



Dedicated to the health, well-being and rights of children and youth

**Canadian Institute of Child Health
The Health of Canada's Children: A CICH Profile, 3rd Edition**

Profile Workshop Final Report

Our Vision

We want all children and youth to feel loved, be safe, be confident and be well.

We want our communities to promote the fullest health and enjoyment of childhood and youth.

We want our society to protect all the rights of children and youth in a sustainable environment.

Background:

The Health of Canada's Children – A CICH Profile, 3rd edition, The Profile, was released in August 2000. *The Profile* contains 10 chapters comprised of 390 data charts, 340 references and has been compiled by 150 volunteer experts from across Canada. It is a collection of national and regional data, research projects, program reviews, and describes the state of the health and well-being of children and youth in Canada.

The Profile received outstanding attention, both by national and community media, including television, radio, magazine and Internet outlets. The immediate attention, while important and exciting, was short lived. It was recognized that the best way to promote the use of the book would be through hands-on reviews, and discussions by service providers, policy makers and multi-disciplinary groups, all interested in the health and well-being of children and youth.

Consequently, The Canadian Institute of Child Health (CICH) embarked on a series of provincial workshops. The workshops varied in length, depending on the preference of the host organization, and participation varied depending on the host's invitations. While the shortest workshop was 3 minutes on Parliament Hill, and the longest was 5 hours, the ideal duration was 3 to 4 hours.

History of The Health of Canada's Children: A CICH Profile:

In 1989, the Canadian Institute of Child Health (CICH) published the first edition of *The Health of Canada's Children: A CICH Profile*, a publication that has helped change the way people in Canada think about their children and youth. This document provided, for the first time, a comprehensive picture of child morbidity and mortality in Canada. The first edition also demonstrated the overall needs of children, and the high burden of suffering from childhood injury.

Over the next five years, CICH expanded their reporting on child health to include a wider array of indicators, such as information about social and emotional health and well-being. In 1994, the second edition of *The Health of Canada's Children: A CICH Profile* was published. This document highlighted the mental and emotional health of children and youth, and illustrated gender differences. It also raised awareness about issues of maternal and infant health. Finally, it succeeded in putting child health and well-being on the public agenda, and stimulated the development of new policies and programs.

As we enter a new millennium, a time for achieving goals and living up to promises to ourselves and others, it is more important than ever that we have accurate, timely information about the state of our children's health and well-being. The third edition of *The CICH Profile* builds on the work of past editions to present a more comprehensive picture of child health and well-being. In addition, it identifies significant gaps in the available statistical data, especially in areas such as children's mental health, and the impact of disabilities on the lives of children and youth.

The Process:

The Health of Canada's Children: A CICH Profile, 3rd edition, The Profile, is the result of a comprehensive process of expert consultation and review, designed to ensure accuracy, reliability and overall usefulness. Because this process is so extensive and so participatory, CICH is confident that the content of the book is credible and dependable, and reflects the views of leading experts on child health in Canada.

The process of consultation began with a series of needs assessment surveys. The purpose of these surveys was to determine the need for a third edition, to identify information gaps, and to elicit recommendations on how to improve the book. Support for a third edition in a similar format to earlier editions was extensive. Readers told us that they valued the broad scope, the emphasis on reliable and accurate statistics, and the accessible, easy-to-read format. Readers also indicated that accessible information regarding the implications of the data would be of value. As a result, the third edition of *The Profile* includes chapter commentaries written by guest writers. These commentaries highlight areas of concern, and propose courses of future action.

After the needs assessment phase, CICH engaged in extensive consultations with experts in child health from across the country. This process was designed to ensure

that all of the information (whether statistical or textual) was accurate, reliable and useful. A multi-disciplinary National Advisory Group was formed to review drafts of the third edition, to identify gaps, and to recommend additional indicators. They ensured that the content of the third edition of *The Profile* was timely, useful and comprehensive. Furthermore, Multi-disciplinary Expert Groups were formed for the chapters on income inequity, mental health, disabilities and the environment. The role of the Expert Groups was to review indicators, to identify additional indicators and data sources, to assist in the interpretation of data, to review drafts of chapters, and to offer advice on matters requiring particular expertise. As *The Profile* went through three separate reviews, these groups were indispensable to the production of this document. One result of these consultations was the decision to reformat the book, organizing the indicators in terms of determinants of health and health outcomes.

