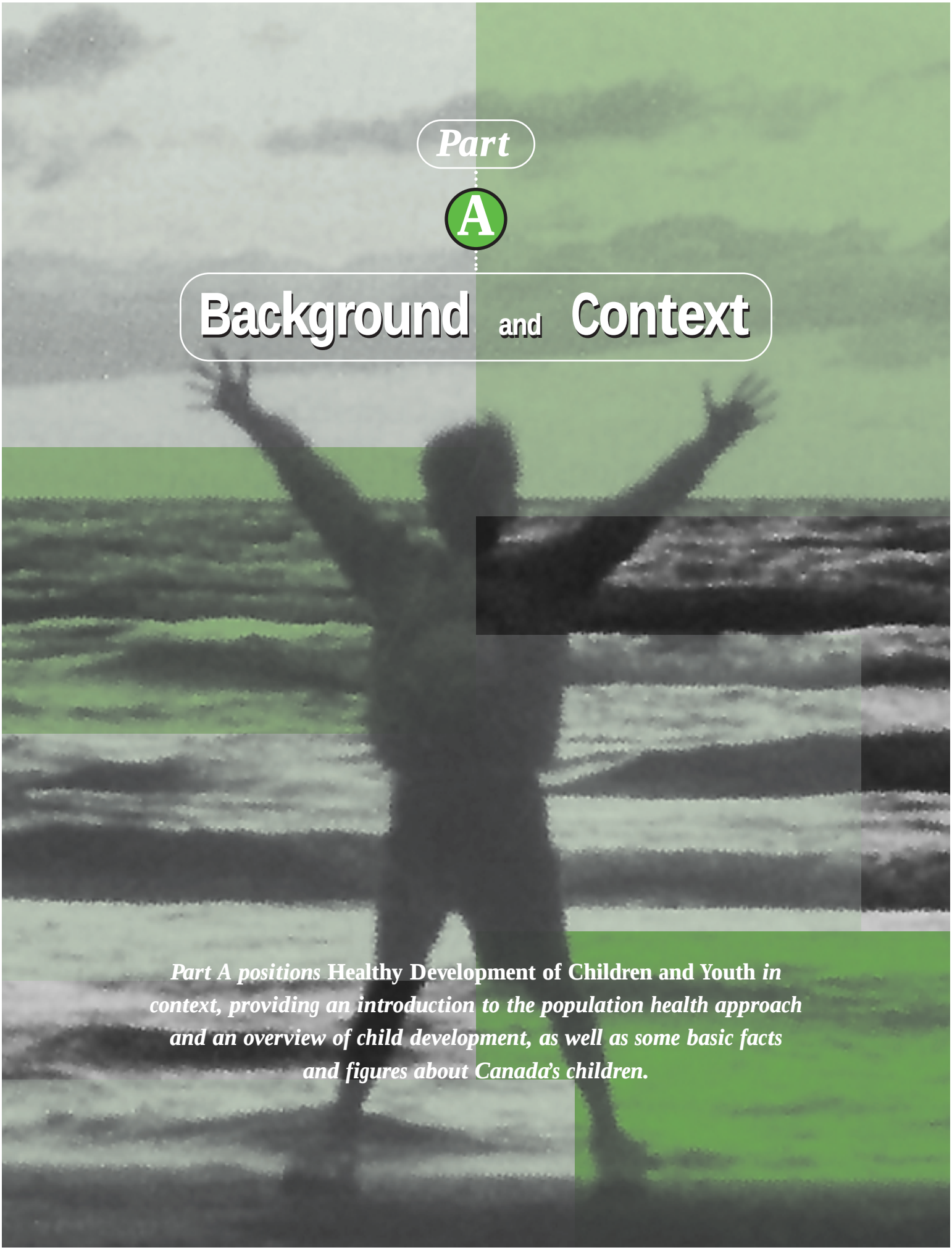


Part

A

Background and Context

Part A positions* Healthy Development of Children and Youth *in context, providing an introduction to the population health approach and an overview of child development, as well as some basic facts and figures about Canada's children.

Introduction

For the most part, our children and youth are growing up healthy, and live, study and work in environnments that promote well-being. Not only do young people and children represent Canada's future, they are also important today as members of Canadian families, communities and the larger society. Yet, a number of significant inequalities exist in the health status of Canadian children and youth. Some young people are more likely to be injured, others to experience physical and mental health challenges. Without appropriate action, these health inequalities are likely to persist into adulthood. On both a personal and societal level, the downstream consequences of these early experiences can be overwhelming.

