2016 Edition

Are We Doing Enough?

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

P-772-17

Canadian Paediatric Society

Canadian Paediatric Society
100-2305 St. Laurent Blvd.
Ottawa, Ont. K1G 4J8
Phone: 613-526-9397
Fax: 613-526-3332
www.cps.ca

ISSN 1913-5645

Development of this report was funded through Healthy Generations Foundation: The Foundation of the Canadian Paediatric Society.

Cette publication est aussi disponible en français sous le titre : *En faisons-nous assez? Un rapport de la situation des politiques publiques canadiennes et de la santé des enfants et des adolescents* (ISSN 1913-5661)

Background

How Canada cares for and nurtures its younger generations is our clearest possible expression of collective values and national well-being. Ensuring the health and well-being of all children and youth is a shared responsibility, with family, community and public institutions each playing key roles. At its broadest level, care means governments enacting evidence-based public policies that safeguard and enhance physical and mental health, safety and well-being.

While children and youth make up one-quarter of Canada's population, they are disadvantaged politically by not being eligible to vote. However, the Canadian Paediatric Society (CPS) knows what a powerful tool public policy advocacy can be in keeping child and youth issues on the national agenda. We have years of experience making sure that best practice and medical evidence inform public policies affecting children and youth. Through their daily work with children, CPS members recognize how investing in child and youth health and family health promotion can net huge gains – both human and financial.[1] The purpose of this report is to share these insights and accompanying evidence-based recommendations with policy makers.

This 5th edition of the status report reviews current policy on critical fronts while specifying improvements and raising the public profile of key paediatric issues. Since its first release in 2005, *Are We Doing Enough?* has examined and evaluated how effectively each provincial/territorial government protects and promotes the health and well-being of children and youth on select measures. This report also assesses the federal government's performance in key areas. Because thoughtful policy change takes time and this federal government's mandate is still in its early days, the CPS is reserving assessment – temporarily – on some federal issues contained in this report. The report's new online format will allow us to track progress and update ratings as needed over the coming months. A pdf version (reflecting status as of May 2016) is also available.

Canada has certainly come a long way since 2005. Governments are doing better in many critical areas. Provinces and territories with tough anti-smoking legislation show reduced smoking rates among youth. The number of publicly funded vaccines has increased significantly. Legislation to prevent youth from accessing tanning booths has been implemented across all provinces. However, on every measure contained in this report, there is still work to do. *Are We Doing Enough?* highlights areas of provincial/territorial strength, as well as weakness, and is intended to help child and youth health advocates, caring agencies and individual governments compare progress on key issues and improve public policy.

As in previous editions, *Are We Doing Enough?* assesses public policy in four major areas:

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

New key issues evaluated in this report include breastfeeding promotion, child death review processes and the management of type 1 diabetes in schools.

We hope this status report provides direction and impetus for all advocates and policy-makers who take the best interests of children and youth to heart – and then a few steps further, into 'city hall' or the corridors of government.

Information in this report is current as of May 2016 and was obtained from government documents, credible web resources and personal correspondence.

The CPS would like to thank the following non-governmental organizations for their assistance in validating information: the Breastfeeding Committee for Canada; the Canadian Hospitals Injury Reporting and Prevention Program at the Hospital for Sick Children; the Diabetes at School Advisory Group; the Jordan's Principle Working Group; McMaster University's machealth; Moms, Boobs and Babies (MBB); the NorthernStar Mothers Milk Bank; Parachute; and the Saskatchewan Prevention Institute.

Summary

Every day, too many children and youth in Canada experience preventable injuries and infections, chronic disease, poverty, or unequal access to quality health care and education. Many of their difficulties are rooted in public policies that do not put the needs of children and youth first. According to the 2016 UNICEF-Innocenti Report Card, Canada ranked 26th among 35 rich countries on the overall well-being of its children.[2] When responses from children and youth to a life satisfaction survey were factored in, Canada only gained one level, meaning our young people are among the least happy in the developed world.

Are We Doing Enough? can help change this picture. The Canadian Paediatric Society has a long and successful history of working with government representatives, agencies and allied organizations to improve the health and well-being of children and youth. Government-led programs and health promotion strategies have proven and substantial powers to save lives, prevent injuries and protect against disease. But we can always do more. While legislation has progressed in some areas since the 2012 status report, some governments still need to coordinate and implement better public policies on the issues evaluated here. Further steps are needed because, as we've already seen, sustained advocacy and sound policies produce amazing results.

Policy matters

Policy matters... In recent years, significant progress has been made in protecting children and youth from vaccine-preventable diseases. With only a few exceptions, children and youth across Canada have publicly funded access to all routine vaccines. Vaccination programs have significantly reduced many vaccine-preventable diseases such as meningococcal and pneumococcal infections, *Haemophilus influenzae*, and rotavirus disease, among others. Three provinces have yet to implement a rotavirus program, though the evidence shows that rotavirus vaccination protects young children and alleviates demands on emergency departments.[3]

Policy matters... When governments implement strong policies to prevent and reduce smoking rates among children and adolescents, smoking prevalence decreases. Fewer children are exposed to second-hand smoke, leading to healthier families and fewer trips to the hospital for pneumonia and asthma-related complications. However, while Canada's efforts on smoking cessation have reaped significant benefits, new challenges lie ahead. Youth are being exposed to a broader spectrum of tobacco products, including smokeless tobacco, flavoured tobacco, water pipes and e-cigarettes, for which traditional government controls are wholly inadequate. Governments must develop policies that regulate e-cigarettes and novel tobaccos as strictly as cigarettes and traditional tobacco products.

Policy matters... Where injury prevention legislation is strong, paediatricians see fewer ER visits, hospitalizations, brain injuries and preventable deaths. However, unintentional injuries are still the leading cause of death, morbidity and disability in Canadian children and youth, and legislation is a sorry patchwork on some key safety issues. For example, there is no consistent approach to bicycle helmet, booster seat or off-road vehicle legislation in this country. Five provinces or territories still have no legislation on bicycle helmets despite evidence that helmet wearing reduces risk of brain injury by up to 80%.[4] Effective safety policies and programs reduce the human and economic costs we all bear.[5] Canada needs a national injury prevention strategy which includes outreach, education and safety legislation that is enforced at all government levels. Injury *prevention* is undoubtedly the best approach to reducing the present burden of harm and, like immunization, could be one of the great public health achievements of the 21st century.[6]

Policy matters… Where child death review processes are standardized – including data collection – positive outcomes follow, such as effective injury prevention campaigns and laws that truly safeguard young lives. Also, stakeholders from multiple disciplines and agencies tend to share information and learn from one another. When we understand how and why children die, we can take better measures to protect them.[7]

Policy matters… Where universal newborn hearing screening programs are in place, early diagnosis leads to earlier interventions and better outcomes for children with a hearing impairment. Permanent hearing loss is one of the most common congenital disorders of childhood, occurring in about about two per 1,000 live births. Children with hearing loss who do not receive timely intervention often have problems with communication and psychosocial skills, cognition or literacy later on.

Advocacy matters

Far too often, physicians see children and youth with preventable medical issues. While every government has the onus to protect through policy and legislation, health experts play an essential role in shaping such laws and programs. *Are We Doing Enough?* is for advocates working with governments to keep kids healthier and safer. As a tool, the status report is most effective in the hands of experts who care about these issues. The changes to public policy recommended here are based on best evidence and decades of experience persuading governments to take paediatric issues seriously.

A few examples... Past CPS President Dr. Richard Stanwick worked for years to raise public understanding about the serious health consequences of second-hand smoke, which has resulted in stronger anti-smoking legislation. In 2013, paediatric residents in Manitoba were instrumental in persuading their provincial government to introduce bicycle helmet legislation. Dr. Susanna Martin's concern over car-related injury and death rates led her to champion booster seat legislation in Saskatchewan, with results clearly reflected in this report. Paediatricians are uniquely qualified to engage government on policies to improve child and youth health and well-being.

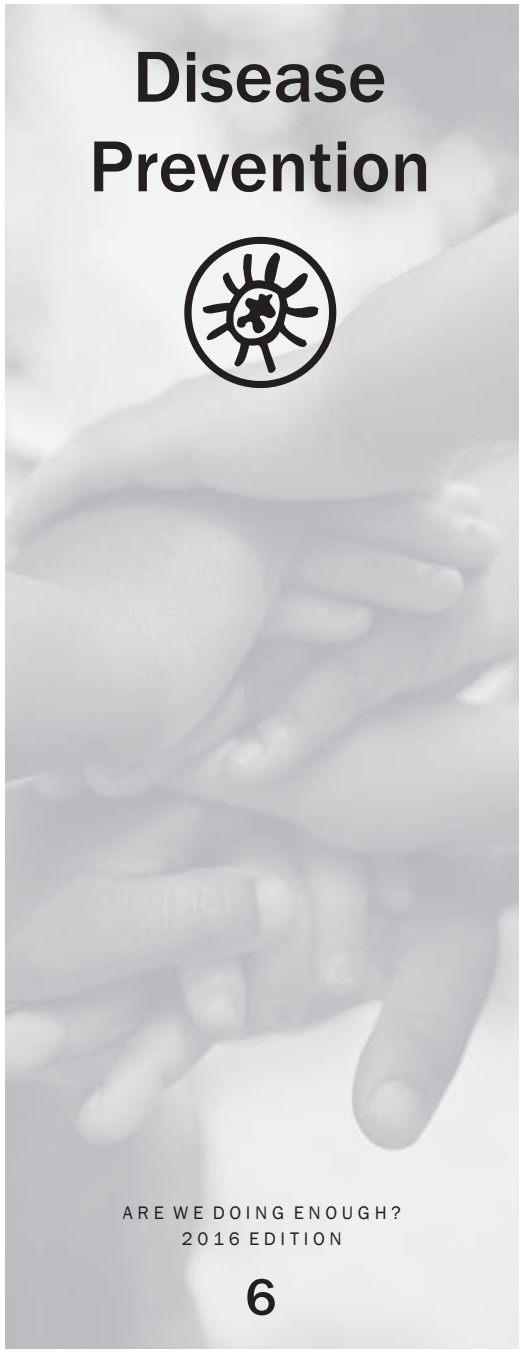
Child and youth mental health strategies have not been re-evaluated in this edition, but the CPS recognizes the serious challenges to mental health in Canada. The need to reduce First Nations and Inuit youth suicide rates may be the loudest call to action, but there are many. Children and youth deserve equitable access to mental health services, treatments and culturally competent support programs. And while some provinces and territories have developed mental health strategies since 2012, CPS members tell us this step has not improved access to services and programs significantly. Wait times and other barriers to mental health services have serious and lasting consequences for individuals, families and communities. Because about 70% of mental illnesses first appear in childhood or adolescence, early prevention, screening, and treatment are key to reducing lifelong impacts.[8] Along with mental health experts and partnering organizations, the CPS urges all levels of government to develop and fund programs providing timely mental health services to young people.

Child poverty is not easy to measure, but a national poverty reduction strategy remains an issue of foremost importance. The federal government has recently committed in mandate letters to help Canadian families living in substandard conditions. In fact, 19% of children and fully half of status First Nations children now live below the poverty line in Canada.[9] Among the many effects of low socioeconomic status is a strong association with poor health later in life. All Canadian children and youth deserve the same opportunities no matter where they live. The CPS urges governments at every level to work together and with allied stakeholders to eradicate family poverty. Supplementary health benefits, accessible and affordable child care, and targeted nutrition and housing programs would all help children and youth to thrive and reach their full potential. Governments must partner with First Nations, Métis and Inuit communities to eliminate the causes of systemic poverty.