In addition to the expert consultation, CICH convened two Aboriginal Roundtable meetings, including representatives from First Nations, Inuit and Métis organizations from across Canada. Like the members of the Expert Groups, the Roundtable participants reviewed drafts of the third edition, identified gaps and recommended additional indicators. They also provided important guidance in terms of the approach to the chapter on Aboriginal children and youth. For example, they emphasized the need to provide a historical context in which to interpret statistics on Aboriginal child health. As a result, the chapter about Aboriginal children and youth includes a discussion of this context, written by an Aboriginal guest writer. Roundtable participants also emphasized the need for better survey and census data on Aboriginal Peoples, and for more community-level data.

Finally, youth consultations were held to elicit the voices of youth, and to offer insight into youth perspectives on matters pertaining to their health and well-being. These youth voices are presented primarily in the chapters on school-age children, youth and Aboriginal children and youth.

Approach:

Indicators

Because health and well-being are not themselves observable and measurable facts, it is necessary to identify indicators that describe their various aspects. To be a health indicator, research must show a strong relationship between the condition the indicator describes and differences in health status. Indicators can report quantitative data (such as how many babies were born of low birth weight in a given year) and qualitative data (such as how many young people felt satisfied with their body size in a given year). Indicators can represent determinants of health (such as poverty) or health outcomes (such as behavioral problems). Some indicators are so strongly associated with an aspect of health that they are referred to as markers (for example, self-esteem is considered a marker of mental health). The use of indicators makes it easier to monitor trends over time, or variation by factors such as age, gender, and region. Indicators are particularly useful when monitoring health status at the population level. *The CICH*

Profile reports on a wide range of health indicators, drawing on reliable, validated data sources. Every effort has been made to ensure that the indicators are clearly presented and easy to understand.

Determinants of health and health outcomes

Social, economic and political factors, psychological, genetic and biological factors, personal health practices, community resources, and the physical environment all shape the health of children and youth (Federal, Provincial and Territorial Advisory Committee on Population Health, 1994). As such, these factors are described as determinants of health. A health determinant approach focuses on the health of populations, rather than individuals, investigating trends and variation within populations. Inequitable access to the determinants of health (due to such factors as gender and ethnicity) is often the explanation for a population's poor health. Although the terminology can be intimidating, many determinants of health are familiar to us all - nutritious food, feeling loved, a safe home, etc.

The measured aspects of health and well-being are described as health outcomes. The same indicator may sometimes be both a determinant of health and an outcome. For example, childhood emotional problems may be viewed as an outcome, shaped by determinants such as gender and income. Childhood emotional problems may also be viewed as a determinant, influencing the rate of social impairment in children.

Child Development

The Health of Canada's Children: A CICH Profile is organized around a child development perspective. It describes what children need from their social and physical environments at different ages, in order to develop healthily. The indicators selected for different age groups reflect their different developmental stages.

Putting the book together

The *Profile* is divided into ten chapters. The first gives an overview of the demographic situation in Canada today, and introduces the key subject areas of the book. The next four chapters profile successive stages in child development: pregnancy and infancy, preschool, school age and youth. The next chapter presents information on the health and well being of Aboriginal children and youth. The final four chapters deal with issues that confront children, youth, and their families: income inequity, mental health, disability, and children's environmental health.

The charts in the first nine chapters of *The Profile* are roughly divided into two parts. The first part deals with determinants of health and well-being, while the second part deals with health outcomes. As mentioned previously, there is some overlap in these categories because some outcomes can also be determinants for other outcomes. The determinants and outcomes described in these chapters were selected on the basis of

the data's availability, accuracy and usefulness. No causal relationship has necessarily been established between them.

Each chapter of *The Profile* includes explanatory text boxes, which serve one of two functions. Sometimes, they provide a brief synopsis of an important issue that cannot be easily presented in terms of statistics. Other times, they offer background information necessary to interpret other charts. The chapters also include "Question Mark" tables (these consist of a map of Canada with a question mark superimposed upon it). These tables highlight areas where data, from surveys or other sources, are urgently needed. The purpose of the question mark tables is to raise awareness, stimulate discussion and promote positive action.

Each chapter of *The Profile* begins with an introduction that highlights the key findings. Each chapter also includes a guest commentary, written by a leading expert in the field, that synthesizes the information and addresses the question of what must be done. These commentaries orient us to the future and address issues of social responsibility. In addition, where relevant, chapters include a brief statement about the extent to which Canada has met its obligations as a signatory of the UN Convention on the Rights of the Child.