Current research shows that much of the ill health and injury evident among young Canadians can be prevented. Moreover, it is now accepted that the health status of young people in Canada is influenced by a wide range of social, cultural, physical and economic determinants, many of which lie outside the traditional health sector. Through research and experience we are coming to know the power of education in improving the life circumstances and health outcomes for young people. There is a growing awareness of the alienation and negative consequences experienced by young people growing up in poverty. Positive social environments, supportive family structures, a healthy and safe environment — all of these factors interact to affect the health of Canadian children.

In fact, the research provides a glimpse of the future for Canada's young people, including a promise of what is possible through concerted action on a number of important fronts. Working together, we can build a healthy and fulfilling future for Canada's children. But while there is cause for optimism, there is also the need for caution. The challenges that lie ahead are daunting and cannot be addressed in isolation. A cooperative, multisectoral approach that addresses the wider determinants of health is essential for enhancing the health of Canadian children and youth.

Purpose, Scope and Organization of the Report

Healthy Development of Children and Youth is intended as a starting point for discussion and action aimed at improving the prospects for Canadian children and youth. Using a population health approach, the report compiles existing research to explain how the various determinants of health interact to shape healthy child development, and to depict conditions and trends relevant to the health and well-being of children and youth in Canada.

The document is aimed at a wide range of audiences concerned with the current and future health of Canada's children and youth, including policy and program developers, researchers working in all levels of government, health and social service agencies, and research organizations. It is hoped that the information presented here will promote broad-based thinking about the conditions and factors that help to shape children's health. To this end, policy and program developers will be encouraged to look outside their traditional areas of influence to consider the impact of their decisions on healthy child development.

Through the Population Health Lens

The population health approach, which incorporates the broad determinants of health and well-being, provides a useful framework for organizing evidence about the factors that contribute to children's health, and for highlighting promising avenues for further research and action. While healthy child development is itself a determinant of health, for the purposes of this report it serves as the filter or lens through which the other determinants of health are viewed and analyzed.

The population health approach is still in its infancy — much work remains to be done before it will be possible to identify with any certainty the specific causes of good health and how the various determinants interact to shape children's health and well-being. An important contribution to both strengthening and broadening the field, the report draws heavily on a plenitude of excellent work that has been carried out by researchers and practitioners working in the field of healthy child development, as well as on the work of those in fields related to the other determinants of health. By drawing together highlights of the literature and presenting the research within a population health framework, the report enables policy and program developers to access relevant information easily and to add to their own knowledge base on issues related to healthy child development. With this goal in mind, key linkages among various determinants have been illustrated throughout the report — again, with a view to encouraging readers to look beyond their own fields and to consider the implications of the full range of factors that influence children's health.

The primary focus of the report is children and youth to the age of 18 years. It should be noted, however, that many of the issues addressed relate to adults (especially parents). So many aspects of children's lives are beyond their individual control that a broader examination of the settings in which they operate — physical, social and economic — is essential to painting the full picture of relevant conditions and trends. For some issue areas, such as income and child poverty, a wealth of information exists; other areas, for example, the incidence of child abuse, lack information at the national level.

Organization of the Report

The report is organized into 12 core chapters, as well as this introduction. The **Introduction** provides useful background information, including basic demographic information about Canada's children and youth, an overview of the population health approach and the determinants of health, and a general description of the process of child development.

Chapters 1 to 11 make up the body of the report. Each chapter examines a specific determinant of health, addressing its relationship to healthy child development, summarizing current conditions and trends relevant to that determinant, and identifying how it relates to other determinants of healthy child development.

Chapter 12 presents a commentary by the Childhood and Youth Division of Health Canada. It takes a broader view of the areas of concern identified in each chapter, compiling some of the key findings about the determinants of health to identify issues, opportunities and priorities for intersectoral collaboration and decision making that will improve the health and future prospects for Canada's children and youth.

Data Sources and Limitations

This report draws on a wide range of health information from a variety of sources. Some major studies were used extensively throughout the report, including the National Population Health Survey (NPHS), the 1996 Census and the National Longitudinal Survey on Children and Youth, 1994–95.