CPS commitment

The status report is only a snapshot, but the picture it provides is clear enough to raise concerns. Despite past efforts, a persistent patchwork of health and safety policies in Canada means that children and youth are not being cared for equitably. Far too often, the quality of care they receive depends on where they live. *Are We Doing Enough?* is a practical starting point for advocates, policy-makers and care providers who want to help all children and youth reach their full potential. They deserve no less.

Disease Prevention



Immunization

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

In addition to vaccines that have been part of the routine immunization schedule for a number of years, the Canadian Paediatric Society and the National Advisory Committee on Immunization (NACI) recommend that children and youth be vaccinated against rotavirus, varicella (chickenpox), pertussis (whooping cough), seasonal influenza, and meningococcal and pneumococcal infections. The CPS and NACI also recommend that the human papillomavirus (HPV) vaccine be provided to girls at no charge. Provinces that have been proactive in adding the HPV vaccine for boys to their publicly funded schedules are to be commended.

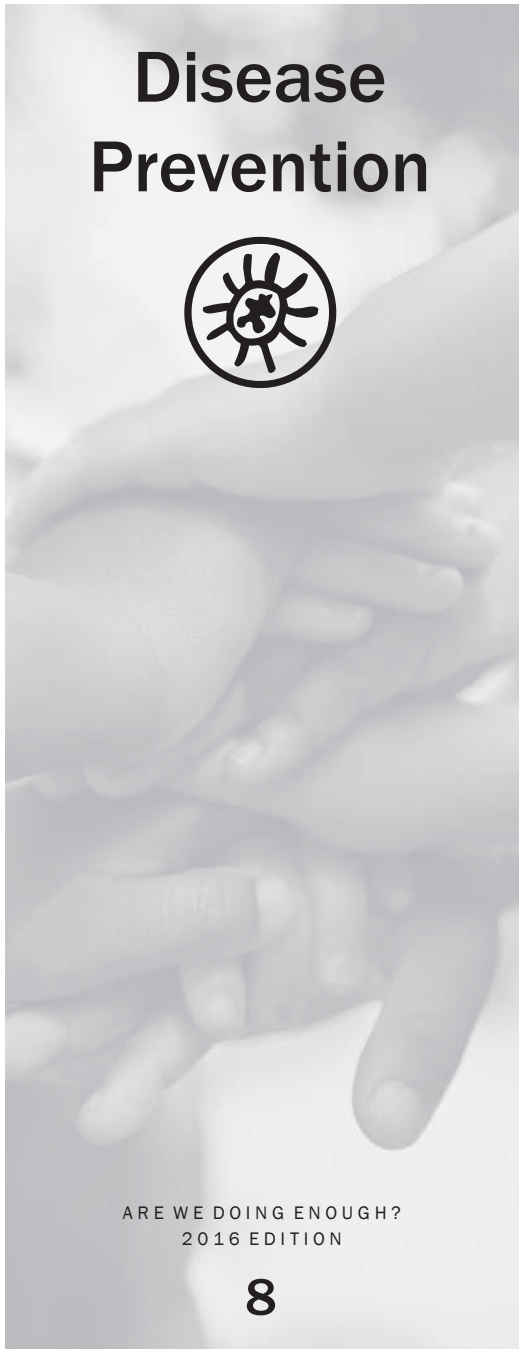
Still, coverage of all routine vaccines is not yet universal across Canada. Not all provinces and territories offer the same vaccines to the same groups at no cost – schedules vary somewhat depending on where you live. A harmonized immunization schedule would be very beneficial, yet continues to be elusive.

Immunization registries help identify children who are (over)due for immunization, provide health care providers with a patient's immunization status at each visit, inform public health campaigns, and help jurisdictions track immunization coverage. A patchwork of registries currently exists in Canada. About half of provinces and territories have an electronic immunization registry, while others use paper-based systems, a combination of the two, or simply do not have a registry in place. The CPS urges provinces and territories to work toward establishing electronic immunization registries and a universal schedule for administering vaccines.

Excellent:	Province/territory provides meningococcal, adolescent pertussis, pneumococcal, varicella, rotavirus, influenza, 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. Province/territory has a central immunization e-registry.
Good:	Province/territory provides all of the recommended vaccines but does not have a central immunization e-registry.
Fair:	Province/territory provides all but one of the recommended vaccines and does not have a central immunization e-registry.

Immunization				
Province/Territory	**2012 status**	**2016 status**	**Recommended actions**	**Comments**
British Columbia	Excellent	Good	Implement a central immunization e-registry.	
Alberta	Fair	Good	Implement a central immunization e-registry.	Personal information on immunization status is available only for the Edmonton area. Efforts to add information held in public health units and physicians' offices province-wide are ongoing.
Saskatchewan	Good	Excellent	Meets all CPS recommendations.	
Manitoba	Fair	Excellent	Meets all CPS recommendations.	
Ontario	Excellent	Good	Implement a central immunization e-registry.	The CPS encourages Ontario to continue working on the full implementation of "Panorama", so that patient records can be accessed and updated by primary care physicians.
Quebec	Good	Excellent	Meets all CPS recommendations.	
New Brunswick	Good	Fair	Implement a rotavirus immunization program. Implement a central immunization e-registry.	Vaccination records can be obtained from providers but are not housed in a centralized e-registry.
Nova Scotia	Fair	Fair	Implement a rotavirus immunization program. Implement a central immunization e-registry.	Vaccination records can be obtained from providers but are not housed in a centralized e-registry.
Prince Edward Island	Excellent	Good	Implement a central immunization e-registry.	There is a registry, but it can only be accessed by public health nurses and select personnel.
Newfoundland and Labrador	Fair	Good	Implement a central immunization e-registry.	Immunization records can be obtained from regional health authorities, but there is no centralized e-registry.
Yukon	Fair	Excellent	Meets all CPS recommendations.	
Northwest Territories	Fair	Excellent	Meets all CPS recommendations.	
Nunavut	Fair	Fair	Add a second dose of varicella vaccine. Implement a central immunization e-registry.	Nunavut does not have a rotavirus immunization program in place. The CPS acknowledges that this decision is based on disease epidemiology and that surveillance is underway to detect cases and assess need. Electronic medical records are being centralized gradually and are available in at least one community in each of the three regions.

Disease Prevention



Prevent smoking among youth

Provincial/territorial legislation to protect children and youth from the effects of smoking continues to strengthen. The most recent data on tobacco use are based on national surveys conducted by Health Canada and Statistics Canada in 2013 (which excluded the territories). About 11% of youth 15 to 19 years of age were smokers in 2013 compared with 22% in 2001.[10]

However, smoking rates appear to be stabilizing and minority groups, particularly Indigenous and LGBTQ youth, have higher than average smoking rates.[11] Among First Nations high school students living off-reserve, 25% reported smoking in 2008.[12] They were also more likely to be exposed to second-hand smoke at home and in vehicles (37% and 51%, respectively) than their mainstream peers (20% and 30%).[13]

Some of the most effective measures to reduce smoking rates in teens are already in place across Canada, such as high taxes, labelling deterrents, bans on point-of sale displays and advertising to minors, and smoke-free spaces (including vehicles transporting minors). And while most jurisdictions have banned smoking in enclosed public spaces and in vehicles when children or youth are present (with the exception of the Northwest Territories and Nunavut), there is still much work to be done.

Youth are now exposed to a broader spectrum of tobacco products, including smokeless tobacco, flavoured tobacco, water pipes and e-cigarettes, over which there is inadequate government control. In 2013, the first national data set on e-cigarette use in Canada revealed that 20% of youth 15 to 19 years of age had tried e-cigarettes.[14] It is possible that e-cigarette use among teenagers will soon surpass cigarette smoking.

The Canadian Paediatric Society urges governments to treat e-cigarettes the same way as traditional tobacco products and to expand all current smoking restrictions in public spaces and workplaces to include them.[15] The CPS also calls on provinces and territories to ban smoking in all public places – including public playgrounds and sports fields and surfaces – as Ontario, Quebec and New Brunswick have done.

Excellent:	Province/territory prohibits smoking in all public places (including outdoors*). Legislation has been introduced to protect children and youth from tobacco in automobiles. Province/territory has passed legislation on e-cigarettes and flavoured tobacco products.
Good:	Province/territory prohibits smoking in some, but not all, public spaces. Legislation has been introduced to protect children and youth from tobacco in automobiles. Province/territory has passed legislation on e-cigarettes and flavoured tobacco products.
Fair:	Province/territory prohibits smoking in some, but not all, public spaces. Legislation has been introduced to protect children and youth from tobacco in automobiles. Province/territory does not have legislation on e-cigarettes and flavoured tobacco products.
Poor:	Province/territory prohibits smoking in some, but not all, public spaces. Province/territory does not have legislation to protect children and youth from tobacco in automobiles. Province/territory does not have legislation on e-cigarettes and flavoured tobacco products.

Prevent smoking among youth				
Province/Territory	**2012 status**	**2016 status**	**Recommended actions**	**Comments**
British Columbia	Excellent	Good	Implement a province-wide ban on smoking in outdoor public places to complement existing municipal bans.	The CPS credits municipalities that have banned smoking in recreational spaces, parks, beaches and publicly owned sports fields.
Alberta	Good	Fair	Implement a province-wide ban on smoking in outdoor public places to complement existing municipal bans. Implement legislation on e-cigarettes.	Alberta banned flavoured tobacco products in 2015. The CPS credits municipalities that have banned smoking in recreational spaces, parks, beaches, and publicly owned sports fields.
Saskatchewan	Excellent	Fair	Implement a province-wide ban on smoking in outdoor public places to complement existing municipal bans. Implement legislation on e-cigarettes and flavoured tobacco products.	The CPS credits municipalities that have banned smoking in recreational spaces, parks, beaches and publicly owned sports fields.
Manitoba	Excellent	Good	Implement a province-wide ban on smoking on outdoor restaurant patios.	Manitoba has banned smoking in provincial park beaches and playgrounds. The CPS credits municipalities that have banned smoking on outdoor restaurant patios.
Ontario	Excellent	Excellent	Meets all CPS recommendations.	
Quebec	Good	Excellent	Meets all CPS recommendations.	
New Brunswick	Excellent	Excellent	Meets all CPS recommendations.	
Nova Scotia	Excellent	Good	Implement a province-wide ban on smoking in outdoor public places.	Nova Scotia prohibits smoking on outdoor licensed areas and patios. The CPS credits municipalities that have banned smoking in recreational spaces, parks, beaches and publicly owned sports fields.
Prince Edward Island	Excellent	Good	Implement a province-wide ban on smoking in outdoor public places, including a full ban on smoking on outdoor restaurant patios.	PEI prohibits smoking on restaurant patios during certain hours of operation only.
Newfoundland and Labrador	Excellent	Fair	Implement a province-wide ban on smoking in outdoor public places to complement existing municipal bans. Implement legislation on e-cigarettes and flavoured tobacco products.	The CPS credits the more than 85 municipalities and cities that have banned smoking in recreational spaces, parks, beaches and publicly owned sports fields. E-cigarette legislation is in development.
Yukon	Excellent	Fair	Implement a province-wide ban on smoking in outdoor public places. Implement legislation on e-cigarettes and flavoured tobacco products.	Yukon prohibits smoking on outdoor licensed areas and patios.
Northwest Territories	Good	Poor	Implement legislation on smoking in cars with minors present. Implement a province-wide ban on smoking in outdoor public places. Implement legislation on e-cigarettes and flavoured tobacco products.	
Nunavut	Good	Poor	Implement legislation on smoking in cars with minors present. Implement a province-wide ban on smoking in outdoor public places. Implement legislation on e-cigarettes and flavoured tobacco products.	

