2009 Edition

Are We Doing Enough?

A status report on Canadian public policy and child and youth health

Canadian Paediatric Society

Disease Prevention

Health Promotion

Injury Prevention

Best Interests of Children and Youth

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Background

"It takes a village to raise a child." The Canadian village is made up of parents, families, communities and governments at various levels. It is our collective responsibility to protect the health and safety of our children and youth. While parents and caregivers play a critical role in their children's healthy growth and development, governments must support their efforts with public policy that safeguards and enhances the health and safety of Canada's youngest residents.

This is the third edition of the Canadian Paediatric Society's (CPS) status report, *Are We Doing Enough?* The report assesses indicators of child and youth health that are backed by evidence of the need for, and effectiveness of, government intervention. It is designed to encourage policy-makers to critically examine their progress on child and youth issues, and to make changes that help make children and youth healthier and safer. The report is produced every two years because we recognize that legislative and regulatory changes take time.

The CPS is pleased to note that past reports have sparked action in a number of areas. For example, provinces have used the information in drafting legislation for smoke-free places, including cars where children are travelling. This report highlights progress made in some areas by the provinces and territories, and the federal government, and provides a benchmark for comparison to other jurisdictions. Advocates must continue to use the power of public policy to foster the full development of children and youth in healthy and safe environments: The CPS is committed to supporting these efforts.

The report looks at public policy in four major areas:

- Disease prevention
- Health promotion
- Injury prevention
- Best interests of children and youth

Please note that influenza pandemic planning is not included in the 2009 report as Canada is actively dealing with the H1N1 outbreak and plans continue to be adjusted. Similarly, because new guidelines around physical activity for children and youth are under development by the Public Health Agency of Canada and experts (including the CPS), we have chosen not to include obesity prevention and promotion of physical activity in this report. We will continue to monitor efforts in both of these areas, and will include them in future reports.

Information is current as of November 25, 2009 and was obtained from government documents, websites and personal correspondence.

Summary

As advocates for child and youth health, the Canadian Paediatric Society (CPS) devotes considerable attention to identifying evidence-based approaches to critical health issues. This focus has served us well in improving clinical practice. However, the long-term well-being of children and youth requires a broader view of the health of populations. In this edition of *Are We Doing Enough?* the CPS looks at issues of health promotion and primary prevention through the lens of the social determinants of health. Income and social status, education, housing, early child development and cultural status all play a far greater role in the health of children and youth than any of the health services we can provide them.

Government leadership has had an impressive impact on issues such as immunization, tobacco control and seat-belt safety. The CPS calls upon all governments to take action on evidence-based policies and interventions to address the basic issues that determine good health. Prime among these is income disparity.

Child poverty – Poor children and youth are not as healthy, and have higher infant mortality rates and shorter life expectancies than others. While this may seem like an obvious statement, it has been the focus of considerable research of late, and the conclusion is irrefutable. Health disparities among Canadian children and youth are primarily linked to differences in family socioeconomic status. Children of new immigrants and Aboriginal children are particularly vulnerable, and are far more likely to grow up in poor families[1]. According to the Health Officers Council of British Columbia, "Among all the policy areas for…reducing health inequity, none is more significant than that of income security and measures for reducing poverty in the province[2]."

Aside from the moral imperative, addressing child poverty makes economic sense. The poorest quarter of residents uses twice the health care services as those in the wealthiest quarter.[2] Referring to early child development programs, Canada's Chief Public Health Officer's report notes that "…$1 invested in the early years saves between $3 and $9 in future spending on the health and criminal justice systems, as well as on social assistance[3]."

Although some efforts have been made in Canada through the introduction of the national child tax benefit system and other tax benefits, these have not been adequate. There has been only a slight reduction in the number of children living in poverty during the past twenty years[4]. More comprehensive strategies that take advantage of the full range of policy and program levers are necessary to both significantly reduce child poverty in Canada and to reduce the impacts of poverty on the life chances of children and youth. These measures include, but are not limited to: income security programs, labour market

training, tailored employment supports for vulnerable groups, minimum wage policies, employment standards, settlement programs, access to quality child care and early childhood education, affordable housing, and drug, dental and vision care insurance for low-income families.

Legislation and public policy have the power to save young lives, and provide the support necessary to allow children and youth to develop to their full potential. Sweden's wealth distribution and child care policies ensure low child poverty rates. Recent efforts in the United Kingdom have resulted in significant progress to reduce poverty[5]. The CPS believes that all children and youth deserve equal opportunities for success in life.

Progress on the issues raised in our two previous reports has been mixed. While important gains have been made on some issues, movement has been much slower or non-existent on others.

Smoking – Canada's efforts on smoking cessation continue to reap benefits. Smoking rates among teens continue to drop, to an all-time low in 2008 of 15% among youth aged 15 to 19 years[6]. At the same time, Aboriginal youth continue to smoke at three or four times the rate of other Canadian youth[7]. Children and youth from low income families also smoke at higher rates than the national average[8]. Four Canadian provinces have recently introduced legislation against smoking in cars where children are present, and others are considering it[9]. Meanwhile, brand-new federal legislation amends the *Tobacco Act* to finally ban all tobacco advertising in magazines and newspapers. It also prohibits the sale of flavoured and small packages of 'cigarillos'.

Mental health – There is still no comprehensive approach to addressing mental health among children and youth in this country. While work is underway to develop a national mental health strategy, including a focus on children and youth, many provinces and territories do not have a mental health plan. Even where plans exist, access to mental health services is lacking and, in some cases, declining. Both screening for and treatment of mental health disorders continue to be severe problems, with three-quarters of children and youth who need specialized treatment not receiving it[10]. About 70% of mental illnesses have their onset in childhood or adolescence, reinforcing the importance of early monitoring, prevention and treatment to reduce their potential lifelong impact[10].

Injuries – Unintentional injuries remain the leading cause of death for children and youth in Canada, yet no cohesive national injury prevention strategy is on the horizon. This is a clear case of inaction in the face of compelling evidence. Strong legislation prevents injuries and saves lives. A 10-year review of data shows that hospitalization and death rates have declined by almost a third, partly due to changes in helmet use and the introduction of helmet laws in six provinces during this period[11]. In provinces where bicycle helmet legislation has been enacted, injuries have been reduced by 25%[12]. Yet there continues to be a hodgepodge of uneven and, in some cases, contradictory, legislation that threatens the safety of children and youth.

Some children are at greater risk of injury. Research shows that children who live in poverty have higher rates of death due to unintentional injuries than those who do not[13].

Among First Nations populations, injury is a leading cause of death and by far the greatest source of potential years of life lost, at almost 3.5 times the national average[14].

Paediatric human resources – The health needs of children and youth are unique and complex. No single health care professional can meet all of them. A commitment to a coordinated team approach – with family physicians, paediatricians, child and adolescent psychiatrists, nurses and other specialists working together – is vital to providing quality health care for young people[15].

The Canadian Paediatric Society continues to raise the alarm regarding the pending shortage of paediatricians. As with other health care professionals, paediatricians are retiring in ever-increasing numbers, without a sufficient group of incoming physicians to replace them. No jurisdiction yet has a plan to address this concern, putting the future health of children and youth in jeopardy.

Rights of the child – Spring 2010 marks the twentieth anniversary of Canada signing the United Nations Convention on the Rights of the Child. In May 1990, Canada recognized the special needs of children and youth, and agreed to protect their rights. Unfortunately, there is no Canadian Commissioner for Children and Youth or other independent mechanism in place to enforce this commitment. Most provinces (but none of the territories) now have child and youth advocates, but many address only children and youth in the care of the province. Their limited mandates and lack of independence impede their power to protect the unique rights of all children and youth.

CPS Commitment

This report raises a number of areas of concern. We hope it serves to spur governments on to meet their responsibilities to children and youth, and that it is useful to other advocates. We aspire to a day when all policies and programs that affect children and youth are automatically reviewed by an independent body designed to stand for the rights of our young people. In the meantime, we hope that legislators take seriously the issues highlighted by Canada's paediatricians. We are committed to working with all Canadians to improve the health and welfare of our children and youth. This is our promise.

1. Campaign 2000. 2008 Report Card on Child and Family Poverty in Canada, accessed [online] at www.campaign2000.ca/reportCards/national/2008EngNationalReportCard.pdf, November 13, 2009

2. Health Officers Council of BC, Health Inequities in British Columbia: Discussion Paper, November 2008, retrieved November 19, 2009 from www.bchealthyliving.ca/files/HOC_Inequities_Report.pdf

3. Grunewald R & Rolnick A (2005), as cited in Public Health Agency of Canada, The Chief Public Health Officer's Report on the State of Public Health in Canada 2008, page 67, retrieved November 19, 2009 from www.phac-aspc.gc.ca/publicat/2008/cpho-aspc/index-eng.php

4. Campaign 2000. 2009 Report Card on Child and Family Poverty in Canada, embargoed copy accessed on November 10, 2009. Available [online] at www.campaign2000.ca/reportcards.html

5. Lemstra M, Neudorf C. *Health Disparity in Saskatoon: analysis to intervention*, Saskatoon: Saskatoon Health Region; 2008

6. Canadian Tobacco Use Monitoring Survey, 2006, retrieved November 19, 2009 from www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/_ctums-esutc_2006/ann-table1-eng.ph

7. Canadian Paediatric Society. First Nations and Inuit Health Committee, Use and misuse of tobacco among Aboriginal peoples – update 2006, Paediatr Child Health 2006;11(10):681-5, retrieved November 19, 2009 from www.cps.ca/english/statements/ii/fnih06-01.htm

8. Pomerleau J, Pederson LL, Østbye T, Speechley M, Speechley KN. Health behaviours and socio-economic status in Ontario, Canada. Eur J Epidemiol 1997;13(6):613-622

9. Canadian Press, June 2008

10. Mental Health Commission of Canada, Towards Recovery and Well-being, A Framework for a Mental Health Strategy for Canada, January 2009, retrieved November 19, 2009 from www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Mental_Health_ENG.pdf

11. Safe Kids Canada. Child and Youth Unintentional Injury: 1994-2003, 10 Years in Review, July 2007, retrieved November 19, 2009 from www.mhp.gov.on.ca/English/injury_prevention/skc_injuries.pdf

12. Macpherson A, Spinks A. Bicycle helmet legislation for the uptake of helmet use and prevention of head injuries. Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD005401. DOI: 0.1002/ 14651858.CD005401.pub2

13. Birken CS, Parkin PC, Macarther C. Trends in rates of death from unintentional injury among Canadian children in urban areas: influence of socioeconomic status. CMAJ 2006; 175(8):867

14. Health Canada, A Statistical Profile on the Health of First Nations in Canada: Health Services Utilization in Western Canada, 2000, June 2009, retrieved on November 13, 2009 from www.hc-sc.gc.ca/fniah-spnia/pubs/aborig-autoch/2009-stats-profil-vol2/index-eng.php

15. Canadian Paediatric Society. A Model of Paediatrics: Rethinking health care for children and youth, Paediatr Child Health 2009;14(5): 319-25, retrieved November 19, 2009 from www.cps.ca/english/statements/HR/CPS09-01.htm

Disease Prevention

ARE WE DOING ENOUGH?
2009 EDITION

8

Publicly-funded immunization programs

Infectious diseases were once the leading cause of death in Canada. They now account for less than 5% of deaths[1], making immunization the most cost-effective and one of the most successful public health efforts of the last century. Universal coverage of paediatric vaccines offers all children and youth protection against many potentially life-threatening diseases.