A range of other reliable data sources and reports were also consulted and credited in discussions of health issues and trends. This has resulted in some discrepancies and inconsistencies in how information is presented. For example, differing age categories may not allow direct comparisons across studies.

Canada's Native Population: Defining the Terms

For the purposes of this report, the terminology used to describe Canada's Native populations is defined as follows:

Aboriginal: *includes the Indian, Métis and Inuit peoples of Canada*

First Nations: *refers specifically to Status Indians (i.e., Registered Indians)*

Status Indian: *is a person recorded as an Indian in the Indian Register. Most registered Indians are members of an Indian band.*

Studies referenced throughout this report do not necessarily use these same definitions.

Similarly, differences in the time periods reported for some indicators do not permit readers to consider relative changes over time with any degree of precision. Many studies of Canada's native population variously define the different groups, making comparisons difficult (see sidebar, p. 5). Likewise, the terms "poverty" and "poor" may be variously defined in the research.

It should be noted that while a wealth of information about the health of Canadian children is collected and published each year, there are a number of significant areas in which data are lacking. Several of these gaps merit particular attention, including the lack of data on the quality of health-care services and the fact that most health service data are hospital based. Moreover, information on Aboriginal peoples and other cultural groups is inconsistent or lacking altogether. Culture and ethnicity are important determinants of health and the paucity of data makes an assessment of trends and implications difficult.

The Population Health Approach

The population health approach explores the ways in which health is determined by the interaction of individual characteristics and endowments, the physical environment, and social and economic factors. As a field of study, it shifts the focus from individual health to the health of the population as a whole and to subgroups of the population. Consistent with this shift is a change of emphasis from individual actions and attributes (such as personal behaviour and knowledge) to collective, societal factors that affect health and well-being.

The following passage describes the approach and its focus:

> The population health approach focuses on the entire range of individual and collective factors and conditions, and the interactions among them, that determine the health and well-being of Canadians. Strategies are based on an assessment of the conditions of risk and benefit that may apply across the entire population or to particular subgroups within the population (Health Canada, 1996a, p. 3).

An Evolution in Thinking

The population health approach builds on a 20-year legacy of Canadian advancements in how to best promote and maintain the health of a nation. Since the early 1970s, Canada has gained international renown for its work in the area of health promotion. This reputation relates to the development of a number of important initiatives, including community action programs for health promotion, health advocacy and healthy public policy.

The release of the highly acclaimed Lalonde report, *A New Perspective on the Health of Canadians* (1974), was a turning point in broadening Canadians' understanding of the factors that contribute to health as well as the role of the government in promoting the health of the population. The report identified human biology, environment, lifestyle and health-care organizations as the four principal elements affecting health.

By the mid-1980s, there was growing recognition of the limitations of many health promotion efforts. It was argued that the health and behaviour of people were also determined by conditions such as income, employment, social status, housing and other environmental factors. The emerging focus on these non-medical determinants of health, as well as the release of both *Achieving Health for All* (1986) (which added social justice and equity to the mix) and the *Ottawa Charter for Health Promotion* (1986) began to shift attention to the societal (population) level — essentially pointing to factors that were beyond the immediate control of individuals, professionals and communities.

Population Health in Action

Health Canada's **Community Action Program for Children** *(CAPC) is an innovative, community-based program that is designed to ensure children living in conditions of risk get a healthy start in life.*

One CAPC initiative, the Trinity Conception Family Resource Program in Newfoundland, offers a range of programs to support children from conception to age 6 and parents. There are parenting programs and children's programs, as well as support groups, discussion groups on budget management and a clothing exchange.

Both *Achieving Health for All: A Framework for Health Promotion* and the *Ottawa Charter for Health Promotion* provided important frameworks for guiding policy and program development, not only in Canada but also internationally. They continue to be relevant today and have served as the basis for key developments in health policy over the past 15 years.

Specifically, *Achieving Health for All* set out a plan for putting health promotion strategies into action and reiterated the need for positive, holistic perspectives on health. In addition to identifying national health challenges, the framework presented a set of health promotion mechanisms (self-care, mutual aid and healthy environments) and a series of implementation strategies (fostering public participation, strengthening community health services and coordinating healthy public policy).

Similarly, the *Ottawa Charter* was an important stage in the progression towards a more comprehensive view of health. It included a clear working definition of health promotion action, specifying the need to build healthy public policy, create supportive environments, strengthen community action, develop professional skills, and reorient health services.