The Data:

Information for *The Profile* comes from traditional sources such as census data, vital statistics (births and deaths), and hospitalization data. It also comes from population-based national and provincial surveys. Some non-population-based survey data are also presented to stimulate discussion and future research.

Census data, vital statistics and hospitalization data:

The hospitalization and death data, reported in the four developmental chapters, are usually presented in three ways:

- by province and territory
- by leading cause (and by gender)
- over time (and by gender)

Exceptions to this include injury hospitalization data, which are presented by province/territory and by leading cause (but not over time), and injury death data, which are presented only by province/territory.

In some death, hospitalization, and injury charts, the Northwest Territories (which for the book's purposes includes both the Northwest Territories and Nunavut) and the Yukon have been reported as a single population. This is because the relatively small populations of these territories can result in misleading rates. When the populations of the two territories are combined, they are roughly comparable in size to that of Prince Edward Island. This is a short-term solution for the purposes of this book. In the long

term, there is a need for Statistics Canada to increase the size of their samples in the Territories. This would increase the accuracy and reliability of the territorial rates.

The Canadian Institute of Child Health, working with data from the Canadian Institute for Health Information, grouped injury hospitalization data into a number of categories. The "ICD9 Codes" (International Classification of Disease, 9th Revision) are indicated in the charts to ensure clarity, and to permit researchers to make the best possible use of the information.

The fact that the provinces and territories have very different population sizes should be remembered when interpreting *The Profile* charts. Population size can be important when interpreting the significance of statistical fluctuations. For example, a small change in the death rate of an age group in Ontario would represent more people than a similar rate change in Prince Edward Island. Similarly, a small number of additional deaths among children would result in a more significant change in the child death rate in Prince Edward Island than the same number of deaths would in Ontario. Thus, fluctuations in rates are more common, but not necessarily as meaningful, in smaller populations than in larger ones. Differences among the provincial and territorial health care systems are also reflected to some extent in the hospitalization data.

Overall, hospitalization data must be viewed as a rough measure of illness and injury in children. The restructuring of the health care delivery system has resulted in a trend towards treatment outside of hospitals, further reducing the capacity of hospitalization data to accurately describe the patterns of illness and injury among children and youth.

Population-based national surveys

The National Longitudinal Survey of Children and Youth (NLSCY), conducted by Statistics Canada for Human Resources Development Canada, is designed to measure child development and well-being in Canada. The first cycle was conducted in 1994-95. It collected information on approximately 23,700 children (birth to 11 years of age), asking questions of the child's primary caregiver (almost always the mother), the child's teacher, and in the case of children aged 10 - 11, the child. The NLSCY will survey these children every two years until they reach adulthood. New infants and toddlers will be introduced at the start of each new survey cycle. Through the NLSCY, information on a wide range of health and well-being indicators has become available. Note that Aboriginal children living on-reserve were not included in the NLSCY.

The National Population Health Survey (NPHS), conducted by Statistics Canada, is designed to measure the health of Canada's population. A cross-section of information is obtained by surveying all members of the survey households, aged 12 years and older (58,000 individuals). Longitudinal information is obtained from one respondent per household (18,000 individuals). Data were first collected in 1994 and are being collected every two years. Data from the NPHS are used extensively throughout *The Profile* particularly in the chapters relating to mental health and disability during childhood. It is important to remember that the NPHS is not a disability survey. It can only provide

limited information on the types of disability experienced by children and youth, and the impact of disability on their lives, and those of their families. A new disability survey, such as the Health and Activity Limitation Survey conducted by Statistics Canada in 1991, is urgently required to address these issues.

Canada is a participating country in the Health Behaviour in School-Aged Children Study (HBSC), a World Health Organization (WHO) cross-national study. The HBSC survey was administered in 1989-90, 1993-94, and 1997-98. In Canada, over 6,000 students in grades 6, 8 and 10 were surveyed on each occasion. The HBSC provides unique information about the health and well-being of young people in Canada, particularly in areas such as mental health, school experiences, and home life.