In addition to a slate of vaccines that have been part of the routine immunization schedule for a number of years, the CPS and the National Advisory Committee on Immunization (NACI) recommend that children and youth be immunized against varicella (chickenpox), adolescent pertussis (whooping cough) and certain forms of meningitis (meningococcal and pneumococcal infections). We also recommend that the human papillomavirus (HPV) vaccine be provided at no charge.

Coverage of these five vaccines is not yet universal across the country. While most provinces/territories offer all vaccines, not all are administering them according to the schedule recommended by the CPS and NACI, and harmonization of schedules across the country has not been achieved[2].

While disparity in vaccine access is narrowing between provinces and territories, children from low-income families are far more likely to have incomplete immunization coverage than those from higher-income families[3]. Increased efforts are required so that all children and youth are adequately protected.

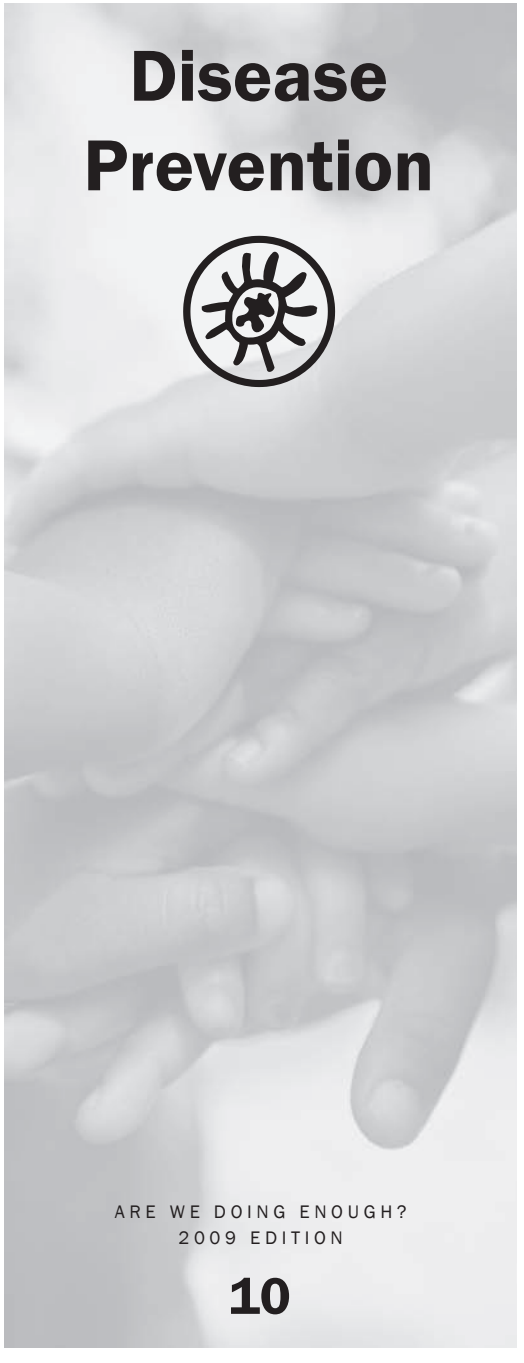
The 2009 report does not deal with the seasonal influenza vaccine, as programs are under review as a result of the H1N1 influenza virus.

1. Canadian Public Health Association, retrieved November 19, 2009 from www.immunize.cpha.ca/
2. Canadian Paediatric Society, Infectious Diseases and Immunization Committee. Immunization Update 2005: Stepping forward. Paediatr Child Health, 2005; 10(6): 315-316, retrieved November 19, 2009 from www.cps.ca/english/statements/id/pidnoteimmunization2005.htm
3. Lemstra M, Neudorf C. *Health Disparity in Saskatoon: analysis to intervention*, Saskatoon: Saskatoon Health Region; 2008, page 167

Excellent:	Province/territory provides meningococcal, adolescent pertussis, pneumococcal, varicella and HPV vaccines according to the schedule recommended by the Canadian Paediatric Society and the National Advisory Committee on Immunization, at no cost to individuals.
Good:	Province/territory provides all five vaccines, but some are not provided according to the schedule recommended by the CPS and NACI.
Fair:	Province/territory offers four of the five recommended vaccines, and the schedule does not match that recommended by the CPS and NACI.
Poor:	Province/territory only offers three or fewer of the recommended vaccines.

Publicly-funded immunization programs			
Province/Territory	**2007 Status**	**2009 Status**	**Comments**
British Columbia	Good	Good	Provides coverage for all five recommended vaccines but meningococcal vaccine is not given in accordance with CPS and NACI recommendations.
Alberta	Excellent	Excellent	Provides coverage for all five vaccines according to the CPS and NACI recommended schedule.
Saskatchewan	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal vaccine is not given in accordance with CPS and NACI recommendations.
Manitoba	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal and pneumococcal vaccines are not given in accordance with CPS and NACI recommendations.
Ontario	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal vaccine is not given in accordance with CPS and NACI recommendations.
Quebec	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal and pneumococcal vaccines are not given in accordance with CPS and NACI recommendations.
New Brunswick	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal vaccine is not given in accordance with CPS and NACI recommendations.
Nova Scotia	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal vaccine is not given in accordance with CPS and NACI recommendations.
Prince Edward Island	Fair	Good	Provides coverage for all five recommended vaccines, but meningococcal vaccine is not given in accordance with CPS and NACI recommendations.
Newfoundland and Labrador	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal vaccine is not given in accordance with CPS and NACI recommendations.
Yukon	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal and pneumococcal vaccines are not given in accordance with CPS and NACI recommendations.
Northwest Territories	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal vaccine is not given in accordance with CPS and NACI recommendations.
Nunavut	Good	Good	Provides coverage for all five recommended vaccines, but meningococcal vaccine is not given in accordance with the CPS and NACI recommendations.

Disease Prevention



ARE WE DOING ENOUGH?
2009 EDITION

10

Measures to prevent and reduce adolescent smoking

The CPS supports legislation that protects both children and adults from secondhand smoke, and sends a clear message that smoking endangers health. We encourage provinces and territories to create and enforce laws that ensure all public places, and private places where children and youth are present, are smoke-free. There is evidence that these protective policies also encourage some smokers to quit for good[1]. As legislation is introduced to limit smoking, we must continue to be vigilant in protecting children and youth from secondhand exposure.

Since the last *Status Report*, Ontario, Nova Scotia, New Brunswick and British Columbia have introduced legislation against smoking in cars where children are present. Prince Edward Island is in the process of introducing such legislation, and Quebec, Saskatchewan and Manitoba are considering a similar ban[2].

Smoking among teens continues to drop in Canada. Between 2005 and 2008, the rate of smoking among youth aged 15 to 19 years fell 3% to an all-time low of 15%. Drops were most significant in Quebec, from 36% in 1999 to less than half that rate—17%—in 2008. In Saskatchewan, the 2008 rate was 20%, down from 31% in 1999[3].

Adolescent consumption of tobacco is price sensitive[4]. Driven partly by taxes, the price of cigarettes is one indication of how aggressively governments are trying to discourage smoking. Enforcing laws against contraband cigarettes is another.

Two groups of youth may be at particular risk. Smoking rates among 15- to 17-year-old Aboriginal youth are at least four times higher than the national rate for youth of this age[3,5]. Income level is inversely related to smoking rates, so children and youth from low income families also require attention[6].

1. Moher M et al. Workplace interventions for smoking cessation. Cochrane Database Syst Rev 2003; (2):CD003440
2. Canadian Press, June 2008
3. Canadian Tobacco Use Monitoring Survey, 2008, retrieved November 13, 2009 from www.hc-sc.gc.ca/hc-ps/tobac-tabac/research-recherche/stat/ctums-esutc_2008-eng.php
4. Canadian Paediatric Society, Drug Therapy and Hazardous Substances Committee. Effect of changes in the price of cigarettes on the rate of adolescent smoking. Paediatr Child Health 1998;3(2):97-8, retrieved November 19, 2009 from www.cps.ca/english/statements/dt/dt97-01.htm
5. Canadian Paediatric Society. First Nations and Inuit Health Committee, Use and misuse of tobacco among Aboriginal peoples – update 2006, Paediatr Child Health 2006;11(10):681-5,, retrieved November 19, 2009 from www.cps.ca/english/statements/ii/fnih06-01.htm
6. Pomerleau J, Pederson LL, Østbye T, Speechley M, Speechley KN. Health behaviours and socio-economic status in Ontario, Canada. Eur J Epidemiol 1997;13(6):613-622

Excellent:	Province/territory has a ban on smoking in all public places. Cost of a carton of 200 cigarettes is in the most expensive quartile. Legislation has been introduced to protect children and youth from tobacco in automobiles. The province/territory has prevention programs specific to youth.
Good:	Province/territory has passed legislation for a province-wide smoking ban. Cost of 200 cigarettes is in the second most expensive quartile.
Fair:	Province/territory has legislation banning smoking in some, but not all, public places. Cost of 200 cigarettes is in the third most expensive quartile.
Poor:	Province/territory does not have a smoking ban. Cost of 200 cigarettes is in the bottom quartile.