* Outdoor spaces should include playgrounds and publicly owned sports fields and surfaces, or anywhere within 20 metres of such an area.

Health Promotion

Breastfeeding promotion
(As per the WHO's Baby-friendly Initiative [BFI])

Breastfeeding is uniquely beneficial in many ways, not least as an effective preventative health measure for both mothers and babies.[16] Except in very few specific circumstances, breastfeeding should be universally encouraged.

To improve worldwide breastfeeding initiation and duration rates, the World Health Organization (WHO) and UNICEF launched the Baby-Friendly Initiative (BFI) in 1991, the cornerstone of which is the Ten Steps to Successful Breastfeeding. Since then, more than 21,000 hospitals in 156 countries have acquired "baby-friendly" status, and breastfeeding initiation and duration have both increased.[17] As of March 2016, Canada reported having 114 BFI-designated facilities (hospitals and community health services) – with the majority in Ontario (23) and Quebec (86).[18]

Health care practitioners are ideally qualified to promote and support breastfeeding. Partnering with the BFI, a global, evidence-based, institutional framework for protecting, promoting and supporting breastfeeding, could vastly improve breastfeeding practice and outcomes for mothers and babies in Canada.[19] Leadership from each province and territory is essential to ensure implementation of the BFI in all health care facilities delivering services to babies and mothers.

The Canadian Paediatric Society recommends that governments implement a BFI policy or strategy, with a designated coordinator and breastfeeding education for all health care providers, managers and volunteers working in hospitals and community services that care for mothers and babies. Provinces and territories should also: develop incentives to encourage and support BFI certification; track breastfeeding practices, especially initiation, duration and exclusivity rates; provide easily accessible supportive services, such as lactation consults in person or by phone/email, and provide pasteurized human milk banking for sick or premature infants.[20]

Excellent: Province/territory:
- Has implemented a BFI policy or strategy, with a designated BFI coordinator and a breastfeeding education strategy for all health care providers, managers and volunteers working in hospitals and community services that care for mothers and babies.
- Provides incentives that encourage and support health facilities to become BFI-certified.
- Tracks breastfeeding initiation, duration and exclusivity rates.
- Provides free access to lactation consultants in person or by phone/email.
- Provides access to banked pasteurized human milk for sick and premature infants.

Good: Province/territory has 3 or 4 of the above components in place.

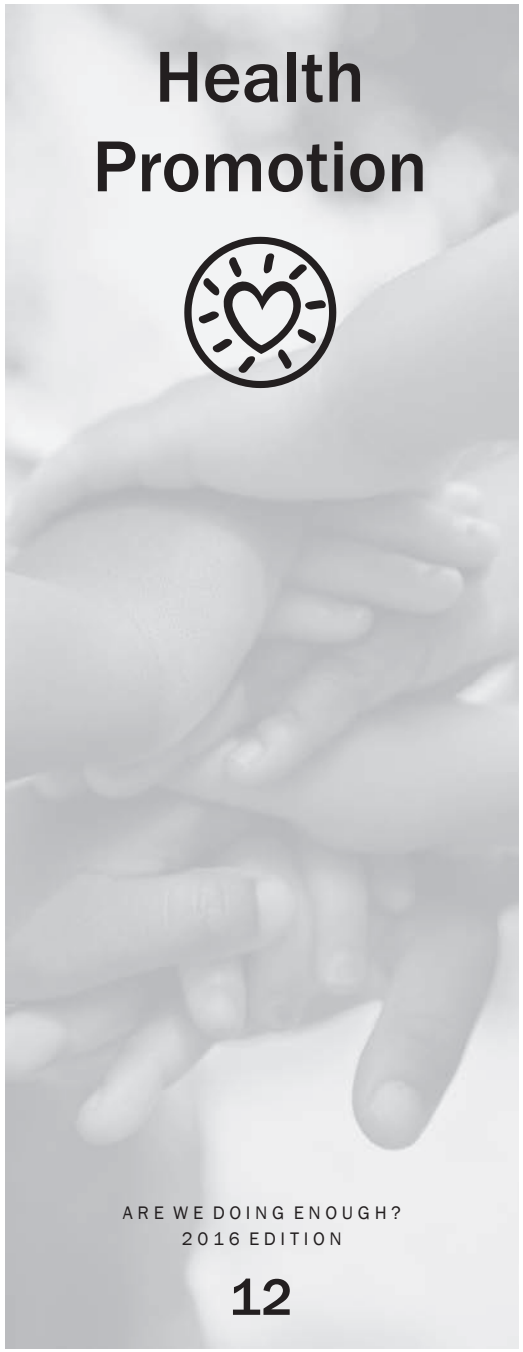
Fair: Province/territory has 1 or 2 of the above components in place.

Poor: Province has none of the criteria specified above in place.

Breastfeeding promotion (not assessed in 2012)

Province/Territory	2016 status	Recommended actions	Comments
British Columbia	Good	Provide incentives that encourage and support health facilities to become BFI-certified.	British Columbia has two facilities due for BFI redesignation. Facilities do not receive funding incentives from government to become BFI-certified.
Alberta	Good	Implement a BFI policy or strategy, with a designated BFI coordinator and a breastfeeding education strategy. Track breastfeeding initiation, duration and exclusivity rates.	Alberta has a milk bank, though it is not government-funded. Revenue comes from hospitals and health centres that use banked milk as well as from granting agencies and corporate and private sponsorship.
Saskatchewan	Fair	Implement a BFI policy or strategy, with a designated BFI coordinator and a breastfeeding education strategy. Provide incentives that encourage and support health facilities to become BFI-certified. Track breastfeeding initiation, duration and exclusivity rates.	Saskatchewan has one community BFI-designated facility. Saskatchewan sends donor milk to the NorthernStar Mothers Milk Bank in Calgary. NICUs in Regina and Saskatoon offer donor milk to sick and premature infants but at a cost to the regional health authority.
Manitoba	Excellent	Meets all CPS recommendations.	Strategy aims to establish a milk bank and specific targets for BFI facilities by 2018. Manitoba has two BFI-designated facilities.
Ontario	Excellent	Meets all CPS recommendations.	The province should consider developing milk depots and should continue to support the The Rogers Hixon Ontario Human Donor Milk Bank.
Quebec	Good	Provide incentives that encourage and support health facilities to become BFI-certified.	Province does not offer logistical or financial incentives to institutions that become BFI-certified. Due to a lack of lactation consultants, access is limited in many areas and they are often not accessible in a timely fashion.
New Brunswick	Fair	Provide incentives that encourage and support health facilities to become BFI-certified. Track breastfeeding initiation, duration and exclusivity rates. Provide access to banked pasteurized human milk for sick and premature infants.	Province tracks breastfeeding initiation and exclusivity at hospital discharge and is working on a process to capture duration rates.
Nova Scotia	Good	Provide incentives that encourage and support health facilities to become BFI-certified. Provide free province-wide access to lactation consultants in person or by phone/email.	Breast milk donated in Halifax is shipped to the NorthernStar Mothers Milk Bank in Calgary and sent back to IWK Health Centre as needed (at the Centre's expense). A pilot project is underway to measure breastfeeding duration.
Prince Edward Island	Poor	Implement a BFI policy or strategy, with a designated BFI coordinator and a breastfeeding education strategy. Provide incentives that encourage and support health facilities to become BFI-certified. Track breastfeeding initiation, duration and exclusivity rates. Provide free province-wide access to lactation consultants in person or by phone/email. Provide access to banked pasteurized human milk for sick and premature infants.	
Newfoundland and Labrador	Good	Provide incentives that encourage and support health facilities to become BFI-certified. Provide access to banked pasteurized human milk for sick and premature infants.	Initiation and exclusivity rates are tracked by the Perinatal Program NL. The provincial government is working with public health nurses to improve access to data on duration rates from the Client Referral Management System.
Yukon	Fair	Implement a BFI policy or strategy, with a designated BFI coordinator and a breastfeeding education strategy. Provide incentives that encourage and support health facilities to become BFI-certified. Track breastfeeding initiation, duration and exclusivity rates. Provide free province-wide access to lactation consultants in person or by phone/email.	There is only one level-4 nursery in the territory. All sick or premature infants are transported out of the territory to sites that offer banked breast milk. No BFI initiative has been implemented but the Whitehorse General Hospital has a breastfeeding policy.
Northwest Territories	Fair	Implement a BFI policy or strategy, with a designated BFI coordinator. Track breastfeeding initiation, duration and exclusivity rates. Provide access to banked pasteurized human milk for sick and premature infants.	NWT Supports Breastfeeding – a government program – provides education to mothers, families and health professionals.
Nunavut	Fair	Implement a BFI policy or strategy, with a designated BFI coordinator and a breastfeeding education strategy. Provide incentives that encourage and support health facilities to become BFI-certified. Track breastfeeding initiation, duration and exclusivity rates. Provide free province-wide access to lactation consultants in person or by phone/email.	All sick or premature infants are transported out of the territory to sites that offer banked breast milk.

Health Promotion



Newborn hearing screening

Permanent hearing loss is one of the most common congenital disorders of childhood, occurring in about two per 1,000 live births. Universal newborn hearing screening (UNHS) leads to earlier diagnosis and intervention, which means better outcomes for children with a hearing impairment.[21]

Without screening, children with hearing loss are typically not diagnosed until they reach 2 years of age, with mild and moderate hearing losses often going undetected until children are in school. Universal screening would detect most infants with hearing loss by the time they are 3 months old, with an intervention started by 6 months of age.

Children with hearing loss who are not supported by early intervention can experience irreversible shortfalls in communication and psychosocial skills, cognition and literacy. Deafness can lead to lower academic achievement, underemployment, difficulty with social adaptation and psychological distress later on. Such effects are directly proportional to the severity of hearing loss and the time lag between diagnosis and intervention. Evidence shows that infants with hearing impairments who are diagnosed and receive intervention before 6 months of age score 20 to 40 percentile points higher on school-related measures (language, social adjustment and behaviour) compared with children who receive intervention later.

The two-step screening procedure implemented by most UNHS programs is highly efficient and cost-effective, particularly considering the lifetime costs of deafness. The Canadian Paediatric Society recommends that provinces and territories provide UNHS for all infants via a fully funded, integrated program that ensures: all babies are screened by 1 month, diagnoses are confirmed by 3 months and interventions are in place by 6 months of age.

Excellent: Province/territory has a fully funded, integrated screening program, with all babies screened by 1 month of age, diagnoses confirmed by 3 months, and interventions in place by 6 months.

Fair: Province/territory has a partial program. Testing is provided selectively (e.g., in neonatal intensive care units to infants at risk for hearing loss) or supportive services are limited by geography.