The First Nations and Inuit Regional Health Survey (FNIRHS) is a broad-based survey of First Nations and Inuit children, youth and adults. Some of its questions approximate those of the NLSCY, allowing for comparisons to be made between the data. The FNIRHS was designed and implemented by First Nations and Inuit people. Similarly, the findings of the study were analyzed by First Nations and Inuit people. The response rate for the FNIRHS was 95%. This high response rate is of particular importance as Aboriginal populations are under-represented or excluded in research such as the census, the NLSCY, and the NPHS, as well as other national surveys. The FNIRHS contributes to the development of regional level data on the health and well-being of Aboriginal children and youth. Out of respect for the FNIRHS process, where the Canadian Institute of Child Health has included data from the FNIRHS, we have also presented the FNIRHS interpretation.

Other surveys and databases

Information from provincial surveys (such as the Adolescent Health Survey in British Columbia, or the Ontario Student Drug Use Survey) is also presented when national data on an important issue are unavailable. The sample sizes of these provincial surveys are sufficiently large, and the data are statistically reliable and valid. Beyond surveys, there are databases that could be of enormous benefit to researchers, planners and policy-makers if they were standardized (for example, child welfare data).

Information from the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP) is presented in the developmental chapters, and in the chapter on income inequity, of *The Profile*. CHIRPP gathers information relating to visits to hospital emergency departments as a result of injuries. Fifteen hospitals participate in CHIRPP, of which ten are paediatric. CHIRPP provides valuable data on childhood injuries, but the Auditor General of Canada noted in its 1999 report that three provinces are not fully represented in the system, and coverage of rural child injuries is limited.

The third edition of *The Health of Canada's Children: A CICH Profile* also includes several charts from small, non-population-based studies. Although the results of these studies cannot be generalized to the population as a whole, they raise important issues

that need public attention. For the readers' information, the sample size is included in the charts developed from non-population-based studies.

The Charts:

The charts used in *The Profile* have been standardized as much as possible to ensure that the presentation of the material is as clear as possible. As the Statistical Compendium (previously published as a companion to *The Profile*) has been discontinued, the data used to create each chart is provided along with the chart itself.

- When the chart is presenting percentages or proportions, the vertical axis is either 100%, 50% or 10%. This allows the reader to compare charts with greater ease.
- When the chart is presenting information by province and territory, the figure for Canada appears in a shaded circle within the chart.
- When the chart is presented by province and territory, the Northwest Territories and the Yukon are sometimes combined. This is to ensure an adequate population size.
- All of the information used to create the chart is presented. For example, with bar graphs, the figures appear directly over the bars. With line graphs, the figures appear in a box below the graph.
- Where possible, the sample size has been included in charts (N=#). This number is often important for interpreting the chart.
- The sources are reported under the charts, with the full citation available in the references section.
- Notes from the original sources are presented, along with any other required notes.

The Canadian Institute of Child Health is committed to presenting data in a clear and accessible format.

Guiding Principles:

The Canadian Institute of Child Health is committed to linking data to action, and thus, to helping our society move towards a healthier future. Our guiding principles for this document connect us continuously to this objective. They remind us that any interventions for the healthy development of the child, if they are to succeed, must reflect the complexity of the lives of children, recognizing that they are embedded in family, school, community and the social structures that shape society. The guiding principles reflect the wisdom we have acquired over the years, in our efforts on behalf of children and youth.

- **Ground the document in child development, while maintaining a holistic approach to the child.**

Because child development is an interactive process, it is important to maintain a holistic approach. Further, children are not small adults, and the determinants of health that have an impact on their lives can only be understood within a child development framework.

- **Recognize sensitive points in the development of children.**

There are sensitive points in the development of children where risks may arise, opportunities may appear, or interventions may be particularly effective. The risks, opportunities, and interventions will help or hinder children and youth, both in the present and in the future. The sensitive points and pathways to healthy development may differ for girls and boys, and there may be cultural variation in the ways that developmental transitions are interpreted.

- **Acknowledge that children are important as children.**

Children are important not just as the next generation of adults; they play a role in shaping their own lives and they contribute to their families, their schools and their communities. Strategies must target improving children's lives now just as much as they aim to improve their futures. Strategies must recognize children's rights as articulated in the UN Convention on the Rights of the Child.

- **Adopt a population-based approach that clearly recognizes the complexity and diversity of children's lives.**

A population-based approach includes everyone and has the potential to reach all children, youth, and families, while still directing attention to the most vulnerable, the most at-risk. A population-based approach can be used to develop a detailed picture of children and youth that recognizes their multifaceted, multidimensional lives.