Measures to prevent and reduce adolescent smoking

Province/Territory	2007 Status	2009 Status	Comments
British Columbia	Good	Excellent	Smoking is banned in public places. Cost of 200 cigarettes is $87.40. Public health programming exists to prevent smoking among children and youth. Legislation in place to ban smoking in vehicles with passengers under 16.
Alberta	Good	Good	Smoking is banned in public places, workplaces, in public vehicles, near public entrances. Cost of 200 cigarettes is $90.55. Has a tobacco reduction strategy. No legislation to protect children from secondhand smoke in cars.
Saskatchewan	Excellent	Good	Smoking is banned in public places and workplaces. Cost of 200 cigarettes is $91.12. Public health programming exists to reduce smoking, aimed specifically at youth. No legislation to protect children from secondhand smoke in cars.
Manitoba	Excellent	Good	Smoking is banned in public places. Cost of 200 cigarettes is $93.23. Public health programming exists to reduce smoking, including programs developed with input from youth. No legislation to protect children from secondhand smoke in cars.
Ontario	Good	Good	Smoking is banned in public places. Cost of 200 cigarettes is $74.49, second lowest in Canada. Public health programming exists, aimed at youth. Legislation in place to ban smoking in vehicles with passengers under 16.
Quebec	Good	Good	Smoking is banned in public places. Cost of 200 cigarettes is $70.18, the lowest in Canada. Public health programming exists to reduce smoking. No legislation to protect children from secondhand smoke in cars.
New Brunswick	Excellent	Excellent	Smoking is banned in public places. Cost of 200 cigarettes is $78.81. Public health programming exists to reduce smoking, including programs specifically for youth. Legislation in place to ban smoking in vehicles with passengers under 16.
Nova Scotia	Excellent	Excellent	With exception of some indoor facilities, smoking banned in all public places and many outdoor public places. Cost of 200 cigarettes is $100.89. Public health programming exists aimed at reducing smoking among children and youth. Legislation in place to ban smoking in vehicles with passengers under 16.
Prince Edward Island	Good	Good	Smoking is banned in public places and workplaces; however, separate smoking rooms permitted. Cost of 200 cigarettes is $95.70. Public health programming exists, aimed at youth. No legislation to protect children from secondhand smoke in cars.
Newfoundland and Labrador	Good	Good	Smoking is banned in public places and workplaces; however, separate smoking rooms for long-term care facilities permitted. Cost of 200 cigarettes is $92.93. Public health programming to reduce smoking includes some youth-specific initiatives. No legislation to protect children from secondhand smoke in cars.
Yukon	Fair	Excellent	Smoking is banned in public places. Cost of 200 cigarettes is $92.65. Public health programming and reduction strategies exist, aimed at youth. Legislation in place to ban smoking in vehicles with passengers under 16.
Northwest Territories	Fair	Good	Smoking is banned in public places and workplaces. Cost of 200 cigarettes is $104.83, the highest in Canada. Public health programming and reduction strategies exist, aimed at youth. No legislation to protect children from secondhand smoke in cars.
Nunavut	Good	Good	Smoking is banned in public spaces, including all enclosed businesses and workplaces. Cost of 200 cigarettes is $92.65. Public health programming exists, aimed at reducing smoking among youth. No legislation to protect children from secondhand smoke in cars.

Health Promotion

ARE WE DOING ENOUGH?
2009 EDITION

12

Child and youth mental health care planning

Mental health problems continue to grow among children and youth and are predicted to increase by 50% by the year 2020. It is estimated that 14% of children and youth under 20 years old—1.1 million young Canadians—suffer from mental health conditions that affect their daily lives[1]. Children of low-income families are especially at risk, as low socioeconomic status is associated with higher rates of depressed mood and anxiety in youth between the ages of 10 and 15[2]. What's worse, three out of every four children and youth who need specialized treatment services do not receive them[3].

The Mental Health Commission of Canada is currently developing a national mental health strategy, including a plan aimed specifically at children and youth[3]. In the meantime, many provinces and territories do not yet have a mental health plan. In jurisdictions where a plan exists, access to mental health services continues to be insufficient and, in some cases, is declining. For example, Ontario's Auditor General recently found an overall decrease in investment in mental health services in that province.

The CPS urges provinces and territories not to wait for the release of a federal strategy, but to act immediately to address critical child and youth mental health needs by developing and implementing coordinated strategies. As part of this process, provinces and territories should also review spending and ensure that the current and future mental health needs of children and youth can be met.

1. Waddell C, Offord DR, Shepherd CA, Hua JM, McEwan K. Child Psychiatric Epidemiology and Canadian Public Policy-Making: The State of Science and the Art of the Possible. Canadian Journal of Psychiatry, 2002,47:825-832
2. Lemstra M, Neudorf C, D'Arcy C, Kunst A, Warren L, Bennett N. A systematic review of depressed mood and anxiety by socioeconomic status in adolescents aged 10-15 years. Canadian Journal of Public Health 2008;99(2):125-129
3. Mental Health Commission of Canada, Towards Recovery and Well-being, A Framework for a Mental Health Strategy for Canada, January 2009, retrieved November 19, 2009 from www.mentalhealthcommission.ca/SiteCollectionDocuments/Key_Documents/en/2009/Mental_Health_ENG.pdf

Excellent: Province/territory has a comprehensive mental health plan for children and youth with timely access to appropriate mental health professionals, including a wait time strategy with specific benchmarks. The plan has specific goals for service improvement, including access to non-medical mental health services at no cost to families, and a mental health promotion component. The development of the plan involved input from community paediatricians and recognizes their role in meeting the mental health needs of children and youth.

Good: Province/territory has a mental health plan for children and youth with specific goals for service improvement, including access to non-medical mental health services at no cost to families, and a mental health promotion component. The development of the plan involved input from community paediatricians and recognizes their role in meeting the mental health needs of children and youth.

Fair: Province/territory has a mental health plan for children and youth but does not recognize the role of paediatricians in the delivery of mental health care.

Poor: Province/territory has no mental health plan for children and youth.

Child and youth mental health care planning

Province/Territory	2007 Status	2009 Status	Comments
British Columbia	Good	Good	A 5-year child and youth mental health plan addresses treatment and support services, risk reduction and prevention programs, improved family and community capacity, and better systems to coordinate services, monitor outcomes, and ensure public accountability. The plan acknowledges the role of paediatricians in the children's mental health system. The plan was reviewed extensively in 2008 with an acknowledgement of the work done to date and a recognition that further investment is needed.
Alberta	Good	Good	A children's mental health plan (2008-2011) aims to build capacity to foster mental health, reduce risks, and provide support and treatment for children, youth and their families. Funds have been earmarked to improve the mental health and access to services for children and youth, and support families and communities. Specific implementation schedules for key issues including determination of wait time standards for children's mental health are proposed. The role of paediatricians is not defined.
Saskatchewan	Good	Good	Plan for child and youth mental health services (2007) addresses prevention and education, treatment and intervention, building expertise and partnerships, and monitoring and evaluation. The role of paediatricians is not defined.
Manitoba	Fair	Good	No specific children's mental health plan or provincial mental health plan. Adopted a youth suicide prevention strategy in 2008. However, mental health promotion is prominent in the Healthy Child Manitoba strategy. Some mental health and addictions programs and services targeted at youth. No specific wait time strategy for child and youth mental health.
Ontario	Good	Fair	*Policy Framework for Child and Youth Mental Health* guides changes to the child and youth mental health sector and help other sectors promote child and youth mental health. The role of paediatricians is not defined. No system to monitor children's mental health wait lists. Ontario Auditor General's 2008 Annual Report showed a diminished investment in mental health for children and youth.
Quebec	Good	Good	*Plan d'action en santé mentale* (2005-2010) includes a chapter on children and youth with mental health problems. Paediatricians recognized as part of the continuum of mental health services and key community/first-line providers. Plan has established goals and targets for wait time for paediatric psychiatry, and first-line and second-line treatment. Changes made to physician billing codes to support mental health care for children and youth.
New Brunswick	Poor	Fair	An overall mental health plan was published in February 2009 with some specific recommendations for children and youth including school-based programs and early diagnosis. No monitoring of wait times for children and youth. The role of paediatricians is not defined.
Nova Scotia	Fair	Fair	Standards for mental health services in Nova Scotia (updated 2007) include reference to children and youth. The role of paediatricians is not defined. In *Strategic Directions for Nova Scotia's Mental Health System* (2005), paediatricians are recognized as key service providers in the specialty areas of neurodevelopmental and eating disorders.
Prince Edward Island	Fair	Fair	*For Our Children: A Strategy for Healthy Child Development* (2000) includes reference to children's mental health. The plan recognizes the need for a broad-based community-wide effort in prevention and early intervention. No information on monitoring mental health wait times for children and youth.
Newfoundland and Labrador	Fair	Fair	Working Together for Mental Health: A Provincial Policy Framework for Mental Health and Addictions Services (2005) recognizes children and youth as a specialized population and outlines a range of recommended services. The role of paediatricians is not defined, but there is reference to collaborative service provision. No information on monitoring mental health wait times for children and youth.
Yukon	Poor	Poor	No information on a children's mental health plan or overall mental health plan. No information on monitoring of mental health wait times for children and youth.
Northwest Territories	Fair	Fair	*A Foundation for Change*, released in November 2009, addresses key issues regarding early childhood development and community health promotion. No information on the role of paediatricians or monitoring mental health wait times for children and youth.
Nunavut	Fair	Fair	An addictions and mental health strategy is underway. No information on a children's mental health plan or monitoring mental health wait times for children and youth.

Health Promotion

Paediatric human resources strategy

Health starts outside the medical system. Supportive families and communities, adequate housing and family income, education, employment, proper nutrition and hygiene are among the key determinants of health. However, when children and youth require the services of the health care system, they need timely access to professionals trained to meet their specific needs. Ensuring that our health care system better meets the needs of children and youth is not only a moral obligation, but also a wise economic investment.

Health care for children and youth is threatened by a significant shortage of paediatricians, with long wait lists. Because children living in poverty have more acute and chronic conditions, they are more negatively affected by the shortages. Surveys by the Canadian Paediatric Society reveal that the paediatric work force is aging, and there are not enough trainees to offset anticipated retirements. In 2005, about 11% of those surveyed said they would retire by 2010, while another 36% planned to reduce their work hours[1]. Smaller communities are particularly vulnerable, as over 80% of Canadian paediatricians work in towns or cities with populations of over 100,000[1,2].

Federal, provincial and territorial paediatric human resources strategies, based on the health needs of children and youth, must be developed in collaboration with provincial paediatric leadership to address issues such as recruitment and retention, human resource planning, and training and professional development.

1. Canadian Paediatric Society. 2005 Paediatric Human Resource Survey. Unpublished data
2. Canadian Paediatric Society. Planning a Healthy Future for Canada's Children & Youth: Report on the 1999-2000 Paediatrician Planning Survey. Ottawa: 2001

Excellent: Province/territory has a paediatric human resources plan that is less than three years old, addresses both generalist and subspecialist supply and demand issues, was developed in consultation with paediatricians, and is endorsed by the provincial/territorial paediatric association or paediatric section of the provincial/territorial medical association.

Good: Province/territory has a paediatric human resources plan that takes into account general and subspecialist paediatricians and was developed within the past six years.

Fair: Province/territory has a paediatric human resources plan that was not developed with paediatricians and has not been endorsed by the provincial/territorial paediatric association.

Poor: Province/territory has no paediatric human resources plan.

Paediatric human resources strategy			
Province/Territory	**2007 Status**	**2009 Status**	**Comments**
British Columbia	Poor	Poor	Does not have a published paediatric human resources plan, although does provide some support for paediatricians in remote communities for locum replacement.
Alberta	Poor	Poor	Does not have a published paediatric human resources plan. Has a model to predict the number of physicians needed, which has predicted a shortage of paediatricians by 2010.
Saskatchewan	Poor	Poor	Does not have a published paediatric human resources plan. Only provision for paediatric human resources is potential funding for up to four residency training spots for international medical graduates.
Manitoba	Poor	Poor	Has a Health Human Resource Action Plan, but no specific plan for paediatrics.
Ontario	Poor	Poor	Introduced Health Force Ontario in May 2006, a 10-year strategy for health human resources. Does not have a published paediatric human resources plan. Province has identified a need for paediatricians in under-serviced communities.
Quebec	Poor	Poor	Does not have a published paediatric human resources plan. Paediatrics has been identified as a priority area for recruitment, however the current number of paediatricians has been deemed sufficient.
New Brunswick	Poor	Poor	Has a human resource strategy, but does not have a published paediatric human resources plan.
Nova Scotia	Poor	Poor	Does not have a published paediatric human resources plan.
Prince Edward Island	Poor	Poor	Does not have a published paediatric human resources plan.
Newfoundland and Labrador	Poor	Poor	Does not have a published paediatric human resources plan.
Yukon	Poor	Poor	Does not have a published paediatric human resources plan.
Northwest Territories	Poor	Poor	Does not have a published paediatric human resources plan.
Nunavut	Poor	Poor	Does not have a published paediatric human resources plan.