In the early 1990s, population health researchers began to publish findings and articulate a model of the determinants of health that provided additional evidence for many of the fundamental principles and activities initiated by the health promotion agendas in many government and health policy circles.

In 1994, the population health approach was officially endorsed by the Federal / Provincial / Territorial Ministers of Health in the report *Strategies for Population Health: Investing in the Health of Canadians*. The report summarized what is known about the broad determinants of health and articulated a framework to guide the development of policies and strategies to improve population health.

The Determinants of Health

The population health approach identifies the broad range of factors that interact to affect personal health and well-being. "Determinants of health" is the collective label given to the multiple factors that are now thought to contribute to the health of populations. An overview of these factors — including a brief description of their relevance to health and healthy child development — is provided below. Each determinant is addressed in greater depth in the following chapters, in terms of how it relates to children's health directly and how it interacts with other determinants of health.

Population Health in Action

"Healthy kids learn better." Since it was first initiated in 1993, Calgary's **Comprehensive School Health Initiative** *has grown to include 88 area schools. The approach, which partners the health and education sectors, as well as schools within the broader community, addresses a range of health issues such as mental/emotional health, nutrition, physical activity, healthy sexuality, tobacco use and substance abuse prevention, and injury prevention.*

Income and social status

Income and social status are the most important determinants of health. There is conclusive evidence that people at each level of the income scale are healthier and live longer than those at the level below. Moreover, countries in which incomes are more evenly distributed have a healthier population in terms of life expectancy, quality of life and mortality rates. Family income has a direct influence on children's health outcomes: inadequate income can negatively affect children's physical and mental health, cognitive and social development, and academic achievement.

Employment and work environment

Unemployment, underemployment and stress at work are associated with poor health. Generally, people who have more control over their work and fewer stress-related job demands are healthier and live longer than those who are unemployed or have high-stress jobs. Conversely, employment contributes to better health for parents and children. Employment status and working conditions affect parents' economic opportunities as well as their ability to carry out family responsibilities and to develop healthy relationships with their children. Not surprisingly, these factors affect the health of the parents' offspring.

Education

Health status improves with level of education. Education affects income level and job security, and equips people with a sense of control over their life circumstances — all key influences on health. Many factors contribute to how long children stay in school and how well they perform in school, including parents' education level and involvement in the child's schooling, and a child's overall readiness for school. In addition, the development of health literacy skills is important in knowing how to access the information needed to make responsible decisions about using the health-care system, as well as those about maintaining and improving personal and family health.

Social environment

Living in safe, supportive communities and having the support of families, friends and neighbours can help to reduce stress and contribute significantly to positive health outcomes. These primary and secondary supports are essential for children and can help parents cope with the stress of raising a family.

Natural and built environments

Physical factors in the natural environment (e.g. air and water quality) can have a direct impact on health. Factors in the human-built environment (e.g. housing, community and road design) also influence health, quality of life and well-being. For example, living in substandard housing may pose a threat to the safety of children and their families, while the design of communities (e.g. common space, lighting, density) can influence social interaction and safety.

Personal health practices

People's health practices — ranging from the amount of physical activity they engage in and the kind of food they eat to whether they smoke and practise safe sex — play a key role in determining health. Environments that support and enable healthy lifestyle choices can have a positive effect on people's overall health. Many of the practices that will contribute to health and well-being in adulthood are established during childhood and adolescence.

Individual capacity and coping skills

Psychological characteristics such as personal competence and sense of control and mastery over one's life play an important role in supporting mental and physical health. They influence people's susceptibility to such health problems as cancer and cardiovascular disease, and affect their risk of mental disorders and suicide. There is strong evidence that coping skills are acquired primarily in the first few years of life and that resilience to stress and negative circumstances is profoundly influenced by the experiences of early childhood.

Genetic and biological factors

The basic biology and genetic make-up of the human body is a fundamental determinant of health. Inherited predispositions to a wide range of health conditions and diseases can affect health status given particular social, physical and environmental circumstances. Additionally, maternal exposure to a variety of microbial and chemical compounds during pregnancy can have an impact on the fetus and thus on the future health of a baby.