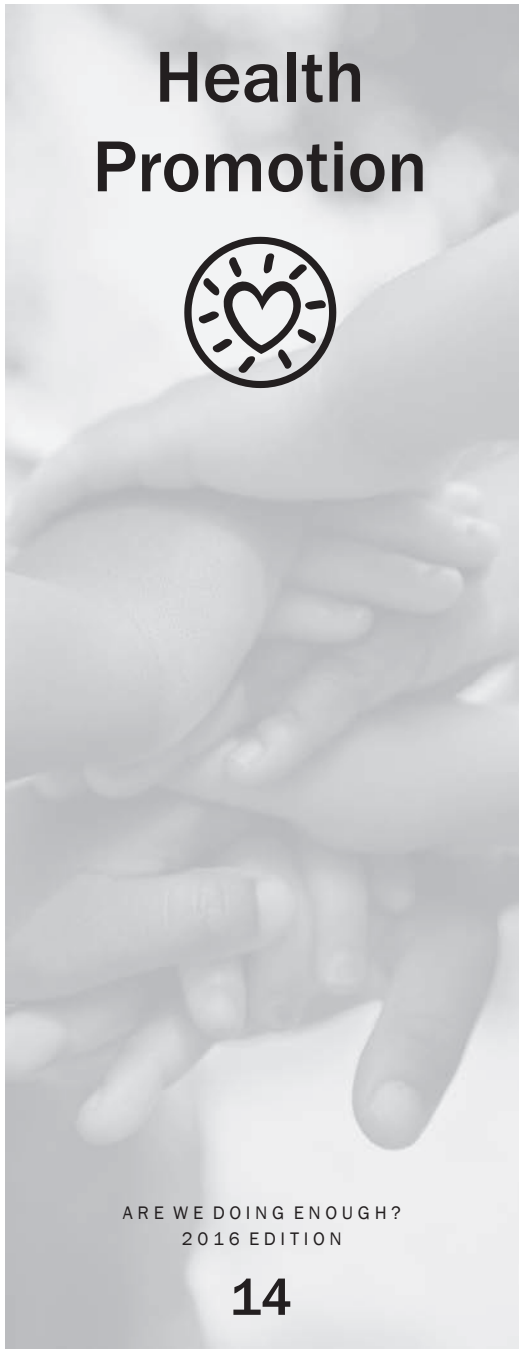
Poor: Province/territory does not offer newborn hearing screening.

Newborn hearing screening

Province/Territory	2012 status	2016 status	Recommended actions	Comments
British Columbia	Excellent	Excellent	Meets all CPS recommendations.	
Alberta	Fair	Fair	Implement a universal newborn hearing screening and intervention program.	A province-wide early hearing detection and intervention program is in development, with full implementation slated for 2017.
Saskatchewan	Fair	Poor	Implement a universal newborn hearing screening and intervention program.	Only the Saskatoon Health Region has a universal hearing screening program.
Manitoba	Poor	Excellent	Meets all CPS recommendations.	*The Universal Newborn Hearing Screening Act* received Royal Assent and the Universal Hearing Screening Program goes into effect on September 1, 2016.
Ontario	Excellent	Excellent	Meets all CPS recommendations.	
Quebec	Good	Fair*	Implement a universal newborn hearing screening and intervention program.	The CPS recognizes that a pilot project announced in 2009 is ongoing with intensive program development to this point. There is concern, however, that full implementation has been delayed due to underfunding.
New Brunswick	Excellent	Excellent	Meets all CPS recommendations.	
Nova Scotia	Excellent	Excellent	Meets all CPS recommendations.	
Prince Edward Island	Excellent	Excellent	Meets all CPS recommendations.	
Newfoundland and Labrador	Fair	Fair	Implement a universal newborn hearing screening and intervention program.	
Yukon	Good	Fair*	Implement a universal newborn hearing screening and intervention program.	While a standardized, fully accessible system is not in place, the CPS recognizes that because most births occur in Whitehorse, nearly 90% of infants are screened. Also, each community health centre has access to newborn hearing screening equipment. The CPS appreciates that retaining clinicians is an ongoing challenge.
Northwest Territories	Good	Fair*	Implement a universal newborn hearing screening and intervention program.	The CPS appreciates that having a scattered population and limited access to centralized testing and corrective services pose significant challenges. There are birthing centres in Inuvik, Hay River and Fort Smith, but audiology services are only available in Yellowknife.
Nunavut	Poor	Poor	Implement a universal newborn hearing screening and intervention program.	The CPS appreciates that having a scattered population and limited access to centralized testing and corrective services pose significant challenges.

* For provinces or territories that have gone from "Good" to "Fair", this does not mean legislation has regressed. Rather, the "Good" indicator from the previous status report no longer exists. The indicators have been compressed into three.

Health Promotion



An enhanced 18-month well-baby visit

With our better understanding of the links between early child development and later health and well-being, well-baby visits are now recognized as key opportunities to assess growth and positively affect life outcomes. For some families, the 18-month visit might be the last regularly scheduled visit with a primary care provider before a child enters school. This visit is a critical opportunity to examine and evaluate a child's progress, to help parents nurture their child's development, and to identify areas where there may be some difficulty. It is also a time to introduce parents to community resources and supports.

Well-baby visits focus on immunization and identifying abnormalities, but the 18-month check-up can also be a pivotal assessment of developmental health. Not only does it happen at an important point in a child's development, it comes at a stage when families are dealing with formative issues such as child care, behaviour management, nutrition/eating patterns, and sleep. The 18-month assessment is an excellent opportunity to counsel and reinforce healthy behaviours, and to promote positive parenting, injury prevention and literacy. Screening for parental health issues, including mental health, domestic abuse and substance misuse can also take place at this visit.

The Canadian Paediatric Society supports a stronger system of early childhood development and care across Canada and recommends that all provinces and territories establish an enhanced well-baby visit with standard guidelines. A standardized developmental surveillance tool and a clinician-prompt health guide with evidence-based suggestions for healthier development should be used.[22] In provinces/ territories where this enhanced visit is conducted by fee-for-service physicians, they should have access to office-based tools and a special fee code.

Excellent: Province/territory has initiated an enhanced well-baby visit at 18 months, with standard guidelines. In provinces and territories where this enhanced visit is conducted by fee-for-service physicians, they have access to office-based tools and a special fee code.

Poor: Province/territory has not initiated an enhanced well-baby visit at 18 months.

An enhanced 18-month well-baby visit				
Province/Territory	**2012 status**	**2016 status**	**Recommended actions**	**Comments**
British Columbia	Poor	Poor	Initiate an enhanced well-baby visit at 18 months, with standard guidelines. If the visit is conducted by fee-for-service physicians, they should have access to office-based tools and a special fee code.	
Alberta	Poor	Poor	Initiate an enhanced well-baby visit at 18 months, with standard guidelines. If the visit is conducted by fee-for-service physicians, they should have access to office-based tools and a special fee code.	
Saskatchewan	Poor	Excellent	Meets all CPS recommendations.	Public Health recently implemented an enhanced 18-month assessment in child health clinics, where 18-month immunizations are administered.
Manitoba	Poor	Poor	Initiate an enhanced well-baby visit at 18 months, with standard guidelines. If the visit is conducted by fee-for-service physicians, they should have access to office-based tools and a special fee code.	
Ontario	Excellent	Excellent	Meets all CPS recommendations.	
Quebec	Poor	Poor	Initiate an enhanced well-baby visit at 18 months, with standard guidelines. If the visit is conducted by fee-for-service physicians, they should have access to office-based tools and a special fee code.	
New Brunswick	Poor	Excellent	Meets all CPS recommendations.	
Nova Scotia	Poor	Poor	Initiate an enhanced well-baby visit at 18 months, with standard guidelines. If the visit is conducted by fee-for-service physicians, they should have access to office-based tools and a special fee code.	
Prince Edward Island	Poor	Excellent	Meets all CPS recommendations.	
Newfoundland and Labrador	Poor	Excellent	Meets all CPS recommendations.	
Yukon	Poor	Excellent	Meets all CPS recommendations.	
Northwest Territories	Poor	Excellent	Meets all CPS recommendations.	The “Well Child Record” is relatively new to health centres, and education to manage the referral process is ongoing. The CPS will be looking for progress toward full implementation.
Nunavut	Poor	Excellent	Meets all CPS recommendations.	

Injury Prevention

Bicycle helmet legislation

Bicycling is a popular activity and a healthy, environmentally friendly form of transportation. However, bicycling is also a leading cause of injuries in children and adolescents, with risk of head injuries being particularly serious. While current injury data is lacking, hospital statistics from a few years ago clearly support the enactment of helmet legislation in many provinces/territories. According to 2009-10 statistics, about 20 young people aged 19 and under die from bicycle-related injuries each year in Canada, while another 50 or so experience permanent disability.[23] Approximately 700 children and youth are hospitalized annually for serious bicycle injuries.[24] The impact of head injuries is often lifelong, with the risk of learning impairment, developmental delay and behavioural challenges as common effects.[25]

Most injuries sustained by children and youth are both predictable and preventable, so there is every reason for governments to legislate proactively. Research shows that more people choose to wear helmets where mandatory bike helmet laws are in effect and that injury rates are about 25% lower than in areas without legislation.[26] Nevertheless, five provinces/territories in Canada still do not have bicycle helmet legislation.

One Cochrane review showed that helmets reduce the risk of head and brain injuries by about 69%, severe brain injuries by 74% and facial injuries by 65%.[27] If every cyclist wore a properly fitted helmet, about 4 out of every 5 head injuries could be prevented.[28] Yet among youth 12 to 17 years of age, only 37.5% said they always wore a bicycle helmet when riding.[29] Up to 70% of deaths occur in boys aged 10 to 19.[30] Emotional costs aside, it is estimated that every $1 invested in bicycle helmets saves $29 in injury costs.[31]

The Canadian Paediatric Society continues to advocate for the mandatory use of Canadian Standards Association-approved bicycle helmets for riders of all ages. Legislation must be accompanied by enforcement, and school- and community-based education programs must reinforce helmet use. The evidence suggests that even legislation without significant enforcement increases use temporarily – for a few years, at least after implementation – but sustained effectiveness requires ongoing enforcement and promotion.[32]

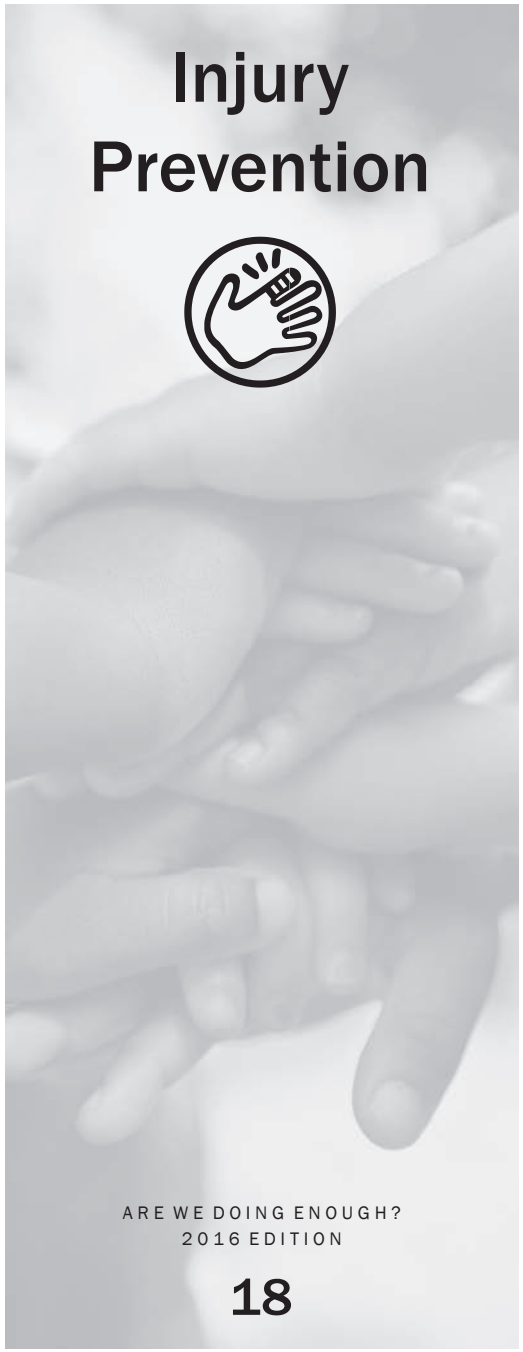
Excellent: Province/territory requires all cyclists to wear helmets, with financial penalties for non-compliance. Parents are responsible for ensuring their child wears a helmet.