Injury Prevention

Bicycle helmet legislation

Bicycle injuries are the third leading cause of injury for children between the ages of 10 and 14 years old[1], with traumatic brain injuries accounting for almost one third (29%) of all cycling-related hospital admissions[2]. Bike helmets reduce the risk of brain injury by 88%, yet a 2002 survey showed that only 45% of children ages 11 to 14 said they wore bike helmets[3]. In jurisdictions with mandatory bike helmet laws, more people use helmets and injury rates are, on average, 25% lower than in areas without helmet legislation[4].

A 10-year review of childhood injury showed that hospitalization and death rates had declined by 29% between 1994 and 2003, attributed at least in part to changes in helmet use and the introduction of helmet laws in six provinces during this period[2].

The Canadian Paediatric Society recommends that everyone riding a bicycle be required to wear a CSA-approved helmet. Laws should be accompanied by enforcement and public education, which have been shown to increase helmet use[5].

1. Health Canada. For the safety of Canadian children and youth: From injury data to preventive measures. Ottawa: 1997
2. Safe Kids Canada. Child and Youth Unintentional Injury: 1994-2003, 10 Years in Review, July 2007, retrieved November 19, 2009 from www.mhp.gov.on.ca/English/injury_prevention/skc_injuries.pdf
3. Safe Kids Canada. National Bike Helmet Survey, 2002
4. Macpherson A, Spinks A. Bicycle helmet legislation for the uptake of helmet use and prevention of head injuries. Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD005401. DOI: 0.1002/ 14651858.CD005401.pub2
5. Royal ST, Kendrick D, Coleman T. Non-legislative interventions for the promotion of cycle helmet wearing by children. Art. No.: CD003985. DOI: 10. 1002/14651858.CD003985.pub2

Excellent: Province/territory has legislation requiring all cyclists to wear helmets with financial penalties for non-compliance. Parents are responsible for ensuring their child is wearing a helmet.
Good: Province/territory has legislation requiring all cyclists under 18 years to wear a helmet.
Poor: Province/territory has no legislation on bike helmets.

Bicycle helmet legislation			
Province/Territory	**2007 Status**	**2009 Status**	**Comments**
British Columbia	Excellent	Excellent	Helmets mandatory for all ages. Parents of children under 16 years must ensure use of a properly fitted helmet. Enforced through fines of up to $100. Education programs in place.
Alberta	Good	Good	Helmets mandatory only for those under 18 years. Parents of children under 16 must ensure use of a properly fitted helmet. Enforced through $69 fine. Education programs in place.
Saskatchewan	Poor	Poor	No provincial bicycle helmet legislation. Some bike helmet education programs.
Manitoba	Poor	Poor	No provincial bicycle helmet legislation. Low-cost bike helmet program available for children. Education and awareness campaign in place.
Ontario	Good	Good	Helmets mandatory only for those under 18 years. Parents of children under 16 must ensure use of a properly fitted helmet. Enforced through $60 fine.
Quebec	Poor	Poor	No provincial bicycle helmet legislation. Several bike helmet education programs in place.
New Brunswick	Excellent	Excellent	Helmets mandatory for all ages, enforced through $21 fine.
Nova Scotia	Excellent	Excellent	Helmets mandatory for all wheeled activities (bicycling, skateboard and in-line skating), whether on public or private lands and roads, skate parks or playgrounds. Enforced through fines up to $128.75 for adults or parents of children under 16 who knowingly violate the law. Education campaign and research programs in place.
Prince Edward Island	Excellent	Excellent	Helmets mandatory for all ages. Parents of children under 16 years must ensure use of a properly fitted helmet. Enforced through fines up to $100. Annual public awareness campaigns exist.
Newfoundland and Labrador	Poor	Poor	No provincial bicycle helmet legislation.
Yukon	Poor	Poor	No territorial bicycle helmet legislation.
Northwest Territories	Poor	Poor	No territorial bicycle helmet legislation.
Nunavut	Poor	Poor	No territorial bicycle helmet legislation.

Injury Prevention

All-terrain vehicle (ATV) safety legislation

ATVs are used widely in rural Canada for work, recreation and transportation. These vehicles are dangerous when used by children and young adolescents, who lack the knowledge, physical size and strength, and cognitive and motor skills to operate them safely. Youth aged 15 to 19 account for the majority of ATV injury-related emergency department visits, with those younger than 16 years old accounting for 30% or more of ATV injury hospitalizations[1].

In the nine years that data has been collected (1996-2004), the ATV-related injury admission rate has increased in Canada from 5.8 to 9.1 per 100,000, despite a 6.7% decrease in the number of ATVs sold annually since 2000[2].

The year after Nova Scotia restricted youth under the age of 14 from operating ATVs, there was a 50% reduction in ATV-related injuries in that age group. ATV-related injuries among youth 14 to 15 years did not change significantly[3].

Based on this and other evidence, the Canadian Paediatric Society recommends that provinces and territories introduce and enforce off-road vehicle legislation that requires the following:

- minimum operator age of 16 years,
- restricting passengers to the number for which the vehicle was designed,
- compulsory helmet use with no exemptions,
- mandatory training, licensing and registration, and
- banning the use of three-wheeled vehicles.

The CPS is disappointed with lack of legislation in most provinces and territories to date.

1. Injury Prevention Committee, Canadian Paediatric Society. Preventing injuries from all-terrain vehicles. Paediatr Child Health 2004;9(5): 337-340, retrieved November 19, 2009 from www.cps.ca/english/statements/ip/ip04-01.htm
2. Canadian Institute for Health Information, National Trauma Registry Analysis in Brief: ATV Injury Hospitalizations in Canada, 2004–2005, Toronto: CIHI, 2007, retrieved November 19, 2009 from www.cihi.ca/cihiweb/en/downloads/ATV_AIB_2007_e.pdf
3. Safe Kids Canada, All Terrain Vehicles, retrieved November 19, 2009 from www.safekidscanada.ca/SKCPublicPolicyAdvocacy/section.asp?s=All+Terrain+Vehicles+%28ATVs%29&sID=22252

Excellent: ATVs banned for children under 16 years old, mandatory driver education and mandatory helmet use.
Good: ATVs banned for children under 14 years, mandatory driver education, mandatory helmet use.
Fair: Some requirement for adult supervision for children under 15 years, restrictions on where youth under 16 years can operate an ATV.
Poor: Province/territory has no ATV legislation, or the minimum driver age is extremely low.

All-terrain vehicle (ATV) safety legislation			
Province/Territory	**2007 Status**	**2009 Status**	**Comments**
British Columbia	Poor	Poor	No legislation on the use of ATVs. No legislation on helmet use.
Alberta	Poor	Poor	No minimum driver age. Drivers under 14 years cannot drive on highways, and must be supervised by an adult on public property. No requirements for helmet use, training or licensing.
Saskatchewan	Fair	Fair	Legislation states minimum age of 16 years with following exceptions: children under 16 may operate an ATV on family-owned land; children 12 to 15 years may operate an ATV under supervision. Helmets only required on public land.
Manitoba	Fair	Fair	No minimum driver age. An adult must accompany and supervise drivers under 14 years. Helmets mandatory (with a few exceptions such as farming, hunting, trapping). Safety courses are available but not mandatory.
Ontario	Fair	Fair	No minimum driver age. Drivers under 12 years cannot use an ATV on public property, and must have adult supervision on private property. Must have driver's license to use an ATV on highways. Helmets mandatory (except on land occupied by the vehicle owner). Safety courses are available but not mandatory.
Quebec	Excellent	Good	Minimum driver age of 16 years, as of 2006. New regulations in 2009 allow children under 16 to operate youth-size ATVs. Drivers 16–17 years must take a course to obtain certificate of competence. Helmets mandatory.
New Brunswick	Fair	Fair	Effective 2009, whether on public or private property, children under 16 must be supervised by an adult. Both must successfully complete an approved safety training course. Those between 6 and 13 are restricted to operating age-appropriate off-road vehicles only on closed courses. Must be 16 years to drive on the highway. Helmets mandatory.
Nova Scotia	Fair	Fair	Off-highway Vehicle Act (2006) states that ATV drivers must be 16 years and over to operate a machine on their own. Children under 14 years require adult supervision and can only operate an ATV on a closed course under prescribed conditions. Both adults and children must complete a safety course. Helmets mandatory.
Prince Edward Island	Fair	Fair	Off-highway Vehicles Act sets 14 as minimum driver age. Children under 14 years may operate ATVs with supervision by an adult with a valid driver's license. Conditions imposed for drivers aged 14–16 years. Helmets mandatory.
Newfoundland and Labrador	Good	Good	Minimum age to operate a full-sized ATV is 16 years. Children under 14 years cannot operate an ATV. Youth 14–16 years can use 90 CC ATVs with adult supervision. Safety awareness campaign is proposed but no mandatory course. Helmets mandatory.
Yukon	Poor	Poor	No ATV-related legislation.
Northwest Territories	Fair	Fair	No minimum driver age. Drivers must be over 14 years to use an ATV on highways. An infant may be transported on an ATV when in a carrying device worn by the driver or passenger. Helmets mandatory.
Nunavut	Fair	Fair	No minimum driver age. Drivers must be over 14 years to use an ATV on highways. An infant may be transported on an ATV when in a carrying device worn by the driver or passenger. Helmets mandatory.

Injury Prevention

Booster seat legislation

Motor vehicle collisions are the leading cause of injury-related death among Canadian children[1]. Child passenger restraints reduce the risk of serious injury by 40% to 60%[2,3].

Although all provinces and territories legislate the use of restraint systems for children up to about 4 years old, children aged 4 to 8 years often graduate prematurely to seat belt use, increasing their risk of injury, disability and death. In a collision, children using seat belts instead of back-seat booster seats are 3.5 times more likely to suffer a serious injury and 4 times more likely to suffer a head injury[4]. Still, booster seats are under-used, with less than one-third (28%) of parents of children aged 4 to 9 reporting that they use them[5].

The CPS recommends that provinces and territories amend their legislation to require that children of 18 kg to 36 kg be properly secured in booster seats in the back seat when traveling in a vehicle. This legislative change should be complemented by appropriate enforcement measures and public education programs that help parents to understand and adopt the proper use of booster seats. Further, legislation should be uniform across Canada to make it easier for parents to comply with the regulations.

