areas affected by these operations from air pollution and odours.

Economic effects include substantive shifts in real estate markets, taxation frameworks, and infrastructure requirements such as roads and water. Restriction on farm operations and expansions as a result of minimum separation distances have direct impacts on the farming communities resulting in tension between farmers and their neighbouring municipalities.

A National Problem

Because intensive livestock operations are influenced by internal market factors and are often owned by non-resident companies with profit as their major motive, they are often discouraged from siting their operations in locations where environmental constraints legislation or regulation exist. As a result, governments in economically challenged areas of the country may be tempted to waive restrictions and remove impediments, to the detriment of the health of their local public and environment, in order to attain economic viability.

Recent trends towards deregulation of public policy initiative in Alberta and Ontario along with a move towards privatization and downloading of government services is resulting in less monitoring of standards aimed at preserving the integrity of the public's health. The recent outbreak of E.Coli infections in Walkerton, Ontario exemplifies this fact.

References

1. Animal Agriculture and Global Food Supply, Council for Agricultural Science and Technology, July 1999.
2. Ministry of Agriculture, Food and Rural Affairs, Government of Ontario Intensive Agricultural Operations in Rural Ontario, May 2000.

2000 CPHA MOTION NO. 1
Amending the Agreement between the International Atomic Energy Agency and the World Health Organization (Res WHA12-40, 28.5.59)

WHEREAS Article I of the Agreement between the International Atomic Energy Agency (IAEA) and the World Health Organization (WHO) of 28 May 1959 recognizes that "... the IAEA has the primary responsibility for encouraging, assisting and co-ordinating research on, and development and practical application of atomic energy for peaceful uses throughout the world without prejudice to the right of the WHO to concern itself with promoting, developing, assisting and co-ordinating international health work, including research, in all its aspects.",

WHEREAS the requirement in Article I(3) of the WHO/IAEA Agreement states that "Whenever either organization proposes to initiate a programme or activity on a subject in which the other organization has or may have a substantial interest, the first party shall consult the other with a view to adjusting the matter by mutual consent.",

WHEREAS Article III(2) of the WHO/IAEA Agreement requires that, allowing for the safeguarding of confidential information, the Secretariat of the IAEA and the Secretariat of the WHO shall keep each other fully informed concerning all projected activities and all programmes of work which may be of interest to both parties,

WHEREAS according to the WHO Constitution, the availability of all information relating to the health risks to a population or populations is necessary to enable the WHO to fulfill its mandate,

WHEREAS promotion of the development and practical application of nuclear energy, as is the mandate of the IAEA, could lead to or contribute to potential health risks for a population or populations,

WHEREAS at the time of this agreement (1959), at the onset of the "Atoms for Peace" programme, the severe health and environmental risks of nuclear energy were generally unknown and under such circumstances, the WHO entered into an agreement with the IAEA which allows for considerable IAEA authority over nuclear energy programmes internationally, and

WHEREAS since 1959 specific nuclear disasters including those at Sellafield, Three Mile Island and Chernobyl demonstrate the health risks of nuclear energy,

THEREFORE BE IT MOVED THAT the Canadian Public Health Association (CPHA) lobby the Canadian government to request that the World Health Assembly amend the Agreement between the International Atomic Energy Agency (IAEA) and the World Health Organization (WHO) (Res. WHA12-40 of 28 May 1959) in the following manner:

i) amend the requirement that any WHO programme on health effects of nuclear energy must be discussed with, and agreed to by the IAEA to read that 'the first party will inform the other'

ii) amend the provision safeguarding confidential information to allow for non-disclosure only of such information that has no bearing on health or environmental risks.

AND FURTHER BE IT MOVED THAT the CPHA bring this resolution to the attention of the World Federation of Public Health Associations and request its support and that of its membership.

CARRIED

2000 CPHA MOTION NO. 2
Regarding Bill S-20

WHEREAS tobacco is the leading cause of preventable illness in Canada,

WHEREAS the tobacco industry targets youth to start smoking to establish future market,

WHEREAS many youth will not start smoking if they have not started by age 20, and

WHEREAS Bill S-20, that will establish a foundation for tobacco use prevention in youth, has received unanimous consent in the Senate but died on the order paper in the House of Commons on the 22nd of October 2000,

THEREFORE BE IT MOVED THAT the Canadian Public Health Association write to the new national Minister of Health, as soon as he or she is appointed, exhorting him

or her to introduce in the House of Commons immediately following the election a Government Bill that achieves all of the health-related objectives of Bill S-20.

CARRIED

2000 CPHA MOTION NO. 3
Comprehensive Approaches to School-based Health Promotion

WHEREAS it is recognized in the literature that learning and health are interdependent,

WHEREAS fostering the social development of children, including their health, is part of the mandate of the Canadian school system,

WHEREAS the school system plays an important role in promoting the health of children and is therefore an important partner of public health agencies which provide a variety of preventive and health-promoting programs and services,

WHEREAS educators and guidance counsellors have expressed concerns about reductions in school-based health and social services that are needed to support teachers, parents and students,

WHEREAS addressing the complex health and social issues facing children and youth requires shared responsibility and collaboration between schools, parents, governmental and non-governmental agencies and the children and youth themselves,

WHEREAS the literature indicates that comprehensive approaches to school-based health promotion such as "Comprehensive School Health" (CSH) or "Health Promoting Schools" are cost effective in reducing illness and in building attitudes and behaviours that are important for healthy living, and

WHEREAS CSH has been endorsed by over 20 national and provincial organizations,

THEREFORE BE IT MOVED THAT the Canadian Public Health Association (CPHA) and the Provincial/Territorial Branches/Associations collaborate with professional organizations in the fields of education and health and with other related organizations to raise awareness within governments and the public of the value of and the need for comprehensive approaches to school-based health promotion,

AND FURTHER BE IT MOVED THAT CPHA lobby Health Canada and provincial and territorial governments to work together to develop policies and funding that will facilitate the full implementation of comprehensive approaches to school-based health promotion in all Canadian schools.

CARRIED