Good: Province/territory requires all cyclists younger than 18 years of age to wear a helmet.

Poor: Province/territory has no bike helmet legislation.

Bicycle helmet legislation				
Province/Territory	**2012 status**	**2016 status**	**Recommended actions**	**Comments**
British Columbia	Excellent	Excellent	Meets all CPS recommendations.	
Alberta	Good	Good	Amend current legislation to include all age groups.	
Saskatchewan	Poor	Poor	Enact legislation that requires all age groups to wear helmets.	Education programs are available.
Manitoba	Poor	Good	Amend current legislation to include all age groups.	
Ontario	Good	Good	Amend current legislation to include all age groups.	
Quebec	Poor	Poor	Enact legislation that requires all age groups to wear helmets.	Education programs are available.
New Brunswick	Excellent	Excellent	Meets all CPS recommendations.	
Nova Scotia	Excellent	Excellent	Meets all CPS recommendations.	
Prince Edward Island	Excellent	Excellent	Meets all CPS recommendations.	
Newfoundland and Labrador	Poor	Excellent	Meets all CPS recommendations.	
Yukon	Poor	Poor	Enact legislation that requires all age groups to wear helmets.	Whitehorse has an all-ages helmet by-law.
Northwest Territories	Poor	Poor	Enact legislation that requires all age groups to wear helmets.	Inuvik has an all-ages helmet by-law. Yellowknife has a helmet by-law for children and youth younger than 18 years old.
Nunavut	Poor	Poor	Enact legislation that requires all age groups to wear helmets.	

Injury Prevention



Booster seat legislation

Motor vehicle collisions are the leading cause of unintentional injury deaths in children over a year old in Canada.[33] In 2013, more than 70 children under the age of 14 were killed and more than 8,900 were injured in car crashes in Canada.[34] Booster seats provide up to 60% more protection than seat belts alone.[35]

Although all provinces and territories have laws requiring the use of restraint systems for children up to about 4 years old, children aged 4 to 8 years often "graduate" prematurely to using seat belts, increasing their risk of injury, disability and death. In a collision, children using seat belts instead of booster seats are 3.5 times more likely to suffer a serious injury and 4 times more likely to suffer a head injury.[36]

According to one U.S. study, in states where the age requirement for booster seats (or harnessed child restraints) was increased to 7 or 8 years old, the rate of children who sustained fatal or incapacitating injuries in a collision decreased by 17%.[37]

Based on strong evidence, the Canadian Paediatric Society recommends that provinces and territories require children in vehicles to use an approved booster seat until they reach 145 cm in height or 9 years of age, and weigh between 18 kg and 36 kg. Legislation should be uniform across Canada to make it easier for families to comply with regulations when travelling.[38] The CPS also recommends using community-based education programs to increase restraint use. Such programs help ensure that car and booster seats are properly installed and used.[39]

Excellent:	Province/territory requires children to be in an approved booster seat until they reach 145 cm in height ***or*** 9 years of age ***and*** weigh between 18 kg and 36 kg. Public education programs are in place.
Good:	Province/territory requires children to be in an approved booster seat until they reach the height of 145 cm ***or*** a specified age younger than 9 years ***and*** a weight between 18 kg and 22 kg. Public education programs are in place.
Fair:	Province/territory requires the use of a booster seat after children have outgrown their front-facing safety seat, but legislation is based on age and/or weight criteria without mentioning height. Public education programs are in place.
Poor:	Province/territory has no booster seat legislation for children weighing over 18 kg.

Booster seat legislation				
Province/Territory	**2012 status**	**2016 status**	**Recommended actions**	**Comments**
British Columbia	Excellent	Excellent	Meets all CPS recommendations.	
Alberta	Poor	Poor	Enact booster seat legislation.	The Alberta Government and Alberta Health Services recognize booster seats as the safest choice for children under 9 years old who have outgrown their forward-facing child safety seat, and weigh between 18 kg and 36 kg or are less than 145 cm tall, but it is not legislated.
Saskatchewan	Poor	Excellent	Meets all CPS recommendations.	
Manitoba	Fair	Excellent	Meets all CPS recommendations.	
Ontario	Excellent	Excellent	Meets all CPS recommendations.	
Quebec	Good	Excellent	Meets all CPS recommendations.	
New Brunswick	Excellent	Excellent	Meets all CPS recommendations.	
Nova Scotia	Excellent	Excellent	Meets all CPS recommendations.	
Prince Edward Island	Excellent	Excellent	Meets all CPS recommendations.	
Newfoundland and Labrador	Excellent	Excellent	Meets all CPS recommendations.	
Yukon	Fair	Good	Require children to be in an approved booster seat until they reach 145 cm in height ***or*** 9 years of age ***and*** weigh between 18 kg and 36 kg.	
Northwest Territories	Poor	Poor	Enact booster seat legislation.	Government website provides advice on child occupant restraints with heights/weights according to CPS recommendations, but there is no legislation.
Nunavut	Poor	Poor	Enact booster seat legislation.	The CPS recognizes that few people own cars in Nunavut.

Injury Prevention

Off-road vehicle safety legislation
(All-terrain vehicles and snowmobiles)

All-terrain vehicles (ATVs) and snowmobiles are widely used in rural Canada for recreation, work and transportation. The popularity of off-road vehicles, particularly ATVs, has increased significantly over the past 20 years, along with the number of severe ATV-related injuries and deaths, particularly among children and youth. Between 2001 and 2010, hospitalization for injuries involving an ATV increased by 31%.[40] Off-road vehicles are especially dangerous when operated by children and young adolescents. They tend to take more risks and lack the experience, physical size and strength, and cognitive and motor skills to operate these vehicles safely.

In Canada, snowmobiling has one of the highest rates of serious injury of any popular winter sport, with most injuries occurring among youth.[41]

According to Parachute's *Cost of Injury in Canada* report, 33 children and youth younger than 19 years of age died in 2010 alone due to off-road vehicle activities, while 1,019 were hospitalized.[42] The total economic burden for ATV and snowmobile injuries in this age group was nearly $150 million dollars.[43]

Surveys conducted in the U.S. and Canada also show that youth rarely follow best practices for ATV use. Less than 50% and possibly as few as 24% of respondents wore helmets consistently, and less than one-quarter reported taking a safety training course.[44] There is little evidence that youth-sized vehicles with limited speed capacity are any safer than full-sized models. The risk to a child or teen operating a 'youth model' ATV is still almost twice as high as that for an adult on a larger machine.

Addressing off-road vehicle safety is culturally and logistically challenging. Legislation, sustained enforcement, engineering modifications and public education are all required. One year after Nova Scotia restricted children younger than 14 years of age from operating ATVs, related injuries in that age group declined by one-half.[45] Yet injury rates have increased to almost pre-legislation levels in recent years, suggesting that policies to restrict children from using ATVs have limited long-term impact. Future preventive strategies should also include engineering modifications to improve vehicle safety.[46]

The Canadian Paediatric Society urges provincial and territorial governments to introduce and enforce off-road vehicle legislation. Children younger than 16 years of age should not be permitted to operate off-road vehicles. Driver education and helmet use should be mandatory.[47] [48]

Excellent:	Province/territory bans off-road vehicle operation for children/youth under 16 years old. Safety training and helmet use are mandatory.
Good:	Province/territory bans off-road vehicle operation for children under 14 years old. Safety training and helmet use are mandatory.
Fair:	Province/territory requires adult supervision of children/youth under 15 years old, and restricts where youth under 16 years can operate an off-road vehicle. Helmet use is mandatory.
Poor:	Province/territory has no off-road vehicle legislation, or the minimum operating age is under 14 years old.

Off-road vehicle safety legislation (All-terrain vehicles and snowmobiles)

Province/Territory	2012 status		2016 status	Recommended actions	Comments
	ATVs	Snowmobiles			
British Columbia	Fair	Poor	Fair	Prohibit off-road vehicle operation for children/youth under 16 years old. Institute mandatory safety training.	
Alberta	Poor	Poor	Poor	Prohibit off-road vehicle operation for children/youth under 16 years old. Make helmet use and safety training mandatory.	
Saskatchewan	Fair	Good	Good	Prohibit off-road vehicle operation for children/youth under 16 years old.	
Manitoba	Fair	Fair	Fair	Prohibit off-road vehicle operation for children/youth under 16 years old. Institute mandatory safety training.	
Ontario	Fair	Fair	Fair	Prohibit off-road vehicle operation for children/youth under 16 years old. Institute mandatory safety training.	
Quebec	Good	Excellent	Excellent	Meets all CPS recommendations.	
New Brunswick	Fair	Good	Good	Prohibit off-road vehicle operation for children/youth under 16 years old.	
Nova Scotia	Fair	Good	Good	Prohibit off-road vehicle operation – including snowmobiles – for children/youth under 16 years old on both public and private lands.	
Prince Edward Island	Fair	Good	Good	Prohibit off-road vehicle operation for children/youth under 16 years old.	
Newfoundland and Labrador	Good	Fair	Fair	Prohibit off-road vehicle operation for children/youth under 16 years old rather than 14 years – the current age limit. Institute mandatory safety training.	
Yukon	Poor	Fair	Fair	Prohibit off-road vehicle operation for children/youth under 16 years old. Institute mandatory safety training. Make helmet use mandatory for all ages and on all terrains.	The CPS credits Whitehorse for having stricter regulations.
Northwest Territories	Fair	Fair	Fair	Prohibit off-road vehicle operation for children/youth under 16 years old. Institute mandatory safety training.	
Nunavut	Fair	Fair	Fair	Prohibit off-road vehicle operation for children/youth under 16 years old. Institute mandatory safety training.	

Best Interests of Children and Youth

Child and youth death review

The death of a child is a tragic event and perhaps all the more so when it could have been prevented. Major causes of death in childhood and adolescence in Canada include sudden death in infancy, congenital and medical disorders, unintentional injuries, suicide, homicide, and child maltreatment.[49]

There are currently no national standards in Canada for child death investigations, data collection around the circumstances of a child's death, or death review processes. Only a few provinces have formal child death review systems. Several other jurisdictions have a child death review committee, but these groups tend only to review cases of children in foster care or whose care is overseen by an appropriate government ministry. Such committees may not have proper or consistent data collection mechanisms. The lack of standardized data makes it difficult to implement effective prevention and intervention strategies, provincially or nationwide.

To ensure evidence-informed injury prevention programs and policies, the Canadian Paediatric Society recommends that a comprehensive, structured and effective child death review program be initiated for every region in Canada. Processes should include systematic reporting and analysis of all child and youth deaths and mechanisms for evaluating the impact of case-specific recommendations.[50]

The importance of having a child death review process – including data collection – is well established in many countries. Research shows that standardized approaches have significant positive outcomes, such as effective injury prevention campaigns and legislative changes that truly safeguard the lives of children and youth.[51]

Excellent:	Province/territory has a broadly representational child death review committee* to review all child and youth deaths and a structured process, including reporting protocols, a linkable database for meaningful data collection, consolidation and dissemination, and an evaluative mechanism.
Good:	Province/territory has a child death review committee* but no reliable data or consistent data collection mechanism and/or no system to consolidate, disseminate or evaluate recommendations.
Fair:	Province/territory only reviews cases of child or youth death while in foster care or under ministerial care, or reviews other cases but has no broadly represented child death review committee. Province/territory has no reliable data or consistent tracking mechanism and/or no system to consolidate, disseminate or evaluate committee or other recommendations.
Poor:	Province/territory does not have any form of child death review.