1. Public Health Agency of Canada. Child and Youth Injury in Review, 2009 Edition – Spotlight on Consumer Product Safety. Ottawa, 2009, retrieved November 19, 2009 from www.phac-aspc.gc.ca/publicat/cyi-bej/2009/index-eng.php
2. Dalmatas D, Kryzewski J. Restraints system effectiveness as a function of seating position. Society of Automotive Engineering. Publication #807 371. 1980
3. Ramsay A, Simpson E, and Rovera FP. Booster seat use and reasons for non-use. Pediatrics 2000;106(2):e20
4. Winston FK, Durbin DR, Kallan MJ and Moll EK. The danger of premature graduation to seat belts for children in crashes. Pediatrics 2000;105(6):1179-83
5. Safe Kids Canada, Booster Seat Use in Canada: A National Challenge, June 2004, retrieved November 19, 2009 from www.safekidscanada.ca/SKCForPartners/custom/EnglishReport_BoosterSeats.pdf

Excellent:	Legislation requires children to be in an approved booster seat until they reach the height of 145 cm or 9 years of age, and a minimum weight of 18 kg to 36 kg. Public education programs are in place.
Good:	Legislation requires children to be in an approved booster seat until they reach the height of 145 cm or an age specified as less than 9 years, and a minimum weight of 18 kg to 22 kg. Public education programs are in place.
Fair:	Booster seat is required after child safety seat, but legislation is based on age and/or weight criteria, without mentioning height. Public education programs are in place.
Poor:	No booster seat legislation on children over 18 kg.

Booster seat legislation			
Province/Territory	**2007 Status**	**2009 Status**	**Comments**
British Columbia	Good	Excellent	Effective July 1, 2008, car booster seat legislation in place, with appropriate age, weight and height restrictions. Some education programs in place; incentive provides free seats to families in need.
Alberta	Fair	Poor	No booster seat legislation; however, examining possibility of booster seats legislation for children under 8 years weighing less than 37 kg. Children under 6 years weighing less than 18 kg must be properly secured in a front-facing child safety seat. Some public education programs in place.
Saskatchewan	Fair	Poor	No booster seat legislation. Children under 18 kg must be in a child restraint system. Some public education programs, and a program to provide child safety seats to those who can not afford them.
Manitoba	Fair	Poor	No booster seat legislation. Children under 5 years weighing less than 22 kg must be properly secured in an approved child safety seat. Revised legislation being considered.
Ontario	Excellent	Excellent	Booster seat legislation in place, with appropriate age, weight and height restrictions. More drivers required to use child car seats when travelling with toddlers, such as babysitters and grandparents as well as primary caregivers. Education and incentive programs in place.
Quebec	Fair	Good	Children with a sitting height (from the seat to the top of the head) of under 63 cm must use a restraint system or booster cushion. Public awareness programs exist.
New Brunswick	Fair	Excellent	Effective 2008, car booster seat legislation in place, with appropriate age, weight and height restrictions. Children under 5 years weighing less than 18 kg must be properly secured in a front-facing child safety seat. Some public education programs.
Nova Scotia	Excellent	Excellent	Booster seat legislation in place, with appropriate age, weight and height restrictions. Anyone transporting children must properly secure them in an infant seat, child seat, or booster seat. Public education programs and incentives exist.
Prince Edward Island	Fair	Excellent	Effective 2008, car booster seat legislation in place, with appropriate age, weight and height restrictions. Some public education programs.
Newfoundland and Labrador	Fair	Excellent	Effective 2008, car booster seat legislation in place, with appropriate age, weight and height restrictions. Children under 5 years weighing less than 18 kg must be properly secured in a front-facing child safety seat. Some public education programs.
Yukon	Fair	Fair	Booster seat legislation currently under development. Children under 6 years must be secured in a child restraint system. Various requirements depending on a child's weight. Some public education and incentive programs.
Northwest Territories	Fair	Poor	No booster seat legislation. Children weighing less than 18 kg must be properly secured in a front-facing child safety seat. Some public education programs.
Nunavut	Fair	Poor	No booster seat legislation. Children weighing less than 18 kg must be properly secured in a front-facing child safety seat.

Injury Prevention

Snowmobile safety legislation

In Canada, snowmobiling has the highest rate of serious injury of any popular winter sport, with younger people the most likely victims of such injuries[1]. Head injuries are the leading cause of mortality and serious morbidity associated with snowmobiling, usually arising when snowmobiles collide or overturn and snowmobilers fall during operation. Children have also been injured while being towed by snowmobiles in a variety of devices. No uniform code of provincial or territorial laws governs the use of snowmobiles by children and youth, making it confusing for parents, who may well cross provincial/territorial boundaries while snowmobiling.

There is little evidence to support the effectiveness of operator safety certification, and no research on its influence on snowmobile-related injuries to people younger than 16 years of age. Also, many children and adolescents do not have the required strength and skills to operate a snowmobile safely.

The Canadian Paediatric Society recommends that children and youth under 16 years of age not be permitted to engage in recreational operation of snowmobiles. Snowmobiles should not be used to tow anyone on a tube, tire, sled or saucer. The CPS also recommends a graduated licensing program for snowmobilers 16 years and older[2].

1. Canadian Institute for Health Information. Most snowmobile-related injuries occur in February (news release, January 25, 2006). retrieved November 13, 2009 from secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_25jan2006_e
2. Canadian Paediatric Society, Injury Prevention Committee. Recommendations for snowmobile safety. Paediatr Child Health 2004;9(9): 639-642, retrieved November 19, 2009 from www.cps.ca/english/statements/ip/ip04-02.htm

Excellent:	Snowmobile safety legislation prohibits children under 6 years as passengers, and youth under 16 years from operating snowmobiles for recreational purposes. Youth 16 years or over with a graduated driver's license may operate snowmobiles after completing an approved training program. Helmets are mandatory.
Good:	Snowmobile safety legislation with a minimum driver age of 14 years, requires drivers to complete an approved training program, and places restrictions on snowmobile use. Helmets are mandatory.
Fair:	Some requirement for adult supervision for children and youth under 15 years, and restrictions on where youth under 16 years can operate a snowmobile. Helmets are mandatory.
Poor:	No legislation covering the use of snowmobiles by children and youth, or the minimum age for operation is less than 14 years.

Snowmobile safety legislation

Province/Territory	2007 Status	2009 Status	Comments
British Columbia	Poor	Poor	No specific legislation, and no minimum age limit. All snowmobiles must be registered. Helmets and training not mandatory.
Alberta	Poor	Poor	Drivers must be at least 14 years to operate a snowmobile independently. Children under 14 must be accompanied by an adult, or supervised closely. No age minimum on private land. No helmet required, unless by municipal bylaw. No operator training required and no license required unless on a highway.
Saskatchewan	Good	Good	Drivers on public property must have a valid driver's license, be at least 16 years old, have completed a safety course. Restrictions on drivers 12-15 years. Helmets mandatory for operators and passengers with some exceptions.
Manitoba	Fair	Fair	Children under 14 years can operate snowmobiles under close adult supervision. Drivers must be 16 and have a driver's license to cross a roadway. With some exceptions, snowmobile riders must wear a helmet, but safety courses not mandatory.
Ontario	Fair	Fair	Drivers must be at least 16 years old and have a driver's license or motorized snow vehicle operator's license (MSVOL) to cross a road or go on trails. Anyone 12 years or older with a MSVOL or a license from another jurisdiction may drive on trails. Helmets mandatory for drivers and passengers.
Quebec	Excellent	Excellent	Minimum driver age is 16 years. Riders aged 16-17 years must complete a training course and have a certificate of competence. Helmets mandatory.
New Brunswick	Fair	Good	Effective 2009, children under 16 years can operate snowmobiles supervised by an adult who has completed an approved safety training course. Children under 16 must complete an approved safety course. Children between ages 6 and 13 restricted to age-appropriate off-road vehicles only on closed courses. Helmets mandatory.
Nova Scotia	Good	Good	Children under 16 years cannot operate off-highway vehicles alone. Children 14–15 require direct parental/guardian supervision and both child and parent must complete an approved safety training course. Drivers under 14 years must stay on private property or a designated trail under certain conditions. Helmets mandatory for drivers and passengers.
Prince Edward Island	Fair	Fair	Drivers must be at least 14 years or closely supervised by an adult with a valid driver's license. Helmets mandatory for drivers and passengers. Annual safety campaign.
Newfoundland and Labrador	Poor	Poor	Minimum driver age 12 years. Children 13 years and older can drive a snowmobile without supervision. Children under 13 may operate a snowmobile with adult supervision. Helmets and training not mandatory.
Yukon	Fair	Fair	Drivers must be at least 16 years to operate a snowmobile on a highway. Helmets mandatory for drivers and passengers.
Northwest Territories	Fair	Fair	Drivers must be at least 14 years to operate a snowmobile on a highway, and at least 16 to cross a roadway/shoulder or operate on a snow-packed surface. Helmets mandatory on highways. Infants may be transported on a snowmobile when in a carrying device worn by the driver or passenger.
Nunavut	Fair	Fair	Drivers must be at least 14 years to operate a snowmobile on a highway, and at least 16 to cross a roadway/shoulder or operate on a snow-packed surface. Helmets mandatory on highways. Infants may be transported on a snowmobile when in a carrying device worn by the driver or passenger.

Best Interests of Children and Youth

Child poverty

Health disparities among Canadian children and youth are primarily linked to differences in family socioeconomic status.[1,2] Poor children are at greater risk of low birth weight (<2500 grams) and poor physical and emotional health as they get older[3]. They tend to have more behavioural issues and achieve lower levels of education, further increasing their chances of lifelong poverty as adults[4]. Chronic poverty is particularly harmful to young children and is associated with increased risk of mortality and morbidity[5].

Low-income families often live under stressful conditions that may impinge on healthy family functioning. Two-thirds of low-income families cannot afford stable housing[6]. Poor children's health and development is also more likely to be compromised by a lack of nutritious food and reliance on calorie-rich, nutrient-poor foods[7]. In many families, both parents work long hours at several different jobs, increasing stress and reducing the time they can spend with their children.

In 1989, the House of Commons unanimously resolved to end child poverty by the year 2000. Despite a decade of unprecedented economic growth beginning in 1996, the number of Canadian children living in poverty in 2007 (9.5%) was only slightly better than it was in 1989 (11.9%)[8]. In 2007, about one in 10 non-Aboriginal and one in four Aboriginal children and youth in Canada were living in low-income families[8,9]. These figures do not reflect the impact of the 2008-2009 recession, which caused significant job losses. Based on the experience of past recessions, poverty rates are expected to increase in 2008 and beyond[10].

By far the greatest number of these lived in single-parent families headed by women. In Canada, over half of lone-parent families live in poverty (51.6%), compared with Sweden's rate of 6.7%[11]. Children with disabilities and those from recent immigrant families are over-represented among the poor.

Internationally, Canada ranks 12th out of 21 OECD countries on child well-being, well behind all the Scandinavian countries, where child poverty rates are less than 5%[12].

The Canadian Paediatric Society calls upon all levels of government to set targets and timetables, and to engage in widespread social and political collaboration to significantly reduce child and youth poverty. Specific attention is required for Aboriginal, disabled and immigrant populations. A number of evidence-based solutions are available, including income support measures, education and job training, and high-quality child care programs[1,2].