- **Define health broadly to include wellness issues.**

Negative indicators report on how poorly children and youth are doing (for example, how many children are injured every year). Positive indicators look at how well children are doing (for example, how many children aged 5 - 6 years are ready to learn). In building a well-rounded understanding of the health of children and youth, both negative and positive indicators are needed.

- **Focus on critical issues.**

Critical issues drive policy development. A focus on critical issues ensures that the document has the greatest possible impact. This means paying enough attention to the most vulnerable children.

- **Build on and foster awareness of Canada's regional, ethnic, linguistic, cultural and religious diversity.**
The population of Canada is increasingly diverse. Strategies to improve and promote the health and well-being of children and youth must be flexible and responsive to community-level needs.
- **Focus on prevention and health promotion.**
Primary prevention seeks to avoid the onset of disease by eliminating, or at least minimizing environmental factors and unhealthy behaviors that increase the risk of death, illness and injuries. Health promotion creates the environment whereby individuals are able to reach their highest potential for health. Strategies must include how one would like things to be in the future, reducing disease and setting goals for the promotion of health.
- **Recognize the major changes that have occurred in the health care system.**
The restructuring of the health care system has changed the way that care is provided. Statistics on hospitalization must be interpreted in the light of these changes, and strategies must be revisited and revised.
- **Identify important issues, even where available data are incomplete at this time.**
The precautionary principle urges action in the best interests of children, based on the information available at a given point. In regard to widely distributed environmental toxicants, to wait for absolute and conclusive research can potentially put a generation of children at unnecessary risk.
- **Recognize the disparities that exist for Canada's children.**
Data needs to be presented in such a way that the disparities within Canada are made visible. Disparities may be regional or economic, or they may be related to ethnicity, disability status or gender.

The Workshops:

The format of the workshops was similar in all presentations:

- an overview of the process emphasizing the collaborative nature, and the issues discussed during the development of the book;
- an overview of each chapter, identifying new information from the previous two editions, and what the challenges were;
- an overview of the data ranging from the good news stories to the emerging issues affecting children's health and well-being; and
- a discussion of what information is helpful, what is not, and what should be included in the fourth edition of the publication

The timing of each component varied, as did the data charts discussed, in response to the requests or special interests of the workshop group. In some presentations, a member of the National Advisory Group or a local “expert” participated (such as in Ottawa-Carleton or Newfoundland), or a government panel responded (such as in Victoria).

Presentations were made as follows:

Newfoundland

St. John’s: Department of Health and Community Services

Nova Scotia

Halifax: two workshops - IWK Grace Health Centre and IWK Grace Health Centre Board of Directors

Sydney: Network of Children and Youth, Eastern Nova Scotia

Prince Edward Island

Charlottetown: Maritime Network for Child and Youth Health

Quebec

Montréal: Hôpital Ste–Justine (funded in part by Santé Canada)

Ontario

London: Health Canada

Minette: Community Action Program for Children (CAPC) Cleveland House, Muskoka Conference

Ottawa: Health Canada (two workshops - one specific to youth issues and one general presentation)

Ottawa: Human Resources Development Canada (HRDC)

Ottawa: Regional Municipality of Ottawa-Carleton Health Department

Ottawa: Rural Health Consortium

Timmins: Porcupine Health Unit

Toronto: Two workshops - Hospital for Sick Children and Funders Alliance

Toronto: Ontario School Board Association

Toronto: Women’s Executive Network

Manitoba

Winnipeg: Manitoba Health - Child Health Programs

Saskatchewan

Saskatoon: Saskatchewan Institute for Prevention of Handicaps

Alberta

Calgary: Calgary Regional Health Authority (CRHA)

Edmonton: Health Canada

British Columbia

Vancouver:

Children's and Women's Health Center of British Columbia

Victoria:

Ministry of Children and Families

Cross Canada Phone-In

Community Foundations of Canada

The Participants:

Most of the community workshops were multi-sectoral and often included public health, education, children's mental health services, government officials, and from time to time, justice and police services. In addition, there were some sessions specific to government officials. Most communities included the managers of their CAPC (Community Action Program for Children) and/or CPNP (Canadian Pre-natal Nutrition Programs) as workshop participants. As such, these sessions had a built-in reality check of the needs of families with young children.