Health services and social services

Health services contribute significantly to health, in particular those services designed to maintain and promote health, to prevent disease and to restore health and function. For children, young people and their families who are disadvantaged in some way, social services are also key to ensuring basic needs and other necessities that serve as a foundation to good health. These services help to keep children on healthy developmental pathways and to reduce the risk of negative consequences for young people who are disadvantaged in some way. Many other community facilities and services such as recreation, transportation, parks, schools and libraries play key roles in helping families raise healthy, socially engaged children.

Culture

Some people in society face additional health risks due to marginalization, stigmatization and lack of access to culturally appropriate services. Culture-specific practices can also have an impact on the overall health of a population. New immigrant and refugee children, as well as children from other ethnic groups and Aboriginal children (including First Nations, Inuit and Métis), are likely to experience unique stresses that can negatively affect their physical and mental health.

Gender

Gender refers to the array of socially determined roles, personality traits, attitudes, behaviours and values that society ascribes to being male or female. Many health issues such as dieting, smoking and sexually transmitted diseases (STDs) are a function of these gender-based roles, the majority of which are established in early childhood and adolescence.

Overview of Children's Development

Good health does not happen automatically. On the contrary, ongoing positive investments are needed for an infant to grow and develop into a competent, participating adult member of society. When such investments are not made (for whatever reason), many children will carry into adulthood physical and/or emotional disabilities that could have been prevented.

Children and young people are particularly vulnerable to conditions in their social and physical environments. As they pass through infancy and early childhood to the teenage years, they are susceptible to a wide range of positive and negative influences. To grow and mature into healthy adults, they require support, care, understanding and nurturing from their family, peers, school community, and community groups. At each developmental stage, the type and source of the support children require may vary considerably.

Traditionally, the course of childhood development has been seen as a progression through a series of predictable stages, each with its own tasks and accomplishments. Health at later stages and in adult life has been thought to be partially determined by the events, conditions and successes at preceding stages. These models have presented development as a ladder-like progression, assuming similar life experiences for all and implying a single route to adulthood (Rutter, 1989).

The nature of the tasks within the different stages is given a different emphasis in different models. Jean Piaget's model, for instance, emphasizes the cognitive ability to adapt to the environment; Eric Erikson's concept concentrates on personality development through conflict resolution at each stage; and Robert Havighurst's framework outlines various developmental tasks that must be mastered at each stage.

Longitudinal studies are offering support for a less rigidly defined line of development, shifting the model to one of pathways. While an individual's growth — physical, psychological and social — does progress through stages marked by important life transitions, these transitional events, their meaning, and their impact seem to be varied, and personal. There may be various routes and detours in a child's movement through life and immense individual variability in important life transitions. Adverse past experiences may be offset by "recuperative" experiences occurring later in life or by the present environment and/or circumstances. A single negative event does not necessarily and inevitably lead to a single effect. Childhood development is less a ladder of linear steps than a series of pathways with innumerable routes and outcomes.

What is shared and vitally important in all these models is that chain effects in development are common. The past *does* affect present health, albeit in individualized ways. If we are to make a difference in the healthy lives of children and the adults they become, we must acknowledge the variety of individual experience and consider them in personal terms; we must see the complex links in causal chains and how they interconnect; and we must search for the unifying principles underlying the diversity of pathways from childhood to adult life.

The early years

More recent research indicates that the period from pre-conception to age 5 is much more important than previously thought (Guy, 1997, p. 6). It is an extremely sensitive and critical time in the development of the child, laying the groundwork physically, mentally and socially for later health, forming resources that may be drawn on later in life or deficits that must be overcome. During this "investment phase," children develop language skills, the ability to learn, to cope with stress, to have healthy relationships with others, and to have a sense of self. The effects can be physically based; poor nutrition before or during pregnancy and during a child's infancy can seriously interfere with brain development. The effects can also be socially or emotionally based; secure attachment to a nurturing adult, positive sensory stimulation, and positive social interactions are crucial to ensure future well-being (Federal, Provincial and Territorial Advisory Committee on Population Health, 1998).

How the Brain Develops

Recent research on the development of the brain has reinforced the belief that the first few years of life are vitally important to healthy development, and that impacts felt early on may well have consequences throughout life.

By the time a baby is born, it will have approximately 100 billion brain cells and will have the ability to learn through the general pathways connecting regions of the brain. If development goes well, so does the ability to learn.