The CPS believes child and youth poverty rates should carry the same political import as rates of interest, inflation and employment. Public reports, including this one, should track progress on this critical health issue.

1. Lemstra M, Neudorf C. *Health Disparity in Saskatoon: analysis to intervention*, Saskatoon: Saskatoon Health Region; 2008
2. Health Officers Council of BC, *Health Inequities in British Columbia: Discussion Paper*, November 2008, retrieved on November 19, 2009 from www.bchealthyliving.ca/files/HOC_Inequities_Report.pdf

3. Irwin LG, Siddiqi A, Hertzman C, (2007) Early *Child Development: A Powerful Equalizer*, Final Report for the World Health Organization's Commission on the Social Determinants of Health
4. Conference Board of Canada (2009), Child Poverty, retrieved November 13, 2009 from http://conferenceboard.ca/HCP/Details/society/child-poverty.aspx
5. Séguin L, et al. Duration of Poverty and Child Health in the Quebec Longitudinal Study of Child Development: Longitudinal Analysis of a Birth Cohort, PEDIATRICS Volume 119, Number 5, May 2007
6. Rothman L. Oh Canada! Too many children in poverty for too long, Paediatr Child Health. 2007 October; 12(8): 661–665
7. Cook J, Frank D. Food Security, Poverty, and Human Development in the United States. Ann. N.Y.Acad. Sci. Oct 2008
8. Campaign 2000. 2009 Report Card on Child and Family Poverty in Canada, retrieved November 13, 2009 from www.campaign2000.ca/reportcards.html
9. Statistics Canada's low-income cut-offs (LICOs) – the income level at which a family may be in "straitened circumstances" because it has to spend significantly more of its income on the basics (food, shelter and clothing), than does the average family
10. National Council of Welfare, Poverty Profile 2007, retrieved November 13, 2009 from www.ncwcnbes.net/en/research/poverty-pauvrete.html
11. Hunsley T. Lone parent incomes and social policy outcomes: Canada in international perspective. Kingston: School of Policy Studies, Queen's University; 1997
12. UNICEF, Child poverty in perspective: An overview of child well-being in rich countries, *Innocenti Report Card 7*, 2007. UNICEF Innocenti Research Centre, Florence, retrieved November 19, 2009 from www.unicef-irc.org/publications/pdf/rc7_eng.pdf

The following criteria refer to effort and action taken. In no case should a rating be taken to mean that no further work is required to address child poverty.

Excellent:	Province/territory has had anti-poverty legislation promoting long term action and government accountability for at least three years. Also has a poverty reduction strategy with specific targets. Child poverty rate is currently in the lowest quartile compared to other jurisdictions.
Good:	Province/territory has a comprehensive poverty reduction strategy with specific targets. Child poverty rate is currently in the second lowest quartile.
Fair:	Province/territory has a poverty reduction strategy but without specific targets. Child poverty rate is currently in the second highest quartile.
Poor:	The province territory has no anti-poverty legislation or poverty reduction strategy.

Best Interests of Children and Youth

ARE WE DOING ENOUGH?
2009 EDITION

25

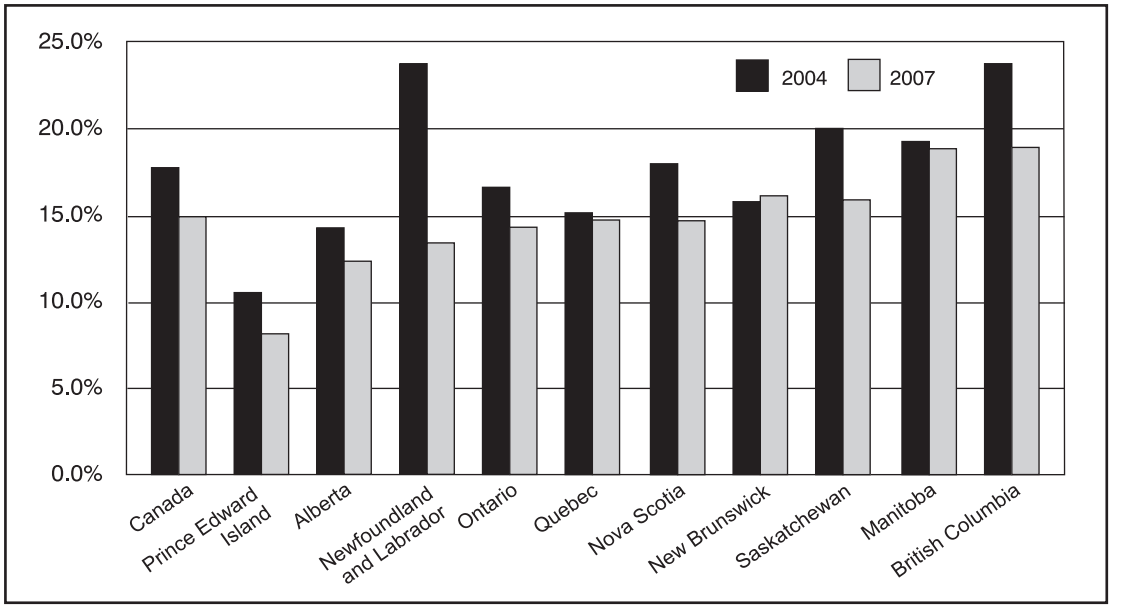
Child poverty

Province/Territory	2009 Status	Comments
British Columbia	Poor	Has neither legislation nor a strategy to reduce child poverty. Currently has the highest child poverty rate in the country.
Alberta	Poor	Has neither legislation nor a strategy to reduce child poverty. Currently has the second lowest child poverty rate in the country. Does offer some extended health benefits for children whose parents receive financial support from the province.
Saskatchewan	Poor	Has neither legislation nor a strategy to reduce child poverty. Currently has the 4th highest child poverty rate in the country.
Manitoba	Fair	Launched a poverty reduction strategy in 2009. Strategy addresses housing, education, jobs, and income support through accessible and coordinated services. No targets are currently identified; an interdepartmental group will monitor progress. Child poverty rate is the second highest in the country.
Ontario	Good	Adopted anti-poverty legislation and a poverty reduction strategy in 2009. Strategy addresses access to health services, housing and specific challenges of vulnerable populations. Has set target to reduce child poverty rate by 25% by 2015. A cabinet level committee is responsible. The province has the 4th lowest poverty rate in the country.
Quebec	Excellent	Adopted anti-poverty legislation and a poverty reduction strategy in 2002. Strategy addresses the economic safety net, access to employment, early childhood and whole community involvement. Has set a target to be one of the industrialized societies with the lowest rate of poverty. A ministerial committee oversees the strategy. Poverty rating is on par with Canadian average.
New Brunswick	Poor	No poverty reduction strategy or legislation, although it is considering an anti-poverty strategy. Has the 3rd highest poverty rate in the country.
Nova Scotia	Fair	Adopted a poverty reduction strategy in 2009. The strategy addresses job creation with a focus on early child development. The goal is to break the poverty cycle by 2020. A ministerial committee oversees the strategy. Poverty rating is on par with Canadian average.
Prince Edward Island	Poor	No poverty reduction strategy or legislation, although it is considering an anti-poverty strategy. While the province has the lowest child poverty rate in the country, Statistics Canada warns that this result should be used with caution, as the sample size is very low.
Newfoundland and Labrador	Excellent	Adopted an anti-poverty strategy in 2006. The strategy addresses access to services, stronger social safety net, incomes, early child development, and education. Has 20 measurable outcomes to be reviewed in 2010. A ministerial committee oversees the strategy. Has 3rd lowest child poverty rate.
Yukon	Fair	Recently announced a social inclusion strategy, which addresses poverty issues. The strategy will be based on evidence-based research and will measure social indicators for government decision-making. Comparable poverty rates are not available.
Northwest Territories	Poor	Has neither legislation nor a strategy to reduce child poverty. Comparable child poverty rates are not available.
Nunavut	Poor	Has neither legislation nor a strategy to reduce child poverty. Comparable child poverty rates are not available.

Child poverty in Canada and provinces 2004-2007

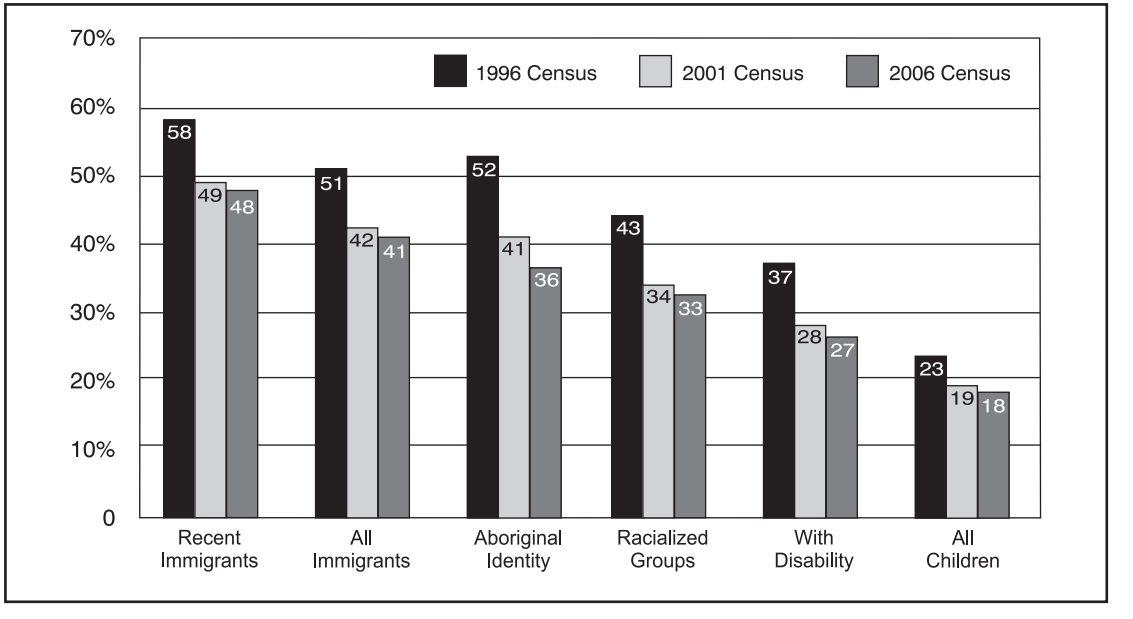
Source: Campaign 2000. 2009 Report Card on Child and Family Poverty using Statistic Canada's *Income Trends in Canada 1976 – 2007*, Table 802. Used with permission.

Note: PEI data should be used with caution due to small sample sizes, per Statistics Canada. Figures are LICO Before Tax.



Child poverty rates for selected social groups in Canada: Children 0-14 years, 1996-2006

Source: Campaign 2000. 2009 Report Card on Child and Family Poverty using Statistics Canada, 2006, 2001 & 1996 Census through the Toronto Social Research and Community Data Consortium (2006) and the Community Social Data Strategy (1996-2001). Used with permission.



