



Taking the pulse of Canadian children

Health report card for the millennium

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The *Health of Canada's Children: A CICH Profile* was published for the first time in 1989 by the Canadian Institute of Child Health (CICH). In the mid-1990s, reviews^{1,2} of the 1994 *CICH Profile* 2nd edition appeared in *Canadian Family Physician* and *Paediatrics & Child Health*. This nationwide picture of child and youth morbidity and mortality called our attention to many disturbing trends in health determinants, indicators, and outcomes for children.

In August 2000, under the direction of Dr Graham Chance, the third *CICH Profile* was released.³ What progress have we made, what issues remain, and what new concerns have emerged with respect to the health of Canada's children?

No time to be complacent

The *CICH Profile* is the result of cross-country consultation and collaboration with leading experts on child health, including representatives from both the aboriginal sector and youth groups. The term "health" in the *CICH Profile* is used in its broadest holistic sense to encompass physical, emotional, intellectual, and spiritual facets. Although available data in some areas are local or anecdotal, the National Longitudinal Survey of Children and Youth (NLSCY) and the First Nations Inuit Regional Health Survey (FNIRHS) add substantially to the current edition.

This report confirms that most of Canada's children are healthy and remain an ethnically diverse, multicultural group, with 84.2% living in two-parent families. Among the youngest of our population, the infant mortality rate is at an historic low, aboriginal neonatal health has dramatically improved, and incidence of neural tube defects and sudden infant death syndrome has declined. Immunization rates have risen, and the death rate in all age groups has fallen.

Though the report is optimistic, we can hardly be complacent about the progress we have made. In 1989, there was a unanimous all-party decision to end child poverty by the year 2000. How are we doing? Sadly, child poverty rates have actually increased in the past 10 years, affecting as many as 20% of all children. Canada ranks ninth among industrialized nations in the Human Poverty Index-2,⁴ with Sweden having the best record in this regard. Greater income inequity translates into poorer population health: increased rates of low birth weight and its attendant morbidity; increased rates of emotional disturbance; decreased academic performance; and less involvement in activities positively affecting mental health, such as sports, music, and the arts.

During their pregnancies, 23% of women continue to smoke, and low birth weight rates have not changed appreciably in the past 10 years. Only 50% of women breastfeed their babies for the recommended 6 months. Almost 63% of women with children younger than 12 are in the work force, increasing the demands for good-quality child care and community supports. Despite the drop in overall death rates, the greatest single cause of mortality among children and adolescents remains injury (particularly falls), most of which occurs at home or at school and is largely preventable. Should we not invest in a national injury prevention strategy?

Many markers point to health issues involving Canadian youth. Quite a few adolescents are engaged in high-risk behaviours; 20% of 14-year-olds have engaged in sexual intercourse, and fewer than half used condoms. Teenage pregnancy rates are higher than they were in the 1980s (49/1000 in the 15 to 19 age range), and there is still no widespread comprehensive approach to this problem. Among adult smokers, almost one third began at age 12 or younger. Bicycle helmet

use declines to a mere 17% to 18% by grade 10, and more than a third of adolescents do not use seatbelts regularly. Youths aged 15 to 19 are second only to the 20- to 24-year-old age group in the proportion who drink and drive.

To increase health promotion opportunities, we can make our encounters with adolescents more "youth friendly" by being open, nonjudgmental, and respectful of their goals and objectives. Given that this group infrequently consults physicians, we need to reinforce healthy behaviours during every encounter.

The number of children with complex health care needs is unknown, but such needs have a profound effect on families. Most parents felt that their employment status was affected, and they had difficulty finding child care. Ninety-three percent of parents experienced moderate to severe tension juggling work, family, and child care. Little financial support is available for caregivers of children with disabilities, and there is no respite care.