It should be noted that two of the workshops were completed over the phone. The first was due to an ice storm where the speaker was stranded. The second was intentionally developed to include many communities throughout Canada, linked through conference call facilities and a PowerPoint presentation.

There was an overwhelming response to the efficiency of the online *Profile* workshops. All participants enjoyed the fact that:

- there was no travel involved
- it was a comfortable session (you could get up and move around without disruption)
- it was cost effective (very inexpensive)
- it was easy to maneuver through the PowerPoint presentation

Participants felt that it was an efficient use of time and money. Furthermore, they felt it was an excellent approach to use when introducing a large amount of information to an audience.

Sponsors:

All sessions were sponsored by a partner, often a non-governmental agency or public health department, and were usually funded by a provincial government, Health Canada, Human Resources Development Canada, or a Foundation. Sponsorship was required to pay for travel expenses, as well as book purchases.

Dissemination:

Workshops had various processes for the dissemination of the books. Some workshops purchased copies of *The Profile* in bulk, and gave a copy to each participant. Others “sold” books at a reduced cost of \$40.00. It soon became apparent that the workshops in which everyone had a book were more interactive, and participants had the ability to seek out in-depth information according to their interests. This was so apparent that it was recommended that workshops only be conducted when all participants had access to a copy of *The Profile*. If a “selling” model was preferred, all participants were informed in advance of the workshop fee of \$40.00, which would include a copy of *The Profile*. This fee would be waived in the case where participants had purchased their own copy prior to the workshop.

Overview to the Responses:

For the purpose of the report, comments have been combined under general headings, and discussion will focus on the main points raised. It should be noted that more comprehensive notes were kept on each session, and very specific requests were dealt with individually.

1. *Special Vulnerable Groups*

It was suggested that the next edition include a chapter dedicated to vulnerable children. Most groups discussed the need for more information on the special vulnerability of children and youth in the care of the state. Data about adoption rates (both national and international) were requested, as well as information on their health and well-being outcomes. The health status of recent immigrant and refugee children, particularly in British Columbia and Ontario, was also requested.

In the prairie provinces and Labrador, the health and well-being of Aboriginal populations was discussed at length. The issue of protective factors was often pivotal to this discussion. There were consistent requests for more information on children with disabilities, ranging from rates of autism and other disability diagnoses, to evaluative work from infant-stimulation projects. The special vulnerability of new immigrants and cultural groups was of particular concern in Ontario and British Columbia.

2. *Impact of the Education System*

“The health and well-being of children will never be accurately described or understood properly until there are solid links and collaboration between the education and health/social systems” said a participant in Baddeck, Nova Scotia (Sydney workshop). There were lengthy discussions about the need to consider our schools and education systems from the perspective of the health and well-being of our children. Furthermore, participants reiterated that the health and education systems can no longer be considered exclusive of each other. It was recognized that we must better describe the linkages between education and

health and well-being, both immediately and in the long run. Nevertheless, participants recognized the tremendous barriers to sharing concerns and information, and creating a tracking system of mutual benefit. For example, one participant, a school board trustee, was experiencing major difficulty in obtaining drop out rates for her own school!

There were repeated discussions about the impact of zero-tolerance school policies on children's mental health and self-esteem, and age-appropriate responses were considered. In addition, the accuracy of violence data was called into question, with differing definitions and reporting mechanisms being seen as problematic.

The erosion of the public health system was a unanimous concern. In particular, its effects on the schools through the reduction or elimination of school nurses, and the resulting increased need for school counselors, psychologists and social workers was discussed. New programs that included a closer working relationship between health and education (such as in Alberta) were debated.

Nutrition and schools, and the impact of the private sector (e.g., Pizza companies, etc.) in the delivery of school meals was discussed in most workshops.

In locations such as Ontario and Nova Scotia, participants were concerned about monitoring the impacts on children of the accessibility to community schools. Furthermore, participants felt that whether the schools were seen as part of the local neighborhood should also be addressed.

Discussions surrounding the linkages between school and health expanded to questions about "summer break". Were there behavioral changes observed during this period, and did the dispensing of Ritalin change in accordance with the school year?