Best Interests of Children and Youth

Jordan's Principle

Jordan's Principle is a child-first principle intended to resolve jurisdictional disputes involving the care of First Nations children. If federal and provincial/territorial governments adopted and implemented Jordan's Principle, First Nations children would no longer face delays or disruptions in essential medical and health services while governments argue over who will pay the bill. A recent research report indicates that jurisdictional disputes involving the costs of caring for First Nations children are common, with nearly 400 occurring in 12 sample First Nations child and family service agencies in one year alone[1].

Jordan's Principle honours a young First Nations child from Norway House, Manitoba, who was born with complex medical needs and languished in hospital for two years while the federal and provincial governments argued over who would pay for his at-home care. Jordan died in hospital, having never spent a day in a family home[2].

While almost all provinces and territories have adopted Jordan's Principle, none has yet developed or is following an implementation plan. Meanwhile, First Nations children continue to be the victims of administrative impasses.

The Canadian Paediatric Society urges governments to implement Jordan's Principle without delay and to provide First Nations children and youth with the care to which they are entitled.

1. First Nations Child and Family Caring Society of Canada. Wen:De: We are Coming to the Light of Day. 2005, retrieved November 19, 2009 from www.fncfcs.com/docs/WendeReport.pdf
2. Lavallee, Trudy. Honouring Jordan: Putting First Nations Children first and funding fights second. Paediatr Child Health 2005:10(9):527-9

Excellent:	Province/territory has adopted and created mechanisms for implementing a child-first principle to resolving jurisdictional disputes involving the care of First Nations children and youth.
Good:	Province/territory has a dispute resolution process with a child-first principle for resolving jurisdictional disputes involving the care of First Nations children and youth.
Fair:	Province/territory has adopted a child-first principle to resolving jurisdictional disputes involving the care of First Nations children and youth, but has not yet developed an implementation strategy.
Poor:	Province/territory has not adopted a child-first principle.

Jordan's Principle			
Province/Territory	**2007 Status**	**2009 Status**	**Comments**
British Columbia	Poor	Fair	Has introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth, but there is not yet a documented implementation plan.
Alberta	Poor	Poor	Has not introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth.
Saskatchewan	Poor	Fair	Has introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth. A interim implementation plan has received unanimous support from First Nations leadership in the province. A long-term implementation plan is still needed.
Manitoba	Poor	Fair	Has introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth, but there is not yet a documented implementation plan.
Ontario	Poor	Fair	Has introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth, but there is not yet a documented implementation plan.
Quebec	Poor	Poor	Has not introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth.
New Brunswick	Poor	Poor	Has not introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth.
Nova Scotia	Good	Good	Tripartite agreement between federal government, province and Mi'kmaq Family and Children's Services that provides a mechanism for dispute resolution in addressing children's needs, including special medical requirements.
Prince Edward Island	Poor	Poor	Has not introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth.
Newfoundland and Labrador	Poor	Poor	Has not introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth.
Yukon	Poor	Poor	Has not introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth.
Northwest Territories	Poor	Poor	Has not introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth.
Nunavut	Poor	Poor	Has not introduced a child-first policy to resolving jurisdictional disputes involving the care of First Nations children and youth.

Best Interests of Children and Youth

Child and youth advocate

Almost twenty years ago (May 1990), Canada signed the United Nations Convention on the Rights of the Child, recognizing that children and youth require special care and protection. While Canada agreed to protect and ensure children's rights, there is no mechanism to hold the government accountable for its commitment before the international community.

UNICEF has noted that "without independent institutions focusing entirely on the rights of children, these rights will rarely receive the priority they deserve. The main task for such institutions is … ensuring that rights are translated into law, policy and practice"[1].

With the exceptions of PEI, the Northwest Territories and Nunavut, all provinces and territories have child and youth advocates. However, most are focused only on children and youth in care. To be effective, their mandates must encompass all children and youth, and they must be independent and meaningfully empowered to protect the unique rights and interests of all children and youth.

At the federal level, a 2007 Senate committee on human rights recommended that Canada establish an independent Children's Commissioner to monitor protection of children's rights and ensure that the federal government is held publicly accountable for fulfilling its responsibilities with respect to child and youth protection[2]. This recommendation remains unaddressed.

1. UNICEF. Independent Institutions Protecting Children's Rights. Innocenti Digest No. 8, June 2001
2. Standing Senate Committee on Human Rights. Children: The Silenced Citizens. Effective implementation of Canada's international obligations with respect to the rights of children. April 2007, retrieved November 19, 2009 from www.parl.gc.ca/39/1/parlbus/commbus/senate/Com-e/huma-e/rep-e/rep10apr07-e.htm

Excellent:	Province/territory has a child and youth advocate who is independent, reports to the legislature, and has broad-based powers to monitor, investigate and ensure compliance with findings/recommendations at both the individual and systemic levels.
Good:	Province/territory has a child and youth advocate who reports to a government minister and has limited powers to monitor, investigate and implement recommendations regarding child/youth welfare at both the individual and systemic levels.
Fair:	Province/territory has a child and youth advocate who reports to a government minister and has limited powers to investigate the welfare of individual children and youth in care, but not address systemic issues.
Poor:	Province/territory has no child and youth advocate.

Child and youth advocate

Province/Territory	2007 Status	2009 Status	Comments
British Columbia	Good	Good	Representative for Children and Youth (March 2007) is independent, reports to the Legislative Assembly, and is mandated to comment publicly on issues affecting children and youth without government interference. Supports participation of children and youth in decision-making and the development of policy, programs and services. Advocates for children and families, monitors ministries or other public bodies, reviews and audits services, and reports on critical injuries and deaths in the child welfare system.
Alberta	Fair	Fair	Child and Youth Advocate provides individual and systemic advocacy, representing children in care. Submits reports to the Legislature through the Minister of Children's Services. May respond to referrals and requests for involvement and assistance and may also initiate a review or an investigation. Youth involved in decision-making processes.
Saskatchewan	Good	Good	Children's Advocate is independent, reports to the Legislative Assembly and provides impartial investigations and recommendations. May investigate any matter relating to children who receive services from government departments or agencies. Publishes annual report, which may include recommendations for systemic change. Youth involvement.
Manitoba	Fair	Good	Children's Advocate is independent, reports to the Legislative Assembly through the Speaker, conducts inquiries, investigates, reports on, and makes recommendations about issues relating to children and youth in care. Effective 2008, responsible for reviewing services after the death of any child in care, to improve safety and well-being of children and ensure no reoccurrences.
Ontario	Fair	Good	Children's Advocate is independent, reports to the Legislature, provides individual and systemic advocacy, represents children, youth and families in care, and provides education and advice on advocacy and rights of children. Youth are involved in the office's activities.
Quebec	Fair	Fair	The *Commission des droits de la personne et des droits de la jeunesse* is an independent agency that reports to the National Assembly. Promotes and upholds principles in the Charter of Human Rights and Freedoms. Intervenes in or investigates any case when it considers that the rights of a child or a group of children are infringed. Reviews proposed legislation to ensure it respects child rights.
New Brunswick	Fair	Good	Child and Youth Advocate, also the provincial Ombudsman, is an independent officer who reports annually to the Legislative Assembly through the Speaker. Mandate is to ensure that the rights and interests of children and youth are protected, that the views of children and youths are heard and considered, that children and youth have access to services, and to hear complaints about those services. Also provides information and advice to the government.
Nova Scotia	Fair	Fair	Youth services division of the Ombudsman's office investigates and resolves complaints from children and youth accessing youth-serving systems. Reports to the House of Assembly. Provides independent oversight and outreach services to youth in correctional facilities, the secure care facility, and residential child-caring facilities. Can examine systemic issues in the province's child and youth care system. May recommend changes to policies, practices, processes, guidelines, regulations or laws to ensure fairness.
Prince Edward Island	Poor	Poor	No child and youth advocate.
Newfoundland and Labrador	Good	Good	Office of the Child and Youth Advocate is an independent office of the House of Assembly and reports to the Speaker of the House. Mandated to protect and advance the rights of children and youth and to ensure their voices are heard, ensure children and youth have access to government services and programs, provide information and advice to government, and act as an advocate for children and youth. Can review and investigate any matter related to government services affecting children and youth whether or not a request or complaint is made. Children and youth are involved in the office.
Yukon	Poor	Fair	Child & Youth Advocate Act approved May 2009, enforcement date to be fixed by Commissioner in Executive Council. Child Advocate will report to Legislative Assembly, help youth in care navigate through designated government services, ensure views of children and youth are heard and considered, promote their rights and interests, and work with them to resolve issues through informal dispute resolution.
Northwest Territories	Poor	Poor	No child and youth advocate.
Nunavut	Poor	Poor	No child and youth advocate.

Federal Government Policies and Programs

As experience with the National Immunization Strategy shows, federal leadership can make an enormous difference in improving the health and well-being of Canada's youngest citizens.

In mental health and injury prevention, the federal government could strengthen the efforts of provinces/territories if it provided national research and surveillance, national policies that could be implemented at the provincial/territorial level, and national awareness and public education initiatives[1].

To address child poverty, the federal government has a pivotal role to play through its fiscal and social policies, including income security, social programs and incentives for action. It can also support parental and community capacity, generate and transfer knowledge, build societal support for action on the determinants of health, and foster action among different sectors. The federal government has direct responsibility for many of the children in greatest need: First Nations and Inuit children and youth.

High-quality, universal child care is too important to be subject to the vagaries of competing government positions. While a number of organizations produce detailed report cards on child care in the provinces and territories[2,3], the CPS is focusing its attention at the national level, addressed in more detail in the following section.

A Commissioner for Children and Youth would provide consideration for the needs of children and youth in all federal government initiatives that affect them. The CPS recommends that this position be created immediately[3].