Highlights of mental and environmental health

In this edition of the *CICH Profile*,³ two new chapters were added highlighting mental and environmental health. Nationally, parental perceptions of emotional, hyperactivity, and conduct symptoms in the 8 to 11 age group are disturbingly high, in the range of 30%, 40%, and 10%, respectively. Though this does not necessarily indicate the actual prevalence of disorders, it clearly identifies emotional and behavioural issues as a priority for all.

Other Canadian statistics are equally sobering. Twelve percent of female subjects aged 15 to 19 have experienced a major depressive episode, and male subjects in the same age group committed suicide at the rate of 18.5/100 000. An Ontario survey of adults' past experiences showed that 31% of men and 21% of women had been physically assaulted as children. Despite a lack of national data, we know the health issues facing street youths and children with disabilities are of concern. Street youths have higher rates of attention deficit disorder and other learning difficulties. Almost all of them have experienced some form of abuse, and they are at higher risk of suicide. Children with disabilities are also more likely to report emotional distress, low self-esteem, and abuse. Similarly, the FNIRHS indicates that aboriginal youths have high rates of depression and alarmingly high rates of suicide. In addition, they are one of the fastest growing segments of the population infected with human immunodeficiency virus.

As physicians, we must promote resilience to improve mental health in children. Participating

in sports, recreation, and leisure activities encourages inclusion, development of new skills, and hence self-esteem. Spirituality, defined as a connection to music, culture, arts, and the community, is emerging as an important determinant of health. Access to these programs should be universal. Children and adolescents who have a close and caring relationship with at least one adult and competence in at least one area are less likely to engage in risky behaviour.

Environment and our children

The environment is another health determinant. Even though questions concerning its health implications are largely unanswered, the effect of environmental toxins on children is greater than on adults because children are more vulnerable due to their physiologic and developmental characteristics. The dramatic rise in the prevalence of asthma might be associated with exposure to environmental toxins, including active and passive smoking, exposure to many viruses at younger ages, or simply improved diagnosis. These concerns have prompted development of the "precautionary principle." When evidence suggests that an activity threatens health, measures should be taken to prevent it even if cause-and-effect relationships are not fully established. Proponents of the precautionary principle should not create unfounded fear in the population and should continue to collect scientific evidence; opponents need to ask themselves how much risk they are willing to accept.

The *CICH Profile* raises as many questions as it answers. Many questions are directly relevant to medical practice. What proportion of children require complex medical care, and what skills and resources do we need to care for them properly? What is the effect of delayed diagnosis of disability and how can we improve early diagnosis and intervention? Which early childhood programs work? How do the Internet and television influence children's physical and mental health? How well are our children integrated into the community?

What family physicians can do

With this daunting list of health issues, what can we as physicians do? We can advocate for and support social policy that values families regardless of incomes: parental leave with income protection, universal access to programs that support child development, and good-quality child care services. We can promote injury prevention programs. We can emphasize the importance of positive parenting, help children discover their

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special talents, and promote their involvement in the community and in school.

We need to be sure that our young people are receiving the easily accessible friendly attention they deserve. We should reach out to high-risk groups in our communities. Alcohol and tobacco exposure are environmental contaminants that we can directly influence throughout patients' lives, as evidence shows physicians can have a positive influence in these areas. We should support and work collaboratively with our community partners in developing programs and resources that provide assessments, information, and resources to fill identified needs and decrease the effect of inequities. We must pursue research and provide answers to some of the important questions posed by the *CICH Profile*.

In 1991, Canada ratified the United Nations Convention on the Rights of the Child. The data presented in this *CICH Profile* show that Canadian children still lack some basic human rights. All of us interested in the holistic promotion of health for children and adolescents can be a resource to our communities and help to improve standards of health care.

We are in an ideal position to play a part in the nationwide responsibility to our children—our future.

To obtain a copy of *The Health of Canada's Children: A CICH Profile*, 3rd edition, contact the Canadian Institute of Child Health, 300—384 Bank St, Ottawa, ON K2P 1Y4; telephone (613) 230-8838; fax (613) 230-6654. ❀

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