3. *Children in a Civil Society*

There were discussions about civil society and what it means to children. Some sessions spontaneously referred to the *Convention on the Rights of the Child*. Furthermore, some participants suggested additions for the fourth edition, such as:

1. Measure charitable giving as an indicator of civil society
2. Monitor accessibility to arts, culture and sports in light of municipal increases in user fees
3. Measure inclusion of children with special needs, both emotional and physical in nature

Considerable time was spent discussing community assets, and again the chart on protective factors in the Aboriginal communities was cited as a progressive course of action. How would other protective factors affect issues such as fetal

alcohol syndrome and street youth? There was a discussion on linking community protective factors on discharge records, particularly after birth.

4. *The Health Care System and How we Collect Information*

There was often spirited discussion on the use of hospitalization data. In particular, participants debated the reasons for higher hospitalization statistics in some provinces, such as New Brunswick and Saskatchewan. There were differing opinions about whether to use hospitalization data without looking at system and human resource issues. There were questions about whether more information on the acute service delivery system (such as available beds, access to alternatives such as clinics, family physicians and sub-specialists, and the existence of home/community care) would have value. Furthermore, participants also discussed the need for secondary diagnosis information, particularly as to how it might affect hospitalization rates for respiratory diseases. Differing policies in emergency room procedures were also considered for their potential effect on hospitalization rates. Finally, the increasing use of tele-medicine was of interest to some participants, particularly in places like Timmins, Ontario.

There was a request to place greater emphasis on provincial expenditures, policies and systems (e.g., beds, accessibility etc.) that could affect the hospitalization data.

5. *Injuries*

It was strongly recommended in a number of sessions (particularly in Nova Scotia and British Columbia), that a chapter of *The Profile* be dedicated to each issue of major importance, such as injuries.

Many participants felt that an examination of societal and parenting values would be beneficial. For instance, a focus on rural and northern communities might shed light on cultural differences. It was proposed that the types of prevention and promotion activities that are generated in communities with children's hospitals and foundations might differ from communities without tertiary care centers. Finally, some participants put forward the idea that the associated fundraising activities might have an indirect consequence of raising community awareness about issues such as injury prevention.

6. *Fathering*

The role of fathers and step-fathers is a theme that runs throughout *The Profile* and therefore was raised in discussion in many workshops. Issues about fathering, step-fathering, and relationships between teenage girls and their fathers were common topics of interest to participants.

7. ***Collapse of Services and Programs for Children Over Six***

Common elements of all sessions included discussions surrounding:

- Erosion of the programs and services for children over 6
- Difficulty in fundraising for services for this age group
- Lack of volunteer and infrastructure support
- Need for a better understanding of both the health and social systems in schools
- Recognition that we have changed the labour force, our family structures, and our communities, and replaced them with sporadic, targeted, short-term programs

Participants discussed the need to capture data about the recent increase in private and home schooling. This data might be in the form of increases in enrollment rates in private schools, increases in the number of private schools, or increases in the number of members in home schooling associations. In addition, there were questions regarding the number of children in same sex families, and the number of children being raised by grandparents.

8. ***Rural/Urban and Northern Differences***

This appeared to be a new and emerging theme of concern to participants, however this may reflect the fact that all workshops but one were held in urban centres. Many rural/urban issues were raised, however one of particular concern involved the mode of transportation and distance to acute care in rural/northern areas. For example, one participant questioned whether the bridge from Prince Edward Island would improve rural access to services.

While Timmins is not considered “far north,” it was felt that many communities north of major population centers have unique issues that should be identified. Such problems as a lack of access to primary or family physicians might be considered. In addition, the concern was raised that population-based funding is leaving smaller northern communities with inadequate funding to support much-needed services.

9. ***New Policy Directions***

Participants requested that the 4th edition of *The Profile* identify policy changes, based on the consultations and data from the current edition. Interesting consequences of policy change were suggested. For example, how will the newly implemented Unemployment Insurance extension impact breastfeeding initiation and duration rates?

There was also a call for a national survey regarding the nutritional status of Canadian children. More information on food consumption patterns, obesity, and eating disorders were requested.