1. Canadian Paediatric Society. Submission to the Standing Committee on Finance on the 2006 Pre-Budget Consultations (September 6, 2006), retrieved November 19, 2009 from: www.cps.ca/English/Advocacy/Reports/2006FinanceCommittee_Pre-BudgetSubmission.pdf
2. Friendly M, Beach J, Ferns C, Turiano M. Early Childhood Education and Care in Canada 2008, 8th edn. Toronto: Childcare Resource and Research Unit, 2008, retrieved November 13, 2009 from www.childcarecanada.org/ECEC2006/index.html
3. Canadian Labour Congress. Child care report cards, retrieved November 13, 2009 from www.canadianlabour.ca/action-center/womens-economic-equality/child-care-report-cards
4. Eggertson L. Physicians challenge Canada to make children, youth a priority. CMAJ 2007;176(12), retrieved November 13, 2009 from www.cmaj.ca/cgi/rapidpdf/cmaj.070593v1

Federal government programs and policies			
Indicator	**2007 Status**	**2009 Status**	**Comments**
National Immunization Strategy	Good	Good	Although the National Immunization Strategy is in place, the support for provincial child and youth vaccines programs is not permanent.
Measures to prevent and reduce adolescent smoking	(not rated)	Good	An October 2009 amendment to the *Tobacco Act* fully bans tobacco advertising in magazines and newspapers, and prohibits the sale of flavoured and small packages of 'cigarillos'.
National Child and Youth Mental Health Strategy	Fair	Fair	Mental Health Commission of Canada established (2007) to create an integrated mental health system, with advice from eight advisory committees, including one on children and youth. Key initiatives include a mental health strategy, an anti-stigma campaign, a knowledge exchange centre, and a strategy for homelessness. No national strategy or framework for child and youth mental health is currently in place.
National Injury Prevention Strategy	Poor	Poor	There is no National Injury Prevention Strategy.
Child poverty	(not rated)	Fair	Recent research highlighted considerable variation in the chronic disease status of low-income residents across Canada, due to differences in behaviours, social policy, and possibly the social environment. The study authors conclude that the right national anti-poverty strategy could improve health outcomes for vulnerable populations and eliminate the effects of poverty on health. Effective policy intervention would reduce inequities in health across Canada, and could also decrease the costs of chronic diseases to the health care system. The federal government has a specific responsibility to work with Aboriginal leadership in improving child poverty among First Nations. The past decade has seen caps on federal transfers to Aboriginal communities frozen at levels below the rate of inflation and Aboriginal population growth.
National Early Learning and Child Care Strategy	(not rated)	Poor	There is no national Early Learning and Child Care Strategy.
Jordan's Principle	Poor	Fair	Unanimous approval by all federal parties in House of Commons (December 12, 2007) for private member's motion supporting Jordan's Principle—a child-first policy to resolve federal/provincial jurisdictional disputes involving the care of First Nations children and youth. However, Jordan's Principle has not been implemented in any jurisdictions to date.
Commissioner for Children and Youth	Poor	Poor	There is no federal Commissioner for Children and Youth.

Federal Government Policies and Programs

Early learning and child care

Most Canadian children spend a significant amount of time in child care. Almost 80% of preschool-age children with employed or studying mothers are in some form of non-parental child care or early childhood program. Data on the quality of care and whether it meets parents' needs are not available[1].

There is strong and growing evidence that public investment in high-quality early childhood development programs leads not only to proven benefits to children and families, but also to governments and national economies. Numerous Canadian and international evaluations confirm that high-quality early learning and care enhances children's cognitive and social development, and that they later benefit from higher levels of school achievement, higher earnings, better health, lower rates of teenage pregnancy, less dependence on welfare, and less likelihood of criminal conduct. Perhaps not surprisingly, those living in poverty benefit most[2,3].

Unfortunately, access to quality child care is not equally available to all families. A Montreal-based survey showed that children four to five years of age who were in low-quality centres were significantly more likely to come from lower socioeconomic status families[4].

Child care is often expensive and consequently unaffordable for many Canadian families. Quebec and Manitoba are the only provinces that have fees set by the provincial government. According to a 2008 report by the Canadian Labour Congress, only 16% of Canadians have access to regulated child care, and 50% of such spaces are in Quebec[5].

In 2004, $5 billion over five years was allocated by the federal Liberal government towards affordable, government-regulated spaces[2], only to be rescinded by the subsequent Conservative government, which favoured the Universal Child Care Benefit of $100 per month taxable payment to parents of all children zero to six years of age. Federal support for a national child care program would ease the burden for all parents, and would enable many more parents on income support to re-enter the work force.

The Canadian Paediatric Society believes that early learning and child care must be universal, affordable, accessible and of high-quality. It calls upon the federal government to take a leadership role in developing a pan-Canadian strategy for early learning and child care. The CPS has developed a position paper that outlines criteria for quality care, including child-staff ratios, and staff training and remuneration[6]. Finally, the CPS calls for more quality research studies to clearly determine the health outcomes of non-parental care.

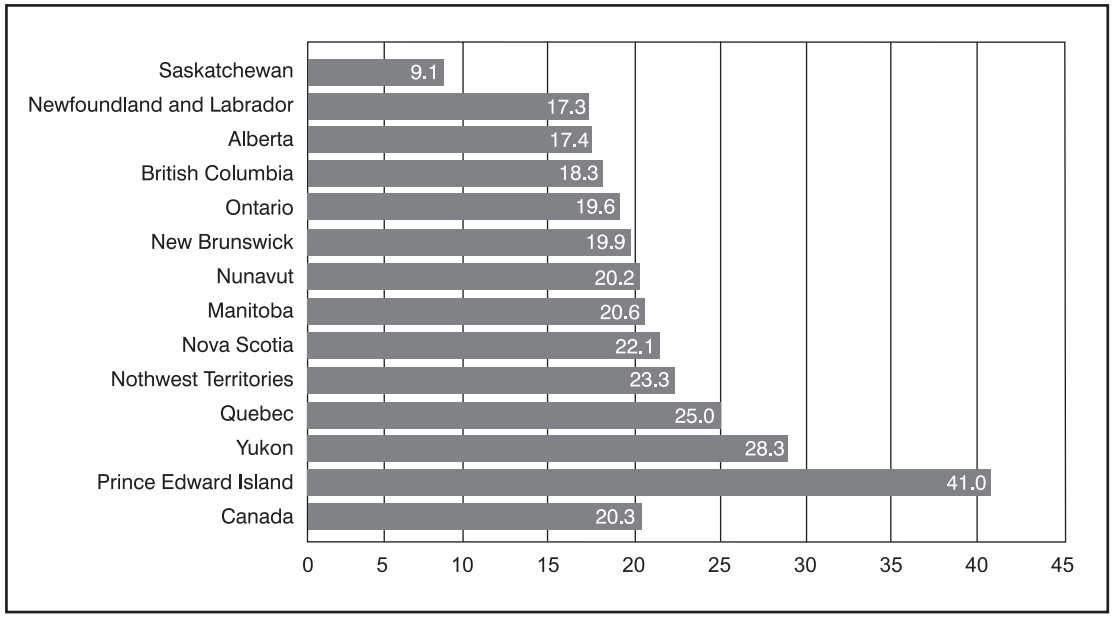
1. Cleveland et al, 2008, as cited in Beach et al, The State Of Early Childhood Education and Child Care in 2008, eighth edition, June 2009
2. Adamson, Peter. The child care transition: A league table of early childhood education and care in economically advanced countries, UNICEF, Innocenti Research Centre Report Card 8, 2008, retrieved November 19, 2009 from www.unicef-irc.org/cgi-bin/unicef/Lunga.sql?ProductID=507
3. Mustard, J. Fraser Experience-based Brain Development, Slide presentation, Centre of Excellence for Early Childhood Development, Quebec City, 25 May 2004
4. Hausfather A, Toharia A, LaRoche C, Engelsmann F. Effects of age of entry, day-care quality, and family characteristics on preschool behavior. J Child Psychol Psychiatry 1997;38:441-8
5. Canadian Labour Congress. Child care report cards, retrieved November 13, 2009 from www.canadianlabour.ca/action-center/womens-economic-equality/child-care-report-cards
6. Canadian Paediatric Society, Health implications of children in child care centres Part A: Canadian trends in child care, behaviour and developmental outcomes, Paediatr Child Health 2008;13(2):863-7, retrieved November 19, 2009 from www.cps.ca/english/statements/CP/cp08-02.htm

Percentage of children 0–5 years with regulated child care space – 2008

Source: Beach J, Friendly M, Ferns C, Prabhu N and Forer B (2009). 8th edition. Toronto: Childcare Resource and Research Unit. Adapted with permission.

Notes:

1. Number of children in regulated family child care by age group are usually not available.
2. For the purpose of comparison with other provinces, part-day kindergarten spaces are excluded from the calculations for Prince Edward Island.
3. Yukon provided total occupied spaces and total regulated spaces, but breakdown by type of service only for occupied spaces. Total regulated spaces have been used in all totals and calculations.

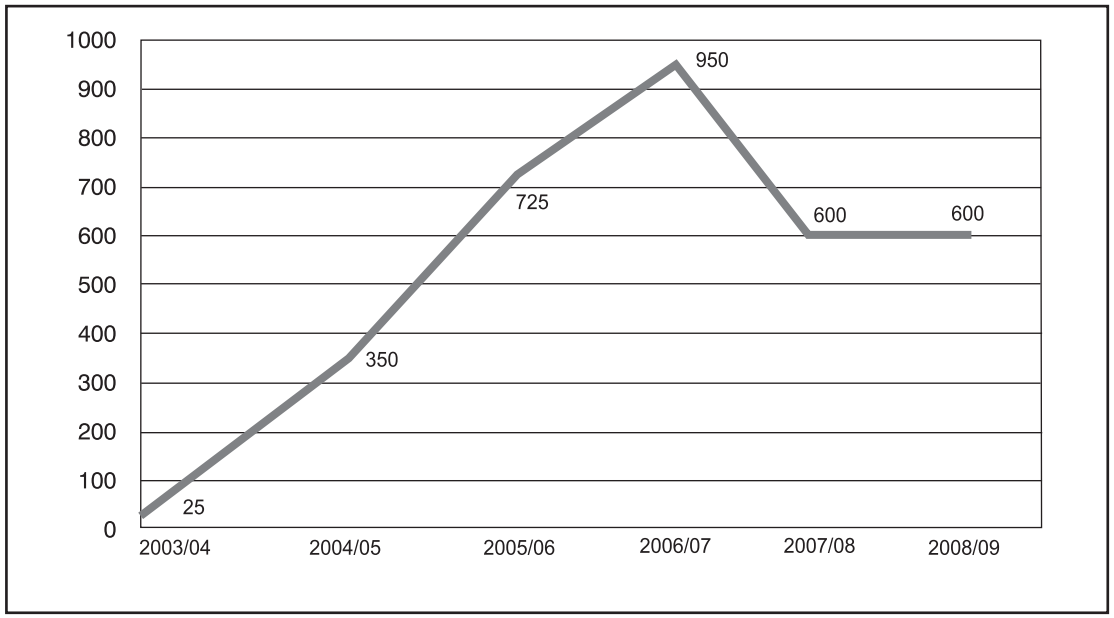


Federal transfers designated for early child education and care ($ millions)

Source: Beach J, Friendly M, Ferns C, Prabhu N and Forer B (2009). 8th edition. Toronto: Childcare Resource and Research Unit. Adapted with permission.

Note: In addition, $300 million in 2001/02, $400 million in 2002/03, $500 million in 2004/05, and $500 million in each fiscal year thereafter was transferred to provinces/territories under the Early Childhood Development Agreement (ECDA). These funds may be used for early learning and child care if a province/territory chooses. An escalator clause of 3% was applied to the ECDA agreement as of 2009/10.

Some of the funds in this chart are included in the Canada Social Transfer, a block fund intended for social programs. The full CST fund (cash portion) transferred to provinces was worth $8.3 billion in 2004/05; $8.4 billion in 2005/06 and $8.5 billion in 2006/07. The 2007 federal budget announced a steep increase in the CST so the cash portion will total $9.5 billion in 2007/08 and $10.8 billion in 2008/09. The federal budget extended the Multilateral Framework Agreement funds to 2013/14. The funds will grow by 3% annually as a result of the CST escalator.



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The Canadian Paediatric Society is the national association of paediatricians, committed to working together to advance the health of children and youth by nurturing excellence in health care, advocacy, education, research, and support of its membership.

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