Child and youth death review (not assessed in 2012)

Province/Territory	2016 status	Recommended actions	Comments
British Columbia	Excellent	Meets all CPS recommendations.	
Alberta	Fair	Implement a child death review committee* and a structured process to review all child and youth deaths. Process should include reporting protocols, a linkable database for meaningful data collection, consolidation and dissemination, and an evaluative mechanism.	A CDR working group in the Ministry of Health is working to establish a standardized process.
Saskatchewan	Fair	Implement a child death review committee* and a structured process to review all child and youth deaths. Process should include reporting protocols, a linkable database for meaningful data collection, consolidation and dissemination, and an evaluative mechanism.	The Office of the Chief Coroner is interested in establishing a formal, standardized review and reporting system on all child deaths. Work is underway. The CPS will monitor progress.
Manitoba	Excellent	Meets all CPS recommendations.	
Ontario	Excellent	Meets all CPS recommendations.	Ontario reviews deaths that fall under the *Coroners Act*, including all deaths of children under 5 years of age, as well as all deaths of children under 19 years of age with involvement of a Children's Aid Society within 12 months of their death. Ontario is working toward a review system that can use aggregate data from *all* child deaths for prevention-focused work.
Quebec	Good	Implement a structured process, including reporting protocols, a linkable database for meaningful data collection, consolidation and dissemination, and an evaluative mechanism.	A formal mandate and structure are being developed.
New Brunswick	Excellent	Meets all CPS recommendations.	Province is exploring whether to review natural deaths that are not reported to Coroner Services.
Nova Scotia	Fair	Implement a broadly representational child death review committee* and a structured process to review all child and youth deaths, including reporting protocols, a linkable database for meaningful data collection, consolidation and dissemination, and an evaluative mechanism.	The Department of Community Services conducts internal reviews. The Office of the Ombudsman can also do reviews, with public reports. The Office of the Ombudsman has called for the establishment of a provincial interdepartmental team to conduct child death reviews.
Prince Edward Island	Poor	Implement a broadly representational child death review committee* and a structured process, including reporting protocols, a linkable database for meaningful data collection, consolidation and dissemination, and an evaluative mechanism.	
Newfoundland and Labrador	Excellent	Meets all CPS recommendations.	
Yukon	Fair	Implement a child-specific death review committee and a linkable database for meaningful data collection, consolidation and dissemination.	Yukon reviews all child deaths but does not have a child-specific death review committee.
Northwest Territories	Good	Implement a structured process, including reporting protocols, a linkable database for meaningful data collection, consolidation and dissemination, and an evaluative mechanism.	Coroner's Service wants to establish a formal, standardized review and reporting system. The CPS will monitor progress.
Nunavut	Fair	Implement a child death review committee* and a structured process to review all child and youth deaths – not just cases in care. Process should include reporting protocols, a linkable database for meaningful data collection, consolidation and dissemination, and an evaluative mechanism.	A death review committee is being established. The CPS will monitor progress.

* Committee includes regional chief medical examiner or coroner and representatives from law enforcement, child protection services, local public health, the crown attorney, as well as a paediatrician, family physician and/or other health care provider.

Best Interests of Children and Youth

Management of type 1 diabetes in school

About 1 in 300 children have type 1 diabetes, a chronic disease where the pancreas no longer produces insulin.[52] People with type 1 diabetes rely on injections or infusions of insulin to keep their blood sugar levels in a target range. Maintaining good control of diabetes, by minimizing low and high blood sugars, reduces the risk of short- and long-term complications.

Children younger than 5 years and early school-aged children are the fastest growing group of new type 1 diabetes diagnoses. These children need support for the daily tasks of diabetes management. Because they spend about 30 to 35 hours a week in school, ensuring that children and youth are safe and well-managed throughout the day is critical. One of the biggest concerns for children with type 1 diabetes in school is the potential for low blood sugar (hypoglycemia) which, if not treated, can rapidly lead to loss of consciousness or seizure.[53]

The Canadian Paediatric Society and the Canadian Paediatric Endocrine Group recommend that all provinces and territories establish a comprehensive policy on the management of type 1 diabetes in school, which should require schools to: develop an Individual Care Plan; identify and require at least two school personnel to be trained to provide support; ensure teachers of students with type 1 diabetes are trained to recognize and treat low blood sugar (hypoglycemia); provide a clean, safe area for diabetes self-care; provide accommodations in the event of hypoglycemia before/during an exam/test.[54] The Canadian Diabetes Association has similar guidelines.[55] [56]

Excellent:	Province/territory has a policy on the management of children and youth with type 1 diabetes in schools, consistent with recommendations from the Canadian Paediatric Society, the Canadian Paediatric Endocrine Group and the Canadian Diabetes Association. Mechanisms are in place to demonstrate that the policy is being implemented consistently and effectively across the province/territory.
Good:	Province/territory has a policy on the management of children and youth with type 1 diabetes in schools, consistent with recommendations from the Canadian Paediatric Society, the Canadian Paediatric Endocrine Group and the Canadian Diabetes Association. The policy requires the development of an Individual Care Plan and the provision of appropriately trained personnel to assist students with daily management, including insulin administration and glucagon as needed.
Fair:	Province/territory has guidelines on type 1 diabetes in elementary and secondary schools, but guidelines lack some components recommended by the CPS/CPEG and CDA, and does not provide for the administration of insulin while in school. Guidelines include provision for management of hypoglycemia, support for blood glucose checks and emergency plans.
Poor:	Province/territory has no guidelines on type 1 diabetes in elementary and secondary schools.

Management of type 1 diabetes in school (not assessed in 2012)			
Province/Territory	**2016 status**	**Recommended actions**	**Comments**
British Columbia	Good	Implement a reporting/evaluation mechanism to demonstrate consistency and effectiveness of policy.	Under BC's provincial standards for supporting students with type 1 diabetes, a template care plan is completed by Nursing Support Services with the child's parents, health team and school administrator. This care plan can be individualized to the student's needs.
Alberta	Poor	Develop comprehensive policy on managing type 1 diabetes in school, consistent with CPS/CPEG and CDA recommendations.	
Saskatchewan	Poor	Develop comprehensive policy on managing type 1 diabetes in school, consistent with CPS/CPEG and CDA recommendations.	
Manitoba	Poor	Develop comprehensive policy on managing type 1 diabetes in school, consistent with CPS/CPEG and CDA recommendations.	
Ontario	Poor	Develop comprehensive policy on managing type 1 diabetes in school, consistent with CPS/CPEG and CDA recommendations.	Ontario is currently developing a Prevalent Medical Conditions policy, which is to include diabetes.
Quebec	Good	Implement a reporting/evaluation mechanism to demonstrate consistency and effectiveness of policy.	A provincial protocol is in place for parents, school administration and school nurses. Extra support may be available when necessary through application of code 33, 'mild organ deficiency' (*déficience organique légère*).
New Brunswick	Fair	Expand guidelines to provide support for insulin administration for students who require assistance with injections or pump.	Diabetes management is recognized as an essential routine service in Policy 704 – Health Support Services, and the province has developed a *Handbook for Type 1 Diabetes Management in Schools* for school administrators and staff.
Nova Scotia	Fair	Expand guidelines to provide support for insulin administration for students who require assistance with injections or pump.	2010 guidelines call for the development of an individual care plan, with information and training for school personnel.
Prince Edward Island	Poor	Develop comprehensive policy on managing type 1 diabetes in school, consistent with CPS/CPEG and CDA recommendations.	
Newfoundland and Labrador	Fair	Expand guidelines to provide support for insulin administration for students who require assistance with injections or pump.	2014 guidelines recommend development of a Diabetes Management and Emergency Plan.
Yukon	Poor	Develop comprehensive policy on managing type 1 diabetes in school, consistent with CPS/CPEG and CDA recommendations.	
Northwest Territories	Poor	Develop comprehensive policy on managing type 1 diabetes in school, consistent with CPS/CPEG and CDA recommendations.	
Nunavut	Poor	Develop comprehensive policy on managing type 1 diabetes in school, consistent with CPS/CPEG and CDA recommendations.	

Jordan's Principle

Jordan's Principle was designed to ensure that First Nations children do not experience delays, disruptions or denials of services ordinarily available to other Canadian children. It is a child-first principle named in honour of Jordan River Anderson, a First Nations boy from Norway House, Manitoba, who was born with complex medical needs and languished in hospital while the federal and provincial governments argued over who would pay for his at-home care. Jordan died before ever spending a day in a family home.

Because responsibility for First Nations children's services is often shared among federal, provincial/territorial and First Nations governments, accessing certain services can be challenging. Funding disputes between federal and provincial governments, or between federal departments, are not uncommon, and can result in delays that unfairly affect children's health and well-being. Jordan's Principle requires the government of first contact to provide the service, and then resolve the funding issue. As such, Jordan's Principle is a mechanism to help ensure children's human, constitutional, and treaty rights.[57]

Although Jordan's Principle was passed unanimously by the House of Commons in 2007 and adopted by most provinces and territories, its implementation has been limited and inconsistent. A 2015 research report[58] found that jurisdictional confusion among provincial, territorial and federal governments still results in First Nations children being denied care, and that Jordan's Principle is not being applied.

The Jordan's Principle Working Group—which includes the Assembly of First Nations, Canadian Paediatric Society, Canadian Association of Paediatric Health Centres, UNICEF Canada, and an academic research team—has called on federal and provincial governments to work with First Nations to implement a governmental response consistent with the vision of Jordan's Principle advanced by First Nations and endorsed by the House of Commons in 2007.

The Truth and Reconciliation Commission (TRC) recognized that Jordan's Principle is critical not only to equity but also to the larger effort to redress the legacy of residential schools. The TRC called for full implementation of Jordan's Principle in its 2015 report.[59]

In a 2016 ruling,[60] the Canadian Human Rights Tribunal (CHRT) described how the federal government's narrow interpretation of Jordan's Principle—relevant only to children with complex medical conditions under the care of multiple service providers—along with complex and time-consuming processes, accounted for the government's report of no cases meeting the criteria for Jordan's Principle. It ordered the Department of Indigenous Affairs to "cease applying its narrow definition of Jordan's Principle and to take measures to immediately implement the full meaning and scope of Jordan's Principle." While focused on a case against the federal government, the CHRT ruling highlights an interpretation of Jordan's Principle shared by many provinces and territories.

Three months after the initial decision, a subsequent ruling[61] again ordered the federal government to "immediately implement" Jordan's Principle, specifically to:

- include all jurisdictional disputes, both between federal government departments as well as between the federal and provincial/territorial governments;
- include all First Nations children, not just those children with multiple disabilities;
- ensure that the government agency of first contact pay for the service without the need for policy review or case conferencing before funding is provided.

The Canadian Paediatric Society surveyed all provinces and territories about their definition of and practices around Jordan's Principle.[62] While not all provinces responded, the feedback that was received indicated significant discrepancies in the interpretation and implementation of Jordan's Principle. Along with other members of the Jordan's Principle Working Group, the CPS recommends a governmental response that is consistent with the vision of Jordan's Principle advanced by First Nations and endorsed by the House of Commons.