The baby's neurons begin to form a dense network of interconnections, with each cell sending messages out to other brain cells and receiving input from others. With the help of special chemicals, they travel from cell to cell, creating connections. Repeated activation of these networks strengthens the connections so that by the time the child reaches age 2 or 3, each neuron has formed an average of 15,000 connections. This network of connections provides the child with built-in flexibility, allowing her to respond successfully to stimulae in her environment. For example, in order to learn language, a child must be physiologically ready for sound structures and grammar.

Children retain these neural connections until about age 10 or 11, after which time pathways that have not been repeatedly stimulated will gradually atrophy and die. Various factors — for example, disease, toxic substances and alcohol — can place a child's developing brain at risk. Social experience is also critical to the process of development; the workings of the brain are profoundly shaped by children's experiences, in particular, their relationships with family and peers (Nash, 1997).

The middle years

In the middle years (to age 12), children experience rapid changes socially, intellectually, psychologically and emotionally, contributing to their personal adjustment and social acceptance. It is a time of expanded social relationships and demands during which they develop values, enhance problem-solving skills, achieve greater independence, and form a framework of attitudes towards society and behaviour towards others. Physical changes decelerate while cognitive intellectual development speeds up. During this period, developmental lags experienced in the early years may be overcome through the mediation of the family, community and school (Federal, Provincial and Territorial Advisory Committee on Population Health, 1998, p. 7).

The adolescent years

During adolescence, from age 12 on, the child acquires more abstract cognitive abilities and develops a social, more gender-based role. Physical changes accelerate at this time; cognitive development continues through puberty, but tends to level off afterwards. Peer influence becomes even more important while the child is shaping an ethical system to guide behaviour in society. During this stage, family and community become important as the adolescent prepares for the transition to adult responsibilities and experiences: work, marriage, and child bearing.

Childhood mediators

As Rutter (1989) points out in "Pathways from Childhood to Adult Life," longitudinal research indicates that while events or conditions in childhood or adolescence may set off a chain reaction of experiences or choices that affect the well-being of the adult, the outcomes are not always the same. Several factors appear to "mediate," strengthening or weakening the link in the potential chain. For example, the nature of a causal factor alone does not determine its effect: timing also appears to be important. Neural structure and functioning may be adversely affected during periods of high neural development, but not after. Infants and babies may not be affected by separation from their parents, while toddlers will be. Timing may also determine societal responses to incidents, influencing how they are experienced, as in the case of teenage pregnancies. As another example, the occurrence of an event in itself is not enough to assess its outcome — how it is experienced and its meaning to that individual may determine its impact on the well-being of the individual. To illustrate, unwanted parenthood at an early age will not be the same experience as the welcome birth of a child to a young, happily married couple.

A dynamic process

The influences in the life of a child or young adult that contribute to their health and future well-being are rich and complex. Their biological conditions (genetically or non-genetically determined), their physical, social and economic environment, the cognitive and social skills they develop, their sense of self and self-esteem, and their habits and coping styles are only a few of the interconnected forces working in their development. The route along the pathway from childhood to adulthood is a dynamic one, characterized by a "continuing interplay over time between intrinsic and extrinsic influences on individual development" (Rutter, 1989, p. 24).

About Canada's Children

Canadian children and youth are a diverse group that make up almost one third of the population. They come from varied ethnic, religious and linguistic backgrounds; they live in a variety of family structures in both urban and rural settings; and they grow up in families with disparate levels of social and economic resources. For the purposes of this report, and in keeping with the United Nations Convention on the Rights of the Child, a child is defined as a person who is 18 years old and under.

This section presents a broad overview of Canada's children. It establishes a general context for the more specific discussion in the remaining chapters of key variables that influence children's health, and provides the reader with basic information about who Canada's children are and how they live. More detail on many of the points below is included in the following chapters of this report.

How Many Are There?

- In 1997, there were slightly more than 8 million children aged 0 (newborn) to 19 years in Canada — 51.2% of these were boys and 48.8%, girls. Children in this age group made up 26.5% of the Canadian population (Statistics Canada, 1998a). The number of children has declined steadily since 1961 (Ross, Scott and Kelly, 1996, p. 17). See **Exhibit 1**.