10. **Additional Recommendations**

The following is a list of specific recommendations made in many of the workshop sessions:

1. Provide an index of charts and figures
2. Include the word Labrador when mentioning Newfoundland
3. Provide data on the long term effects of solvent abuse
4. Provide data on literacy rates and the effects of parental literacy on children's health and well-being
5. Provide data on drop-out rates for children whose maternal language is neither English nor French
6. Provide information on attachment disorders
7. Provide data on inter-provincial migration and the effects on children
8. Provide an examination of rehabilitation services and alternative families
9. Examine the long term effects of junior kindergarten
10. Provide an evaluation of child/family friendly workplace policies
11. Provide information/data on gay youth health and well-being
12. Provide information/data on youth in transition
13. Provide data on diabetes rates
14. Provide information about the special cultures of hard of hearing and deaf children
15. Provide data on the oral health of children and youth
16. Provide data on access to services for minority populations, particularly French language services outside of Quebec
17. Provide data on the results of early intervention
18. Provide data on family life and migration
19. Provide information about adoption issues.

Challenges and Considerations:

The limitations and problems with some data processes were discussed throughout the workshops. Both provincial and non-governmental officials and academic researchers identified problems in accessing national data from a variety of government sources.

Many participants suggested that information from regional/provincial studies be used in a comparative way. For example, when referring to street children data from British Columbia, similar data from a regional survey could be used for comparative purposes. Many felt that provincial program comparisons such as early child development evaluations and infant stimulation/development programs might be beneficial. As mentioned previously, there was a strong feeling among participants that the hospitalization data is subject to distortion. For example, one participant said "In the north if we don't hospitalize, we don't get funds".

More information about the supports and services in place across the provinces was requested. In particular, information on provincial expenditures was requested. Many

expressed the hope that with the National Children's Agenda, more information of this type would become available.

Participants expressed frustration with the absence of a national mental health strategy. They discussed the need for best practices in children's mental health, and the growing momentum calling for such a strategy. As mentioned previously, there was considerable discussion about the impact of the school system's zero tolerance policies both on data collection, and more importantly, on children themselves.

Finally, lack of quality child care was a common topic of discussion at the workshops sessions. Participants felt that the issue was ignored by politicians and media alike. Time and time again, groups expressed frustration with their inability to "tell the story", to motivate communities and politicians to improve access to quality child care. More data were requested on flexible child care and other models of care delivery.

In Conclusion:

The Canadian Institute of Child Health (CICH) is committed to monitoring the health, well-being and rights of children and youth in Canada, and to disseminating reliable, comprehensive and current information to a broad audience. This commitment is fulfilled in part through publishing *The Health of Canada's Children: A CICH Profile*.

The third edition of this document, while reflecting CICH's beliefs, is a product of an extensive consultative process, involving experts in a wide range of fields relating to child health from across the country. While this process contributes to the comprehensiveness and reliability of the document, it also ensures a dynamic exchange of ideas. It is CICH's sincerest hope that this book will be useful to everyone interested in creating a healthier, safer world for children and youth.

The Profile workshops were exciting events that brought multi-disciplinary groups together to examine national trends, and to discuss their own community assets and challenges, in a holistic and comprehensive way.

FACT SHEET

Fathering

Supporting Fathers is a relatively new concept in policy and program development, yet it is just as important as supporting mothers. Supportive workplace policies, comparable to those needed by mothers, such as paternity leave or child sick leave, and supportive community programs, such as parent-infant groups, help fathers fulfil their parenting roles.

- There were 3,171,900 fathers living with at least one child under 18 years of age in 1996
- There were 110,540 lone-parent fathers in 1996

Fathers can be important contributors to the healthy development of their children. A positive relationship with at least one caring adult is an important contributing factor in resiliency. Also, a positive relationship daughter-father relationship has been linked with higher levels of self-esteem.

- In 1998, 33% of girls in grade 10, compared with 51% of boys in grade 10, reported finding it “easy” or “very easy” to talk to their father about things that really bother them.

Programs for Children over Six Years of Age

Participation in sports, recreation and the arts may contribute to the resiliency of children and protect against psychosocial problems.

- In 1994-95, the majority of children 6-11 years of age “almost never” participated in the arts and community programs.
- In 1994-95, approximately one third “almost never” participated in supervised sports.

These findings suggest that significant populations of children are inadequately served by recreational programs: programs may be unavailable in some communities; available programs may have limited registration; or families may be unable to afford registration costs.

Better Linkages Between Mental Health and Education Systems

There are currently insufficient national and provincial data available on the mental health and well-being of school age children. A wealth of health data may be “hidden” in difficult to access, non-standardized systems, such as the school system. The development of health indicators and measures that report on these data is essential to developing a stronger, evidence-based picture of the health and well-being of school age children.