Jordan's Principle

Province/Territory	Highlights of provincial/territorial response to Jordan's Principle
British Columbia	No response at time of publication.
Alberta	Expressed support for Jordan's Principle in 2008, but did not describe how this works in practice.
Saskatchewan	Limits Jordan's Principle to "all First Nations children with intensive health care needs." Reports three "potential" Jordan's Principle cases as resolved through case conferencing protocol.
Manitoba	First province to announce an agreement to implement Jordan's Principle (September 2008), although no resources have been dedicated to the process. Reports that "informal case conferencing" has minimized impact of jurisdictional disputes, but did not provide the number of cases addressed in this manner.
Ontario	Applies Jordan's Principle to children with "complex medical conditions" but reports no cases to date or "any jurisdictional disputes between Canada and Ontario that have been resolved by reference to Jordan's Principle."
Quebec	No response at time of publication.
New Brunswick	Tripartite agreement (First Nations' Chiefs of New Brunswick, province, and federal government) reached in December 2011, which includes "public services" such as health care, child welfare and other social services, and special education. The document includes a dispute resolution process, as well as communications material for the public in four languages. New Brunswick reports that two potential Jordan's Principle cases were resolved.
Nova Scotia	No response at time of publication.
Prince Edward Island	No response at time of publication.
Newfoundland and Labrador	Reports that programs and services are provided by the government "consistent with Jordan's Principle while waiting for funding decisions from another source." But the province "has not implemented the jurisdictional dispute mechanism of Jordan's Principle."
Yukon	Has not formally adopted Jordan's Principle, noting "Yukon's health system funds services on a universal basis for all Yukon residents and does not distinguish between First Nation and non-FN, nor does our insured program embody a 'child-specific' lens."
Northwest Territories	Has not formally adopted Jordan's Principle, noting that "NWT has a single health and social services system that does not have separate health and social services for on-reserve First Nations children and families, and does not differentiate between the provision of any health or social service based on ethnicity."
Nunavut	The population of Nunavut is approximately 85% Inuit. "The Government of Nunavut is interested in any discussions regarding the inclusion of Inuit children under the protections of Jordan's Principle."

Federal Government Policies and Programs

Child and youth well-being is essential to a strong and prosperous country. Provincial and territorial governments play a critical policy-making role in education, health and transportation, while federal leadership can improve the public health and socio-economic well-being of Canada's youngest citizens in major ways, for the long term.

The recently elected federal government made serious policy commitments on behalf of children and youth and included several in ministerial mandate letters in the fall of 2015. Besides the landmark issues rated below, the Canadian Paediatric Society (CPS) urges the government to enact evidence-based legislation in other 'high impact' areas for children and youth: firearm safety, recreational marijuana use, access to mental health services, injury prevention strategies, and youth criminal justice system reforms.

The government's mandate is still in its early days. Because thoughtful policy change takes time, the CPS is reserving assessment – temporarily – on a number of issues contained in this report. The report's new online format will allow us to track progress and update ratings as needed over the coming months.

Immunization

Rating: Pending

Infectious diseases were once the leading cause of death in Canada but now account for less than 5% of deaths, making immunization the most cost-effective public health effort of the last century. While provincial/territorial immunization programs have clearly benefited from federal involvement, the lack of a national immunization registry is a significant gap that should be addressed at the highest levels. A registry would help increase uptake and ensure that vaccines reach all segments of the population. It would facilitate the transfer of patient immunization records across jurisdictions. It would also enhance national surveillance of vaccine-preventable diseases and help track any adverse reactions.

The CPS credits the federal government with:

- Recognizing the need to increase vaccination rates in the Health Minister's mandate letter. Federal departments should continue working closely with their provincial/territorial counterparts and allied stakeholders to increase overall national immunization rates.
- Introducing label changes for certain homeopathic products – specifically nosodes – that fall under the *Natural Health Products Regulations*.
- Investing $3.5 million over three years for ImmunizeCA (phase two), an innovative mobile app that helps Canadians keep their immunization information close at hand.

The CPS urges the federal government to work with provinces and territories to establish a national immunization registry – an important step toward providing full clinician access to *all* provincial and territorial registries.

Prevent smoking among youth

Rating: Pending

In recent years, youth have been exposed to a broader spectrum of tobacco products, including

smokeless tobacco, flavoured tobacco, water pipes and e-cigarettes, over which there is inadequate government control. The current *Tobacco Act* has not kept pace with the availability of these new products.[63] Despite national prevention strategies and legislation, thousands of teenagers become addicted to tobacco products each year and smoking rates seem to be stabilizing in Canada.[64] Proper funding and coordinated inter-jurisdictional regulation are needed to forge a comprehensive tobacco control strategy. Studies show that population-based interventions should be culturally appropriate, target particular groups (such as Indigenous or LGBTQ youth, who have higher-than-average smoking rates), and overlap environments (e.g., home and school/school and community).[65]

Positive developments at the federal level include:
- Health Canada's *Federal Tobacco Control Strategy (2012-2017)*, which has helped reduce demand for tobacco products by making smoking less affordable, less accessible and less appealing to young Canadians.
- The Health Minister's mandate letter, which introduced plain packaging requirements for tobacco products.

The CPS urges the government to:
- Initiate work on the next iteration of the *Federal Tobacco Control Strategy.* It should include strategies and policies to regulate e-cigarettes and *all* flavoured tobacco products, including menthol.
- Introduce legislation banning advertising and products aimed at youth.
- Implement and fund evidence-based smoking prevention and cessation programs.

Early learning and child care/ Early childhood development

Rating: Pending

Quality child care is a key determinant of health, development and learning in the early years. Canada has nearly 5 million children aged 0 to 12, but fewer than 990,000 regulated child care spaces.[66] Spending on child care and preschool education is low in Canada compared with other OECD nations.[67] The vast majority of families find child care expensive and difficult to access. Ensuring accessible, affordable child care for low-income families would ease their economic burden, make it easier for parents to enter the labour market, and help children learn alongside more advantaged peers.

A positive first step was including a National Early Learning and Childcare Framework in mandate letters to the Minister of Indigenous and Northern Affairs and the Minister of Families, Children and Social Development. The outline for a national child care agreement, to be used as the basis for funding agreements between federal and provincial/territorial governments, is projected for the summer of 2016.

The CPS urges the government to work closely with provinces, territories, Indigenous communities and experts in early learning to implement a national early childhood education and child care program. Quality of service should be the same wherever children live and whatever their socio-economic status or cultural origins.

Child and youth poverty

Rating: Pending

Nineteen per cent of children and fully half of status First Nations children now live below the poverty line in Canada.[68] Income and socio-economic status are prime determinants of child and youth health.[69] Federal investments are critical for reducing child poverty.

Positive developments at the federal level include:
- Introducing the Canada Child Benefit (CCB).
- The Minister of Families, Children and Social Development's mandate letter promised development of a national poverty reduction strategy and an affordable housing strategy.
- The reinstatement of the mandatory long-form census – an essential tool for tracking poverty rates in specific or marginal populations.

The CPS urges the government to develop – in consultation with provincial and territorial governments, Indigenous leadership and nongovernmental organizations – a federal action plan with targets and timelines to reduce child poverty. This plan should include an affordable housing strategy[70] and a national child care program.

Jordan's Principle

(please consult page 26 for context).

Rating: Pending

In a 2016 ruling,[71] the Canadian Human Rights Tribunal described how the federal government's narrow interpretation of Jordan's Principle—as relevant only to children with complex medical conditions under the care of multiple service providers—along with complicated and time-consuming processes, accounted for the government's report of no cases meeting the criteria for Jordan's Principle. The Tribunal ordered the Department of Indigenous and Northern Affairs to "cease applying its narrow definition of Jordan's Principle and to take measures to immediately implement the full meaning and scope of Jordan's Principle." In a response to the Tribunal dated May 10, 2016,[72] the federal government said that it had expanded the scope of Jordan's Principle, and "committed to providing the necessary resources to implement Jordan's Principle". The CPS and other advocates will continue to monitor and assess progress toward full implementation.

Commissioner for Children and Youth

Rating: Poor

Canada signed the United Nations Convention on the Rights of the Child 25 years ago, agreeing to protect and ensure children's rights.[73] That commitment also acknowledged Canada's obligation to make sure all children have opportunities to develop cognitively, physically, socio-emotionally and spiritually.[74] As yet, there is no federal child and youth advocate to hold the government accountable for this commitment. The CPS urges the government to establish this independent office to monitor the well-being of Canada's children and youth, help guide investments in future generations, and promote equitable public policies, with specific focus on Indigenous, immigrant, refugee and other marginalized groups.

Interim Federal Health Program

Rating: Excellent

The CPS commends the government for fully restoring the Interim Federal Health Program, which provides limited, temporary coverage of health care benefits to all protected persons, including resettled refugees, refugee claimants and certain other groups who are ineligible for provincial/territorial health insurance.

Recommendations of the Truth and Reconciliation Commission

Rating: Pending

The federal government has committed to implement all *94 'calls to action' framed by the Truth and Reconciliation Commission* in late 2015. What is urgently needed is an implementation plan, with roll-outs designed in partnership with Indigenous community leaders and provincial/territorial authorities.

Endnotes

1. Pekeles G; Canadian Paediatric Society. Make your voice heard: Don't let the report on child and youth health fade away. *Paediatr Child Health* 2008;13(5):363-4.

2. UNICEF Office of Research-Innocenti, 2016. Fairness for children: A league table of inequality in child well-being in rich countries (Report card 13): www.unicef-irc.org/publications/pdf/RC13_eng.pdf (page 12, accessed May 20, 2016).

3. Coyle D, Coyle K, Bettinger JA, et al. Cost effectiveness of infant vaccination for rotavirus in Canada. *Can J Infect Dis Med Microbiol* 2012;23(2):71-7.

4. Parachute Canada. Safe Cycling. http://www.parachutecanada.org/injury-topics/item/safe-cycling1 (accessed April 20, 2016).

5. Parachute. The cost of injury in Canada report, 2015: www.parachutecanada.org/downloads/research/Cost_of_Injury-2015.pdf (accessed April 20, 2016).

6. Yanchar NL, Warda LJ, Fuselli P; Canadian Paediatric Society, Injury Prevention Committee. Child and youth injury prevention: A public health approach. *Paediatr Child Health* 17(9):511.

7. Ornstein A, Bowes M, Shouldice M, Yanchar NL; Canadian Paediatric Society, Injury Prevention Committee. The importance of child and youth death review. *Paediatr Child Health* 2013;18(8):425-8.

8. Mental Health Commission of Canada, 2009. Toward recovery and well-being. A framework for a mental health strategy for Canada: www.mentalhealthcommission.ca/English/system/files/private/FNIM_Toward_Recovery_and_Well_Being_ENG_0.pdf (accessed April 20, 2016).

9. Campaign 2000. *Report Card on Child and Family Poverty in Canada*, 2015: http://www.campaign2000.ca/reportCards/2015RepCards/NationalReportCardEn2015.pdf (accessed April 20, 2016).

10. Government of Canada. Canadian Tobacco Use Monitoring Survey (CTUMS) 2012: healthycanadians.gc.ca/publications/healthy-living-vie-saine/tobacco-monitoring-survey-2012-enquete-surveillance-tabac/index-eng.php (accessed April 20, 2016).

11. Harvey J, Chadi N; Canadian Paediatric Society, Adolescent Health Committee. Preventing smoking in children and adolescents: Recommendations for practice and policy. *Paediatr Child Health* 2016;21(4):209-21.

12. Elton-Marshall T, Leatherdale ST, Burkhalter R. Tobacco, alcohol and illicit drug use among Aboriginal youth living off-reserve: Results from the Youth Smoking Survey. *CMAJ* 2011;183(8):E480-6 : www.cmaj.ca/content/early/2011/05/09/cmaj.101913.full.pdf+html (accessed April 20, 2016).

13. Ibid.

14. Government of Canada. Canadian Tobacco, Alcohol and Drugs Survey (CTADS). Summary of results for 2013: healthycanadians.gc.ca/science-research-sciences-recherches/data-donnees/ctads-ectad/summary-sommaire-2013-eng.php (accessed April 20, 2016).