1 Population of children and youth, by sex and age, Canada, 1997

	Both sexes	Male	Female	Both sexes	Male	Female
	Number			% of total population		
All ages	**30,286,596**	**14,999,677**	**15,286,919**	**26.5**	**27.4**	**25.6**
0–4	1,915,801	981,837	933,964	6.33	6.55	6.11
5–9	2,049,449	1,049,529	999,920	6.77	7.00	6.54
10–14	2,027,130	1,035,369	991,761	6.69	6.90	6.49
15–19	2,024,088	1,037,276	986,812	6.68	6.92	6.46

Source: Adapted from the Statistics Canada Web site: www.statcan.ca

- In 1996, there were 280,415 Aboriginal children under the age of 15 living in Canada; they accounted for 35% of all Aboriginal people identified in the census that year (Statistics Canada, 1998b).

- Canada's natural growth rate accounted for 47% of the population's growth in 1996, while immigration accounted for the remaining 53%. The natural growth rate declined substantially between 1990 and 1995, from 7.7 to 5.7 per 1,000 population (Statistics Canada, 1998c).

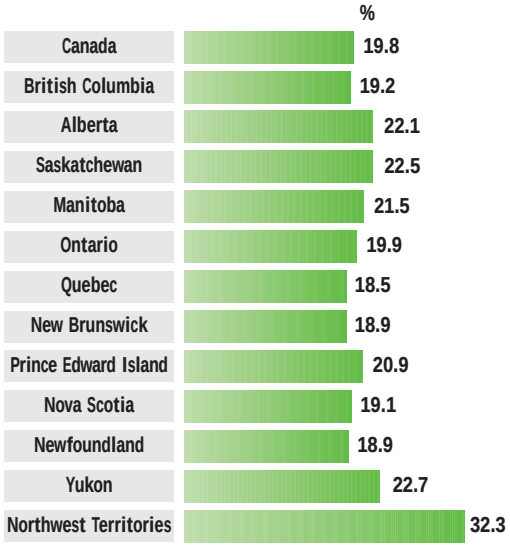
Where Do They Live?

- The proportion of children aged 0 to 14 years in terms of total population varies by province/territory, ranging from a low of 19% in Quebec to a high of 32% in the Northwest Territories (Statistics Canada, 1998a). See **Exhibit 2**.

- The majority of the Canadian population lives in urban settings. However, this proportion varies considerably across the country. For example, in 1996, more than half of all residents of the Northwest Territories, Prince Edward Island and New Brunswick lived in rural settings, while the same could be said of only 17% and 18% of residents in Ontario and British Columbia, respectively (Statistics Canada, 1997a, p. 183). See **Exhibit 3**.

- In 1996, 6 out of 10 Registered Indians lived on reserve, a drop from 7 out of 10 in 1982, and this trend is expected to continue. See **Exhibit 4**. Overall, the Registered Indian population is expected to increase at a rate of 2.1% per year over the next five years — compared with a growth rate of 1.2% for the general Canadian population over the same period (DIAND, 1998, pp. 4–5).

2 **Children aged 0–14 years as a proportion of the total population, by province/territory, 1997**



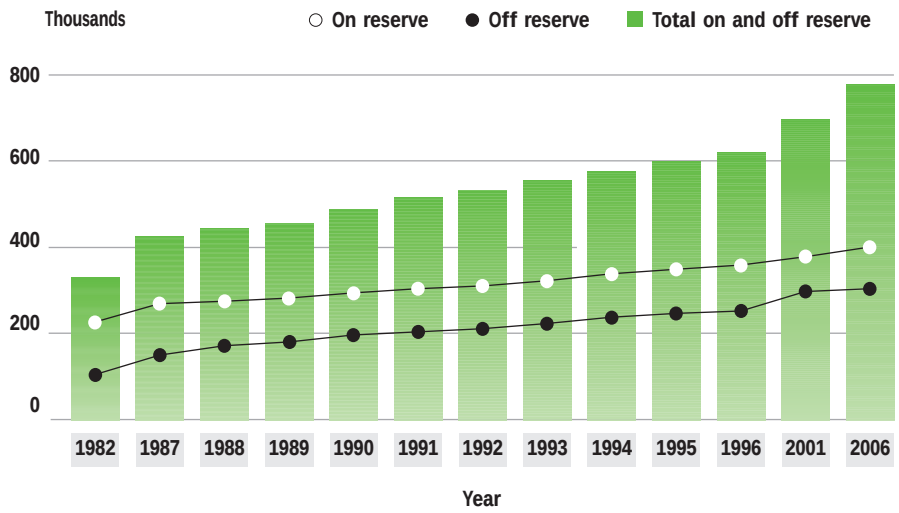
Source: Adapted from the Statistics Canada Web site: www.statcan.ca