15. Stanwick R; Canadian Paediatric Society. E-cigarettes: Are we renormalizing public smoking? Reversing five decades of tobacco control and revitalizing nicotine dependency in children and youth in Canada. *Paediatr Child Health* 2015;20(2):101-5.

16. American Academy of Pediatrics, Section on Breastfeeding. Breastfeeding and the use of human milk. *Pediatrics*2005;115(2):496-506.

17. Pound CM, Unger SL; Canadian Paediatric Society, Nutrition and Gastroenterology Committee. The Baby-Friendly Initiative: Protecting, promoting and supporting breastfeeding. *Paediatr Child Health* 2012;17(6):317-21.

18. Breastfeeding Committee for Canada. Baby-Friendly facilities in Canada: http://breastfeedingcanada.ca/documents/Designated%20facilities%20in%20Canada%20(November%202015).pdf (accessed April 20, 2016).

19. Pound CM, Unger SL; Canadian Paediatric Society, Nutrition and Gastroenterology Committee. The Baby-Friendly Initiative: Protecting, promoting and supporting breastfeeding. *Paediatr Child Health* 2012;17(6):317-21.

20. Ibid.

21. Patel H, Feldman M; Canadian Paediatric Society, Community Paediatrics Committee. Universal newborn hearing screening. *Paediatr Child Health* 2011;16(5):301-5.

22. Clinton J, William R; Canadian Paediatric Society, Early Years Task Force. Getting it right at 18 months: In support of an enhanced well-baby visit. Paediatr Child Health 2011;16(10):647-50.

23. Parachute. The cost of injury in Canada report, 2015: www.parachutecanada.org/downloads/research/Cost_of_Injury-2015.pdf (accessed April 20, 2016).

24. Canadian Institute for Health Information. Cycling Injury Hospitalizations in Canada, 2009–2010: https://www.cihi.ca/en/info_cycling_injury_09-10_en.pdf (accessed April 20, 2016).

25. Parachute Canada. *The Financial Costs, and Prevention Strategies of Unintentional Injuries*, January 2011: http://www.parachutecanada.org/downloads/injurytopics/PublicSectorDigestInjuryPrevention.pdf (accessed April 20, 2016).

26. 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. DOI: 0.1002/14651858.CD005401.pub2.

27. Thompson DC, Rivara FP, Thompson R. Helmets for preventing head and facial injuries in bicyclists. Cochrane Database Syst Rev 2000;(2):CD001855.

28. Parachute Canada. Helmet FAQ: http://www.parachutecanada.org/injury-topics/item/helmet-faqs (accessed April 20, 2016).

29. Statistics Canada. Canadians that wore a helmet when bicycling, by age group and frequency of use, household population aged 12 and older, 2013/2014: http://www.statcan.gc.ca/daily-quotidien/150624/t001b-eng.htm (accessed April 20, 2016).

30. SmartRisk. The economic burden of injury in Canada, 2000: www.parachutecanada.org/downloads/research/reports/EBI2009-Eng-Final.pdf (accessed April 20, 2016).

31. Parachute. The cost of injury in Canada report, 2015: www.parachutecanada.org/downloads/research/Cost_of_Injury-2015.pdf (accessed April 20, 2016).

32. Hagel BE, Yanchar NL; Canadian Paediatric Society, Injury Prevention Committee. Bicycle helmet use in Canada: The need for legislation to reduce the risk of head injury. *Paediatr Child Health* 2013;18(9):475-80.

33. Public Health Agency of Canada. Analysis of mortality data from Statistics Canada (unpublished).

34. Government of Manitoba. Booster seats and child car seats: www.gov.mb.ca/healthyliving/hlp/injury/booster.html (accessed April 20, 2016).

35. Yanchar NL, Warda LJ, Fuselli P; Canadian Paediatric Society, Injury Prevention Committee Child and youth injury prevention: A public health approach. *Paediatr Child Health* 17(9):511.

36. Winston FK, Durbin DR, Kallan MJ, Moll EK. The danger of premature graduation to seat belts for young children. *Pediatrics* 2000;105(6):1179-83.

37. Eichelberger AH, Chouinard AO, Jermakian JS. Effects of booster seat laws on injury risk among children in crashes. *Traff Inj Prev* 2012;13:631–9.

38. van Schaik C; Canadian Paediatric Society, Injury Prevention Committee. Transportation of infants and children in motor vehicles. *Paediatr Child Health* 2008;13(4):313-8.

39. Ehiri JE, Ejere HOD, Magnussen L, Emusu D, King W, Osberg SJ. Interventions for promoting booster seat use in four to eight year olds travelling in motor vehicles. Cochrane Database Syst Rev 2006; (1):CD004334.

40. Canadian Institute for Health Information, July 2011. National Trauma Registry Analysis in Brief: Summer is peak season for wheel- and water-related injuries: http://www.cihi.ca/CIHI-ext-portal/internet/en/Document/spending+and+health+workforce/spending/RELEASE_21JULY11?WT.ac=homepage_banner_20110728_e (cited July 29, 2011).

41. Canadian Institute for Health Information, 2012. Number of hospitalizations due to winter sports and recreational activities, by cause and fiscal year, 2006-2007 to 2010-2011: www.cihi.ca/en/types-of-care/specialized-services/trauma-and-injuries/more-than-5600-canadians-seriously-injured (accessed April 20, 2016).

42. Parachute. The cost of injury in Canada report, 2015: www.parachutecanada.org/downloads/research/Cost_of_Injury-2015.pdf (accessed April 20, 2016).

43. Ibid.

44. Yanchar NL; Canadian Paediatric Society, Injury Prevention Committee. Preventing injuries from all-terrain vehicles: www.cps.ca/documents/position/preventing-injury-from-atvs (accessed April 20, 2016).

45. Parachute. All-terrain vehicle safety: www.parachutecanada.org/injury-topics/item/all-terrain-vehicle-safety (accessed April 20, 2016).

46. Jessula S, Murphy N, Yanchar NL. Injury severity in pediatric all-terrain-vehicle related trauma in Nova Scotia. *Journal of Pediatric Surgery* 2016, submitted.

47. Yanchar NL; Canadian Paediatric Society, Injury Prevention Committee. Preventing injuries from all-terrain vehicles:www.cps.ca/documents/position/preventing-injury-from-atvs (accessed April 20, 2016).

48. Stanwick R; Canadian Paediatric Society, Injury Prevention Committee. Recommendations for snowmobile safety. *Paediatr Child Health* 2004;9(9):639-42.

49. Ornstein A, Bowes M, Shouldice M, Yanchar NL; Canadian Paediatric Society, Injury Prevention The importance of child and youth death review. *Paediatr Child Health* 2013;18(8):425-8.

50. Ibid.

51. Sidebotham P, Pearson G. Responding to and learning from childhood deaths. *BMJ* 2009;338:b531.

52. Lawrence SE, Cummings A, Pacaud D, Lynk A, Metzger DL; Canadian Paediatric Society; Canadian Pediatric Endocrine Group. Managing type 1 diabetes in school: Recommendations for policy and practice. *Paediatr Child Health* 2015;20(1):35-39.

53. Ibid.

54. Ibid.

55. Canadian Diabetes Association, 2014. *Guidelines for the care of students living with diabetes at school*: www.diabetes.ca/getmedia/173678f6-1a4a-4237-bd55-aa7ba469a602/guidelines-for-students-in-school.pdf.aspx (accessed April 20, 2016).

56. Canadian Diabetes Association. Position on students living with diabetes at school, 2014: www.diabetes.ca/about-cda/public-policy-position-statements/students-living-with-diabetes-at-school (accessed April 20, 2016).

57. The Jordan's Principle Working Group, 2015. Without denial, delay, or disruption: Ensuring First Nations children's access to equitable services through Jordan's Principle. Ottawa, Ont.: Assembly of First Nations: http://www.afn.ca/uploads/files/jordans_principle-report.pdf (accessed May 20, 2016).

58. Ibid.

59. Truth and Reconciliation Commission, 2015. Calls to Action. Winnipeg, Man.: Truth and Reconciliation Commission.

60. First Nations Child and Family Caring Society of Canada et al. v. Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada), Canadian Human Rights Tribunal, 2016 CHRT 2, T1340/7, January 26, 2016.

61. First Nations Child and Family Caring Society of Canada et al. v. Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada), Canadian Human Rights Tribunal, 2016 CHRT 10, T1340/7008, April 26, 2016.

62. Canadian Paediatric Society. Unpublished data, April 2016.

63. Justice Canada. Tobacco Act (S.C. 1997, c. 13): http://laws-lois.justice.gc.ca/eng/acts/T-11.5/ (accessed April 20, 2016).

64. Statistics Canada. Changes in smoking between 1994/1995 and 2004/2005, 2006/2007, 2008/2009 and 2010/2011, by sex: www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/health59-eng.htm (accessed April 20, 2016).

65. Harvey J, Chadi N; Canadian Paediatric Society, Adolescent Health Committee. Preventing smoking in children and adolescents: Recommendations for practice and policy. *Paediatr Child Health* 2016;21(4):209-21.

66. Childcare Resource and Research Unit. Early childhood education and care in Canada 2012: http://childcarecanada.org/sites/default/files/CRRU_ECEC_2012_revised_dec2013.pdf (accessed April 20, 2016).

67. The Organisation for Economic Co-operation and Development (OECD). PF3.1: Public spending on childcare and early education, 2011: www.oecd.org/els/soc/PF3_1_Public_spending_on_childcare_and_early_education.pdf (accessed April 20, 2016).

68. Campaign 2000. Report Card on Child and Family Poverty in Canada, 2015: www.campaign2000.ca/reportCards/ 2015RepCards/NationalReportCardEn2015.pdf (accessed April 20, 2016).

69. Health Council of Canada, 2010. *Stepping it up: Moving the focus from health care in Canada to a healthier Canada*: www.healthcouncilcanada.ca/tree/2.40-HCCpromoDec2010.pdf (accessed April 20, 2016).

70. Waterston S, Grueger B, Samson L; Canadian Paediatric Society, Community Paediatrics Committee. Housing need in Canada: Healthy lives start at home. *Paediatr Child Health* 2015;20(7):403-07.

71. UNICEF Canada. About the Convention on the Rights of the Child: www.unicef.ca/en/policy-advocacy-for-children/about-the-convention-on-the-rights-of-the-child (accessed April 20, 2016).

72. Department of Justice Canada. Government response: http://s3.documentcloud.org/documents/2829073/Fed-Govt-Response-to-CHRT.pdf (accessed April 20, 2016).

73. UNICEF Canada. About the Convention on the Rights of the Child: http://www.unicef.ca/en/policy-advocacy-for-children/about-the-convention-on-the-rights-of-the-child (accessed April 20, 2016).

74. UCL Institute of Health Equity, 2010. Fair Society Healthy Lives: The Marmot Review; Strategic review of health inequities in England post-2010: www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf (accessed April 20, 2016).

Acknowledgement

The Canadian Paediatric Society acknowledges, with best thanks, both the CPS Action Committee for Children and Teens (chaired by Dr. Michael Dickinson) and our Board of Directors for their guidance and careful review of this document. Thanks also to Francine Charbonneau (CPS Manager, Public Affairs) for her research and writing, Elizabeth Moreau (Director, Communications and Public Education) for her research, and to Jennie Strickland (Publications Coordinator) for copy editing.

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.

Canadian
Paediatric
Society

100–2305 St. Laurent Blvd.
Ottawa, Ont. K1G 4J8
Telephone: 613-526-9397
Fax: 613-526-3332
E-mail: info@cps.ca
Web: www.cps.ca; www.caringforkids.cps.ca; www.kidsnewtocanada.ca