3 **Proportion of population living in urban and rural areas, by province/territory, 1996**

Province/Territory	Urban (%)	Rural (%)
Canada	77.9	22.1
British Columbia	82.1	17.9
Alberta	79.5	20.5
Saskatchewan	63.3	36.7
Manitoba	71.8	28.2
Ontario	83.3	16.7
Quebec	78.4	21.6
New Brunswick	48.8	51.2
Prince Edward Island	44.2	55.8
Nova Scotia	54.8	45.2
Newfoundland	56.9	43.1
Yukon	60.0	40.0
Northwest Territories	42.5	57.5

Source: Adapted from Statistics Canada (1997). *A National Overview: Population and Dwelling Counts*. Catalogue No. 93-357-XPB. Ottawa: Statistics Canada.

4 **Current and projected registered Indian population growth on and off reserve, Canada, 1982–2006**



Source: Department of Indian Affairs and Northern Development (1998). *Basic Departmental Data 1997*. QS3575-000-BB-A1, Catalogue No. R12-7/1997. Ottawa: DIAND, p. 4.

What Do Families Look Like?

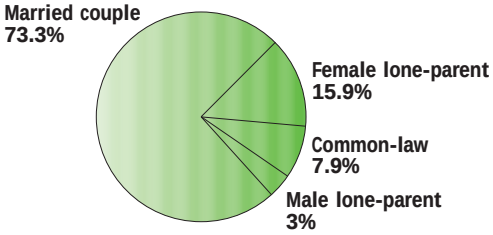
- In 1996, the average family size in husband-wife families was 3.0 persons; in lone-parent families, 2.5 persons (Statistics Canada, 1998a).

- In 1996, 73 of every 100 children lived in married-couple families, down from 78 children of 100 in 1991 (Statistics Canada, 1997b). See **Exhibit 5**.

- The proportion of children living in common-law families is on the rise. As of 1996, 8 out of 100 children lived in common-law families, a 52% increase over 1991 (Statistics Canada, 1997b). See **Exhibit 5**.

- Almost one in every five children in Canada lived with a lone parent in 1996, compared with one in six children in 1991; 84% of these children lived with a female lone parent (Statistics Canada, 1997b).

5 **Proportion of children living in selected family structures, Canada, 1996**



Note: Numbers do not total 100% due to rounding

Source: Adapted from Statistics Canada (1997). *The Daily*, Catalogue No. 11-001, October 14, 1997.

How Many Children Live in Poverty?

- In 1996, 20.9% of children under 18 years of age lived below Statistics Canada's low income cut-off (LICO) compared with 14.9% in 1980 (National Council of Welfare, 1998, p. 12).

- In 1994–95, more than one quarter (25.7%) of children in Canada lived in households with incomes of less than $30,000 per year; 41.6% were in households with total incomes ranging from $30,000 to $60,000 per year; and almost one third (32.8%) lived in higher-income households, those with annual earnings of more than $60,000. (Ross, Scott and Kelly, 1996, p. 33).

- While an accurate poverty rate for Aboriginal children is not available, some authorities consider that many Aboriginal children in Canada experience living conditions similar to those in Third World countries (CICH, 1994, p. 140).

How Healthy Are They?

- Almost 10% of children included in the 1996 National Longitudinal Survey of Children and Youth (NLSCY) were born prematurely (i.e. before 259 days' gestation) (Ross, Scott and Kelly, 1996, p. 19).

- In 1996, 5.8% of babies were considered to be of low birthweight (below 2,500 grams), declining slightly from 5.9% the previous year (Statistics Canada, 1998d).

- In 1998, life expectancy at birth was 81 years for women and 75 years for men for the general Canadian population (Health Canada, 1998). The most recent figures available (1995) for the First Nations population show life expectancy to be 76.2 years for women and 69.1 for men (Health Canada, 1996b).

- In 1996, the infant mortality rate was 5.6 deaths per 1,000 live births, declining from 6.1 per 1,000 live births in 1995 (Statistics Canada, 1998d). The most recent data available for First Nations indicate a higher and increasing infant mortality rate — 12 deaths per 1,000 live births in 1994, up from 10.9 per 1,000 in 1993 (Health Canada, 1996b).

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